Counseling for Effective Use of Family Planning

Trainer's Manual

USAID
FROM THE AMERICAN PEOPLE

the ACQUIRE project

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Preface

In the public health community at large—and among many of EngenderHealth's country and global programs in particular, including the ACQUIRE Project and Action for West Africa Region–Reproductive Health (AWARE-RH)—health workers have expressed a need for a new approach to family planning counseling. Several countries have reached a plateau in contraceptive prevalence rates, as well as having a high level of contraceptive discontinuation. These facts suggest that counseling needs to be reoriented and refocused to:

- Offer a tailored approach to meeting clients' individual needs
- Address the needs of returning clients
- Strengthen management of side effects
- Strengthen integration with other areas of sexual and reproductive health, including HIV and other sexually transmitted infections, postabortion care, and sexuality

Many colleagues in the field find existing counseling materials either outdated or insufficient in terms of family planning information and the needs of family planning clients. For this reason, the ACQUIRE Project has developed a new family planning counseling curriculum.

The curriculum builds on EngenderHealth's previous work in counseling, including *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*. At the same time, it responds to the identified gap in existing materials and fills the needs expressed by those in the field.

The intended audiences for this curriculum are service providers, their supervisors, and the managers of the programs in which they work. The counseling skills addressed here are expected to be relevant to the provision of both preventive and curative health services through the participants' national health systems. Finally, the curriculum's participatory approach to defining terms and to generating profiles of potential clients is designed to assist trainees in addressing the realities and exploring the reproductive health priorities of their communities in a culturally appropriate manner.

Acknowledgments

Counseling for Effective Use of Family Planning represents the work of many teams and country programs at EngenderHealth, the ACQUIRE Project, and AWARE–RH. It is the culmination of a process that began in 2002 with the initial development and field testing of EngenderHealth's counseling curriculum, *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*. Based on pilot tests in the field and the growing need to strengthen family planning counseling in particular, the concept for this curriculum emerged. The original concept was developed by John Pile, Jill Tabbutt, Jan Kumar, and Levent Cagatay; the latter was the lead writer and was the cofacilitator of all but one of the field tests. Subsequent field tests yielded input from the following staff and consultants: Gebeyehu Mekonnen in Ethiopia in 2002, Nirmala Selvam in Nepal in 2003, Nisreen Bitar and Huda Murad in Jordan in 2004, Nirmala Selvam in Kenya in 2006, Akif Hasanov in Azerbaijan in 2006, and 29 experienced counseling trainers representing nine countries (Azerbaijan, Bangladesh, Cameroon, Ethiopia, the Gambia, Ghana, Nepal, Sierra Leone and Tanzania), who all participated in a counseling standardization workshop in Ghana in 2007.

Over the years, internal reviewers at EngenderHealth have included Jan Kumar, Karen Beattie, Dr. Carmela Cordero, Maj-Britt Dohlie, Dr. Roy Jacobstein, Edna Jonas, Anna Kaniauskene, Erin Mielke, Feddis Mumba, John Pile, Mizanur Rahman, and Damien Wohlfahrt.

Revisions of the curriculum based on each of the field tests were written mainly by Levent Cagatay, with assistance from Edna Jonas, Erin Mielke, and Elizabeth Oliveras.

We thank our U.S. Agency for International Development reviewers, Patricia MacDonald and Carolyn Curtis.

The curriculum was edited by Sandra J. Crump and was formatted by Robert Vizzini; Michael Klitsch provided overall editorial management.

Introduction for Trainers and Program Planners

This introduction provides information to trainers and program planners about why this curriculum is needed and how it differs from other family planning (FP) counseling curricula. It also contains practical guidance on how the components of the curriculum (the Trainer's Manual, the Participant Handbook, and job aids and tools) should be used, preparations for the workshop, what to pay attention to during the workshop, and how to evaluate the workshop at different levels of impact.

Why a New FP Counseling Curriculum?

The counseling provided by an FP program plays a key role in FP uptake and continuation and is essential for ensuring informed and voluntary decision making—one of three elements comprising the fundamentals of care.[1] Yet studies conducted worldwide by the ACQUIRE Project and others have repeatedly shown that the quality of FP counseling is weak because providers' skills are inadequate. This is not surprising, since the skills-building component of training for counselors is usually kept short and sometimes is even skipped. Counseling training traditionally focuses on addressing the needs of new clients. In their effort to provide information, many providers end up giving clients too much information. The communication is usually one-way. Clients are not prepared for what side effects to expect or for what to do when those side effects occur.

This new counseling curriculum was developed to close these gaps in counseling training, by recognizing counseling as a skill and allocating sufficient classroom time for practicing skills and receiving feedback; by addressing the needs of return clients in addition to new clients; and by bringing the client perspective into training to trigger client-centered thinking and counseling.

What Is New in This FP Counseling Curriculum?

This counseling training curriculum aims to improve the knowledge, skills, and attitudes of trainees in assessing and addressing clients' FP needs through individualized counseling. Because counseling is recognized as a skill to be mastered, this curriculum puts emphasis on building counseling skills through practice and feedback. The new curriculum specifically emphasizes the individual client's circumstances and broader reproductive health (RH) needs and the importance of considering these factors when helping clients select an appropriate FP method. Appropriate selection and personalized counseling contribute to the successful use of FP methods, which contributes to personal well-being and programmatic success.

The *approach* to FP counseling training, the *content*, and the *training methods and tools* presented in this curriculum are designed to overcome some of the traditional shortcomings of FP counseling. The different emphasis of this curriculum, explained below, distinguishes it from other curricula and FP counseling training.

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[1] The ACQUIRE Project. 2006. The *fundamentals of care: Ensuring quality in facility-based services—A resource package*. New York: EngenderHealth.

Approach

This training curriculum is based on the concepts and approach used in EngenderHealth's most recent counseling training curriculum for RH, *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*, which was published in 2003. The approach has the following features:

- **It is a rights-based approach** that focuses on the client's rights to family planning services and methods and the role of the provider in supporting and protecting those rights.
- **It is holistic and integrated,** recognizing the client as a whole person with a range of interrelated sexual and reproductive health (SRH) needs. These needs include correct and appropriate information, help with decision making, and emotional support. The selection of an FP method must be made with consideration of a client's circumstances and other SRH issues, including the client's risk for HIV and other sexually transmitted infections (STIs), HIV status, reproductive intentions and pregnancy/obstetric history, and sexual relationship(s) and practices. The training curriculum emphasizes the client's needs and rights and how the decision-making process is influenced by factors both inside and outside the facility setting.
- **It is client centered,** building on the two approaches mentioned above and putting the client at the center of the counseling service and counseling training. Assessing each client's needs and tailoring counseling to address those needs is the main goal of the FP counseling service. This approach recognizes that the counseling service will need to be tailored each and every time a client is counseled. The **client profiles** (explained under *Training Methods and Tools*) help the trainees empathize with clients and see the counseling service through their clients' eyes.

Content

Categorizing Clients

Categorizing clients helps FP counselors easily recognize clients' particular needs and tailor the counseling for each client accordingly. This technique encourages counselors to use the limited time usually available for counseling in a more targeted, efficient, and useful manner. New clients often are the focus of counseling training, but it is important to distinguish between two categories of new clients as well as two categories of returning clients. The curriculum addresses the following categories of clients:

- ***New clients with a method in mind.*** For these clients, it is best to center the counseling on the particular method for which the client expresses interest, to the extent that this method meets the client's and the partner's needs and preferences.
- ***New clients with no method in mind.*** These clients need more information on all methods, with a focus on methods that would be appropriate given the client's and partner's needs and preferences.
- ***Dissatisfied return clients.*** Clients who return with questions, concerns, or problems (such as side effects) should be counseled to carefully identify the reasons for their dissatisfaction or problems. These clients need help with different options to address their particular situation. Carefully providing targeted information to these clients contributes to continued successful use of their current method or the decision to try a new method, which helps to avoid discontinuation of FP.

- ***Satisfied return clients.*** Counselors should check to see whether clients who return for a revisit or resupply are using their method correctly and if there is any change in their needs. These clients should not be overloaded with unnecessary information.

Clients can also be categorized based on their wish to space, limit, or delay births or based on recent pregnancy (postabortion, postpartum, interval). These categories help counselors tailor counseling to the needs of the individual client.

Addressing Challenges in FP Counseling

In addition to enabling FP counselors to categorize clients and better meet their needs, the curriculum and training materials focus on a number of issues that often challenge counselors, including the following:

- Handling misconceptions
- Preparing new clients for common side effects
- Helping return clients cope with side effects and other problems
- Helping clients continue using FP or switch to a new FP method

Assessing and Addressing Individual Risk for HIV and Other STIs

HIV and other STIs pose a potential risk to everyone who is sexually active, not only to those who are considered high-risk. Counselors need to recognize that monogamous housewives might be at high risk; STI prevention should be a routine part of their FP counseling. Following this curriculum, counselors learn to help clients assess their individual risk for HIV and other STIs and take action to reduce their risk, including dual protection and dual-method use.

Training Methods and Tools

The curriculum relies on a number of methods, materials, and tools to ensure transfer of training.

REDI Counseling Framework

The **rapport building, exploration, decision making,** and **implementing** (REDI) framework encourages open communication and less rigid counseling. REDI lends itself well to counseling clients from different categories (e.g., new vs. return). Unlike other counseling frameworks, REDI also addresses whether and how the client will be able to carry out the decision he or she has made.

Client Profiles

Because of the range of sensitive issues related to SRH in different countries, this curriculum uses the training participants' input to create "client profiles" that reflect the unique SRH situation in a given country. The client profiles are used for case studies and role playing throughout the training and provide the basis for a "daily reflection" from the client's perspective.

Creating client profiles that accurately cover the range of local issues and that challenge providers' stereotypes, biases, and misconceptions requires close attention and sensitivity on the part of the trainer. Throughout this curriculum (see Session 5), guidance is given to help trainers use these profiles to consider the possible range of issues to address and to lead discussions into potentially difficult areas (e.g., postabortion FP, postpartum FP, and FP for HIV-positive clients).

Family Planning Cue Cards (Contraceptive Technology Update)

This curriculum contains no didactic sessions dedicated to contraceptive technology. Instead, it updates the trainees' knowledge of contraceptive methods through the use of FP cue cards. The information on the cue cards is based on two authoritative resources.[2] The participants learn about the methods and the latest evidence-based guidance through practice with the cue cards. To enhance the trainees' understanding and retention of the information on FP methods, the FP cue cards can be given in advance (one or two weeks before the workshop) or at the end of the first day of the workshop. After receiving the training, the participants can use the cue cards as job aids.

In situations where the participants in the training workshop are new to FP or contraception, **a didactic contraceptive technology update might be needed before the workshop. For guidance, details, and materials on a one-day update, see Appendix J.**

The Training Package and How It Should Be Used

Intended Audience

Everyone working at a health care facility that provides FP services has a role to play in making the FP program successful, regardless of whether they provide clinical, counseling, or support services. Therefore, this Trainer's Manual contains instructions for training all levels of staff and can be used for training at the facility where the participants work (referred to as "onsite training") or for training at a different site (referred to as "offsite training").

One of the challenges of training FP counselors is meeting the training needs of the wide variety of providers and service settings. Some providers work in FP settings, while others (e.g., counselors who work in postabortion care) work in medical settings. Some providers offer the full range of FP services and counseling, but others are responsible only for providing FP counseling and referrals or a limited number of FP methods. The unifying theme in training these different providers is the **focus on the client and on meeting his or her needs.**

The training curriculum is intended for a group of 15–20 participants. It is appropriate for the following cadres of health care workers who are responsible for FP counseling:

- Physicians
- Nurses
- Counselors
- Technicians
- Supervisors
- Health educators
- Frontline staff
- Outreach workers
- Public-sector providers
- Private-sector providers

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[2] World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs. 2007. *Family planning: A global handbook for providers*. Baltimore, MD: The INFO Project, and Geneva; and WHO. 2007. *Medical eligibility criteria for contraceptive use and standard practice recommendations for contraceptive use*. Geneva.

Throughout this text, the term *health care workers* is used to refer to *all* facility staff, including direct service providers (usually called *providers*) as well as frontline staff. *Service providers* include doctors, medical officers, nurses, counselors, health educators, and medical or surgical assistants. The term *frontline staff* refers to all of the other staff or volunteers at a facility who interact with clients. Frontline staff include receptionists, switchboard operators, doormen, guards, janitors, records staff, appointment clerks, accounts clerks, lab technicians, interpreters, drivers, and maintenance workers.

Some parts of this curriculum might also be appropriate for administrative or supervisory staff who do not actually work with clients but who supervise or make decisions affecting those who do. Such staff should be encouraged to attend training whenever possible.

Trainer Requirements

Although this manual refers to a single trainer, a team of 3–4 trainers is needed for the intensive workshop described in the curriculum. The training team might consist of either 2–3 cotrainers or a lead trainer and assistants. While one trainer facilitates a session, the others can record information on flipcharts, monitor the time, help keep the discussion focused on the session objectives, moderate small-group work, and act in sample role plays. Once the trainers have enough experience with the curriculum, they can conduct training in teams of two.

A solid grounding in counseling is imperative for the trainers. Trainers with *client-centered counseling* experience are difficult to find because the client-centered approach is still a novelty. Because the training is about FP counseling in an integrated approach, it is helpful to have trainers whose backgrounds represent a range of SRH services (e.g., maternal care, HIV and other STIs, sexuality) in addition to FP. If possible, the training team should include one male and one female trainer so that the perspectives of both sexes are represented. A mixed-sex training team might be more successful in building trust with the participants, especially when presenting sensitive material. The sex of the training team members, however, should not be the main criterion for trainer selection. Trainers should be selected for their knowledge, expertise, and training skills.

This Trainer's Manual has been designed for use by skilled, experienced trainers. Although the manual contains information to guide training workshops and to assist the trainer in making decisions that will enhance the learning experience, it is assumed that the trainer understands adult learning concepts, employs a variety of training methods and techniques, and knows how to adapt materials to meet the participants' needs. Before conducting training with this curriculum, the trainers should observe or participate in a training workshop conducted with this curriculum. Without firsthand experience with the curriculum and an understanding of the complexity of the training methods and tools, trainers might find the curriculum difficult to use.

The trainer for this course must be aware of the facility's or institution's standards and guidelines regarding certification, training follow-up, and ongoing supervision of the facility or institution sponsoring the training. While reviewing this Trainer's Manual, the trainer should keep these in mind.

Timeframe and Structure

The curriculum is structured as a five-day or six-day workshop to cover basic principles and approaches and to practice skills and provide a framework for FP counseling with an integrated approach. Sample agendas for five days and six days are provided in Appendix A. A six-day workshop allows more room and flexibility for interaction and practice. The five-day version reduces the duration of some sessions but assumes a longer schedule for each day of the workshop. There are no clinical practice sessions.

If needed, the workshop can be conducted over a longer period of time with shorter daily workshop hours—for example, by conducting the workshop in 10–12 days using only the afternoons—so as not to hamper the provision of services at the training site. Regardless of how the workshop is scheduled, ***it is important to follow the recommended sequence of sessions*** because the later sessions build on knowledge, attitudes, and skills developed in the earlier sessions.

Trainer's Manual

The trainer's guide for each session has nine components:

- Session Title
- Participants' Learning Objectives (or Facilitator's Objectives)
- Time
- Materials
- Session Outline
- Advance Preparation
- Activities
- Training Tips (only in some sessions)
- Trainer's Tool (only in some sessions)

At the beginning of each day, the trainers should note the **Titles** of and **Objectives** for the sessions to be covered that day. The objectives can be prepared in advance on flipchart paper or can be read from the handouts in the Participant Handbook. The objectives should also be reviewed at the end of each day as a summary of what was covered.

The trainer's guide suggests the amount of **Time** to allot for each entire session. The **Materials** section of the guide describes all of the educational and training materials that will be needed for the session. Some of these materials need to be adapted, developed, or gathered in advance. The **Session Outline** provides the list of activities to be conducted by theme, training methodology, and duration. **Advance Preparation** lists what needs to be done in preparation for each session. Suggestions for information to be written on flipcharts are provided in this section. (A checklist for preparing for sessions is included below, under the heading "Training Preparation.") The **Activities** section of each session gives detailed instructions for conducting the session, with a suggested time allotment for each step. Some of the sessions include **Training Tips**, which include considerations for the trainer, alternative ways to conduct an activity, and factors to pay special attention to. Finally, **Trainer's Tools** are located at the end of several of the session guides. These are the tools that the trainers use either during exercises

or as background information. They are not to be distributed to the participants. Each session in the Trainer's Manual has a corresponding handout in the Participant Handbook.

The exercises in this curriculum have been carefully designed to achieve specific objectives. Although it will be necessary to adapt certain portions of the sessions based on the setting, culture, and other circumstances, trainers should follow the instructions as closely as possible.

Participant Handbook

The Participant Handbook consists of handouts for each session covered during the workshop. It is the written record of the workshop. The handouts also provide background information for the trainer. They should be reviewed by the trainer before the sessions. The handouts include **Essential Ideas** sections, which provide a summary of the central ideas for each session. The Participant Handbook can be printed or copied in advance to be distributed as a book, or the handouts of the sessions can be copied and distributed separately as each session is held. In the latter case, the participants should be given binders in which to compile the hole-punched handouts. Instructions are given in each session as to when in the flow of a session the trainer should refer the participants to a handout.

Training Preparation

Trainers need to be well-prepared for the training. As a trainer, you should prepare yourself in the following ways:

Familiarize yourself with the entire Trainer's Manual and Participant Handbook, by reading them once to get an overall sense of the purpose, content, and approach of the training.

Observe or attend a training workshop conducted with this curriculum, or **cotrain** with another trainer who is experienced in using this training curriculum. This will help you to better understand how training methods such as the client profiles are used.

Get buy-in for the training and select appropriate trainees. If you have been asked to present this training, program administrators at the service sites are probably well aware of the goals, objectives, and intended audience for the training. However, after your first reading of the curriculum, you should meet with them to:

- Clarify the purpose of the training
- See if appropriate participants have been selected
- Confirm the time committed for the workshop
- Finalize plans for follow-up and ongoing support to the participants after the workshop
- Finalize plans for evaluation, if needed

Study the curriculum in more depth. Read the curriculum again, this time slowly. Think about each session in terms of the needs of clients and providers in the local service sites. Carefully review each handout in the Participant Handbook—the handouts are the permanent record of the workshop that will be left with the participants and possibly seen by others who did not attend the training. Revise them as necessary to reflect and be sensitive to the local situation, issues, and attitudes.

Make copies of the Participant Handbook. After reviewing and revising (if necessary), make copies of the handbook for all of the participants. Each participant also should have a notebook and pen.

Write the list of objectives for all of the sessions on flipchart paper and prepare the other flipcharts listed in the Advance Preparation section of each session. At the beginning of each day, briefly state the objectives for the sessions to be covered that day. You might also refer the participants to the objectives listed at the beginning of each session's handout in the Participant Handbook. Use Appendix C for conducting daily warm-up and daily wrap-up sessions. Review the day's objectives during the wrap-up at the end of each day to provide a framework for assessing how well objectives were achieved and where there might be gaps in the participants' understanding. (These gaps can be addressed in subsequent sessions.)

Resolve issues listed below before the workshop starts:

All sessions	• Check to see if the participants have access to resources such as: ○ *Family Planning: A Global Handbook for Providers* or its predecessor, *Essentials of Contraceptive Technology* ○ *World Health Organization (WHO) Medical Eligibility Criteria for Contraceptive Use* ○ *WHO Standard Practice Recommendations for Contraceptive Use* • If they do not, check to see if you can provide copies of these documents to the participants' facilities. • Determine how familiar the target audience is with FP and contraceptive methods. If this is the first time they will be trained in those topics, consider conducting a one-day contraceptive technology update before the workshop. See Appendix J for detailed guidance on how to conduct the update.
Session 1	• Identify any guest speakers you might need and thoroughly brief them in advance. Explain the purpose of the training and be clear about the length and subject desired for their opening remarks. • Decide when refreshments will be served.
Session 2	• Identify any specific policies in the country related to rights to FP methods and services. • Identify local program and service-delivery guidelines relating to informed and voluntary decision making.

continued

Session 5	• With members of the training team, identify the types of clients (age, gender, social background, and special population characteristics such as postpartum, postabortion, HIV-positive) that need to be represented among the client profiles that will be developed by the participants. This decision should be based on the local situation, informed by consultation with representatives of the local organization receiving the training. Considerations could include the most popular FP method, least popular FP method, a recently introduced FP method, FP methods subject to local misconceptions, STIs common in the region, HIV and AIDS, common problems like antenatal care, postpartum care, abortion, emergency contraception, need for dual protection, and so on. If some of the identified client types are not included in the initial set of client profiles, the trainers can include these later by using **situation cards** (see Session 5).
Session 8	• Check to see whether the participants are familiar with the GATHER framework for FP counseling, and decide whether to cover optional Activity E in Session 8. (Also see also the Advance Preparation section of Session 8.)
Session 10	• Explore the participants' previous exposure to communication skills like listening, paraphrasing, verbal and nonverbal communication, and asking questions. If the participants have already been trained in these skills, you might choose to do the short version of this session. See Advance Preparation in Session 10 for more guidance.
Session 11	• Identify local community misconceptions about FP methods.
Session 12	• Identify which FP methods are available and commonly used in the country and region (i.e., where the participants come from).
Session 13	• Explore the types of visual aids that are available in the country, and collect samples for use in this session and through the rest of the workshop. These may include illustrations of anatomy, anatomical models, counseling flipcharts, client brochures, wall charts, posters, or FP cue cards.
Session 18	• Determine the legality of permanent FP methods in the country. Obtain sample informed consent forms used in the country.
Session 20	• Check on the availability of female condoms in the country, and decide whether to cover female condom use in this session's activities. • Make sure that there are enough penis models for every participant to practice condom use. If there are not, you can use cucumbers, bananas, or markers as substitutes. • Make sure you have enough condoms for the participants to use in practice. • Have small prizes, such as candies, for the group that wins the condom race.
Session 21	Learn about local resources for people in violent or abusive relationships.

Session 27	• Identify and invite guests from the organizing institution and/or the participants' institution(s). If possible, invite them to attend the afternoon session beginning after the first hour, which will allow them to listen and contribute to the action plan presentations, as well as to the closing ceremony. • Discuss follow-up plans for this training with the institution organizing the workshop and with the participants' institution(s), and determine what follow-up will be conducted, by whom, and when. See Trainer's Tool No. 7 (Session 27). • If follow-up plans have been made, arrange for a representative of the institution(s) to inform the group about follow-up plans. • Discuss with the institution organizing the workshop and with the participants' institution(s) whether to give certificates to participants. Determine who will print and sign the certificates, and have them ready before this session.

Training Implementation

Checklist for Knowledge Assessments, Client Profiles, and Daily Warm-Ups and Wrap-Ups

- Score the precourse knowledge assessment at the end of the first day, and announce the results (only the highest, lowest, and average scores) during the daily warm-up on Day 2. See Advance Preparation in Session 1 for more details.
- At the end of the first day (or at the end of Session 5), assign client roles to five volunteers from among the participants (one for each client profile group). See Session 5 for more guidance.
- At the end of the first day, assign the reading of FP cue cards as homework.
- At the end of the first day, conduct the daily wrap-up. See Appendix C for a complete session plan for daily wrap-up sessions.
- On days 2, 3, 4, and 5, start the day with a daily warm-up. See Appendix C for a complete session plan of daily warm-up sessions.
- On days 3 and 4, after the participants report in their client profile roles about their impressions on the previous day, assign new participants from each group for the client profile roles. See Session 5 for more guidance.
- Before Day 5, make copies of the postcourse knowledge assessment (same as precourse knowledge assessment).
- On Day 5, after the postcourse assessment, distribute the precourse assessments of the participants and go over the questions with correct answers. The participants will keep their precourse assessments.

Training Tips

Avoid overusing flipcharts: The training relies heavily on the use of flipcharts to guide and summarize discussions. Most of them can be prepared in advance. However, there are dangers in overusing flipcharts: Paper is expensive and sometimes scarce. Participants can become bored with "training by flipchart," even though it is meant to be more interactive. And some information should be distributed on handouts so that the participants can save it. Specific instructions are given for when to write on a flipchart and when not to; try not to do so more than is suggested.

Consider using an LCD projector and overheads: If an LCD projector, computer, and electricity are available, they can be used for slide presentations. Alternatively, an overhead projector and transparencies can be used instead of flipchart paper for some presentations. In addition, handouts can be read during the session and then kept for later reference. Below are a few guidelines for when to use each presentation aid:

- Use flipchart paper when you are recording suggestions or ideas from the participants (e.g., during brainstorming); when you want to post information on the wall or refer to it later in the training; or when you want the participants to think through a question or concept by themselves (maybe referring to a handout later).
- Use an LCD or overhead projector/transparencies when you want to present a piece of text for everyone to read and discuss but not save, or when you want to post instructions for group work.
- Use handouts when you want the participants to save the information to refer back to after the training.

Training Evaluation

The training can be evaluated at four different levels, and this curriculum provides the tools for evaluation at the first three levels. The evaluation plans should be made before the training through discussions with the organization or institution of the training participants. This also allows for baseline assessments before the training, such as observation of counseling.

Level 1—Reaction: Did the participants like the training?

Participants' reactions should be evaluated at the end of each day, during the daily wrap-up session. Appendix C provides guidance on how to lead this activity. There is also a workshop evaluation form for the participants to fill out at the end of the last day of the workshop (see Appendix G).

Level 2—Learning: Did the participants learn?

Learning can be measured using the precourse and postcourse knowledge assessments. The assessment tool and the key are found in Appendix B. Comparing the precourse and postcourse assessments helps in quantifying improvement in participants' knowledge levels. The communication and counseling skills are measured during role plays using the Counseling Skills Observation Guide in Appendix E. Trainers can continually observe and assess the participants' knowledge and skill levels through the discussions and role plays during the workshop.

Level 3—Application: Did the participants apply what they learned in this workshop?

The application of information is usually evaluated through follow-up visits. Trainees (participants) can be interviewed and observed while counseling clients. Trainees' supervisors also can be interviewed about whether the trainees are implementing what they have learned during the workshop. The Provider Interview Form can be used to interview trainees (see Appendix H), and the Counseling Skills Observation Guide (Appendix E) can be used while observing the actual counseling service provided by the trainees at their workplaces.

Level 4—Impact: What was the impact of this training on the quality and use of FP services?
Evaluation of the impact of training is quite difficult. This curriculum provides only one tool for measuring the satisfaction of counseled clients. The Client Interview Form is included in Appendix I. An increase in the use of FP services can be tracked from service statistics, and the quality of the services can be measured by using tools like EngenderHealth's Quality Measurement Tool (QMT).

Part I:

Getting to Know Our Clients

Session 1:
Welcome and Introduction

Facilitator's Objectives

- To officially welcome all participants and guests and to introduce the participants, guests, and facilitators (trainers)
- To describe the purpose, goal, objectives, and agenda for this training
- To administer the precourse knowledge assessment

Time

1 hour, 20 minutes

Materials

- Flipchart paper and pens
- Workshop agenda (Appendix A)
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 1: Goals and Objectives
- Precourse knowledge assessment (Appendix B)

Session Outline

Training Activities	Methodology	Time
A. Welcome and Introduction		5 mins.
B. Opening Remarks	Lecture	10 mins.
C. Introduction of Trainers and Participants	Icebreaker	15 mins.
D. Workshop Objectives, Agenda, and Logistics	Presentation/discussion	20 mins.
E. Precourse Knowledge Assessment	Written assessment	30 mins.

Advance Preparation

1. Any guest speakers should be identified and thoroughly briefed in advance about the purpose of the training and the length and subject desired for their remarks.
2. Refreshments could be served *before* the start of this session, if appropriate.
3. Prepare copies of the agenda and precourse knowledge assessment for all guests and participants. Write numbers on the precourse assessments. (These numbers will be used by the participants to identify their precourse and postcourse assessments after scoring and

by the trainers to compare the pretest with the posttest scores.) To ensure confidentiality, shuffle the assessments so that they are not distributed sequentially. After the participants have filled out the precourse knowledge assessments, collect the papers and score them at the end of the day. On Day 2, during the warm-up session in the morning, inform the participants of the average score of the group, as well as the highest and lowest scores. This information helps them understand how much they already know and how much they do not know. Tell them that you will give back the precourse assessments on the last day of the workshop, after they fill out the postcourse assessment. The participants and the trainers will be able to compare the improvement that each participant has made. Advise them to remember the number on their assessment papers so they can track and match their precourse and postcourse assessments.

4. Prepare flipcharts with the goal and objectives of the workshop for Step D-2.

[Flipchart for Step D-2]

COURSE GOAL

To improve your knowledge, attitudes, and skills in assessing and addressing clients' family planning (FP) needs, through individualized counseling that considers the client's circumstances and broader reproductive health (RH) needs and their impact on the client's choice and use of FP

[Flipchart for Step D-2]

COURSE OBJECTIVES

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

1. Explain the importance of quality client-centered counseling for improving FP uptake and continuation
2. Effectively communicate with clients
3. Better assess individual clients' FP needs, knowledge, and concerns and meet these needs in a more effective and efficient manner
4. Identify the key decisions clients need to make or confirm, and assist and support them
5. Assist clients in strategizing how to carry out their FP decisions
6. Identify the barriers to conducting "ideal" counseling that exist in your practice setting, and develop a plan to overcome them

Session 1
Activities

Activity A. Welcome and Introduction *(5 minutes)*

Have a representative of the local host organization, serving as the session moderator, formally open the workshop by welcoming the participants, explaining the purpose of the training, and introducing guest speaker(s), if any have been invited.

Activity B. Opening Remarks *(10 minutes)*

Have a guest speaker give opening remarks, if appropriate.

Activity C. Introduction of Trainers and Participants *(15 minutes)*

The moderator will introduce the facilitators and then ask the participants to introduce themselves.

> **➳ Training Tip**
>
> The length of this introductory exercise can vary, depending on whether the participants are already acquainted with one another. If they know each other, the introductions can be brief (e.g., name, where they are from, where they work, and what their job is). If they do not know each other, the exercise should be longer (e.g., all of the above, plus why they think they were selected for this training or what strengths they think they can bring to this work). Even if the introductions are brief, the trainer should try to include a quick icebreaker, such as asking the participants to add something interesting about the town, village, or facility where they work.

Activity D. Workshop Objectives, Agenda, and Logistics *(20 minutes)*

1. Ask the participants about their expectations of the course. List these on a piece of flipchart paper.
2. Present the course goal and objectives, using the prepared flipchart. (See the Introduction for Trainers and Program Planners for background on why this counseling curriculum was developed. Your comments can be drawn from this background, if relevant to the background and interests of the participants. See also Essential Ideas.) Be sure to check that the overall objectives of the workshop are clear and well understood by the participants.
3. Hand out the agenda (Appendix A). Explain the workshop timeframe.
4. Point out to the participants that the Participant Handbook includes Essential Ideas and points from the sessions. The participants need to take notes only on additional points or issues that are of particular relevance or interest. Explain that the intent is to enhance their participation.

5. Tell the participants that at the end of the course, they will develop action plans. To better inform their action plans, they will be given time at the end of each day to note down the new ideas they want to pursue as result of their learning from that day.
6. Together with the moderator, address the participants' logistical questions, which may include questions about their lodging, per diem, transportation, and reimbursable expenses. Tell the participants where meals will be served and coffee breaks will occur.

Activity E. Precourse Knowledge Assessment *(30 minutes)*

1. Explain to the participants that to get a sense of the effectiveness of the workshop, you would like them to complete a self-assessment of their knowledge and attitudes, both at the beginning of the workshop and at the end. Explain that this is not an individual test (i.e., the assessment will be scored, but the participants will not be graded) and that the trainers will use the results to better tailor the content of the workshop and to judge how well they and the workshop were able to meet their objectives, not how well the participants learned. Assure them that all answers and scores will be confidential and anonymous.
2. Explain that to ensure confidentiality, names will not be written on the self-assessment. Instead, each participant will be given a numbered test, and they will have to remember that number to match and compare their precourse and postcourse assessments.
3. Distribute the precourse assessment (Appendix B), briefly pointing out the different sections, and ask if the participants have any questions. Tell them to pay attention to the number on the first page of their tests and note it somewhere in their notebooks. Give them 25 minutes to complete the assessment, with time checks at 15 and 20 minutes.

Session 2:
Supporting Clients' Informed and Voluntary Decision Making

Participants' Learning Objectives

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

- Name three rights recognized by international conventions and explain their relevance for FP counseling
- Define *informed and voluntary decision making* and explain its importance in FP and RH
- List at least four of the seven "rights of clients" and explain how they apply to FP services
- Describe the roles of providers and other health care staff in supporting clients' informed and voluntary decision making

Time

1 hour, 20 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Index cards (Step C-4)—three per pair of participants
- Participant Handbook—Handout 2-A: Supporting Clients' Informed and Voluntary Decision Making; Handout 2-B: A Rights-Based Approach to Family Planning and Sexual and Reproductive Health; Handout 2-C: Informed and Voluntary Decision Making in Sexual and Reproductive Health; and Handout 2-D: Clients' Rights

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	2 mins.
B. Defining Rights to Family Planning Services and Methods and Informed and Voluntary Decision Making	Discussion/presentation	20 mins.
C. Elements That Support Informed and Voluntary Decision Making	Brainstorm/presentation	15 mins.
D. Clients' Rights	Presentation	10 mins.
E. How Health Care Staff Can Support Clients' Rights	Exercise in small groups/discussion	30 mins.
F. Summary	Question and answer	3 mins.

Advance Preparation

1. Identify any specific local or national policy statement or document related to rights to family planning services and methods, and incorporate a brief mention or summary of the session. (See the section on training preparation in the Introduction for Trainers and Program Planners.)
2. Identify local program and service-delivery guidelines related to informed and voluntary decision making, and incorporate these into the presentation. (See the section on training preparation in the Introduction for Trainers and Program Planners.)
3. Prepare flipcharts for Steps B-2, B-6, C-2, C-4, D-2, and E-1.

[Flipchart for Step B-2]

ICPD, 1994

The rights of individuals or couples:

1. To decide freely and responsibly the number, spacing, and timing of their children
2. To have the information they need to make those decisions
3. To attain the highest standard of sexual and reproductive health
4. To make decisions concerning reproduction free of discrimination, coercion, and violence

[Flipchart for Step B-2]

INFORMED AND VOLUNTARY DECISION MAKING:

The process by which an individual arrives at a decision about health care, based on options, information, and understanding

[Flipchart for Step C-2]

ELEMENTS THAT SUPPORT INFORMED AND VOLUNTARY DECISION MAKING:

- ➤ Service options are available.
- ➤ Decisions are made without coercion.
- ➤ People have appropriate information.
- ➤ Good client-provider interaction, including counseling, is ensured.
- ➤ Rights are respected at the community and program levels.

[Flipchart for Step C-4]

WHAT HEALTH CARE STAFF CAN DO TO SUPPORT INFORMED AND VOLUNTARY DECISION MAKING:

[Flipchart for Step D-2]

CLIENTS' RIGHTS

1. Information
2. Access to services
3. Informed choice
4. Safety of services
5. Privacy and confidentiality
6. Dignity, comfort, and expression of opinion
7. Continuity of care

[Flipchart for Step E-1]

HEALTH CARE STAFF

- Frontline and support staff (receptionists, secretaries, guards, drivers, cleaners, operators, clerks)
- Providers (counselors, physicians, nurses, midwives, outreach volunteers, health educators)
- Administrators and supervisors

Instructions for small-group work:

Identify whether and how health care staff in each category can support—or threaten—each of the clients' rights.

Session 2
Activities

Activity A. Introduction *(2 minutes)*

Review the objectives of the session with the participants.

Activity B. Defining Rights to Family Planning Services and Methods and Informed and Voluntary Decision Making *(20 minutes)*

1. Lead a discussion on rights to family planning services and methods, asking the participants to reflect on what the term means to them.

2. Post the prepared flipchart sheet for Step B-2 (see Advance Preparation), and explain that this definition of rights was developed and endorsed at the United Nations International Conference on Population and Development, in Cairo, Egypt, in 1994. Briefly discuss the different aspects of rights to family planning services and methods.
3. Explain that the following year (1995), the Fourth World Conference on Women, which was held in Beijing, affirmed the specific rights of women to **have control over and decide freely and responsibly** on matters related to their sexual and reproductive health, relationships, and behavior, **without coercion, discrimination, and violence.** Ask the participants why they think this would be important.
4. Reflect on the results of the discussion and compare it with the ICPD flipchart.
5. Note that much of the language related to rights to family planning services and methods focuses on the right to make decisions "freely and responsibly . . . without coercion, discrimination, and violence." Thus, one of the most concrete and significant ways in which we can support the rights associated with sexual and reproductive health (SRH) is to ensure informed and voluntary decision making by individuals. These rights apply to all individuals, regardless of age, sex, marital status, or ethnic group. Providers should be aware of their own beliefs and values in this area so that they avoid imposing them on clients.

6. Ask the participants what they think is meant by the word *informed*. After a few responses, ask what they think is meant by *voluntary*. Post the prepared flipchart for Step B-6 (see Advance Preparation) and explain what is meant by *informed and voluntary decision making*, as follows:

   > The benefits of informed and voluntary decision making in FP have been well documented in numerous studies. These benefits include better use of methods (and thus greater effectiveness), higher continuation rates, and more satisfied clients who in turn are good program promoters.
   >
   > At the same time, research has shown clearly the *negative consequences* of people not being able to make informed and voluntary FP decisions. These include higher rates of discontinuation when clients are not adequately informed about possible side effects, health risks, and complications or are not

allowed to use their preferred method, and overall rejection of program services in the community when clients are coerced into using contraception.

Stress that gender issues often play a very important but overlooked role in influencing decision making, especially for women:

Pressure on and coercion of clients to make a particular decision about their RH or their FP use are not always easy to detect, and often people (especially women and adolescent girls) find it difficult to discuss these issues. Pressure and coercion are also experienced by men, especially young men, because of peer pressure to conform to societal expectations about how a man should express his masculinity. Often, young men do not have sufficient awareness of how these types of pressures influence their risk-taking behavior or the way they relate to and interact with their sexual partners.

7. Ask the participants the following questions:
   - What does *informed choice* mean? How does it differ from *informed and voluntary decision making*?
   - What does *informed consent* mean? How does it differ from *informed and voluntary decision making*?

   Make sure that the points included in Handout 2-C are covered during the discussion.

Activity C. Elements That Support Informed and Voluntary Decision Making *(15 minutes)*

1. Ask the participants what they think would support informed and voluntary decision making for FP.

2. After a few responses, post the prepared flipchart C-2 (see Advance Preparation), discuss the elements that support voluntary and informed decision making, and compare those on the flipchart with the participants' responses.
3. Ask the participants to work in pairs and distribute three cards to each pair. Each pair should discuss and identify at least three answers to the following question:
   - ✱ As health workers, how can you influence these elements to support informed and voluntary decision making?

4. Ask the pairs to write their answers on the cards (one answer on each card) and post them on the flipchart you prepared for Step C-4 (see Advance Preparation).
5. Let the participants spend a few minutes standing in front of the flipchart and reading all of the cards. Then facilitate a brief discussion using the discussion points below to fill in any possible gaps.

Discussion Points

- Providers can make sure that clients are aware of the range of onsite services and can make referrals to services that are offered at other facilities. Providers also can help to ensure that access is not denied on the basis of age, sex, marital status, or ethnic group.

- Providers can explore clients' decision-making process to ensure that they are not being pressured or coerced by anyone (including other providers) and that they are making their own decisions.
- Providers can confirm that the client has full and accurate information, can fill in missing information, and can correct misinformation.
- Providers can offer counseling that helps clients to accurately assess and address their own needs, to understand the consequences of their decisions, and to determine whether the needed/desired services are available onsite and, if not, where they may be obtained.
- Through counseling, providers can ensure that clients are aware of their rights to family planning services and methods and can support them in developing the knowledge and skills necessary to exercise those rights.
- Providers can help clients develop skills for communicating with their partner.
- Providers can offer counseling for the client's partner.

Activity D. Clients' Rights *(10 minutes)*

1. Explain that, having considered the rights of individuals and how these relate to informed and voluntary decision making, the next step will be to look more specifically at the rights of individuals *once they decide to become clients*. This means that the individual or couple has reached a decision to seek FP information or services and has succeeded in finding and getting to a service site. Those are major steps in which rights play an important role; this activity, however, will focus on the rights that apply once people walk through the door of the service site.

2. Explain that, originally, 10 "rights of clients" were established for FP clients by the International Planned Parenthood Federation.[3] EngenderHealth subsequently modified and consolidated these to seven rights. Post the flipchart listing the seven rights (see Advance Preparation).

3. Briefly describe each right shown on the flipchart. Answer any questions the participants may have and refer them to Handout 2-D in the Participant Handbook.

Activity E. How Health Care Staff Can Support Clients' Rights *(30 minutes)*

1. Post the flipchart entitled "Health Care Staff" (see Advance Preparation). Cover or fold over the instructions for small-group work. Briefly describe each category of health care staff listed on the flipchart. *(5 minutes)*
2. Divide the participants into three groups. Assign one group to be providers, one to be frontline staff, and one to be administrators or supervisors. Ask each group to choose someone to serve as a reporter.
3. Ask each group to take 10 minutes to review the seven rights of clients and identify whether and how health care staff in their category can support or impede each right.

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[3] *Adapted from:* Huezo, C., and Diaz. S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129-139.

4. Have the reporter make a list in his or her notes of the rights that the group's health care staff can influence, either positively or negatively. Remind them that they will be reporting orally only.
5. While the groups are working, draw three columns on the right-hand side of the flipchart entitled "The Rights of Clients," and label them as shown below.

Clients' Rights	Frontline staff	Providers	Administrators/ supervisors
1. Information 2. Access to services 3. Informed choice 4. Safety of services 5. Privacy and confidentiality 6. Dignity, comfort, and expression of opinion 7. Continuity of care			

6. To facilitate reporting by the groups, take one right at a time and ask each group whether and how they might influence the right. (This way the focus is more on the rights than on the category of health care staff.) Allow for only very brief explanations, because you have only 30 seconds per group per right. As the reports are being given, put a checkmark in the appropriate column next to each of the rights that a group can influence. *(10 minutes)*

➳ Training Tip

You should find that each type of health care staff can have some effect on most, if not all, of the clients' rights. While the reporting might get repetitive, this is precisely how the learning impact of the session is achieved. The participants generally do not expect that frontline staff, in particular, would have such an important role to play in clients' rights. They might even be surprised by the role played by administrators and supervisors, who rarely have direct contact with clients but who have a significant effect in terms of the decisions they make about staffing and space allocation, staff development, standards (performance monitoring), and ensuring that a referral system is in place and operating well.

Activity F. Summary *(5 minutes)*

Ask the participants to summarize the session by volunteering essential ideas that have been discussed (see Essential Ideas for Session 2 in the Participant Handbook).

Session 3:
The Difference That Counseling Makes

Participants' Learning Objectives

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

- Define good client-provider interaction and its role in ensuring informed and voluntary decision making
- Describe strategies to improve client-provider interaction and to support clients' rights more effectively in the health care facility setting
- Define good counseling and its role in informed and voluntary decision making
- Explain how counseling supports clients' rights and makes a difference
- Identify specific tasks that need to be carried out in counseling
- Explain the counseling-related role of various staff
- List the needs of health care staff that must be addressed for improved client-provider interaction and counseling

Time

1 hour, 35 minutes

Materials

- Flipchart paper, markers, and masking tape
- Flipcharts prepared with text (see Advance Preparation)
- Appendix D: The Difference That Counseling Makes (PowerPoint Presentation)
- Participant Handbook—Handout 3: The Difference That Counseling Makes
- PowerPoint projector and computer or overhead projector and transparencies (optional)

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. Defining Client-Provider Interaction	Discussion/presentation	15 mins.
C. Defining Counseling	Discussion/presentation	25 mins.
D. The Difference That Counseling Makes	Discussion/slide presentation	25 mins.
E. Staff Needs	Discussion/presentation	20 mins.
F. Summary	Question and answer	5 mins.

Session 3

Advance Preparation

1. Review the PowerPoint presentation (Appendix D) and decide how you will present the material. Create a presentation using PowerPoint or transparencies, or make copies for the participants.
2. Prepare flipcharts for Steps B-4, E-1, and E-2. After the session, leave the flipchart for Step B-4 on the wall for reference during role plays throughout the course.

[Flipchart for Step B-4]

PRINCIPLES OF GOOD CLIENT-PROVIDER INTERACTION

- Treat each client with respect
- Tailor the interaction to the individual client's needs, circumstances, and concerns
- Interact; elicit the client's active participation
- Avoid information overload
- Provide the client's preferred method (for FP) or address the client's primary concern (for other SRH issues)
- Use and provide memory aids

[Flipchart for Step E-1]

REASONS FOR THE GAP

[Flipchart for Step E-2]

NEEDS OF HEALTH CARE STAFF

- Facilitative supervision and management
- Information, training, and development
- Supplies, equipment, and infrastructure

Session 3
Activities

Activity A. Introduction *(5 minutes)*

1. Tell the participants that after having reviewed rights to family planning services and methods, informed and voluntary decision making, and clients' rights, you will now be examining in greater depth how these rights and processes can be safeguarded and the role of all facility staff in doing so.
2. Review the session objectives with the participants.

Activity B. Defining Client-Provider Interaction *(15 minutes)*

1. Explain that one way of helping health care staff to support the rights of clients is to work with them to strengthen the quality of their interaction with clients.
2. Ask the participants what *client-provider interaction* means to them.
3. After a few responses, refer the participants to Handout 3 in the Participant Handbook and review the definition, purposes, and principles of client-provider interaction.

4. Post the prepared flipchart with principles of good client-provider interaction (see Advance Preparation). Tell the participants that you will come back to these six principles later and will refer to them during role plays throughout the course. (Ensure that the principles remain on the wall throughout the rest of the workshop.)
5. Referring back to the flipchart from Session 2 that lists categories of staff, ask the participants how the three categories of staff can influence client-provider interaction in the facility.
6. Conclude by saying that all interactions between clients and various facility staff influence clients' perception of the quality of services. FP programs in many countries have discovered that good client-provider interactions are essential for successful use of services, contraceptive continuation, and correct use of methods.

Activity C. Defining Counseling *(25 minutes)*

1. Explain that the discussion will now focus on a specific form of client-provider interaction: counseling.
2. Ask the participants:
   - ✱ What does *counseling* mean to you? How is it different from *client-provider interaction*?
   - ✱ What role does counseling play in helping clients to make informed and voluntary decisions about sexual and reproductive health?
   - ✱ Which clients' rights are addressed through counseling?

3. Refer to the section on counseling in Handout 3 in the Participant Handbook. Review the main points, including the definition of counseling, the responsibilities and tasks involved in counseling, and the importance of counseling in helping clients to make informed and voluntary decisions and supporting clients' rights.
4. Ask the participants:
   - ✱ In your work setting, how could various staff be involved in carrying out the specific tasks that comprise counseling?
5. Explain that the rest of the training will focus on helping staff to develop the knowledge, attitudes, and skills necessary to offer FP counseling, with the goals of helping clients meet their own informational, emotional, and decision-making needs and supporting clients' rights.

Activity D. The Difference that Counseling Makes *(25 minutes)*

1. Ask the participants:
   - ✱ What difference does counseling make? Why do we do counseling?
   - ✱ How does counseling help clients?
   - ✱ How does counseling help us (as service providers and as an FP program)?
2. After discussing for five minutes, conclude by saying that you will now be examining some facts supporting the value of counseling.
3. Present PowerPoint slides 1–17.

Activity E. Staff Needs *(20 minutes)*

1. Ask the participants the following questions, and note the answers for all three questions on the flipchart entitled "Reasons for the Gap" (see Advance Preparation):
   - ✱ What are the reasons for the gap between ideal counseling and the way that counseling is conducted within their practice setting? *(Remind them about the points made in the Activity D slide presentation.)*
   - ✱ What challenges do staff face in providing counseling-related services?
   - ✱ What barriers and unmet needs undermine staff's performance?

2. Ask how staff needs can be addressed. After a few responses, post the prepared flipchart with staff needs (see Advance Preparation). Present the staff needs and briefly discuss what they think about them.
3. Wrap up by stressing that staff needs should be taken into consideration as they develop action plans at the end of this workshop.

Activity F. Summary *(5 minutes)*

Ask the participants to volunteer their thoughts about the implications of this information for their work.

- ✱ What are you planning to do differently now?

Session 4:
Who Are Our Clients?

Participants' Learning Objectives

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

- Identify the most common reasons why clients come for FP services
- Identify different categories of FP clients
- Explain why it is important to become familiar with each client's situation and reproductive health needs
- Identify the different information and emotional support needs of all FP clients and specific population groups (e.g., men, adolescents, HIV-positive clients)

Time

1 hour, 30 minutes

Materials

- Flipchart paper, markers, and masking tape
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 4-A: Who Are Our Clients?; and Handout 4-B: Providers' Role in Supporting Clients with Differing Needs

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation/brainstorm	10 mins.
B. Categorizing FP Clients	Discussion	20 mins.
C. Informational and Emotional Support Needs of FP Clients	Small-group work/large-group discussion	1 hour
D. Summary	Question and answer	5 mins.

Advance Preparation

1. Prepare flipcharts for Steps A-3, B-1, B-3, B-4, B-5, and C-1. See templates on page 4-2.

Session 4

[Flipchart for Step A-3]

REASONS FOR CLIENTS' VISITS:

[Flipchart for Step B-1]

CLIENTS BY REASON FOR VISIT:

- New clients who have no method in mind
- New clients with a method in mind
- Clients returning for resupply (satisfied return clients)
- Clients returning with problems or a different need (such as dissatisfied return clients)

[Flipchart for Step B-3]

CLIENTS BY FERTILITY PLAN:

- Delayers
- Spacers
- Limiters
- Want to get pregnant

[Flipchart for Step B-4]

CLIENTS BY POPULATION GROUP:

- Men, women
- Married, unmarried
- Adolescents
- Clients with high individual risk for STIs
- Clients living with HIV

Note: This is not an exhaustive list of all possible population groups. These are examples to trigger the participants' thinking about the needs of various groups.

[Flipchart for Step B-5]

CLIENTS BY TIMING OF LAST PREGNANCY:

- Postpartum
- Postabortion
- Interval

[Flipchart for Step C-1]

- What are the special information needs of these clients?
- What are the special emotional needs of these clients?
- What can providers do during counseling to support these clients?

Session 4
Activities

Activity A. Introduction *(10 minutes)*

1. Review the objectives of the session with the participants. For a change of pace, you might ask a volunteer to read the session objectives from the Participant Handbook.
2. Tell the participants that in this session you will be examining different categories of clients and their different needs and expectations from counseling. State the following:

   Quickly identifying the category or categories in which a client fits helps providers streamline and tailor their counseling to meet their needs. In this way, providers can better address their needs and avoid spending time on unnecessary issues.

3. Ask the participants to describe the clients who seek FP services at their facility.

   ✱ What are the most common reasons that FP clients come to the health care facility?

4. Write all answers on the prepared flipchart and post it on the wall.

Activity B. Categorizing FP Clients *(20 minutes)*

1. Provide a summary of the categories of reasons for FP clients' visits by posting and discussing the first prepared flipchart for this activity.
2. Explain that counseling would be different for each category of client described here. Ask what would be different in the counseling for each client category. After getting a few answers, quickly move on to the next question.

3. Ask the participants how clients could be grouped according to their fertility plans. After getting a few answers, post the second prepared flipchart and briefly explain.

4. Next ask the participants what population groups their clients belong to. Probe if necessary to elicit a few responses, and then post the third prepared flipchart. Remind them that only a sample of those population groups is listed on the flipchart.

5. Finally, post the last flipchart and explain how clients can also be grouped according to the timing of their last pregnancy.
6. Compare the brainstormed list from Activity A to the four flipcharts posted during this activity, and highlight the fact that a client can belong to more than one category (e.g., an adolescent girl who has just given birth; a satisfied return client learning that he is HIV-positive; or a new client with no method in mind who wants to delay first pregnancy).
7. Ask the participants:

   ✱ Why do you think it may be important to know what kind of client you are counseling?

   Get a few answers but do not record them.

8. Tell the participants to open Handout 4-A in their Participant Handbook, and briefly go over the Essential Ideas and describe the content. (Do not have them read the details!)

Activity C. Informational and Emotional Support Needs of FP Clients *(1 hour)*

1. Post the flipchart prepared for this activity. Referring to one client category from one of the flipcharts you have posted in the previous activity (Activity B, steps 1, 3, 4, and 5) as an example (e.g., adolescents or postpartum clients), ask the participants to answer the following questions:
   - ✱ What are the special information needs of these clients?
   - ✱ What are the special emotional needs of these clients?
   - ✱ What can providers do to support these clients during counseling?
2. Tell the participants that they will work in small groups to identify the informational and emotional support needs of clients and what providers can do to support these needs, per the three questions listed above. Each group will be assigned one of the four flipcharts from the previous activity (Activity B, steps 1, 3, 4, and 5), and they will work on all client categories listed on that flipchart. (*Note:* Groups do not need to list informational or emotional needs that apply universally to all client types; rather, they should list those unique to their assigned client category.)
3. Divide the participants into four groups by asking them to count off by four. Assign each group one of the four flipcharts in Activity B (i.e., clients by reason for visit, clients by population group, clients by fertility plan, and clients by timing of previous pregnancy). *(10 minutes total for steps 1–3)*
4. Ask the participants to spend 15 minutes describing the counseling needs of the client categories on their assigned flipchart, by answering the questions in Step 1 (flipchart for Step C-1). They should consider the kind of situations that might affect each category of client.
5. Invite the participants back into the larger group. Ask each group to present their results. Then facilitate a discussion on the counseling needs of each client group, focusing on similarities and differences and the need to tailor counseling to each client's needs. *(30 minutes)* Refer the participants to Handout 4-B in the Participant Handbook again at the end of the discussion.

Activity D. Summary *(5 minutes)*

Ask the participants:

✱ What are the implications of our discussions (different categories of clients and their varying counseling needs) for your practice of counseling?

If the following responses are not among those offered by the group, the trainer should probe for them during the discussion.

- Exploring the category or categories to which each client belongs helps providers tailor counseling to clients' individual needs and makes the counseling more client-centered.
- Making counseling more client-centered:
  - ○ Saves the client and provider time, by eliminating unnecessary discussions
  - ○ Reduces the revisits that might otherwise result from initial counseling that does not meet the client's needs

Session 5:
Factors Influencing Clients' Decisions

Participants' Learning Objectives

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

- Describe factors that influence clients' FP decisions, including other RH considerations, and their effects on counseling
- Explain how the characteristics of different contraceptive methods may affect clients' FP decisions
- Describe different FP needs the client may have at different stages in life (if optional Activity C is used)

Time

35 minutes (50 minutes with the optional Activity C)

Materials

- Flipchart paper, markers, and masking tape
- Flipcharts prepared with text (see Advance Preparation)
- Index cards for responses to Activity B (as many as the number of participants)
- Participant Handbook—Handout 5: Factors Influencing Client Decisions
- Appendix A—Cue card on Healthy Timing and Spacing of Pregnancy

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. Exploring Factors That Influence FP Decisions	Exercise/discussion	25 mins.
C. Changing FP Needs throughout the Lifecycle (optional)	Large-group exercise/ discussion	15 mins.
D. Summary	Question and answer	5 mins.

Session 5

Advance Preparation

1. Prepare flipcharts for use in Steps B-1 and C-3 and C-4 (optional).

[Flipchart for Step B-1]

A. Are you currently using (or planning to use in the future) an FP? If not, why not?

B. Have you ever used and then stopped using an FP method (different or the same as the method you are now using) method? If yes, why did you stop using that method?

C. What factors or people influenced your decision to use FP or a particular method?

[Flipcharts for Step C-3]

Prepare five flipcharts with one age range on each one: Ages 13–20, Ages 21–29, Ages 30–39, Ages 40–49, and Ages 50+.

[Flipchart for Step C-4]

- What are the clients' reproductive intentions?
- What are their sexual relationships like?
- What other RH needs might the client have?

Note: This session was adapted from AVSC International. 1995. *Family planning counseling: A curriculum prototype*. New York; and EngenderHealth. [No date]. Topics in Reproductive Health online minicourse. Accessed at www.engenderhealth.org/res/onc/sexuality/approach.html.

Session 5
Activities

Activity A. Introduction *(5 minutes)*

1. Review the objectives of the session with the participants.
2. Explain to the participants that one of the counselor's main responsibilities is helping clients to reflect on their experiences, attitudes, and values so as to make well-considered decisions about their sexual and reproductive health. Tell the participants that they will now examine the factors that influence clients' FP choices.

Activity B. Exploring Factors That Influence FP Decisions *(25 minutes)*

1. Show the participants the questions that you have written on the prepared flipchart (see Advance Preparation). Tell the participants that when answering these questions, they can draw on their own experience or on that of someone they know (friend, relative, or client) and that they will answer the questions individually by writing their responses to all three questions on the same card. Distribute index cards, one per participant. Read each question out loud to the group, pausing to give them time to write their responses on the cards.
2. Collect the responses, shuffle them, and then hand them out to the group (so that each participant will have cards that are not her or his own).

3. Make five columns on two sheets of flipchart paper taped side by side, and in each column write one of the following: Individual Characteristics, Community Influences, Method Characteristics, Service Factors, and Other Reproductive Health Conditions. Ask the participants to volunteer responses from the cards they have received. These responses represent the factors that influence the choice of whether to use FP and which method to use. Each time a response is volunteered, ask which type of influence it is and record it accordingly.
4. Ask the participants to brainstorm other factors that influence clients' choice of a method. Write their responses on the same flipchart. *(For a list of possible responses, see Essential Ideas in Handout 5 in the Participant Handbook.)*
5. Add missing factors, making sure that the impact of individual methods on sexual relations is also listed (for details, see Handout 5 in the Participant Handbook).
6. Ask the participants what they understand from the term "healthy timing and spacing of pregnancy." After taking a few answers, tell them that while helping clients to consider all of those factors, the counselor should also inform the clients about healthy timing and spacing of pregnancy (HTSP), and review briefly the cue card on HTSP (in Appendix A of the Participant Handbook).
7. Lead a discussion by asking the following questions:
   - ✱ Why is it important to consider a client's other reproductive or sexual health needs in addition to FP?

- What are some possible effects of STIs on FP choices?
- What are the effects of partner, family, and community on FP decisions?

  *(**Note:** Probe as needed for partner support, power imbalances, and sexual coercion and abuse.)*
- How can the characteristics of an FP method affect decision making and method use? (The participants may find it helpful to refer to Handout 5.)

Link these issues to choosing and using a method and to the counselor's role in helping clients choose an FP method.

Activity C. Changing FP Needs throughout the Lifecycle (optional) *(15 minutes)*

1. Explain to the participants that they will now examine how clients' (both men's and women's) physical condition and life situation change with time and how these changes affect a client's priorities, reproductive intentions, and FP needs.
2. Start the discussion with the following questions:
   - How do reproductive goals and FP needs (e.g., postponing or spacing pregnancy, ending childbearing) change throughout the life cycle?
   - What are some of the factors that affect reproductive goals and FP needs?

3. Post the prepared flipcharts with an age-group written on each (13–20, 21–29, 30–39, 40–49, and 50+).

4. Post the flipchart with the questions (see Advance Preparation) and have the participants walk around the room and list circumstances of clients in each age-group on the appropriate flipchart, referring to the factors listed above. They should consider the following questions:
   - What are the clients' reproductive intentions?
   - What are their sexual relationships like?
   - What other RH needs might clients have?
5. After completing Step 4, tell the participants to stand in front of the flipcharts on the wall, and ask them:
   - How do the clients' reproductive goals and FP needs differ?
   - What factors might affect the client's FP choice (e.g., delaying or limiting childbearing, need for protection against STIs or HIV, a method that does not require partner cooperation)?
   - What types of FP might each one need/want in light of each of these factors?

Activity D. Summary *(5 minutes)*

1. Ask the participants:
   - How do the issues we have just discussed relate to FP counseling?
2. Emphasize the importance of exploring with the client all individual, service, community, method, and other RH factors that could influence a client's decision and satisfaction with a chosen method. The client can make a well-informed decision only by taking into consideration all factors that might be relevant to his or her situation.

3. Refer the participants to Handout 5 in the Participant Handbook and briefly review its contents with the participants.
4. Ask the participants to discuss the implications of the various factors for counseling and what the impact of these factors would be. (The "Essential Ideas" section of Handout 5 in the Participant Handbook summarizes these factors.)

Session 6:
Bringing in the Client Perspective

Participants' Learning Objectives

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

- Develop client profiles* that reflect the range of clients who might seek FP services
- Identify decisions that clients have to make and the information they need to make those decisions
- Identify the emotions that clients experience

Time

1 hour, 5 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. Developing Client Profiles	Small-group work	30 mins.
C. Finalizing Client Profiles	Large-group discussion	25 mins.
D. Assignment of Client Roles	Question and answer	5 mins.

Advance Preparation

1. Prepare two flipcharts with the guidelines for developing client profiles, as shown on page 6-2.

[Flipchart for Step B-2]

CLIENT PROFILE GUIDELINES: PART 1

WHO IS THE CLIENT?
(BASIC INFORMATION)

Name:

Age:

Gender:

Marital status:

Total number and outcome of pregnancies:

Number of children currently living:

Breastfeeding status:

Socioeconomic status (occupation, income level, etc.):

Educational level:

Social background (ethnic, cultural, religious):

[Flipchart for Step B-2]

CLIENT PROFILE GUIDELINES: PART 2

THE CLIENT'S SITUATION AND NEEDS

- What is the client's current immediate FP need?
- Who else is affected by the client's RH situation?
- How does the client feel about his or her current situation? What concerns or worries does he or she have?
- What decisions will he or she have to make concerning FP?
- Who else will be involved in making the decisions?

Using Client Profiles as a Training Tool

- The client profiles will provide the foundation for keeping the focus of the training on the client's perspective. They should represent the variety of clients—in terms of backgrounds, needs, and concerns—that providers can expect to encounter. Although it would save time to have the trainer prepare the client profiles in advance—or to have a selection of profiles in the curriculum that the trainer could choose from—case studies are much more effective if the participants themselves have input and feel responsible for the clients they will be discussing throughout the training. The use of client profiles helps focus the participants on the issues and specific needs, conditions, and concerns affecting clients from various communities and cultural settings.
- When the participants are developing the client profiles, they should be encouraged to include population groups who might not currently be using services and with whom the participants are less familiar. Such groups might include unmarried adolescents, men, minority groups, people who do not speak the language taught in schools, refugees, sex workers, and people who are HIV-positive.
- To ensure consistency among the client profiles and representation of the full range of issues that might need to be addressed during counseling, guidelines are provided for developing the profiles. To avoid duplication between groups, spend a few minutes in the large group to assign basic elements, such as the category of client (e.g., new, return), the sex of

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* The client profiles are descriptions of typical clients; they are used throughout the training for role plays and reflections on the client perspective. For details on how they will be developed, see Advance Preparation and Activity B in this session. For details on their use throughout the training, see Introduction for Trainers and Program Planners. Also see Appendix C: Daily Warm-Ups for instructions on how to use them to elicit reflections on the client perspective.

the client, and his or her age. Be sure that the profiles represent the four main categories of clients: new clients with a method in mind; new clients without a method in mind; returning clients without concerns; and returning clients with concerns (see Handout 4-A in the Participant Handbook).

- Of course, all issues cannot to be covered in these initial five profiles. Trainers can use *situation cards* to make modifications to the situation of each client, to ensure that important issues not included in the original client profiles are covered and addressed. The situation cards are developed by the trainers by writing a few words on a card that describe a change in the client's situation. A separate card should be written for each client profile, and the situation cards should be handed out to each "client" during each morning's warm-up session (or as the trainers deem necessary). The situation cards may be used to introduce a change in the client's physical, economic, social, or emotional condition (see instructions in Appendix C). They can be used to help the participants focus on issues that they might be reluctant to bring out when developing the initial profiles. For example, if STIs have not been sufficiently taken into account, trainers can write a situation card for one of the client profiles that states that the client has started to have itching, lower abdominal pain, and/or vaginal discharge (i.e., symptoms of a possible STI). Or if community influences have not been considered, the trainer would add that a client might hear a rumor about the method she or he has been using. The situation card for postpartum family planning might state that the client is pregnant or has just delivered a healthy baby. For more examples of situation cards, see Advance Preparation in Sessions 19, 21, 22, and 24.

Session 6
Activities

Activity A. Introduction *(5 minutes)*

Explain to the participants that, to better understand clients' FP decision-making process, they will develop client profiles. These will be in-depth, detailed descriptions of various clients, based on the categories introduced in Session 4 (e.g., clients by reason for visit). Although it is not possible to represent *every* type of client in this exercise, we will try to ensure a broad representation of backgrounds, needs, and concerns. These profiles will be used as case studies in some sessions and for role plays in others. They will also reflect special population groups (e.g., men, unmarried adolescents, HIV-positive clients) and clients who wish to space future pregnancies as well as those who want to limit future pregnancies.

Activity B. Developing Client Profiles *(30 minutes)*

1. Explain to the participants that they will be divided into five groups, and that each group will describe a person who might have FP-related needs and might need to make decisions about FP. They will create a *client profile*, which will be similar to a case study. Tell the participants that they will work in their small groups to develop the details of their clients, reminding them that these individuals might not have sought FP services before (e.g., a postpartum or postabortion client who has not used an FP method) and thus might not yet be an actual client. These client profiles should present the problem and the situation but *not the outcome*.

2. Post the flipcharts entitled "Client Profile Guidelines: Part 1" and "Client Profile Guidelines: Part 2." Tell the participants to follow the guidelines to describe their client in each of these areas. Instruct them to choose someone from the group to write the information about the client on the flipchart. Explain that they will have 30 minutes to do this. Thus, they should strive to provide basic answers to the flipchart questions; there will be more time later in the workshop to learn more about each client.
3. Split the participants into five groups, give each group several sheets of flipchart paper and markers, and ask them to choose one person to be the group's reporter. Assign one client category to each group—two groups should be assigned a client who returns with a problem with an FP method. Remind the participants to think creatively in developing their client profiles and to choose from the range of population groups (i.e., not always including only married women but incorporating men, adolescents, unmarried people, and other groups as well). Tell them that you will be circulating among the groups to make sure that they do not all develop similar profiles.
4. Tell them to start, and move among the groups to answer questions and to make sure they do not spend too much time on any one point. Check for any similarities between the client profiles of the groups. If necessary, request that they make changes. (For example, if more than one group develops a female client in her 30s with many children, ask one of the groups to change either the age, the number of children, or the gender of

the client, so that a broader range of clients can be represented. The idea is to develop different client profiles that would require and yield different counseling scenarios.)

Activity C. Finalizing Client Profiles *(25 minutes)*

Invite each group's reporter to share the group's client profile with the rest of the participants. After each group has presented, ask the following:

- Does this client need to make any other *key decisions*? (Examples of key decisions include whether to talk to the partner, whether to get treatment for an STI, and whether to seek health care for another problem.) If the client group agrees that the client has other decisions to make, these can be added to the flipchart.
- What information will the client need to make these decisions, and where can he or she get that information?

With five groups, each group will have only four or five minutes for reporting and discussion, but allow brief comments and discussion, if time permits.

Activity D. Assignment of Client Roles *(5 minutes)*

1. Tell the participants that each group will work with the client profile they have developed during the rest of the workshop. They will use it in exercises, as a case study, and in role plays.
2. Tell them that an additional use of the client profiles will be for reflecting on the clients' feelings, thoughts, and impressions—in other words, empathizing with the client. Every day a different member of each client profile group will assume the role of the profiled client, and the following morning they will report back about their feelings, thoughts, and impressions as that client.

3. Make a list of the members of each client profile group on a piece of flipchart paper.
4. Ask for one volunteer from each group to assume the role of the client on the following day (or the rest of the same day, if the session is held in the morning), and mark those participants' names on the groups' lists.
5. Tell the participants that for the rest of the day (or the following day, if this session is held as the last session of the first day), those who have volunteered from each group will assume the role of their profiled client and will observe the sessions through the eyes of that client. Those "clients" will be asked about their impressions, feelings, opinions, and experience in the room the following morning during the warm-up. (For detailed instructions, see Appendix C. On the following morning, the volunteers will be asked about their experience—feelings, thoughts, impressions—and new volunteers from each client profile group will be assigned to serve in the role of the client for that day. This exercise will continue throughout the workshop.)

Session 7:
Providers' Beliefs and Attitudes

Participants' Learning Objectives

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

- Explain how providers' beliefs and attitudes can affect their interactions with clients, both positively and negatively
- Explain the importance of being aware of our own beliefs and attitudes so we can avoid imposing them on clients or having them become barriers to communication

Time

45 minutes

Materials

- Flipchart paper, markers, and tape
- Make three signs on pieces of flipchart paper reading AGREE, DISAGREE, and UNSURE
- Participant Handbook—Handout 7: Providers' Beliefs and Attitudes
- Trainer's Tool #1 (Session 7)

Session Outline

Training Activities	Methodology	Time
A. Introduction	Discussion	5 mins.
B. Exploring Beliefs and Attitudes	Large-group exercise	25 mins.
C. Summary	Discussion	15 mins.

Advance Preparation

1. Review the list of belief statements included in Trainer's Tool #1 (Session 7). Select seven statements to use in this exercise, addressing each of the FP services covered in this training (see Training Tips, page 7-2). (You may develop your own statements that address specific local issues in addition to using the statements provided in this curriculum.)

Adapted from: AVSC International. 1999. *Counseling the postabortion patient: Trainer's guide*. New York: AVSC International.

➳ Training Tip

- FP and reproductive health include some of the most controversial and sensitive topics in most cultures around the world. However, specific issues and concerns differ from place to place. Therefore, it is important to read these statements carefully ahead of time. Choose only those that are most relevant to the beliefs and attitudes of service providers in the context where training is taking place. Also, make sure to include statements that will create controversy and disagreement. The idea is to demonstrate that not everyone is in agreement, despite similarities in backgrounds, professions, and so on. Add other statements, if necessary.
- These statements are listed in no particular order. You will need to decide which you want to read first, second, and so on.

2. Post the AGREE, DISAGREE, and UNSURE signs in three different locations, with space for people to gather near each sign.
3. Arrange the chairs and tables so that people can move easily between the signs.

Session 7
Activities

Activity A. Introduction *(5 minutes)*

1. Explain that this session is about our individual beliefs and the effects they may have on our attitudes toward and interactions with clients. Ask the participants what the word belief means to them, and then ask how we form our beliefs.
2. Ask what *attitudes* are, and then ask how our beliefs influence our attitudes.

Activity B. Exploring Beliefs and Attitudes *(25 minutes)*

1. Explain that you will lead a group exercise intended to help the participants examine their own beliefs about FP methods, different types of clients, and various sexual practices.
2. Emphasize that there are no right or wrong answers. They should respond based on their own beliefs because the main purpose of the exercise is to help explore differences in attitudes and beliefs.
3. Read one of the seven belief statements chosen from the list in Trainer's Tool #1 (Session 7) or that you developed, and ask the participants to decide if they agree, disagree, or are unsure how they feel about the statement.
4. After they decide, ask them to get up and stand under the sign that best reflects their opinion (AGREE, DISAGREE, or UNSURE). Then ask one or two volunteers from each opinion group to describe their thinking about the statement.
5. Repeat this process with more of the statements for as long as time permits.

➳ Training Tip

- The belief statements are *not* to be distributed as a handout because the participants or others who might read them might misunderstand the intent of this exercise and think that these statements reflect the beliefs of EngenderHealth and the trainers, which they do not.
- During this exercise, emphasize that there are no right or wrong answers. People respond based on their own beliefs. The main purpose of the exercise is to help explore differences in the participants' beliefs and attitudes. Therefore, it is important that you remain *neutral* throughout the exercise and maintain a balance between the different viewpoints expressed during the discussion, by making sure that no one opinion dominates the discussion and that disagreement is accepted and even encouraged.
- For this exercise to be effective, each participant must decide whether he or she agrees, disagrees, or is unsure about each statement. This will help the participants become more aware of their own beliefs. In addition, discussing their beliefs in front of others will help raise awareness of how their beliefs can affect their interactions with clients (and others).
- To cover the full range of issues in the time available, responses will have to be limited to just one or two opinions per opinion group (agree, disagree, unsure) per statement.

Activity C. Summary (15 minutes)

1. Ask the participants to return to their seats.
2. Use the following questions to lead a discussion about the exercise:
   - ✱ Which statements revealed the widest range of beliefs? What could explain these differences?
   - ✱ What happens when providers and clients hold different beliefs about FP and SRH issues?
   - ✱ Why is it important for us, as providers, to be aware of our own attitudes and beliefs about FP and SRH issues?
   - ✱ What can we do, as providers, when our beliefs about a particular FP method or SRH issue make us uncomfortable talking about it with clients?
3. Conclude by saying:

   Many of you are from similar backgrounds, yet you have had different responses to some of these statements. Consider what differences there might be when clients come from educational, social, cultural, or religious backgrounds different than their providers.
4. Refer the participants to Handout 7 in the Participant Handbook and add any issues from the Essential Ideas that have not already discussed.

Trainer's Tool #1 (Session 7)

****Do Not Distribute to the Participants****

Belief Statements about Family Planning and Sexual and Reproductive Health

Family Planning

1. In a couple, it is the woman who should be responsible for using contraception.
2. Unmarried adolescents should not engage in sexual activity.
3. If a woman never experiences childbirth, she will feel less like a woman.
4. FP methods should be available to unmarried adolescents.
5. Illiterate women cannot use oral contraceptives effectively.
6. Natural FP methods are ineffective, difficult, and time-consuming to teach.
7. It is okay for a woman to have an intrauterine device (IUD) inserted without telling her husband.
8. Some clients want to continue getting pregnant until they have children of both sexes. Providers should discourage this behavior.
9. If a woman wishes to have a tubal ligation, she should have one, even if her spouse disagrees.
10. If a man wishes to have a vasectomy, he should have one, even if his spouse disagrees.
11. A 21-year-old woman with only one child should be refused a tubal ligation.

HIV and AIDS

12. People who do not use condoms can only blame themselves for getting HIV.
13. Service providers have the right to know the HIV status of their clients.
14. People with HIV should not have sex.
15. It is a crime for people who are infected with HIV to have sexual relations without informing their partner.
16. People who get HIV through sex deserve it because of the behaviors that they practice.
17. AIDS is mostly a problem of prostitutes.
18. Women with HIV should be sterilized so they can't have children and pass on the infection.

Sexuality

19. Sex without intercourse is not real sex.
20. To be "good," sex must end in orgasm.
21. It is acceptable for someone to have more than one sexual partner at the same time.

22. It should be recommended that couples not marry until they have had sexual intercourse.
23. Prostitutes provide a useful service.
24. If people go too long without sex, it is bad for them.
25. The purpose of having sex is to show love for someone.
26. Any sexual behavior between two consenting adults is acceptable.
27. A person can lead a perfectly satisfying life while being celibate.
28. Celibacy goes against human nature.
29. Oral sex is wrong.
30. Anal sex is normal behavior.

Condoms

31. Condoms should be distributed to secondary school students who request them.
32. Condom use is a sign of caring and not distrust.
33. Condoms ruin the enjoyment of sex.
34. Couples can have an enjoyable sex life while using condoms every time they have sex.
35. Educating teenagers about condoms will only encourage them to have sex.
36. If my teenage son asked me for condoms, I would give them to him.
37. If my teenage daughter asked me for condoms, I would give them to her.

Judgments about Clients

38. Most uneducated women are incapable of making their own decisions about FP.
39. It is hard for me to understand why people who know how HIV is transmitted would continue to expose themselves.
40. Clients who have good, up-to-date information about HIV transmission will make good choices about keeping themselves safe.
41. Clients with two children or more should be sterilized.
42. Sterilization is indicated for women with medical reasons to prevent pregnancy.
43. Our facility should make contraceptive methods available to adolescents.
44. Fourteen is too young for a boy to have sex.
45. Schools should provide sex education for children before puberty, starting at age 9 or 10.
46. In most cases, it is not worth discussing condoms with young people because they will never use them.
47. Children should be taught about HIV and other STIs in school.
48. The parent of a teenage client who reports she is having sex has a right to know about it.
49. Young, unmarried people should not have sex.

Adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York. Volume 1, pp. 70–72.

Part II:

Building Communication and Counseling Skills

Session 8:
Introduction to the REDI Framework

Participants' Learning Objectives

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

- Explain the importance of addressing clients' social context when assisting them in making decisions about FP
- Describe how counseling supports clients' informed and voluntary decision making
- Explain the importance of using a counseling framework flexibly
- Describe REDI, a framework for FP counseling
- Identify similarities and differences between REDI and GATHER (if optional Activity E is used)

Time

1 hour, 5 minutes (1 hour, 10 minutes with the optional activity)

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 8: Introduction to the REDI Framework; and Participant Handbook Appendix B: Learning Guides for FP Counseling Skills

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. Overview of REDI	Presentation	10 mins.
C. What Changes Does REDI Bring to What We Know and Do?	Small-group work	15 mins.
D. How REDI Supports Client-Centered Counseling	Large-group discussion	30 mins.
E. Comparing REDI and GATHER (optional)	Large-group discussion	5 mins.
F. Summary	Discussion	5 mins.

Advance Preparation

1. Decide whether you want to include the optional Activity E (Comparing REDI and GATHER) based on the participants' exposure and orientation to GATHER in the past. If they have been trained in GATHER and/or are using it, covering Activity E would be a

good idea, especially if the participants seem to be using the GATHER framework slavishly, without assessing clients' needs or tailoring counseling according to the assessed needs. As part of the discussion, explain that regardless of which framework is used, meeting clients' needs is more important than the framework itself. So instead of simply following the framework, providers should always tailor counseling to the individual client's needs.

2. Prepare flipcharts for Steps B-1, C-1, C-2 through C-6, and E-1 (see below).

[Flipchart for Step B-1]

R – Rapport Building

E – Exploration

D – Decision Making

I – Implementing the Decision

[Flipchart for Step C-1]

QUESTIONS FOR EXERCISE

- Which steps are you already using in your counseling?
- For which steps do you think it would be helpful to have further training—for knowledge, skills, or making providers more comfortable?
- Which steps would you find difficult to implement in your practice setting, and why?

[Flipchart for StepS C-2 through C-6]

Group 1

Rapport Building *(all clients)*	**Already doing**	**Need training**	**Anticipated challenges**
1. Greet client with respect			
2. Make introductions			
3. Assure confidentiality and privacy			
4. Explain the need to discuss sensitive and personal issues			

Group 2

Exploration *(new clients)*	**Already doing**	**Need training**	**Anticipated challenges**
1. Explore in depth the client's reason for the visit			
2. Explore the client's future RH-related plans, current situation, and past experience			
3. Discuss the client's preferred FP method, if any, or relevant options; give information, as needed; and correct misconceptions			
4. Rule out pregnancy and explore factors related to monthly bleeding, any recent pregnancy, and medical conditions			

Group 3

Exploration *(return clients)*	**Already doing**	**Need training**	**Anticipated challenges**
1. Explore the client's satisfaction with the current method			
2. Confirm correct method use			
3. Ask the client about changes in his or her life (e.g., plans about having children, risk for HIV and other STIs, and HIV status)			
4. Explore in depth with the client the reasons for dissatisfaction and possible solutions *(for dissatisfied clients only)*			

Group 4

Decision Making	**Already doing**	**Need training**	**Anticipated challenges**
1. Identify the decisions that the client needs to make or confirm			
2. Explore relevant options for each decision			
3. Help the client weigh the benefits, disadvantages, and consequences of each option			
4. Help the client determine his or her individual risk for contracting HIV or another STI			
5. Encourage the client to make his or her own decision			

Group 5

Implementing the Decision	**Already doing**	**Need training**	**Anticipated challenges**
1. Assist the client in making a concrete and specific plan for carrying out the decision(s)			
2. Have the client develop skills to use his or her chosen method and condoms			
3. Identify the barriers that the client may face in implementing the plan			
4. Develop strategies to overcome the barriers			
5. Make a plan for follow-up and/or provide referrals			

[Optional Flipchart for Step E-1]

Comparing REDI and GATHER	
R **Rapport Building** E **Exploration** D **Decision Making** I **Implementing the Decision**	G **Greet** A **Ask/assess** T **Tell** H **Help** E **Explain** R **Return visit**

Session 8
Activities

Activity A. Introduction *(5 minutes)*

At this point, the workshop is moving from setting the stage to building the skills of the participants.

1. Review the objectives of the session.
2. Explain that in all counseling, the focus should be on the client rather than on the framework. During the following exercises and discussions, the participants should keep in mind that frameworks can be helpful to providers by giving them a structure for talking with clients so they will not miss important steps. However, the framework is only good if it allows them to attend to the individual client's unique needs and concerns.

Activity B. Overview of REDI *(10 minutes)*

1. Tell the participants that they will now examine a new counseling framework. Post the flipchart with the names of the four phases of REDI (see Advance Preparation).
2. Refer the participants to Handout 8 in the Participant Handbook and ask them to find the table that describes REDI ("Phases and Steps of REDI"). Briefly review the phases and steps. Point out that the REDI framework:
   - Emphasizes the client's right and responsibility for making a decision and carrying it out
   - Provides guidelines for how to explore the client's sexual relationships and social context
   - Helps identify the barriers that a client may face in carrying out this decision and builds skills and develops strategies to help the client address them
3. Encourage questions and give brief answers, noting that the next exercise will give them a chance to examine and discuss the REDI framework in detail.

Activity C. What Changes Does REDI Bring to What We Know and Do? *(15 minutes)*

1. Post the flipchart with the following questions for small-group work (see Advance Preparation). Explain that the groups will work on different phases of REDI, and that two groups will work on the **exploration** phase—one on exploration with new clients and the other on exploration with return clients. All groups will answer the following questions for their assigned step:
   - ✱ Which steps are you already using in your counseling?
   - ✱ For which steps do you think it would be helpful to have further training—for knowledge, skills, or making providers more comfortable? (Further training might also be considered useful for steps that they are already using.)
   - ✱ Which steps would you find difficult to implement in your practice setting, and why?

2. Post one of the prepared flipcharts (see Advance Preparation) and explain how each group will fill one flipchart as it reviews a phase of REDI.

3. Explain to the participants that for each step, they should review the relevant description in Appendix B of the Participant Handbook (Learning Guides for FP Counseling Skills), consider these questions, and check any boxes (cells) in the table that apply to their work setting. Participants might check more than one box—or all three boxes—for some steps. Explain that if there are different opinions within the group, they may put a question mark in the box.
4. Divide the participants into five groups.
5. Ask each group to choose one member to fill in the table for their group.

6. Assign one phase of REDI to each group and distribute the separate prepared flipchart sheets accordingly.
7. Give the groups 10 minutes to complete their tables. Check each group quickly to ensure that they understand the instructions. If some groups finish in less than 10 minutes, they can go on to review another phase of REDI and discuss their answers to those questions among themselves.

Activity D. How REDI Supports Client-Centered Counseling *(30 minutes)*

1. Starting with the **rapport building** group, ask each group's reporter to post the group's flipchart and explain the group's findings. If there are question marks, ask for a brief explanation. Also ask for a brief explanation of the challenges. *(15 minutes total for all groups)*
2. Ask the participants what they learned from this exercise. *(5 minutes)*

> **➳ Training Tip**
>
> - Stress that the REDI framework is a guide for the process of counseling and that its purpose is to ensure informed and voluntary decision making. It should be adapted as appropriate to meet clients' needs. Providers should not lose sight of the client by focusing on the framework.
> - Remind the participants that they are already following many of the steps. However, all steps will be reviewed during this training to ensure that there is mutual understanding of what the steps entail and to provide an opportunity for discussion. Anticipated challenges to applying new knowledge and skills can be addressed in the action plans that will be developed later in the training. In addition, the trainers can share the participants' anticipated challenges with their supervisors or program managers (who may be participating in this workshop or a separate orientation), and this can become part of training follow-up (see Session 27).

3. Facilitate a discussion by asking the questions below. (Possible responses are listed under each question.) *(10 minutes)*

   ✱ How does this framework ensure that the counseling is client-centered?
   Possible responses:

- *The framework starts with and is focused on the client's individual circumstances. Each counseling session is then tailored to the specific needs of the individual client, taking into consideration their specific circumstances, needs, and desires—e.g., whether they are new or returning; whether they have a specific method in mind, concerns about the method they are using, or changes in their circumstances; and whether they are a member of a special population group.*
- *The REDI framework treats the client as a whole person with different and interrelated needs and circumstances. In addition to helping providers with counseling for FP, it helps providers explore and address clients' needs and problems in other RH areas (such as sexuality and STIs) in an integrated way.*
- *REDI also takes into consideration whether the client will be able to implement his or her decision to use FP. It helps providers guide the client through a reality check, identify potential barriers, and strategize to overcome them. Therefore, the* ***implementing the decision*** *phase of REDI evolves differently based on each client's unique set of needs and circumstances.*

✱ How much time do counselors in your facility generally spend counseling each client? Do you have ideas about how to make counseling more efficient and effective in your practice setting?
Possible responses:

- *Counselors can save time with new clients by learning first about the client's situation and then limiting the information-giving portion of the session to addressing the client's identified needs, rather than routinely providing detailed information on every FP method. Avoiding overloading the client with unnecessary information not only saves time but also better meets the client's needs.*
- *For return clients, counselors can save time by determining whether the client has any concerns or problems and then focusing on those.*
- *It might initially take longer for counselors to follow the framework because they will need to adjust to the new way of interacting with clients.*
- *One study in Egypt showed that client-centered counseling added only one additional minute to the consultation.1 The clients were three times more likely to be satisfied and to continue to use the method after seven months.*

✱ Why does the framework address clients' social context and personal circumstances?
Possible responses:

- *Clients need to make realistic decisions that they can carry out successfully and safely. Examining the social context helps them to understand the potential outcomes of their decisions. Questions might include the following:*
  - ➤ *Who has the decision-making power in the relationship and who influences decisions (i.e., partners, friends, family members)?*
  - ➤ *What will happen if the partner or family finds out that a woman is using FP in secret (e.g., a partner may have an objection or even a violent reaction if a client insists on using FP in general or a particular method)?*

- ➤ *What will happen if/when the client experiences side effects such as bleeding? (This is particularly significant in many religions and cultures.)*
- ➤ *What economic pressures might affect the client's decisions (e.g., whether he or she can afford a continual supply of condoms or other methods)?*

✱ How does this framework ensure a client's informed and voluntary decision making?
Possible responses:

- *The framework ensures informed and voluntary decision making by helping the provider tailor the information to the client's needs and circumstances; helping the client reach realistic decisions after having considered his or her life circumstances (e.g., social context and sexual relationships); reminding the client to weigh options and consider their implications; and helping the client anticipate potential barriers to the implementation of his or her decision and strategize how to overcome them.*
- *The framework guides providers in helping clients to better understand their personal risks for unintended pregnancy and contracting and transmitting HIV or other STIs and in sharing information about the relevant options for protecting themselves, thus enabling clients to make informed decisions.*
- *The framework also ensures that the provider checks to see whether there may be pressure from partners, family, community, and service providers that is influencing the client and makes sure that the decision the client makes is voluntary and free of coercion.*

Activity E. Comparing REDI and GATHER (optional) *(5 minutes)*

Note: This activity is only necessary if many of the participants are already familiar with the GATHER framework. If they are not familiar with GATHER, there is no need to introduce it. See guidance in Advance Preparation.

1. Post the flipchart entitled "Comparing REDI and GATHER" (see Advance Preparation).
2. Beginning with "Greet," ask the participants to identify which steps of GATHER correspond to the phases of REDI. Draw lines between the corresponding steps and phases.

> **➳ Training Tip**
>
> Many steps in REDI and GATHER overlap. **Rapport building** generally corresponds to Greet, with elements of Ask/Assess. **Exploration** incorporates Ask/Assess and Tell. **Decision making** includes the Help step and also elements of Ask/Assess and Tell. **Implementing the decision** includes Help, Explain, and Return Visit. Because the counseling process is different for each client, the participants might also have other valid ideas about overlaps.

3. Facilitate a brief discussion by asking:

   ✱ What similarities can you identify between REDI and GATHER? What differences?

4. Explain: REDI was designed specifically to incorporate the client's comprehensive needs and to incorporate a focus on the client's responsibilities and actions. There is more emphasis in REDI on considering the life circumstances of the client, including the client's relationships, sexual practices, social context, and individual risk for contracting HIV and other STIs. The client is responsible for developing a plan for implementing the decision. The client and counselor identify potential barriers to the implementation of the decision and then address them accordingly. REDI recognizes that many client decisions are never implemented because of barriers that have not been identified at the time of decision making. Keep in mind that the counseling process applies the same skills, attitudes, and knowledge, whether the framework is REDI, GATHER, or something else, but in this training the REDI framework is used.

Activity F. Summary *(5 minutes)*

1. Ask if the participants have any further comments or questions. Review the "REDI Algorithms" section of Handout 8 in the Participant Handbook to recap how REDI applies to different categories of FP clients (e.g., new and returning clients).
2. Note that the participants will spend the rest of the workshop developing and practicing skills for counseling, addressing the attitudinal challenges faced by providers who conduct FP counseling, and identifying and meeting the information needs of clients. As they advance through the sessions of the workshop, they will use the learning guides to improve their practice of FP counseling.

Session 9:
Sexuality

Participants' Learning Objectives

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

- Define the terms *sex* and *sexuality*
- Explain how sexual preferences and practices relate to the choice and use of FP methods
- Identify their personal biases and attitudes about various sexual behaviors
- Recognize that there are differences in perspectives on sexual behavior, including differences in what is considered normal or acceptable
- Explain why it is important to be nonjudgmental about sexual behaviors when counseling clients

Time

1 hour, 15 minutes

Materials

- Large cards or writing paper and scissors
- Cards prepared with text (see Advance Preparation)
- Markers—one for each participant, if possible
- Masking tape
- Participant Handbook—Handout 9: Sexuality

Session Outline

Training Activities	Methodology	Time
A. Defining Sexuality	Pairs exercise/discussion	40 mins.
B. Identifying Biases and Judgments Related to Sexual Behaviors	Large-group exercise/discussion	30 mins.
C. Summary	Discussion	5 mins.

Advance Preparation

1. Review the list of behaviors (see Trainer's Tool No. 2 at the end of this session), and select 25 to 30 to use in this session. Add any additional behaviors that occur locally.

➳ Training Tip

Try to ensure the selection of a mixture of behaviors—some that the participants will be familiar with and some that they will not. Add or omit behaviors based on the local situation. The exercise should include some behaviors that are outside of the mainstream or that are taboo, even if these behaviors are not generally acknowledged in the local setting.

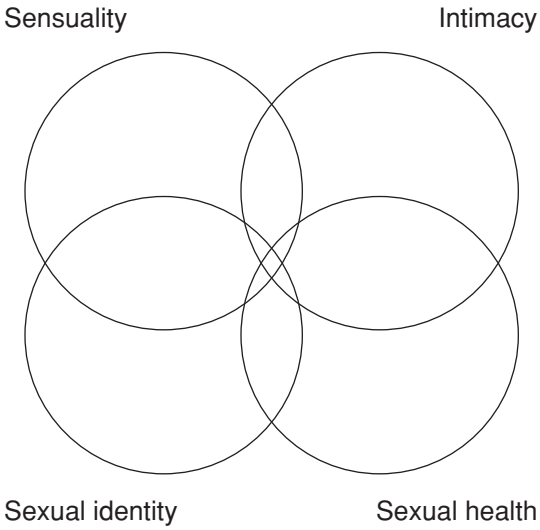
2. Prepare flipcharts for Steps A-3 and A-10.

[Flipchart for Step A-3]

1. Define the term "sex."
2. Define the term "sexuality."
3. How does sexuality relate to FP counseling?

[Flipchart for Step A-10]

ASPECTS OF SEXUALITY



3. Prepare the behavior cards. Use heavy paper or card stock, if available, or half-sheets of letter-sized paper if cards are not available. Write one sexual behavior on each piece of paper. Print using a large marker and large letters, or print the pages using a computer in a large, bold typeface so the words can be read from a distance (see example).

Vaginal Sex

4. Prepare three additional sheets, one with the phrase "OK for me," a second with the phrase "OK for others but not OK for me," and a third with the phrase "Not OK" written in large print. Use different colors of paper for each of these three sheets, if possible. Post these sheets high on the wall, ensuring that there is sufficient space between them to place three to five vertical columns of cards beneath each.
5. Before the exercise, prepare small pieces of tape, enough to affix all of the behavior cards to the wall.

Session adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York

Session 9
Activities

Activity A. Defining Sexuality *(40 minutes)*

1. Introduce the session by reviewing the objectives. Tell the participants that the REDI framework emphasizes the integration of sexuality into FP counseling. It guides the provider in exploring the client's sexuality and helping the client consider his or her sexual life when choosing an FP method.
2. State that some participants might be thinking, "I know about FP counseling and reproductive health. So, why are we talking about sexuality?" Tell the participants that you will explore the answer to that question during the following exercise.

3. Tell the participants that they will work in pairs to define two terms and answer one question. Post the flipchart with questions that you have prepared (see Advance Preparation, flipchart for Step A-3).
4. Ask the participants to spend 10 minutes defining the terms and answering the question and to write their answers in their notebooks.
5. After 10 minutes have passed, ask the participants to volunteer their definitions of *sex*. Remind them not to repeat definitions already given but to mention different aspects that they would like to add to the definition.
6. Repeat Step 5 with the term *sexuality*.
7. Ask the participants about the similarities and differences between *sex* and *sexuality*.
8. Repeat Step 5 with the question, "How does sexuality relate to FP counseling?"
9. Give a short presentation on the definitions of *sex* and *sexuality*, *how sexuality relates to FP counseling*, and *aspects of sexuality*, based on the information in Handout 9 in the Participant Handbook. Compare these "official" definitions with those developed by the participants. Note any aspects of the definitions that were missed and clarify any remaining questions.

10. Post the flipchart with the intersecting circles (see Advance Preparation, flipchart for Step A-10), and explain *aspects of sexuality*. *(20 minutes)*
11. Facilitate a brief discussion by asking:
    - ✱ Where is sexual intercourse included in the definition of sexuality? In those circles on the flipchart?
      Possible responses: In the center; at the intersection; as small as a do.
12. Emphasize that people often reduce the meaning of sexuality to sexual intercourse, but that that is a very limited and inaccurate view. Sexual intercourse is only one of the ways of expressing sexuality.

Activity B. Identifying Biases and Judgments Related to Sexual Behaviors *(30 minutes)*

1. Introduce this exercise by saying that the group will explore the range of sexual behaviors that people engage in and the attitudes and values that we have about those behaviors. Explain that this interactive exercise will allow everyone to examine their personal values, beliefs, and attitudes about different sexual behaviors in a completely confidential way. It will also help them understand how their beliefs and values might affect their attitudes and behaviors toward clients and the way in which they discuss sexual behaviors with them.
2. Tell the participants that you will give each person one or more cards with a sexual behavior written on it. Instruct them to think about how they personally feel about the particular behaviors written on their cards and to indicate this by writing one of these phrases on the back of the card:
   - *OK for me* (meaning that it is a behavior that I personally would engage in)
   - *OK for others but not for me* (meaning that it is a behavior that I personally would not engage in but that I have no problem with other people doing)
   - *Not OK* (meaning that it is a behavior that no one should engage in because it is morally, ethically, or legally wrong)
3. Remind the participants that this exercise is meant to be completely confidential, so they should not show the behavior on their card or their response to anyone. To ensure confidentiality, you might ask the participants to rearrange their seats or spread around the room so that no one can see their cards and responses.
4. Distribute the sexual behavior cards (face down) and one marker to each participant, attempting to give each person the same number of cards, until all of the cards have been distributed. Invite the participants to look at their cards and think about the behavior written on them.

> **➳ Training Tip**
>
> Instruct the participants that if someone gets a card with a behavior that he or she does not understand, he or she should signal you to ask for an individual explanation. If the behavior is explained in front of the group, the confidentiality of the exercise will be compromised.

5. Repeat what is meant by "OK for me," "OK for others but not for me," and "not OK," and ask if everyone understands.
6. Instruct the participants *not* to write their names on the cards. Ask them to mark on the back of each card their response to the behavior, without showing their cards to anyone. When they are done, they will place the cards, with the behavior face down, in a pile in the center of the room (or a trainer can collect them, without looking at what is written on them).
7. Remind the participants that this exercise is about values and judgments related to sexual behaviors in general; it is not about risk for contracting HIV or some other STI.

8. Mix up the cards and redistribute them to the participants, asking them to take as many cards as they put on the pile.
9. Have the participants take turns, one by one, reading aloud each card and then taping their cards on the wall under the appropriate category ("OK for me," "OK for others but not for me," or "not OK"), according to what is indicated on the back of the card. Remind them to put the card in the category that is marked, even if they personally do not agree with it. Encourage them to line (queue) up to read and post their cards and to move quickly one after the other.

> **➳ Training Tip**
>
> Have the participants take turns, if possible, allowing each to read his or her card aloud and then tape it onto the wall. Although this process takes time, reading aloud is also part of the learning process. The activity contributes to the participants' comfort with pronouncing terms about sexual practices. However, if time is short, the exercise can be completed faster by asking all of the participants to approach the wall at once and to place their cards in the appropriate place on the wall, without reading them.

10. Once all of the cards have been posted, instruct the participants to gather around the wall and to take a few minutes to observe the placement of the cards.
11. Ask the participants: Why do you think I asked you to read aloud as you placed the cards on the wall? After a few responses, tell them that you have done this to increase their level of comfort with using these terms.
12. Facilitate a group discussion based on the questions below. Do not move the cards if there is disagreement. Simply acknowledge the difference of opinion and leave the cards as they are.
    - ✱ Are you surprised by the placement of some of the cards? Which ones surprised you and why?
    - ✱ How would you feel if someone placed a behavior that you engage in yourself in the "not OK" category?
    - ✱ How would you feel if someone placed something you felt was wrong or immoral in one of the "OK" categories?
    - ✱ How did you feel placing someone else's response card on the wall? Would you have felt comfortable placing your own responses in front of the group?
    - ✱ What does this exercise tell us about how clients might feel when providers ask them about their sexual practices?
13. Summarize by stating that we should not question or judge different sexual behaviors or practices as right or wrong. Rather, providers must recognize that these behaviors exist and that they need to be considered during clients' decision making about FP.

➳ Training Tips

- If some of the participants indicate that a particular sexual practice does not exist in their culture (e.g., anal sex), ask other participants whether they agree. Some participants are more aware of variations in sexual behavior than others and can help their colleagues understand the range of behaviors.
- Do not ask the participants to identify who placed any one response in a particular category. If a participant would like to volunteer such information to explain his or her answer, they may do so, but asking might make the participants uncomfortable and would take away the anonymity of the exercise.

Activity C. Summary *(10 minutes)*

Summarize the session by reviewing any of the Essential Ideas on Handout 9 that were *not* covered during the discussions.

Trainer's Tool No. 2 (Session 9)
Different Types of Sexual Behavior

This list includes a wide range of sexual activities and behaviors. Trainers should feel free to add or omit behaviors, depending on the local situation. For the average-sized group (12 to 15 participants), select 25 to 30 behaviors to allow enough time for discussion. If there is more time (e.g., one hour), you can increase the number of behaviors.

Hugging
Kissing
Giving oral sex
Receiving oral sex
Having group sex
Having anal sex
Having sex with someone of the same sex
Using objects or toys during sex
Getting paid for sex
Having sex in public places
Being faithful to one partner
Masturbating
Having vaginal sex
Watching pornographic movies
Having sex with many partners
Having sex with people you do not know
Initiating sexual encounters
Having sex with someone other than your spouse (adultery)
Agreeing to have sex with someone who will not take no for an answer
Paying someone for sex
Having premarital sex
Having sex with a relative considered too close (incest)
Having sex with someone of another race or ethnicity
Having sex whenever your partner wants it
Having sex with someone who is married
Having sex under the influence of drugs or alcohol
Watching other people have sex
Sharing sexual fantasies with others
Being celibate
Having sex in exchange for money to support your children
Having sex without pleasure
Having sex with your spouse because it is your duty
Rape
Placing objects in the rectum
Placing objects in the vagina

Session 10:
Ensuring Optimal Communication

Participants' Learning Objectives

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

Section I: Respect for Clients
- Explain the importance of showing respect for clients
- Describe at least two ways of showing respect for clients

Section II: Praise and Encouragement
- Explain how praise and encouragement can help to build rapport between providers and clients

Section III: Nonverbal Communication
- Describe nonverbal behaviors (such as gestures and body language) and explain how they can affect the client-provider interaction during counseling
- Demonstrate the effect of tone of voice on communication

Section IV: Eliciting Information
- Describe two types of questions to use when attempting to elicit information from clients
- Explain the use and importance of open-ended (and feeling/opinion) questions in assessing clients' needs and knowledge
- Demonstrate how to convert closed-ended questions into open-ended questions

Section V: Listening and Paraphrasing
- Describe at least two purposes of listening as a key communication skill for counseling
- List at least three indicators of active listening
- Name at least two purposes of paraphrasing during counseling
- Demonstrate paraphrasing

Section VI: Challenging Moments in Counseling
- Describe the appropriate provider attitudes when faced with challenging moments in counseling

Time

2 hours, 50 minutes

Materials

For All Sections:
- Flipchart paper, markers, and tape

For Section II: Praise and Encouragement:
- Flipcharts prepared with text (see Advance Preparation)

- Participant Handbook—Handout 10-A: Ensuring Optimal Communication; Handout 10-B: Praise and Encouragement; and Handout 10-C: Examples of Using Praise and Encouragement

For Section IV: Eliciting Information:

- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 10-E: Asking Questions during Counseling

For Section V: Listening and Paraphrasing:

- Flipcharts prepared with text (see Advance Preparation)
- Trainer's Tool No. 1 (Session 7): Belief Statements about Family Planning and Sexual and Reproductive Health
- Participant Handbook—Handout 10-F: Listening and Paraphrasing

For Section VI: Challenging Moments in Counseling:

- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 10-G: Challenging Moments in Counseling

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
Section I: Respect for Clients		
B. Respect for Clients	Discussion	5 mins.
C. Showing Respect for Clients	Exercise/large-group discussion	10 mins.
Section II: Praise and Encouragement		
D. Praise and Encouragement	Large-group discussion	15 mins.
E. Practice	Pairs exercise/discussion	15 mins.
Section III: Nonverbal Communication		
F. Nonverbal Communication	Brainstorm/discussion	15 mins.
G. Tone of Voice	Exercise/discussion	15 mins.
Section IV: Eliciting Information		
H. Purpose of Asking QuestionsBrainstorm	Brainstorm	10 mins.
I. Types of Questions	Presentation	10 mins.
J. Converting Questions.	Large-group work	15 mins.
Section V: Listening and Paraphrasing		
K. Listening and Paraphrasing	Introduction/discussion	15 mins.
L. Practice	Small-group work	20 mins.
Section VI: Challenging Moments in Counseling		
M. Challenging Moments in Counseling	Discussion	10 mins.
N. Summary	Discussion	10 mins.

Advance Preparation

Note: This session includes activities that address multiple aspects of creating a positive counseling environment. Because the participants in this training have experience with counseling FP clients, they are likely to have already mastered at least some of these skills. This session is designed to be adapted by facilitators based on the participants' needs.

As the facilitator, you should be able to identify the participants' common strengths and weaknesses, based on:

- Your exploration of the participants' needs before the workshop
- The results of the precourse knowledge assessment
- Your observations of the way that the participants communicate and talk about communication with and respect for clients

Select the sections of this session that will address the areas in which the participants are weakest. The guidance provided below can assist you in this process.

Complete version: If the strengths and weaknesses of the group are quite varied, you should cover all sections of this session. This gives you an opportunity to use the knowledgeable participants as resource persons during activities such as discussions and role plays.

Short version: If all of the participants are skilled and knowledgeable, you should still give them an opportunity to share what they know about communication skills and review together key aspects of each section. You can lead a large group discussion to achieve this, using questions from each activity to trigger discussion. Encourage them also to give examples of how they use these communication skills in their practice. All of the participants should be encouraged to review all of the handouts for this session before the session. This will help to refresh them and will help them identify questions they have about the topics. Alternatively, you can also use some of the activities from this session as part of warm-up sessions or icebreakers.

The activities address five content areas:

- Respect for clients
- Praise and encouragement
- Nonverbal communication
- Eliciting information (with a focus on open-ended questions)
- Listening and paraphrasing

Section I: Respect for Clients

1. Prepare slips of papers describing in brief keywords characteristics of the client profiles that you choose to use in the "showing respect" exercise (Activity C, Step 1). (You will use the client profiles that were developed by the five groups in Session 6. The description of the client profile might include characteristics such as gender, age, main problem, and so on, which will give a hint to the participant playing that client. For example, if the client is an adolescent, the participant might pretend to be shy.) Make enough copies of the client profile slip so that each participant has one.

Section II: Praise and Encouragement

1. Prepare a flipchart defining praise and encouragement.

[Flipchart for Step D-2]

Praise is the expression of recognition, approval, and admiration.

Encouragement is the provision of support, courage, confidence, and hope.

The purposes of praise and encouragement are to:

- Show that you are listening to the client and valuing what he or she says
- Show your support
- Motivate the client to continue the discussion (telling and asking)

Section III: Nonverbal Communication

1. On separate pieces of paper, write the names of emotions and feelings such as *anger, boredom, sadness, happiness, impatience, disapproval, nervousness, shame, respect, understanding,* and *kindness*.
2. Prepare the flipchart for Step G-6.

[Flipchart for Step G-6]

THREE ASPECTS OF COMMUNICATION

The following three key components of communication have been shown to have varying degrees of impact on the person(s) with whom you are interacting:

Body Language	**55%**
Tone of Voice	**38%**
Actual Words	**7%**

Section IV: Eliciting Information

1. Prepare a flipchart grid (at least two sheets) as follows:

[Flipchart for Step H-2]

Questions: Closed or Open? Information or Feeling/Opinion?		
(C or O)	(I or F)	QUESTIONS

Section V: Listening and Paraphrasing

1. Prepare copies of Handout 10-F from the Participant Handbook.
2. Prepare the "Active Listening" and "Paraphrasing" flipcharts (see below).
3. Select four statements from the "Belief Statements about Family Planning and Sexual and Reproductive Health" (see Trainer's Tool No. 1, Session 7) that were not used during Session 7.

[Flipchart for Step K-2]

ACTIVE LISTENING

Active Listening is listening to another person in a way that communicates **understanding, empathy, and interest.**

- It is different from hearing.
- It requires energy, attentiveness, skills, and commitment.
- It makes the speaker feel important, acknowledged, and empowered.

[Flipchart for Step K-4]

PARAPHRASING

Paraphrasing means restating the client's message simply and in your own words.

The purposes of paraphrasing are to:

- Make sure you correctly understand the client
- Let the client know that you are *trying* to understand what he or she is saying
- Summarize or clarify what the client is saying

Section VI: Challenging Moments in Counseling

1. Prepare a flipchart listing challenging moments in counseling.

[Flipchart for Step M-1]

CHALLENGING MOMENTS IN COUNSELING

- Client becomes silent
- Client cries
- Client refuses help
- Client feels unimportant
- Client is uncomfortable with the provider
- Client accuses the provider
- Provider believes that there is no solution to the problem the client has come for
- Provider makes mistake(s)
- Provider does not know the answer to the client's question
- Provider is short of time

Session 10
Activities

Activity A. Introduction *(5 minutes)*

1. Explain to the participants that you will be reviewing communication skills used in counseling and that these skills are all important in making the client comfortable and ensuring a quality counseling interaction. Communication skills are used in all phases of REDI to build trust and a positive environment between the client and the provider. However, they are especially important in **rapport building** and **exploration**.
2. If you have decided not to include all sections of this session, tell the participants that they will have a chance to ask questions about the other skills that will not be covered explicitly during the session. They will also have the opportunity to practice all of the skills outlined in the Participant Handbook during subsequent counseling practice sessions.

Section I: Respect for Clients

Activity B. Respect *(5 minutes)*

Ask the participants how they show respect to their clients in their own facility setting. *Possible responses:*

- Smiling
- Standing up to greet the person
- Saying "hello" and/or "welcome"
- Shaking hands
- Inviting the person to sit down
- Introducing oneself
- Addressing the person by his or her name
- Maintaining eye contact

Note that what is considered respectful is highly dependent on the social and cultural setting. And not all of the materials below will be appropriate to all settings.

Activity C. Showing Respect for Clients *(10 minutes)*

1. Arrange the chairs in the room to make two concentric circles, with the inner circle being for the "providers" and the outer circle for the "clients." Refer to the client profiles and have each "provider" practice greeting that "client" and showing respect. *(2 minutes each)* Then rotate the client circle so that each provider gets a new client. To make it easier to remember the client's characteristics, you can describe the characteristics briefly in keywords on slips of paper and give these slips to clients before the exercise (see Advance Preparation).

2. Discussion: How did the participants in the provider role feel when they were showing respect? How did the clients feel? What can be done to improve the communication?

Section II: Praise and Encouragement

Activity D. Praise and Encouragement *(15 minutes)*

1. Ask the participants the following questions:
   - ✱ What does *praise* mean to you?
   - ✱ What does *encouragement* mean to you?
   - ✱ How could praise and encouragement be useful in building rapport with clients?

2. Post the flipchart with the definitions of praise and encouragement (see Advance Preparation) and briefly review the definitions listed on Handout 10-B in the Participant Handbook, comparing them to the participants' responses.
3. Before referring the participants to the handout, read one of the examples of clients' statements from the praise/encouragement chart in Handout 10-C. Ask the participants what kind of response from the provider would show praise or encouragement; then read the response given in the chart and compare it to what the participants offered.
4. Continue with the rest of the client statements and possible provider responses.

Activity E. Practice *(15 minutes)*

1. Pair each participant with the person sitting next to him or her. Distribute pieces of writing paper, one sheet to each pair.

   (***Note:*** Brainstorming in the group as a whole can be used instead to shorten the time needed and to allow more participants to respond. The advantage of the pairs exercise is to avoid repetition of the same training method.)
2. Ask each pair to think of one "client statement" that could be challenging for providers to respond to with respect, praise, or encouragement (i.e., because clients are angry, accusing, or frustrated). Participants should write their statement on a sheet of paper and then fold it. Collect the papers, mix them up, and then redistribute them randomly.
3. Give the participants a few moments to read their client statement and to discuss with their partner what kind of response would show respect, praise, or encouragement. If the participants got their own statement, ask them not to let anyone else know but simply act as if it came from someone else.
4. Ask one pair at a time to read their client statement and their response. Ask the group for other possible responses that would show respect, praise, or encouragement.
5. Continue until each pair has responded (or as time permits).

Section III: Nonverbal Communication

Activity F: Nonverbal Communication *(15 minutes)*

1. Explain that when we hear the word *communication*, we usually think of words or what is said. Yet much of our communication with others is done without words.

2. Ask the participants to think for a moment about how babies and young children communicate. How do they get their message across before they learn to talk? *(Possible responses could include smiling, crying, pointing, and frowning.)*
3. Explain that nonverbal signals can communicate interest, attention, warmth, and understanding to clients. Write the word "positive" on the left side of a piece of newsprint and "negative" on the right. Ask the participants to draw on their own experience for examples of positive and negative nonverbal communication. Write each response in the appropriate column on the newsprint. *(See Handout 10-D in the Participant Handbook for possible examples.)*
4. Summarize the discussion by explaining the Essential Ideas in Handout 10-D.

Activity G. Tone of Voice (15 minutes)

1. Explain that tone of voice is an important component of verbal communication for building rapport and tell them that the following exercise will show how tone of voice can communicate different emotions.
2. Ask for 11 volunteers to participate in the exercise. Distribute to the volunteers pieces of paper with the names of emotions and feelings written on them (see the Materials and Advance Preparation).
3. Tell the volunteers that you will say a sample sentence and then ask them to repeat the same sentence using the emotion written on their slip of paper. Sample sentences include "The nurse will see you in a few minutes," "So, you have three sexual partners," and "Please fill out this form." Volunteers can invent other sentences.
4. Ask the rest of the group to guess which emotion is being displayed and discuss how the feeling is shown.
5. Summarize by discussing the following:
   - ✱ Which tone of voice would you prefer were used when you go to someone for help?
   - ✱ Which tones of voice are inappropriate in an FP setting?
6.  To wrap up the activities, post and review the flipchart describing the impact of the three aspects of communication[1] (see Advance Preparation).

Section IV: Eliciting Information

Activity H. Purpose of Asking Questions (10 minutes)

1. Ask the participants:
   - ✱ What is the purpose of asking questions during counseling?
     (Because you will be referring in a moment to the handout, do not write their answers on the flipchart.) *(See the list below for possible responses.)*

[1] This information is taken from work conducted by Albert Mehrabian that was published in 1971 (Mehrabian, A. 1971. *Silent messages*. Wadsworth, CA: Belmont). Of course, the percentages shown in the flipchart relate to interpersonal communication, and they cannot be generalized to all types of communication (e.g., e-mail, communication in a different language, etc.). However, they do help to provide a more general understanding about the nonverbal aspects of communication. (See http://changingminds.org/explanations/behaviors/body_language/mehrabian.htm for more information.)

To accurately assess needs, the provider must elicit information about the client's circumstances, health status, and FP needs and knowledge. This information is key to effective counseling for several reasons:

- To establish a good relationship by showing concern and interest
- To determine what educational/language level will be most easily understood by the client
- To prioritize key issues to target during the counseling session
- To learn what the client already knows and avoid repeating such information
- To identify areas of misinformation that need to be corrected

2. Post the "Questions" flipchart sheets in a place where you can write on them (see Advance Preparation).
3. Ask the participants to brainstorm typical questions that are asked of FP clients. Write each question in the "Question" column exactly as it is stated by the participant. Continue until there are at least 10 questions.

Activity I. Types of Questions *(10 minutes)*

1. Refer the participants to Handout 10-E in the Participant Handbook. Discuss the purposes of asking questions, comparing the information included in the section "Why Do We Ask Questions during FP Counseling?" with what they have just discussed.
2. Then discuss two types of questions—*open-ended* and *closed-ended*—and the purpose of each. Review the examples.

Activity J. Converting Questions *(15 minutes)*

1. Return to the "Questions" flipchart from the brainstorm. For the first question, ask the participants, "Is this closed-ended or open-ended?" Write a "C" or "O" in the first column. Then, for the same question, ask, "Is the content about information or about the feelings/opinions of the client?" Write an "I" or "F" in the second column. Continue for the rest of the list. *(5 minutes)*
2. Tally the number of closed-ended, open-ended, information-related, and feeling/opinion-related questions, and note the totals on the flipchart.
   (***Note:*** In most cases, this list will be predominantly closed-ended questions and questions revealing information but not feelings and opinions.)
3. Ask the participants:
   - ✱ What do you observe from this brief exercise about the kinds of questions most often asked during client-provider communications?
   - ✱ Why does this happen?
   - ✱ What effect would this have on counseling? *(10 minutes)*

   (***Note:*** Probe about the balance or imbalance between open-ended and closed-ended questions and between information-eliciting and feeling-eliciting questions.)

4. Demonstrate how to change a closed-ended question into an open-ended question, using one question from the list. Ask the participants to volunteer to do the same (if possible) for the rest of the questions. If most of the questions are appropriately closed (e.g., age, marital status, number of children, or date of last menstrual cycle, among others), ask for more examples of open-ended questions that would be useful in FP counseling. List these additional questions on a separate piece of flipchart paper. *(5 minutes)*

Section V: Listening and Paraphrasing

Activity K. Listening and Paraphrasing *(15 minutes)*

1. Explain to the participants that while it may seem obvious that listening to the client is an important task in counseling, most observations of client-provider interaction reveal that providers do most of the talking and do not listen well. Ask the participants:
   - ✱ What are some reasons this might be true?
2. Ask the participants:
   - ✱ What is *active listening*?
   - ✱ Why is it important?

3. After a few responses, post the flipchart with the definition of active listening.
4. Ask the participants:
   - ✱ What behaviors and body language (gestures and the movements of the body) would show that a provider is listening actively to what the client is saying?

   (See Essential Ideas in Handout 10-F in the Participant Handbook for possible answers.)

5. Post the "Paraphrasing" flipchart (see Advance Preparation) and briefly review it.
6. Demonstrate paraphrasing with a participant or cotrainer, using one of the belief statements from Trainer's Tool No. 1 (Session 7). See Handout 10-F in the Participant Handbook for examples. Briefly explain how *reflecting* and *clarification* differ from paraphrasing, and emphasize that all of these techniques are used together to enhance active listening.

Activity L. Practice *(20 minutes)*

1. Divide the participants into groups of three. Explain that they will practice listening and paraphrasing in their groups three times. Ask them to decide which person will be the speaker, which one will be the "paraphraser," and which one will be the observer for the first practice. Tell them that the roles will be rotated for the second and third rounds.
2. Give the following instructions: "I will read a statement. The speaker will have one minute to explain why he or she agrees with, disagrees with, or is unsure how he or she feels about the statement. Then the paraphraser will try to restate what the speaker has said, using his or her own words. Finally, the observer will comment and make suggestions about the listening and paraphrasing skills they have observed. Then the group will rotate roles, and I will read another statement." *(about 5 minutes total for Steps 1 and 2)*

3. Read aloud one of the statements from among the "Belief Statements about Family Planning and Sexual and Reproductive Health" (see Trainer's Tool No. 1, Session 7) and ask the speakers to give their opinion—agree, disagree, or unsure—within their group. Stop them after a minute, and ask the paraphrasers to paraphrase. Stop them after a minute and ask the observers to give feedback. *(5 minutes total)*
4. Repeat this exercise twice (with different statements). Tell the participants to rotate roles before each round, so that each person has had a chance to practice listening and paraphrasing. *(10 minutes)*

Challenging Moments in Counseling

Activity M. Challenging Moments in Counseling *(10 minutes)*

1. Tell the participants that despite good communication, counseling includes challenging moments. Post the flipchart entitled "Challenging Moments in Counseling" (see Advance Preparation), and ask a volunteer to read.
2. Taking one challenge from the list at a time, ask the participants what they would do in that situation. Get answers from volunteers and add your own comments as necessary.
3. Repeat Step 2 with other challenges from the list. Make sure there is equal participation from all of the participants. Direct questions to individuals if needed.
4. Refer the participants to Handout 10-G in the Participant Handbook for the full list of challenges and provider attitudes discussed.

Activity N. Summary *(10 minutes)*

1. Ask the participants to summarize what they have learned from this session. Add your own comments as necessary. Ask the participants:
   - ✱ What did you learn from these exercises?
   - ✱ What was difficult? What was easy?
   - ✱ How might these communication skills help you in your work?

   (5 minutes)
2. Ask the participants if they have any questions about the topics covered in the handouts that were not addressed during this session.

Session 11:
Addressing Misconceptions

Participants' Learning Objectives

By the end of the session, the participants will be able to:
- Describe how to address misconceptions about FP methods
- Demonstrate how to correct misconceptions

Time

1 hour

Materials

- Flipchart paper, markers, and tape
- Large cards or writing paper and scissors
- Participant Handbook—Handout 11: Addressing Misconceptions
- Method-specific cue cards (Appendix F)

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. Misconceptions	Brainstorm/discussion	15 mins.
C. Introducing Family Planning Cue Cards	Presentation	10 mins.
D. Handling Misconceptions: Practice	Small-group work/ discussion	30 mins.

Advance Preparation

1. Identify misconceptions prevailing in the local community. (See the "Training Preparations" section in the Introduction for Trainers and Program Planners.)
2. Refer to Trainer's Tool No. 3 (Session 11). Choose six common misconceptions to use during the misconceptions role play. Write them on cards.
3. Review the FP cue cards (Appendix F of this manual) for correct information.
4. Prepare a role play for Activity C. The role play should start with the "client" (already seated) telling the "provider" about a rumor or misconception that he or she has heard. (To keep the role play focused on the skill of handling misconceptions in the course of a counseling session, have the participants start the role play after the initial welcome and introductions.)

5. Prepare a flipchart for Step D-1 (see below). *Note:* This flipchart will stay posted on the wall until the end of the workshop. The participants will refer to this flipchart to structure their feedback for role plays during sessions. For the last item on the flipchart, refer to the guidance presented in each session.

[Flipchart for Step D-1]

FEEDBACK GUIDELINES FOR ROLE PLAYS

- Ask the "client": How did you feel during the role play? How well were your needs met (or not)?
- What did the "provider" do well? What improvements would you suggest?
- What communication skills did the provider use effectively?
- How well did the provider accomplish all the tasks listed for this phase/step?

Session 11
Activities

Activity A. Introduction *(5 minutes)*

1. Review the objectives of the session with the participants.
2. Explain that providers need to be able to respond to common rumors and misconceptions about FP methods. Misconceptions usually surface during the **exploration** phase of REDI. The provider should effectively address them and alleviate the concerns of the client.

Activity B. Misconceptions *(15 minutes)*

1. Brainstorm about local misconceptions and rumors prevailing in the community. Ask the participants to tell the group the most common misconceptions within their communities. Write all answers on a flipchart. See Trainer's Tool No. 3 (Session 11) for examples of misconceptions about various FP methods.
   - Ask what the sources are of rumors or misconceptions.
     Possible responses include:
     - ➤ Unintended misinformation when a person passes on what he or she has heard
     - ➤ Traditional beliefs about the body and health
     - ➤ Exaggerations to make a story more entertaining
     - ➤ Unclear explanations from health care providers or no explanation at all
     - ➤ People trying to explain something that has no obvious explanation, such as an unexpected side effect
     - ➤ Errors or exaggerations in news reports or mass media
     - ➤ Someone trying to hurt the reputation of FP, other reproductive health care, or health care providers
     - ➤ Health care providers who do not feel prepared to provide certain methods—for example, the IUD
2. Direct questions to individuals, asking how they would handle the situation if a client revealed a misconception during counseling. Upon receiving answers from a couple of participants, present the recommendations (from Handout 11) for handling misconceptions with a client and within a community.

Activity C. Introducing Family Planning Cue Cards *(10 minutes)*

1. Tell the participants that the focus of this training is on counseling skills, not on FP methods. Nevertheless, counseling cannot be accurate without correct knowledge of FP methods. In order to ensure that the participants have the most up-to-date information on FP methods, this curriculum provides FP cue cards. These cue cards are used as reference material for the participants and can be used as job aids during counseling.

2. Distribute all cue cards to the participants.
3. Start with the cue card on HTSP and with the Pregnancy Checklist and continue with the method-specific cue cards. Refer also to the Postpartum Family Planning and Postabortion Family Planning cue cards at the end. Using one of the cards as a sample, review the common sections on cards:
   - What is the method?
   - How effective is the method?
   - What are the side effects, health benefits, and health risks of the method?
   - Who can use the method?
   - Who cannot use the method?
   - When should a person start using the method?
   - How is the method used?
   - How should new and returning clients be counseled?
4. Tell the participants that they will need to refer to and use the cards as they prepare for role plays during this training and even when they are conducting role plays. Mention the next role play exercise about handling misconceptions, and remind the participants to familiarize themselves with the layout of the cards, so that they can easily find the information they are looking for.

Activity D. Handling Misconceptions: Practice *(30 minutes)*

1. Post the flipchart entitled "Feedback Guidelines for Role Plays" (see Advance Preparation), and explain how feedback should be structured and presented after role plays. Tell the participants that they will be using this guidance for all role plays conducted during the rest of the workshop. Answer any questions that the participants may have.
2. Do a brief demonstration with another trainer or participant of a role play about handling misconceptions..
3. Ask the participants to comment on how the provider in the role play handled the client's misconception. What was done in accordance with the recommendations in Handout 11? What could the provider have done differently or better? Ask the participants to refer to the flipchart when structuring their feedback.
4. Tell the participants that they will be doing three rounds of similar role plays in groups of three, each time using a different misconception. Group members will assume the roles of provider, client, and observer, and they will switch roles for each new round. Remind the group and emphasize that the role plays will start with the client already seated (i.e., no welcoming or introductions) and raising a misconception or rumor—just like in the role play they have just observed.
5. Tell the participants that after each role play, the observers in each group will provide feedback to those who played the role of the provider. The feedback should cover whether the provider handled the misconception correctly, as per the recommendations in Handout 11, and whether the information given by the provider was correct. Did it accurately reflect the information on the relevant FP cue card?

6. Divide the participants into groups of three and ask them to choose the role of client, provider, or observer. Distribute three misconception cards to each group. *(5 minutes)*
7. Have one of the members of each group role play a counselor interacting with a client who has come to the health care facility with a misconception or rumor about the method they or their partner is using.
8. Every three minutes, have the group members switch roles, using a different misconception card each time. In each round they will use two minutes for the role play and one minute for feedback.
9. Wrap up by asking for volunteers to discuss the importance of providing accurate information to dispel misconceptions.

➳ Training Tip

Make sure there is even representation of all available FP methods and misconceptions prevailing in the local community. Observe the role plays with all members of the training team. During the plenary following the role plays, correct any wrong information that you may have noticed, referring to the relevant FP cue cards.

Trainer's Tool No. 3 (Session 11)

****Do not distribute to the participants****

Common Misconceptions about Family Planning Methods

Pills (both combined and progestin-only)

- Pills cause cancer.
- A woman should take a break from pills after some time.
- Pills will cause deformed babies.
- Pills can make a woman sterile.
- A woman should not take pills if she has not had a baby.
- Pills can make a woman weak.
- If a woman takes pills for a long time, she will still be protected from pregnancy after she stops taking the pills.
- Pills will cure acne.

Injectables

- Women without children cannot use depot medroxyprogesterone acetate (DMPA).
- DMPA causes cancer.
- DMPA causes abortion.
- DMPA makes a woman sterile.

Implants

- Norplant causes cancer.
- Implants can break and move around within a woman's body.

Female Sterilization

- Sterilization will change a woman's monthly periods.
- Sterilization will make menstrual bleeding stop.
- Sterilization will make a woman lose her sexual ability.
- Sterilization will make a woman weak.
- Sterilization will make a woman fat.
- Sterilization involves tying the tubes and can be undone whenever she wants.

Vasectomy

- Vasectomy will make a man lose his sexual ability.
- Vasectomy will make a man weak.

Condoms

- Condoms are mostly used by prostitutes.
- Condoms will make a man weak and impotent.
- Female condoms are too big.
- Condoms often break during sex.

Intrauterine Devices (IUDs)

- An IUD can travel from the woman's uterus to other parts of her body, such as her heart or her brain.
- An IUD will prevent a woman from having babies after it is removed.
- A woman who has never had a baby cannot use an IUD.
- A woman should have a "rest period" after using an IUD for several years.
- An IUD will cause discomfort to the woman's partner during sex.

Spermicides

- Spermicides will cause birth defects.
- Spermicides cause cancer.

Diaphragm

- A diaphragm is uncomfortable for the woman.

Lactational Amenorrhea Method (LAM)

- LAM is not an effective FP method.
- Any type of breastfeeding can protect a woman from pregnancy.

Standard-Days Method

- A woman cannot get pregnant when she is menstruating.
- A woman with irregular cycles cannot get pregnant.

Emergency Contraception (EC)

- EC causes abortion.
- EC is not safe for adolescents.
- Using EC over and over is dangerous.
- If I use EC, I am protected against pregnancy until my next period.
- I can't get EC until it is an emergency.
- EC will harm a pregnancy.

Session 12:
Filling Clients' Knowledge Gaps

Participants' Learning Objectives

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

- Explain how to assess clients' information needs—what topics to cover and in how much depth
- List basic principles of information giving
- Describe a strategy for talking to clients about side effects
- Describe a strategy for telling clients about health risks and complications
- Demonstrate information giving for different FP methods
- List the side effects of four or five of the most commonly used FP methods (in the country)

Time

1 hour, 45 minutes

Materials

- Markers, flipchart paper, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 12-A: Filling Clients' Knowledge Gaps; Handout 12-B: How to Give Information; Handout 12-C: Using REDI to Give Key Information on Contraceptive Methods; and Handout 12-D: Talking about Side Effects, Health Risks, and Complications
- Method-specific cue cards (Appendix F)
- Flipchart from Session 11 ("Feedback Guidelines for Role Plays")
- Cards or candies of four different colors or types to use to divide participants into four groups

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. How to Give Information	Discussion/reading	20 mins.
C. Essential Information for Choosing an FP Method	Mini-lecture/discussion	10 mins.
D. Telling the Client about Side Effects, Health Risks, and Complications	Discussion/presentation	15 mins.
E. Practice Talking about Side Effects	Small-group work/role play	50 mins.
F. Summary		5 mins.

Session 12

Advance Preparation

1. Prepare flipcharts for Steps B-1 and C-2.

[Flipchart for Step B-1]

HOW TO GIVE INFORMATION

[Flipchart for Step C-2]

KEY INFORMATION FOR CLIENTS CHOOSING AN FP METHOD:

1. Effectiveness
2. Side effects, health benefits, health risks, and complications
3. How to use, how to obtain, what to expect during the procedure
   (for IUD, injectables, implants, and sterilization)
4. When to return
5. Prevention of HIV and other STIs

[Flipchart for Step E-3—already prepared in Session 11]

FEEDBACK GUIDELINES FOR ROLE PLAYS

- Ask the "client": How did you feel during the role play? How well were your needs met (or not)?
- What did the "provider" do well? What improvements would you suggest?
- What communication skills did the provider use effectively?
- How well did the provider accomplish all the tasks listed for this phase/step?

2. Prepare a mini-lecture (maximum 5 minutes) for Step C-2, using the information from Handout 12-C in the Participant Handbook.
3. Identify the available FP methods in the country/region.

Session 12
Activities

Activity A. Introduction *(5 minutes)*

1. Tell the participants that the title of this session is "Filling Clients' Knowledge Gaps." Explain that one of the purposes of counseling is to share information that is tailored to the client's needs and fills the client's knowledge gaps. This is simply about assessing what the client already knows and giving information accordingly. This counseling task falls under the **exploration** phase of REDI.
2. Review the objectives of the session.

Activity B. How to Give Information *(20 minutes)*

1. Post the flipchart for Step B-1 ("How to Give Information") (see Advance Preparation), and lead a brainstorming session about how information should be given to a client during counseling. To guide the discussion, ask:
   - ✱ What do you think the key principles are when providing information to the client?
   - ✱ How can we help clients understand and remember the information we give them?
2. Note the responses for both questions on the same flipchart.
3. Refer the participants to Handout 12-B in the Participant Handbook. Invite the participants to read the handout on their own and ask if they have any questions or anything to add.
4. Ask the participants:
   - ✱ What do you think *tailoring* information means?
   - ✱ What does *putting the risk* into perspective mean?

   Ask for concrete examples of how they would tailor the information and how they would "put the risk into perspective."

Activity C. Essential Information for Choosing an FP Method *(10 minutes)*

1. Tell the participants that you will now examine what the client needs to know about FP methods to be able to choose one. Remind them that the information covered in each counseling session will vary depending on the client. There should not be preset scripts. The provider needs to interact with the client, explore what the client wants and needs to know and any concerns he or she might have, assess the client's situation, and respond appropriately.
   Ask the participants:
   - ✱ What information does the client need to have when choosing an FP method?

   Take a few answers without writing anything down.

2. Post the flipchart you have prepared (see Advance Preparation, flipchart for Step C-2) and give a mini-lecture about the key information for clients choosing an FP method. (Refer to Handout 12-C in the Participant Handbook for information to include in the mini-lecture.)
3. Ask the participants:
   - ✱ How will the information differ for new clients who have already chosen a method and those who have not?
   - ✱ How will the information differ for returning clients who are already using a method?

Activity D. Informing the Client about Side Effects, Health Risks, and Complications *(15 minutes)*

1. Start a discussion about side effects by asking the following questions to the large group. For every question, ask the participants to reflect on their own experience. Remind them that the provider should begin with exploring what the client knows and any questions he or she might have.

   Key questions to ask:

   - ✱ What is the difference between side effects and health risks/complications?
   - ✱ How should a provider talk about side effects during counseling?
   - ✱ How should a provider tell the client about possible health risks/complications?
2. Refer the participants to Handout 12-D in the Participant Handbook and walk them quickly through the handout.

Activity E. Practice Talking about Side Effects *(50 minutes)*

1. Divide the participants into four groups—new groups this time, not the groups they were in when they developed the client profiles. Assign each group one FP method and ask them to use the cue card for that method as their source of information. Ask them to discuss and decide on an appropriate way to talk about the side effects, health risks, and complications of that method with a new client.
2. Give them 10 minutes for preparation. Remind them that at the end two people from each group will be asked to role play giving information about a specific method and talking about side effects of that method with a new client for four to five minutes. Remind them that role plays will start at the point where the "client" has shown interest in a specific FP method. The "provider" will start by saying, "Let me give you some information on this method."

3. Invite each group, one by one, to demonstrate their role play for the large group. After each group has demonstrated, spend four or five minutes soliciting feedback from the larger group. To structure the feedback, refer the participants to the flipchart posted in Session 11 ("Feedback Guidelines for Role Plays"). First ask the role players to comment on their own performance. Then ask the larger group to give feedback. Discuss and clarify the side effects of each method (see FP cue cards), as needed.

4. Ensure that the groups adhere to the principles and elements of giving information during the role plays.

Activity F. Summary *(5 minutes)*

Ask for two volunteers to summarize the two parts of the session: (1) principles of giving information and (2) talking about side effects, health risks, and complications (see Handouts 12-B and 12-D in the Participant Handbook).

Session 13:
Using Simple Language and Visual Aids during Counseling

Participants' Learning Objectives

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

- Identify the colloquial terms that clients use to describe reproductive anatomy and physiology as well as sexual practices
- Explain how visual aids should be used during counseling
- Demonstrate the use of nontechnical language to explain reproductive physiology and medical terms to clients

Time

1 hour, 5 minutes

Materials

- Flipcharts with text (see Advance Preparation)
- Participant Handbook—Handout 13-A: Using Simple Language and Visual Aids during Counseling; Handout 13-B: Using Visual Aids for Counseling; and Handout 13-C: Female and Male Reproductive System

(*Note:* The last two pages of Handout 13-C contain illustrations of the female and male reproductive systems. These illustrations are also intended as visual aids that the participants can use in the future.)

Session Outline

Training Activities	Methodology	Time
A. Introduction		5 mins.
B. Exploring Terms That Clients Use	Large-group exercise	15 mins.
C. Using Visual Aids	Demonstration	15 mins.
D. Explaining in Clients Terms	Role play	20 mins.
E. Summary	Discussion	10 mins.

Advance Preparation

1. Prepare three flipcharts for Step B-2 with some of the medical terms that are defined in Handout 13-C in the Participant Handbook, allowing plenty of space below each term for the participants to write the words used locally (see Training Tip, page 13-2).

➳ Training Tip

The sample flipcharts are just suggestions. Based on the participants' needs identified in previous sessions of the workshop (such as lack of comfort using terms about sexuality and tendency to use too many medical terms), you might replace some of these with other terms from Handout 13-C.

[Flipchart for Step B-2]

VAGINA	UTERUS
CERVIX	OVUM

[Flipchart for Step B-1]

PENIS	SEMEN
TESTICLES	SCROTUM

[Flipchart for Step B-1]

OVULATION	MENSTRUATION
SEXUAL INTERCOURSE	EJACULATION

2. Post the flipcharts on a wall or on flipchart stands, with plenty of space between them.
3. Make sure that the space in front of the wall is cleared so that participants will have enough room to move around as they write the local terms for these words.
4. With another member of the training team, prepare a brief demonstration on how to use visual aids in counseling, using locally available materials. For guidance, see "Tips on Using IEC Materials" on Handout 13-B in the Participant Handbook.

5. Practice using the illustrations on Handout 13-C in the Participant Handbook and explaining reproductive anatomy and physiology. Refer to the text for simple descriptions of anatomy and physiology to incorporate into your demonstration.
6. Assemble a variety of visual aids that might be used in counseling—examples include illustrations of anatomy, anatomical models, counseling flipcharts, client brochures, wall charts, posters, and FP cue cards. Choose the three that are the most commonly available and practice using them before the demonstration.

Session 13
Activities

Activity A. Introduction *(5 minutes)*

1. Review the objectives of the session with the participants.
2. Explain that in this session, you will continue strengthening skills for the **exploration** phase of REDI. This session specifically addresses two skills: using language that clients can understand and using visual aids.

Activity B. Exploring Terms That Clients Use *(15 minutes)*

1. Tell the participants that the first activity will be an exercise to identify the terms that clients use to describe reproductive organs and their functions.

2. Show the three flipcharts that you posted on the walls (see Advance Preparation).
3. Ask the participants to spend five minutes writing colloquial terms or phrases that are **used by clients** to describe the listed terms. They should write terms they have heard, even if they do not personally use them and even if they find the words objectionable.

> **➳ Training Tip**
>
> Emphasize that you are asking for terms that their clients use. Otherwise, some participants might list crude or offending words that are not actually used by clients.

4. When the participants finish writing, ask them to come and stand close to the wall.
5. Review the terms used. Comment on where terms are clustered. Discuss the following:
   - What was it like for you to hear and say these words?
   - Which category of words are clients most likely to know or understand?
   - How could you respond if a client uses a term that you consider crude or inappropriate?
   - How do you think this exercise can help us in communicating with our clients?
6. Tell the participants that at the end of the session, they will practice explaining medical terms to clients, using colloquial terms that they can understand.

Activity C. Using Visual Aids *(15 minutes)*

1. Tell the participants that another way of enhancing clients' understanding is to use visual aids and that you will be demonstrating how to do this.
2. Using any locally available visual aids, give a demonstration of how to use one of the job aids in counseling (see Advance Preparation). *(5 minutes)*
3. Ask the participants to observe and comment at the end. *(5 minutes)*

4. Review "Tips on Using IEC Materials" on Handout 13-B in the Participant Handbook.
5. Refer the participants to the illustrations of female and male reproductive systems on Handout 13-C in the Participant Handbook. Tell them that in the next activity and going forward, they will practice the use of visual aids at each role play they conduct. Add that they can also use those illustrations as visual aids in their workplaces.

Activity D. Explaining in Clients' Terms *(20 minutes)*

1. Explain that the purpose of this exercise is to use role plays to practice using nontechnical language that can be easily understood by clients and using visual aids. Everyone will get a chance to practice.
2. Refer the participants to Handout 13-C in the Participant Handbook. Have them take turns reading each definition out loud for the group. After going through a few definitions, remind them that these are just guidelines; everyone will have their own way of saying things, but these explanations demonstrate that it is possible to explain medical terms using nontechnical language.
3. Explain that they will work in groups of three to practice explaining medical terms to clients in nontechnical language. Within each group, one person will play the provider and another will play the client. The third person will be the observer. There will be three rounds of practice, with different sets of medical terms to be explained in each round. The "provider" will have three minutes to explain the medical terms to the "client." The medical terms will be shown to the participants on a flipchart at the beginning of each round. Remind the participants that the provider needs to ask what the client already knows and to use colloquial terms and visual aids, as appropriate, and that the client can ask questions at any time. After the role play has been completed, the participants playing the observer and the client will have one minute to give feedback to the participant playing the provider (within each small group), including what was done well and what could be improved. When the first round is finished, the members of the group will switch roles, so that somebody else becomes the provider and another person becomes the client. (By the end of this exercise, each participant will have played each role.)
4. Divide the participants into groups of three, with as much space as possible between the groups, and ask them to decide who will play the provider, the client, and the observer.

5. Write the words *ovulation, sexual intercourse,* and *ejaculation* on a flipchart in the front of the room. Ask the "providers" to start the role play.

> **➳ Training Tip**
>
> During the first role play, remember to move quickly from group to group, both to observe and to make sure that the instructions have been understood correctly. If one group is not following the instructions, correct them gently but immediately. If more than one group is confused, stop the role plays, explain the instructions again to all of the participants, and start over. If one participant in particular is having problems with the task, come back to that group after checking with the other groups, and provide additional guidance.

6. After three minutes, ask the participants playing the providers to stop their explanations. Each group's client and observer should now begin one minute of feedback.

7. Write the words *menstruation, conception,* and *miscarriage (spontaneous abortion)* on the flipchart and ask the new providers to begin. Ask them to explain these three terms to the new clients.
8. After three minutes, stop the providers. After one minute for feedback, ask the participants to switch roles again.

9. Write the words *sexually transmitted infection, discharge,* and *contraception* on the flipchart and ask the new providers to begin. Stop them after three minutes and start the feedback.

Activity D. Summary *(10 minutes)*

Facilitate a discussion based on the following questions:

- What did you learn from this exercise?
- Which terms were the most difficult to explain? Why?
- Did the providers always check to see what the clients already knew before beginning the explanation? What happened when they did not?
- How did the visual aids help in explaining the terms?
- How can you apply what you have learned from this activity in your work?

Session 14:
Exploring Clients' Sexual Relationships

Participants' Learning Objectives

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

- Explain to clients that sensitive and personal issues and sexual relationships and behaviors will be discussed in counseling
- Identify a strategy to introduce sexuality during counseling
- Demonstrate comfort when introducing the topic of sexuality with clients
- List at least three questions that providers can use to help clients explore their sexual lives, including the social context of their sexual relationships

Time

1 hour, 35 minutes

Materials

- Markers—one for each participant, if possible
- Flipcharts prepared with text (see Advance Preparation)
- Masking tape
- Participant Handbook—Handout 14: Exploring Clients' Sexual Relationships; Participant Handbook Appendix B: Learning Guides for FP Counseling Skills
- Trainer's Tool No. 4 (Session 14)

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Introducing the Subject of Sexuality	Brainstorm/discussion	20 mins.
C. Practice	Role plays/discussion	25 mins.
D. Exploring Clients' Sexual Relationships	Discussion/presentation	10 mins.
E. Developing Questions and Statements	Small-group work	30 mins.
F. Summary	Discussion	5 mins.

Advance Preparation

1. Review the **exploration** phase of REDI, with a focus on steps for this session (see Trainer's Tool No. 4).

2. Prepare the three flipcharts for Step E-1.

[Flipchart for Step E-1]

SEXUAL RELATIONSHIPS	COMMUNICATING WITH PARTNER	PARTNER'S OTHER RELATIONSHIPS
Issues to explore: • What sexual relationship(s) are you in? • What is the nature of your relationship(s) (including violence or abuse)? • How do you feel about it? **Questions you could ask your clients:**	**Issues to explore:** • How do you communicate with your partner about sexuality, FP, and HIV and other STIs? **Questions you could ask your clients:**	**Issues to explore:** • What do you know about your partner's sexual behaviors outside your relationship? **Questions you could ask your clients:**

3. For Activity E, think of sample questions for each category that would be easier for providers to ask their clients, given the social and cultural norms of their community. (See Trainer's Tool No. 4 for some ideas. These will differ from one culture and community to the next.)

Adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York.

Session 14
Activities

Activity A. Introduction *(5 minutes)*

1. Remind the participants that you have already discussed in Session 9 why clients' sexual life and practices need to be explored in FP counseling. Explain that during counseling, sexuality should be introduced tactfully and not abruptly. In the **rapport-building** phase of REDI, the counselor should prepare the client to discuss personal and sensitive issues during counseling. Then in the **exploration** phase, the counselor should explore the context of the client's sexual relationships. This session will build skills for introducing the subject of sexuality and exploring the client's sexual relationships during counseling.
2. Review the objectives of the session by referring the participants to Handout 14 in the Participant Handbook.

Activity B. Introducing the Subject of Sexuality *(20 minutes)*

1. To introduce the discussion of sexuality issues in a counseling session, the provider must overcome his or her own nervousness and the client's possible embarrassment. Having a structured approach for beginning the discussion will increase the provider's confidence and ensure that issues that are important to the client are addressed. The provider must remember, however, that it is his or her responsibility to initiate these discussions and put the client at ease.
2. Ask the participants:
   - ✱ How can providers introduce the subjects of sexuality, sexual relationships, and sexual behaviors in a way that puts clients at ease?
3. Encourage three to four responses. (Because you will be referring quickly to Handout 14, do not write their answers on the flipchart.)
4. Refer the participants to Handout 14 in the Participant Handbook. Discuss the Essential Ideas and each of the key points listed in the "Sample Statements for Introducing Sexuality" table. Review sample statements for each point and then ask:
   - ✱ How would you say this to clients in your own service setting?

Activity C. Practice *(25 minutes)*

1. Divide the participants into pairs. Explain that they will role play being a provider and introducing the subject of sexuality to a client, following the guidelines in the handout and keeping in mind how their own beliefs may affect the way they introduce the topic. The participant in the client role will choose one of the client profiles as his or her role. The pair will have only two minutes for each role play and then will switch roles, with the new "client" choosing a new profile.

2. Before starting the first role play, check to see that each pair has identified who will be the provider, who will be the client, and which profile the client is playing. (It is okay for more than one group to role play the same client profile at the same time.) *(5 minutes)*
3. Ask the participants to start their role play. Stop them after two minutes. Allow for one minute between role plays to let the new "client" choose a different profile. Announce the time for the new role plays to start. Stop them after two minutes. *(5 minutes)*
4. Briefly request feedback from the participants by asking the following questions:
   - ✱ How did it feel to play the role of the provider?
   - ✱ How did it feel to play the role of the client? What did you observe about the provider's body language and mannerisms as he or she explained the need to ask questions about your sexual life? *(5 minutes)*
5. From your observations during the practice role plays, select one pair to demonstrate how to introduce the subject of sexuality to a client. *(2 minutes)*
6. Ask the rest of the participants to give feedback on the role play by asking the following questions:
   - ✱ What was going on between the provider and the client?
   - ✱ What did the provider do that was effective in this situation?
   - ✱ What might the provider consider doing differently next time?

Activity D. Exploring Clients' Sexual Relationships *(10 minutes)*

1. Ask the participants whether and how they have been exploring the context of clients' sexual relationships (see Essential Ideas on Handout 14 of the Participant Handbook). Solicit a couple of answers and proceed to the next step.
2. Now ask the participants to look at Appendix B in the Participant Handbook. Refer them to Steps 9 and 10 in the Learning Guide for FP Counseling Skills for New Clients.
3. Explain that the right-hand column (next to Steps 9 and 10) contains a list of issues that the provider should address. The issues need to be restated as questions in simpler language and in a way that would be acceptable to providers and clients in their own communities. The purpose of this session is to draft questions that the participants would feel comfortable asking a client and that would elicit the information needed to help the client accurately assess his or her risk for unintended pregnancy and HIV and other STIs.
4. Note that in a counseling session, the provider already would have identified the reason for the client's visit and told the client that personal and sensitive issues would be discussed. Also, for the purpose of this session, the participants should assume that they have asked the client about his or her situation, concerns, and desired outcome from the visit. Now they are ready to ask some of the more sensitive questions about sexual behaviors and relationships.

Activity E. Developing Questions and Statements (30 minutes)

1. Post the flipcharts with the headings of the areas to explore (see Advance Preparation).
2. Read the issues for exploration that you wrote under each flipchart heading. Ask for suggestions for how to make these more acceptable to both the provider and the client in their own facility settings. Explain that the participants should draft questions and statements that they would feel comfortable using with a client and that would elicit the information needed for their assigned flipchart. If they feel they could ask the question(s) written on the flipchart, this is fine, but they should also add more questions, in case the client does not understand.
3. Explain that they will have 10 minutes to draft their suggestions on Participant Worksheet No. 1 and write them on the flipchart.
4. Divide the participants into three groups. Assign questions to the groups. Distribute the flipcharts and ask them to start.

> **➳ Training Tip**
>
> If the groups are too large (i.e., more than five participants per group), split them into six groups and assign two groups to each heading. They can record their questions on Participant Worksheet No. 1, and then a trainer can write them on the flipchart during the large-group discussion. It might prove interesting to compare the questions from the two groups.

5. Quickly visit each group to be sure that they understand the assignment and ask if they have any questions. *(10 minutes for Steps 1–5)*
6. Have the first group (sexual relationships) post their flipchart and read the questions they drafted. Ask for comments or additions from the others. Add, as appropriate, from Trainer's Tool No. 4 for this activity. Have each group present their questions in this way. *(15 minutes)*
7. Ask the participants:
   - ✱ How do you think clients would feel about your asking these questions?
   - ✱ What could you do to make the client more comfortable?
8. Remind the participants that they can use Participant Worksheet No. 1 in the Participant Handbook to record some of the questions that their teams drafted for this exercise.

Activity F. Summary *(5 minutes)*

Ask the participants:

1. What would you do differently now to help clients consider their sexual relationship(s) when making well-considered FP decisions?
2. Wrap up the session by reviewing any of the Essential Ideas from Handout 14 that were *not* covered during the feedback. Emphasize that it is the provider's responsibility to be comfortable enough to introduce the subject of sexuality and to help the client feel comfortable about responding to questions.

Trainer's Tool No. 4 (Session 14)

Sample Questions to Use to Explore the Context of a Client's Sexual Relationships

Questions from the REDI framework	Questions you could ask your clients
• What sexual relationships are you in? • What is the nature of your relationship(s) (including violence or abuse)? *Probe all if more than one.* • How do you feel about it (them)?	***Note:*** *Confirm marital status before asking one of the following sets of questions.* If not married, ask: • Now I will ask you a personal question: Are you with somebody now? • How long have you been with this man or woman? • Do you have more than one partner? If married, ask: • How long have you been married? • Is this your first marriage? For all clients, ask: • What decisions can you make in your current relationship(s)? • How many children do you have? • How many children do you want to have? • Who influences your decisions about how many children to have and when to have them? • Are all of your children from the same father/mother? • How does he or she (or they) treat you? • How do you feel about that?
• How do you communicate with your partner(s) about sexuality, FP, and HIV and other STIs?	• How do you talk about FP with your partner(s)? • If you do not talk with him or her, why not? • Now I will ask a sensitive question: How do you talk about sex with your partner(s)? • If you do not talk with him or her, why not? • How do you talk about HIV and other STIs with your partner(s)? • If you do not talk with him or her, why not? • Does your partner support you in using FP? • What is his or her attitude about whose responsibility it is? • Is he or she willing to use an FP method/a condom? • Does he or she have preferences or concerns regarding specific methods? ***Note:*** These questions should be asked for all partners if the client has more than one partner.
• What do you know about your partner's or partners' sexual behavior outside of your relationship?	• How do couples deal with outside relationships in your community? • Now I will ask some very sensitive and personal questions: Do you know if your partner has any outside relationships? What do you know about your partner's outside relationships (if any)? • How do you feel about that? • Does he or she have other wives? [depending on the culture] • What do you know about signs of STIs? [If nothing, then briefly explain.] • Have you ever noticed anything like these signs in your partner(s)? What about you?

Session 15:
The Risk Continuum

Participants' Learning Objectives

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

- Identify the risk for pregnancy and transmission of HIV and other STIs associated with various sexual and nonsexual behaviors
- Explain how particular behaviors can be high-risk in one situation and low-risk in another
- Identify ways of lowering the risk associated with some behaviors
- Explain in simple terms which behaviors put people at risk for pregnancy, HIV, and other STIs

Time

50 minutes

Materials

- Four white cards or pieces of paper to be used for risk levels
- 39 cards or pieces of paper of three different colors (13 of each color) prepared with text (see Advance Preparation)
- Computer and printer (if behavior cards will be printed from electronic file)
- Scissors
- Pens and markers
- Masking tape
- Participant Handbook—Handout 15-A: The Risk Continuum; Handout 15-B: Behaviors by Type of Risk; and Handout 15-C: Risk Factors for HIV and Other STIs

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Risk Continuum	Large-group exercise	10 mins.
C. Factors Affecting Risk	Discussion	25 mins.
D. Summary	Discussion	10 mins.

Advance Preparation

1. Review Trainer's Tool No. 5 (Session 15) for background on the risk continuum and the factors that influence risk.

2. Review the Training Tips for Activity B, and decide how you want to distribute the behavior cards.
3. Prepare four risk-level cards, using white cards or paper, with the following titles: "No Risk," "Low Risk," "Medium Risk," and "High Risk."
4. Prepare behavior cards using colored paper or cards; these cards should be about half the size of a standard sheet of writing paper. Each behavior will be written on three cards—one card labeled "Pregnancy Risk," the second one labeled "HIV Risk," and the third labeled "STI Risk." Try to use one color of paper for all of the "Pregnancy Risk" cards (e.g., blue), a different color for all of the "HIV Risk" cards (e.g., yellow), and a third color for all of the "STI Risk" cards (e.g., pink). (See Trainer's Tool No. 5 for the behaviors and for details on the preparation of the cards.) Cards can also be printed.
5. Post the risk-level cards high on a wall, with plenty of space between the cards and plenty of space below them so that the participants can post the behavior cards. Place the cards in the order shown below to create a continuum from no risk to high risk.

No Risk	Low Risk	Medium Risk	High Risk

6. Make sure that the space in front of the wall is cleared so that the participants will have enough room to move around as they post the behavior cards.
7. Prepare enough small pieces of tape in advance so that the participants will be able to stick cards or pieces of paper to the wall quickly.

Adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York.

Session 15
Activities

Activity A. Introduction *(5 minutes)*

1. Explain to the participants that, having already focused on the attitudes and communication skills needed for effective counseling, the group now will consider the information that clients and providers need to help clients assess their own FP needs. Helping clients perceive their risk for unintended pregnancy and HIV or other STI transmission is among the counselor's tasks in the **exploration** phase of REDI. This session provides background information about assessing clients' individual risk for HIV, other STIs, and unintended pregnancy.
2. Explain that helping clients to explore their FP needs is about helping them to perceive their own risk accurately—whether for unintended pregnancy or STIs—so they can make decisions that will reduce their risk. The concepts of risk and risk reduction pose a challenge to providers and clients alike. One reason is that many people are confused about the facts related to the transmission of HIV and other STIs and about conception. Another reason is that the same behavior may be risky in one situation and not risky in another or risky for pregnancy but not risky for STIs (and vice versa). This session is intended to clarify the various levels of risk related to different behaviors and different outcomes.
3. Conduct a quick brainstorm: Ask the participants to describe, in simple terms, the behaviors that put people at risk for pregnancy and HIV and other STIs. (Hold no discussion at this point.) Explain that you will return to these concepts at the end of the session.

Activity B. Risk Continuum *(10 minutes)*

1. Distribute all of the behavior cards to the participants, ensuring that, if possible, each participant has the same number of cards.
2. Explain that each card has a risk outcome label (pregnancy, HIV, or STI) *and* a behavior. The participants must determine what level of risk that behavior poses for pregnancy, HIV transmission, or STI transmission (whichever is written on the card). For example, if a card says "Pregnancy Risk" and "Masturbation," they must determine the level of risk that masturbation poses for pregnancy, using the four risk-level categories ("No Risk," "Low Risk," "Medium Risk," or "High Risk"). (***Note:*** The "STI Risk" cards refer to risk for transmitting STIs *other than* HIV.)
3. Tell them that they will work in pairs to determine the level of risk for the behaviors listed on the cards they have received.
4. Point out the risk-level cards placed on the wall. Once the pairs have determined the risk level for a behavior and a condition, they should go to the wall and, using the tape provided, place each of their cards on the wall under the sign for that level of risk.

➳ Training Tips

Working individually or in pairs (teams)

This exercise can be conducted in pairs or small teams. If the participants are already knowledgeable on this subject, working individually is fine. However, if the participants do not know much about this area, it might be advantageous to put two or more participants together, because they will have to pool their knowledge and justify their placement of the cards. Greater learning happens when the participants discuss these issues among themselves before hearing the answers from the trainer. In addition, individual participants will not feel as awkward about having misconceptions about this subject if they can see that their colleagues are also confused.

Distribution of cards

The purpose of the exercise is to clarify the participants' thinking about different types of risky behavior and how to explain this clearly to clients. The two options for distributing the cards will achieve this purpose in slightly different ways.

Option A: The basic issues of risks for pregnancy, HIV, and STIs would be reinforced most effectively by giving each participant (or team) a set of three cards *with the same behavior* and asking them to decide the level of risk that that one behavior poses for pregnancy, HIV, or some other STI.

Option B: If the group is somewhat knowledgeable in these areas, it would be more challenging to mix up the cards and distribute them randomly. This might require additional time, however.

When participants get stuck

For some of the cards, there is no right answer. The placement of the behavior in a risk category depends on many factors, such as whether either partner is already infected (for HIV and STI risk), whether it is the fertile time of the woman's cycle (for pregnancy risk), or whether the spouse tells the truth about not having other relationships. So it is absolutely correct for the participants to say "it depends" when trying to figure out where to place their card. The trainer should encourage the participants to do their best with the information (or lack thereof) that is given on the card. If that becomes too frustrating, the trainer can suggest that the participants add the information they need to place it in a particular category. Encouraging this kind of thinking is precisely the goal of this exercise—to understand risk and the necessity of individualizing that information to each client's unique situation. The participants' conclusion when "it depends"—in cases in which they feel they need more information in order to assess the risk—should be that the provider should do an in-depth exploration of clients' circumstances through counseling.

Activity C. Factors Affecting Risk *(25 minutes)*

1. Once all cards are placed on the wall and the participants are still standing near the wall, read the cards in each category, beginning with "No Risk," and ask:
   - ✱ Do you have questions about the placement of any behaviors in this category?
   - ✱ Where do you think the cards should go and why?
2. Allow the participants to answer each other's questions whenever possible and to share their knowledge of the relative risks of various behaviors. Affirm accurate responses and correct any misconceptions that do not get resolved in discussion among the participants. Place the cards in their correct categories if they have been incorrectly placed.

➳ Training Tips

- The purpose of the discussion is to explore all of the different conditions that can change the risk level of a behavior. Emphasize that "it depends" is the right answer most of the time. (This applies to the table in Handout 15-B of the Participant Handbook as well.) The fact that it is very difficult to correctly assess risk with limited information about the client's circumstances highlights once again the importance of an in-depth exploration of each client's social context, sexual relationships, and circumstances during counseling. If there is disagreement about the placement of a card, encourage the participants to explain how they decided the risk level for that card.
- Sometimes the participants place behaviors that they find offensive in the "high risk" category, even if they present little risk for pregnancy or infection. If this happens in your group, recall how attitudes and judgments can influence a provider's perception and assessment of a client's behavior.

Refer to Handout 15-B: Behaviors by Type of Risk

- If the participants have very little knowledge in this area, another option for discussion would be to refer them to Handout 15-B in the Participant Handbook, which includes a table showing a risk continuum. The participants can then compare their own placement of behaviors with what is shown in the table and discuss the differences. However, if they do this, the discussion might lose focus because many of the participants will be reading the table rather than listening and thinking.
- If at all possible, help them think through these issues on their own and refer them to the continuum at the end of the session. Consider scheduling time later (during the warm-up or wrap-up) for questions related to the continuum.

3. After reviewing the categories, ask the following questions about the whole continuum *(see Handouts 15-B and 15-C in the Participant Handbook for possible answers):*
   - ✱ Why do some behaviors belong in both the "no risk" and the "high risk" categories?
   - ✱ How does the relationship between two individuals affect their level of risk? (Facilitate a discussion based on the information in the "Relationship Factors and Risk for HIV and Other STIs" section of Handout 15-C in the Participant Handbook.)

- How do biological factors affect an individual's level of risk? (Facilitate a discussion based on the information in the "Biological Factors and Risk for HIV and Other STIs" section of Handout 15-C in the Participant Handbook.)
- How can some behaviors be moved to a lower level of risk?

Activity D. Summary *(10 minutes)*

1. Ask the participants again:
   - How would you explain to clients which behaviors put people at risk for pregnancy?
   - How would you explain to clients which behaviors put people at risk for STI transmission?
   - How would you explain to clients which behaviors put people at risk for HIV transmission?
2. Refer the participants to Handouts 15-A, 15-B, and 15-C in the Participant Handbook and review with them the Essential Ideas. Briefly review the contents. Point out the risk continuum table (Handout 15-B), if you have not done so already, and the "Family Planning Methods and the Risk for HIV and Other STIs" and "Preventing Mother-to-Child Transmission of HIV" sections of Handout 15-C for their future reference. Suggest that they review the handouts on their own, and offer to answer further questions related to the risk continuum at a later time in the training.

Trainer's Tool No. 5 (Session 15)

****Do not distribute to the participants****

Sexual and Reproductive Health Risk Continuum: Sample Behavior Cards

Behaviors

- Abstinence
- Masturbation
- Anal sex using a condom
- Sitting on a public toilet seat
- Unprotected vaginal sex with your spouse
- Rubbing genitals together without penetration, unclothed
- Unprotected vaginal sex with a monogamous, uninfected partner
- Vaginal sex with multiple partners, always using a condom
- Vaginal sex with one partner, using a condom
- Oral sex on a man
- Oral sex on a woman
- Deep (tongue) kissing
- Anal sex without using a condom

Make three cards for each behavior—one for each area of risk. If possible, make all of the risk cards the same color (e.g., all of the pregnancy risk cards blue, all of the HIV risk cards yellow, and all of the STI risk cards pink).

Example:

PREGNANCY RISK

UNPROTECTED VAGINAL SEX WITH A MONOGAMOUS, UNINFECTED PARTNER

HIV RISK

UNPROTECTED VAGINAL SEX WITH A MONOGAMOUS, UNINFECTED PARTNER

STI RISK

UNPROTECTED VAGINAL SEX WITH A MONOGAMOUS, UNINFECTED PARTNER

Session 16:
Risk Assessment: Improving Clients' Perception of Risk

Participants' Learning Objectives

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

- Define *risk assessment*
- Explain why and how risk assessment is used in counseling
- Identify at least three reasons why it is difficult for people to perceive their own risks
- Describe at least two ways in which they can help clients perceive and understand their own risks for unintended pregnancy and for transmission of HIV and other STIs
- Describe how *self risk assessment* is done

Time

50 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 16: Risk Assessment: Improving Clients' Perception of Risk

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Risk Assessment	Presentation/discussion	20 mins.
C. Applying Risk Assessment and Self Risk Assessment	Discussion	25 mins.

Advance Preparation

1. Review Steps 11 and 12 of the **exploration** phase of REDI in Learning Guide for FP Counseling Skills for New Clients (Appendix B in the Participant Handbook) with a focus on the steps for this session.

2. Prepare flipcharts for Steps A-3 and B-2 (see below).

[Flipchart for Step A-3]

Risk assessment is a counseling process to help clients understand the risk of getting pregnant or becoming infected that is associated with sexual practices in which they or their partners engage, and how the level of risk might increase or decrease depending on changes in circumstances and behaviors.

Why do we do it?

- To help clients assess their own risk so that they can use this information to reduce their risk by changing risky behaviors
- To gain an increased understanding of clients' behaviors and circumstances so that we can better tailor counseling

[Flipchart for Step B-2]

Reasons why people underestimate their risk:

- Stereotyped beliefs about who is at risk
- The illusion of invulnerability
- Fatalism
- Bigger or more urgent problems
- Misconceptions about risk
- Traditional gender roles and societal expectations

Adapted from: EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York.

Session 16
Activities

Activity A. Introduction *(5 minutes)*

1. Explain to the participants that, having discussed different categories of risk and the behaviors and social factors that influence risk (Session 15), it is time to focus on the provider's role in helping the client to assess his or her own risk. Risk assessment is one of the tasks under the exploration phase of REDI.
2. Ask the participants:
   - ✱ What does risk assessment mean to you?

3. After getting a couple of responses, post the flipchart with the definition of risk assessment and briefly explain it (see Advance Preparation, flipchart for Step A-3).

Activity B. Risk Assessment *(20 minutes)*

1. Explain that most people generally underestimate their own risks, including their risk for unintended pregnancy and transmission of HIV and other STIs. Ask the participants to give a few reasons why people find it difficult to perceive their risks for SRH problems. Solicit just a few responses without writing them down.

2. Post the flipchart with the six reasons why clients underestimate their risk (see Advance Preparation). Ask for volunteers to explain each reason.
3. Facilitate a brief discussion by asking the following questions *(see Handout 16 in Participant Handbook for possible responses)*:
   - ✱ Why is a client's perception of his or her own risk so important?
   - ✱ Which of the reasons why clients underestimate their risk apply to our "portrayed" clients? Why?

Activity C. Applying Risk Assessment and Self Risk Assessment *(25 minutes)*

1. Ask the participants to refer to Step 11 of the Learning Guide for FP Counseling Skills for New Clients (Appendix B in the Participant Handbook). Invite the entire group to brainstorm how they would actually ask the following questions from Step 11:
   - Ask the client if he or she feels at risk for contracting HIV or another STI.
   - Ask the client if he or she thinks that his or her partners might be at risk for unintended pregnancy or STI transmission, and explore the reasons.

2. Discuss each suggestion briefly to see if people agree with the questions; then write them on a flipchart.
3. Take one of the client profiles as an example and note that we should assume that the client has answered "no" to the first two questions (i.e., the client has answered that he or she is not at risk for contracting an STI, nor is his or her partner) but that you know he or she is indeed at risk. Ask the participants:

- ✱ How would you explain the risk of HIV or STI transmission to this client?
- ✱ What questions could you ask to help the client relate these risks to his or her own situation?

4. Ask the participants the following question (see "Importance of Client's Perception of Risk" on Handout 16 in the Participant Handbook for possible points to cover):

   ✱ What are some ways in which providers can help clients perceive and understand their risks?

   After getting answers from volunteers, refer to Handout 16 in the Participant Handbook and review the ways in which counselors can help clients perceive their risks.

5. Explain what self risk assessment is. (See "Self Risk Assessment" in Handout 16 of the Participant Handbook for possible points to cover and for an example of self risk assessment for an IUD client.)

6. To summarize, ask the participants the following question:

   ✱ How can you apply risk assessment in the counseling you provide?

   (See "How do we use REDI in risk assessment?" on Handout 16 in the Participant Handbook.)

Session 17:
Helping Clients Make or Confirm Decisions

Participants' Learning Objectives

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

- Identify the types of decisions clients might need to make
- Explain the steps in the decision-making process
- Describe how providers can help clients eliminate FP methods that do not respond to their needs
- Practice use of a quick reference chart for the WHO Medical Eligibility Criteria
- Demonstrate how to help and support clients in making their own decisions

Time

1 hour, 45 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts with text (see Advance Preparation)
- Participant Handbook—Handout 17-A: Helping Clients Make or Confirm Decisions; Handout 17-B: FHI's Quick Reference Chart for the Medical Eligibility Criteria of WHO

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation/discussion	15 mins.
B. Helping Clients Eliminate Methods	Large-group discussion	10 mins.
C. The Decision-Making Process and the Impact of Power Imbalances	Demonstration role play and feedback/discussion	20 mins.
D. Medical Eligibility Criteria for FP Methods	Handout review and exercise	15 mins.
E. Helping Clients Make Decisions	Role play/large-group discussion	40 mins.
F. Summary	Large-group discussion	5 mins.

Session 17

Advance Preparation

1. Prepare the flipchart for Step A-5 (see below).

[Flipchart for Step A-5]

DECISION-MAKING PROCESS

1. Identify the decisions that need to be made or confirmed during the counseling session.
2. Explore relevant options for each decision.
3. Help the client weigh the benefits, disadvantages, and consequences of each appropriate option.
4. Encourage the client to make his or her own decision.

2. Prepare the demonstration role play with one of the training team members, using Trainer's Tool No. 6.
3. Decide which three of the client profiles (among the ones already developed) you want the participants to use for practice in groups. The demonstration role play will have a woman with no method in mind as the client. Make sure that the selected profiles reflect all three of the other categories of clients: new clients with a method in mind, returning clients with no concerns, and returning clients with concerns. If the existing client profiles do not match those categories, change the situation of the client profiles by giving each client profile group a situation card (see Introduction for Trainers and Program Planners)—for example, one client returns to the facility with complaints, another comes in as a new client, and so on.

Session 17
Activities

Activity A. Introduction *(15 minutes)*

1. Tell the participants that, starting with this session, they will begin building skills for the **decision-making** phase of REDI.
2. Remind the participants about your discussions at the beginning of the workshop on the decisions that different categories of clients face (see Session 4). Stress that different categories of clients must make different types of decisions. Tell them that in this session you will be taking a closer look at the decisions clients can make or confirm during counseling.
3. Ask the participants to give examples of decisions that clients have to make. *(See Handout 17-A in the Participant Handbook for possible answers.)* Solicit a few answers but do not write them down. For each answer mentioned, ask the participants if the decision is for new clients or return clients.
4. Review Handout 17-A in the Participants Handbook with the participants, highlighting how the decisions and counseling differ for new and return clients.

5. Post the flipchart listing the steps of the decision-making process (see Advance Preparation).

Activity B. Helping Clients Eliminate Methods *(10 minutes)*

1. Tell the participants that for new FP clients, exploring relevant options mostly means ruling out FP methods that are not relevant to the client's expressed needs or wishes. At this point, the provider has already given sufficient information on all relevant FP methods (see Session 12), and the client only needs guidance on eliminating methods that are not suitable for him or her. This guidance can be given in a structured way by reviewing what has been explored about the client's situation and preferences.

2. Ask the participants to tell how they are helping their clients eliminate FP methods that do not meet their needs and methods that are medically contraindicated. Solicit a couple of answers and list them on a flipchart.
3. Remind the participants about the questions they would ask the client in the **exploration** phase to decide which methods to cover and in what level of detail. Note only the parts in bold on the flipchart as you remind them of the questions.
   - Does the client want any more children? (**permanent vs. temporary** methods)
   - How long does the client want to be protected from pregnancy? (**long-acting vs. short-acting** methods)
   - Can the client use and does the client want to use hormonal methods? (hormonal vs. nonhormonal methods)
   - Does the client want a method for herself or himself or for his or her partner? (**male vs. female methods**)

- Does the client want a method that will be **used each time he or she has sexual relations**, or does he or she want continuous protection?

Since these questions have already narrowed down the client's choices to a few methods, at this point the provider will list the methods and remind the client why each one would or would not be an option for the client, based on the client's answers to the questions above. For example:

> *Sterilization is not an option for you because you said you are still considering having one more child. Since you said you might want to get pregnant after this year, and you do not mind using a hormonal method, both pills and monthly injectables might work for you. As I said, copper IUDs work for up to 12 years, and implants work for three to seven years. And you thought it wouldn't be worth all the hassle of insertion of these methods, given the relatively short amount of time that you need protection. You said your husband would not be interested in using condoms, didn't you? In this case, you are left with the options of pills and monthly injectables.*

4. Ask the participants if they have any questions and tell them to observe how the provider will help the client rule out FP methods during the role play in the next activity.

Activity C. The Decision-Making Process and the Impact of Power Imbalances *(20 minutes)*

1. Have members of the training team conduct the demonstration role play of the decision-making phase of counseling, based on the guidance provided in Trainer's Tool No. 6 (Session 17). *(10 minutes)*

2. Ask the participants for feedback on how well the role play demonstrated the steps in decision making and what improvements they would suggest. Refer them to the flipchart from Session 11, "Feedback Guidelines for Role Plays," and this session's flipchart that lists the steps in the decision-making process.
3. Ask: How did the provider help the client eliminate methods? *(5 minutes for Steps 2 and 3)*
4. Remind the participants that a client's decision making might be affected by a power imbalance between the provider and the client. The power imbalance might result from the difference in the status of the client and the provider. Ask:

   ✱ What are some signs of a power imbalance between the provider and the client in this counseling session?

   (Possible answers include not respecting the client, not establishing or maintaining eye contact, not listening to the client, not allowing the client to ask questions, taking an authoritative attitude, not allowing the client to decide, and dictating or prescribing the approach.)

   ✱ What impact could a power imbalance have on this interaction?

   (Possible answers include client not trustingthe provider, client not revealing all the information about her or his life, client hesitating to ask questions, client not being able to make his or her own decision, and client leaving the facility with unanswered questions and needs.)

- What could the provider do to overcome the barriers caused by this imbalance? *(Possible answers include exploring his or her own values, beliefs, and attitudes to prevent them from interfering with the client-provider interaction; accepting that each client is an expert on his or her own life; accepting that decisions made out of the client's own context are not easy to implement and are not long-lasting; and improving communication skills.) (5 minutes for all three questions)*

Activity D: Medical Eligibility Criteria for FP Methods *(15 minutes)*

1. Ask the participants what they should do if the client chooses a method that is not medically appropriate for him or her. Get as many views as you can from different participants.
2. Tell the participants that providers should be aware that they might be pressuring the client to make the decision that seems medically "correct." The client's decision should be his or her own, while taking the provider's medical opinion into consideration. *(5 minutes for Steps 1 and 2)*
3. Tell the participants to use the WHO medical eligibility criteria as a reference for the most up-to-date medical opinion on which groups of clients are eligible for which methods. Refer them to Handout 17-B in the Participant Handbook and briefly review the summary chart on medical eligibility criteria for contraceptive use. Explain the categories and which colors represent which categories; give examples; and ask the participants to find the categories for a couple of situations or medical conditions. For example, ask them:
   - What category is combined oral contraceptive use for a client with severe cirrhosis?
   - What category is Cu-IUD use for a client with a history of pelvic inflammatory disease two months ago?
   - What category is DMPA use for breastfeeding women less than six weeks postpartum?
   - What category is copper IUD use for a client who has AIDS but is well and on antiretroviral therapy? *(10 minutes for all four questions)*
4. Wrap up the discussion by telling the participants that they will use this summary chart on medical eligibility criteria as a reference in the role plays and at their workplaces.

Activity E. Helping Clients Make Decisions *(40 minutes)*

1. Divide the participants into groups of three, with as much space as possible between the groups. Ask for a volunteer in each group to be the first one to play the provider and another to be the first client. The third person will be an observer. (The roles should be changed for each of the three role plays, so that by the end of this exercise, each participant will have played each role.)
2. Assign one of the client profiles you have identified so that each group is using the same "client" (see Advance Preparation).
3. Ask the groups to do a five-minute role play on the decision-making process. Remind all groups to start at the point where the **rapport-building** and **exploration** phases of the REDI counseling process have been completed. Encourage them to use the FP cue cards (Appendix A in the Participant Handbook) before and during the role play. Those con-

ducting the role play and the observer should refer to the flipchart that identifies the steps involved in the decision-making process as a guide. The observer should write down notes about the client-provider interaction, answering the following questions:

a. Did the provider help the client identify decisions that needed to be made?
b. Did the provider explain the appropriate options for the client?
c. Did the provider help the client weigh the consequences of each option?
d. Did the provider help the client reach or confirm his or her decision?

The trainers should circulate among the groups to observe the role plays. *(10 minutes for Steps 1–3*)

4. Lead a brief large-group discussion after the role play to discuss the participants' experience in each role, what worked, and what was difficult from the perspectives of client, provider, and observer. *(5 minutes)*
5. Repeat the role play two more times with different client profiles and different participants playing the providers. At the end of the activity, each participant will have played the client, the provider, and the observer. *(15 minutes)*

Activity F. Summary *(5 minutes)*

1. Ask the volunteers to describe how decision making differs for each type of client.
2. Ask the participants what they would like to change in their practice now that they have completed this session.

Trainer's Tool No. 6 (Session 17)
Guidance for Decision-Making Role Play

The role play starts when the rapport-building and exploration phases of counseling have been completed. Therefore, there will not be any greeting or introductions, and the role play will start with the client and the provider already seated.

The dialogue below is not intended as a script and should not be read word for word. Rather, it is intended to provide guidance on the language that should be incorporated into the role play. The desired language is underlined.

Provider	Now, let's review the decisions you need to make. You said that you want to use a family planning method. Now that we have discussed all available methods, you need to make a decision about which method to use. Do you need any more information? **(Identifying the decisions that need to be made)**
Client	No, I am interested in the IUD. I think I will have it.
Provider	Since you don't want any more children, the IUD will work for you because it provides long-term protection. Female sterilization and vasectomy also provide long-term protection, but they need to be considered permanent. I also told you about the implant, but as you know it is not available in our province, and you said you do not want a hormonal method. **(Exploring relevant options for the decision; eliminating other methods)**
Client	I'll go for the IUD.
Provider	Let me remind you of the side effects you might experience in the first few months. You might have longer periods and more cramping during periods. How do you feel about this? Do you think you can tolerate it? **(Helping the client weigh the benefits, disadvantages, and consequences of options)**
Client	That's fine, if it is only for the first couple of months.
Provider	What about your husband? How would he feel about your using an IUD? **(Helping the client weigh the benefits, disadvantages, and consequences of options)**
Client	He never interferes with that. He doesn't want any more children, and he supports me in doing something to prevent that.
Provider	If an IUD is inserted, you will need to come to the facility after your first period following the insertion. Can you do that? **(Helping the client weigh the benefits, disadvantages, and consequences of options)**
Client	Oh, that's no problem. I come to town every Wednesday for the market.
Provider	Okay. What about the cost? **(Helping the client weigh the benefits, disadvantages, and consequences of options)**
Client	Well, it is fine since I'll pay only once.
Provider	And we don't charge anything for the follow-up visit after your first period. **(Helping the client weigh the benefits, disadvantages, and consequences of options)**
Client	Good to know.
Provider	So, your decision is . . . **(Encouraging the client to make his or her own decision)**
Client	. . . the IUD, yes.

Session 18:
Decision Making for Permanent Methods

Participants' Learning Objectives

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

- Explain how permanent methods differ from temporary methods and why they warrant special attention during counseling
- List the factors contributing to sound decision making and possible regret
- List the topics that should be covered when counseling for permanent methods
- List the seven information elements of informed consent for permanent methods

Time

1 hour, 5 minutes

Materials

- Flipchart paper, marker, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 18: Decision Making for Permanent Methods

Session Outline

Training Activities	Methodology	Time
A. Introduction	Large-group discussion	15 mins.
B. Preventing Future Regret	Brainstorm/large-group discussion	20 mins.
C. Informed Consent	Large-group discussion	25 mins.
D. Summary	Large-group discussion	5 mins.

Advance Preparation

1. Determine the legal situation regarding permanent methods in the country. Obtain copies of the informed consent forms used in the country.

2. Prepare flipcharts for Step B-1 and Step C-5 (see below).

[Flipcharts for Step B-1]

FACTORS CONTRIBUTING TO SOUND DECISION MAKING	FACTORS CONTRIBUTING TO POSSIBLE REGRET

[Flipchart for Step C-5]

THE SEVEN INFORMATION ELEMENTS OF INFORMED CONSENT FOR CONTRACEPTIVE STERILIZATION

1. **Temporary methods of contraception are available** to me and my partner.
2. **The procedure to be performed on me is a surgical procedure,** the details of which have been explained to me.
3. **This surgical procedure involves risks, in addition to benefits,** which have been explained to me, and I understand the information that has been given to me. Among the risks is the possibility that the procedure might fail.
4. If the procedure is successful, **I will be unable to have any more children.**
5. **The effect of the procedure should be considered permanent.**
6. **The procedure does not protect me or my partner from infection** with sexually transmitted infections, including HIV/AIDS.
7. **I can decide not to have the operation at any time before the procedure is performed, even on the operating table** (without losing the right to medical, health, or other services or benefits).

Session 18
Activities

Activity A. Introduction *(15 minutes)*

1. Tell the participants that you will again be working on the **decision-making** phase of REDI in this session. This time the focus will be on decision making for permanent methods.
2. Review the session objectives with the participants.
3. Ask the participants the following questions *(see Handout 18 in the Participant Handbook for possible responses)*:
   - ✱ How do permanent methods differ from temporary methods?
   - ✱ Why and how does counseling clients who are interested in permanent contraception differ from counseling them about temporary methods?
   - ✱ Why is it important to inform clients about the possible risks associated with female sterilization and vasectomy, and how should this be done?
   - ✱ Even though reversal might be possible, why should counselors tell clients that female sterilization and vasectomy are meant to be permanent? How would you talk to a client who expresses interest in the possibility of reversal? What would this interest indicate to you?
   - ✱ Because female sterilization and vasectomy are considered permanent, they often involve unique legal considerations, which may have a bearing on counseling. What is the legal situation in your country and what are the associated implications for counseling?

Activity B. Preventing Future Regret *(20 minutes)*

1. Ask the participants to reflect on their experience with clients (or their relatives and friends) who are making a decision about female sterilization or vasectomy. Post the two prepared flipcharts with the headings "Factors Contributing to Sound Decision Making" and "Factors Contributing to Possible Regret" (see Advance Preparation).
2. Ask the participants the following questions *(see Handout 18 in the Participant Handbook for possible responses)*:
   - ✱ Which factors would you look for to ensure that a client is making a sound decision about undergoing sterilization?
   - ✱ Which factors would suggest to you that the client may regret his or her decision in the future?
   - ✱ When is the appropriate time for a postabortion or postpartum client to make a decision about sterilization?
3. Write the answers on the flipcharts under the matching heading.
4. Review Handout 18 in the Participant Handbook.

5. Conclude the discussion by making the following points:
   - Regret can be triggered by a major change in circumstance, such as the loss of a child or partner or divorce and remarriage. It can also result from unrealistic expectations about the operation, uncertainty about having additional children, and the psychological and social importance of fertility and the implications of ending it.
   - Regret is sometimes strong enough to lead clients to seek reversal. Because reversal is usually not a feasible option, it is important to try to help clients avoid later regret.
   - Clients who are at risk for regretting their decision require careful attention during counseling. If a client appears to be at risk for regret, the counselor should explore his or her situation and discuss future situations and life changes that might lead the client to change his or her mind about having another child.
   - If a client does not seem to be making a well-considered choice or has unrealistic expectations, encourage him or her to take more time to make a decision. Also encourage use of a temporary, long-acting method in the meantime and provide appropriate information.

Activity C. Informed Consent *(25 minutes)*

1. Ask the participants what they think should be covered during counseling for permanent methods. *(See the Essential Ideas on Handout 18 in the Participant Handbook for possible responses.)*
2. After getting a few answers and adding missing key points, remind them that the cue cards on female sterilization and vasectomy contain detailed technical information on these methods.
3. Tell the participants that a unique aspect of permanent methods counseling is the need to document informed consent by having the client complete and sign an informed consent form.
4. Ask whether any of the participants have used an informed consent form and/or whether these are used in their country. If the form is used in their country, what does it contain?

5. Refer the participants to Handout 18 in the Participant Handbook and review the seven information elements of informed consent on the flipchart prepared in advance. Ask if the informed consent form used in their country contains all of the seven information elements.
6. Ask the participants the following questions *(see Handout 18 for possible responses)*:
   - ✱ Why is informed consent important?
   - ✱ When should informed consent be documented?
   - ✱ When is it not appropriate to obtain informed consent, and why?

Activity D. Summary *(5 minutes)*

Wrap up the session by asking the participants how counseling for permanent methods is done in their facilities.

Session 19:
Helping Clients Implement Their Decisions

Participants' Learning Objectives

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

- Identify the components of an implementation plan
- Demonstrate how to help clients develop a plan to implement their decisions (such as FP decisions, decisions about risk reduction to prevent HIV and other STIs, and so on)
- Demonstrate how to explain the FP method chosen by the client and how to use it
- Demonstrate how to help clients identify challenges in using their choice of method and strategies for overcoming the challenges

Time

1 hour, 15 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Participant Handbook—Handout 19: Helping Clients Implement Their Decisions
- Flipchart from Session 11, "Feedback Guidelines for Role Plays"

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	10 mins.
B. Making a Concrete Plan	Brainstorm/small-group work	40 mins.
C. Practice and Feedback	Role play/discussion	20 mins.
D. Summary	Discussion	5 mins.

Advance Preparation

1. Prepare flipcharts for Steps A-4 and B-2 (see sample flipcharts on page 19-2).

[Flipchart for Step A-4]

PHASE 4: IMPLEMENTING THE DECISION

1. Assist the client in making a concrete and specific plan for carrying out his or her decision (including correct use of the method chosen).
2. Have the client develop the skills to use his or her chosen method and condoms.
3. Identify barriers that the client might face in implementing the plan.
4. Develop strategies to overcome the barriers identified.
5. Make a plan for follow-up and provide referrals, as needed.

[Flipchart for Step B-2]

What does the client need to know about obtaining and using the chosen method?

[Flipchart for Step B-2]

What possible barriers might the client encounter?

What skills might the client need?

2. In this session, the participants have the opportunity to refer to the FP cue cards and to refresh their knowledge of FP methods. Make sure that all of the FP methods available in the country are represented in the client profiles defined by the groups. To make sure that all methods are discussed, you might ask some groups to change methods. You can do this by giving the client profile group a situation card. The card might include a change in the client's situation, as in the example below.

SITUATION CARD

Ms. Client [replace with the name of the actual client in the profile for that group] ***comes back to the facility saying that she has had her IUD removed*** [replace with the method that you want the client to discontinue] ***and now she wants to try the three-monthly injectables*** [replace with the method you want the client profile to switch to].

Session 19
Activities

Activity A. Introduction *(10 minutes)*

1. Tell the participants that starting with this session, you will be focusing on the last phase of REDI, **implementing the decision.** This session will provide an overview of the **implementing the decision** phase and will focus on the first two implementation steps. The remaining steps of this phase will be covered in greater detail in Sessions 20–24.
2. Review the session objectives with the participants.
3. Tell the participants that clients might make one or more decisions during a counseling session, including deciding on an FP method, deciding to reduce the risk of contracting HIV and/or other STIs, deciding to communicate with the partner, and so on. After a client has made a decision, it is important to have a specific plan for how he or she will carry it out. The plan should help the client develop the skills needed for communicating with his or her partner(s) and implementing any behavior change necessary to use the chosen method.

4. Post the prepared flipchart on implementation (see Advance Preparation) and briefly review the five steps.
5. Note that in this session the participants will practice helping the client to develop a plan to carry out his or her decision(s) (Step 1). This includes reviewing information about how to use the method correctly and identifying barriers that might interfere with implementing the decision. (***Note:*** Sessions 20–24 focus on specific skills for condom use, partner communication and negotiation, making a plan for follow-up, and helping return clients continue their decisions through follow-up visits.)

Activity B. Making a Concrete Plan *(40 minutes)*

1. Tell the participants that assisting the client in making a concrete plan is the first step of the **implementing the decision** phase of REDI. Start a discussion by asking the following questions *(see "Implementing the Decision—Steps in Detail" on Handout 19 in the Participant Handbook for possible answers)*:
   - ✱ Why is a concrete plan needed?
   - ✱ What should the client's plan include?
   - ✱ How can the provider make sure that the client is making a concrete implementation plan? *(5 minutes for all three questions)*

2. Post the prepared flipcharts (see Advance Preparation) and brainstorm the major considerations in the first step (making a concrete plan) of the **implementing the decision** phase of REDI. Probe as needed by asking, "What does the client need to know?" "What possible barriers to implementing the decision might the client encounter?" "What strategies or skills might the client need to develop?" Write responses on the prepared flipcharts. *(See "Implementing the Decision—Steps in Detail" on Handout 19 in the Participant Handbook for possible responses.)*

3. Remind the participants that although the provider and the client already discussed how the method is used in the exploration and decision-making phases, now it is time to explain in detail how the client should use the chosen method. This will require more detail than covered previously. Tell the participants that in this session they will practice giving detailed information about the client's chosen method.
4. Ask the participants:

   ✱ How would you help the client identify possible challenges and barriers to the implementation of his or her decision?

   (See "Implementing the Decision—Steps in Detail" on Handout 19 in the Participant Handbook for possible responses. If necessary, remind the participants to consider decisions other than choosing an FP method, such as deciding to reduce one's risk for STIs.)
5. Ask the participants to turn to Handout 19 in the Participant Handbook. Review the "Implementing the Decision—Steps in Detail" and "Essential Information on Method Use to Impart to Clients" sections together.
6. Tell the participants that now they will work in their client profile groups to prepare for a role play. Refer them to Worksheet No. 2 in the Participant Handbook. Point to the guiding questions to be answered in Worksheet No. 2, which will help them prepare for the role play. Their tasks are to help their portrayed client make a concrete plan, to give their client the information he or she will need to be able to use the specific method he or she has chosen, and to help the client identify possible challenges and barriers to the implementation of his or her decision.
7. Give groups 20 minutes to complete the task. During this time, they should also practice brief role plays modeling how to cover this information with their client profile. Remind them that they can refer to "Implementing the Decision—Steps in Detail" on Handout 19 and the method-specific FP cue cards in Appendix A of the Participant Handbook. Tell them that you will select two groups to present their work to the large group in a five-minute role play in which one member will play the provider and another will play the client. The role plays will start after the client has decided on a specific method and will address how to use the method—that is, the provider will start the role play by saying, "So, you have decided to use [name of the method]. Now let's talk about how to use the method that you have selected and what you need to be able to use it correctly" (or "Now let's make a plan about how to use it"). The role play will continue from that point and will include reviewing what the client needs to know about using the method, exploring what barriers the client foresees, helping the client develop strategies for overcoming the barriers, and assisting the client with building the skills necessary to overcome the barriers.

Activity C. Practice and Feedback *(20 minutes)*

Select two groups to present their role plays for five minutes each. After each role play, solicit feedback based on the "Feedback Guidelines for Role Plays" already posted (flipchart from Session 11):

- Check with the "client" to see how satisfied he or she was with the counseling provided during the role play.

- Then ask the "provider" to comment on his or her own performance, referring to the flipchart with the five steps of the **implementing the decision** phase of REDI.
- Finally, ask the large group to comment on the role play based on the five steps (tasks) of the **implementing the decision** phase of REDI that were posted at the beginning of the session.
  - ✱ Did the provider help the client develop a concrete plan?
  - ✱ Did the provider give all of the information on how to obtain and use the method? Was anything missing?
  - ✱ Did the provider help the client identify possible challenges and barriers?
  - ✱ Did the provider help the client develop strategies and acquire skills to overcome these barriers?
  - ✱ Did the provider develop a follow up plan with the client?

Activity D. Summary *(5 minutes)*

Discuss and summarize the session by asking:

- ✱ How different is this from the counseling that you were doing before?
- ✱ How can you apply this in your workplace?

Session 20:
Dual Protection and Condom Use

Participants' Learning Objectives

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

- Define *dual protection and dual-method use*
- List ways of achieving dual protection
- Explain how counseling on dual protection supports informed and voluntary decision making
- Identify challenges to dual protection
- List the steps for using a male condom in the correct order
- List the steps for using a female condom in the correct order (if the female condom is used in the activity)
- Demonstrate the use of a male condom on a penis model

Time

1 hour, 10 minutes (1 hour, 35 minutes if all activities related to the female condom are covered)

Materials

- Flipcharts prepared with text (see Advance Preparation)
- One set of "condom race cards" for each team
- Penis models and a pelvic model for the female condom (optional)
- Condoms (male and female)
- Participant Handbook—Handout 20: Dual Protection and Condoms

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Dual Protection	Discussion	20 mins.
C. Condom Races	Small-group work	20–30 mins.
D. Condom Use Demonstration and Practice	Discussion Demonstration/practice	20–35 mins.
E. Summary	Discussion	5 mins.

Session 20

Advance Preparation

1. Prepare flipcharts for Steps B-1, B-2, and B-3 (see below).

[Flipchart for Step B-1]

Dual protection is:

A strategy to prevent both transmission of STIs and unintended pregnancy by using condoms alone, using condoms combined with other methods (dual-method use), or avoiding risky sex

[Flipchart for Step B-2]

Dual-method use is:

- Condom + another contraceptive method against pregnancy
- Condom + emergency contraception (EC)
- Selective condom use + another FP method (e.g., using the pill with a primary partner but the pill plus condoms with other partners)

[Flipchart for Step B-3]

Ways of achieving dual protection:

1. Condom alone
2. Dual-method use
3. Avoiding risky sexual behaviors
   - Mutual monogamy between uninfected partners + FP method
   - Abstinence
   - Avoiding penetrative sex
   - Delayed sexual debut

2. Familiarize yourself with the correct order of steps for using male and female condoms.
3. Check on the availability of female condoms in the country (this should have been done before the course) and make the following decisions:
   a. Will the female condom be included in the condom races exercise? If so, this exercise requires female condoms and at least two pelvic models, and it will add 10 minutes to the exercise.
   b. Will you demonstrate the use of the female condom? Demonstrating the female condom requires two female condoms (one spare) and one pelvic model.
   c. Will the participants practice the use of the female condom on a pelvic model (and if so, when and how)? This requires enough female condoms (at least one for each participant) and pelvic models to allow a number of participants to practice concurrently in pairs or small groups. The duration of practice will depend on how many participants can practice concurrently on models.

4. Prepare one set of condom race cards for each team. You can print them from the electronic file included with the curriculum. (The teams should consist of six to 10 people each.) Each set of cards consists of 13 8.5 x 11 inch sheets of paper. Print or write one step from "Steps for Using a Male Condom" (Handout 20 in the Participant Handbook) in large letters on each sheet. To keep the sets of cards separate, you might want to write the steps on different-colored sheets of paper. If you have decided to do the exercise with the female condom, copy the steps from "Steps for Using a Female Condom" from Handout 20.
5. Make sure that there are enough penis models for every participant to practice condom use. If you do not have enough models, you can use cucumbers, bananas, or markers as substitutes.
6. Make sure you have enough condoms for all of the participants to practice.
7. Have small prizes, such as candies, for the group that wins the condom race.

Session 20
Activities

Activity A. Introduction *(5 minutes)*

1. Begin by explaining that clients who have identified themselves or their partners in the **exploration** phase of REDI as being at risk for HIV or other STIshave probably made a decision to reduce their risk in the **decision-making** phase. For such clients, the **implementing the decision** phase should cover information and skills for how to reduce the risk of contracting an STI. Therefore, in this session, the participants will be taking a close look at the concept of *dual protection and skills for condom use*.
2. Review the objectives of the session with the participants.

Activity B. Dual Protection *(15 minutes)*

1. Ask the participants what *dual protection* means. After taking a few answers, post the flipchart with the definition of dual protection (see Advance Preparation).

2. Ask the participants to explain what they understand from the term *dual-method use*. Post the prepared flipchart with the definition of dual-method use, and review the types of dual method use (see Advance Preparation) .

3. Next, ask them the ways of achieving dual protection. After getting answers from a few volunteers, post the prepared flipchart with *ways of achieving dual protection* (see Advance Preparation).
4. Lead a discussion by asking the following questions *(see Handout 20 in the Participant Handbook for possible answers)*:

   ✱ How does counseling about dual protection support the concept of informed and voluntary decision making?

   ✱ Why do you think some clients would find it challenging or unappealing to use dual methods (i.e., condoms along with another FP method)?

   ✱ How would you respond to clients who tell you that their partners refuse to use condoms?

   Probe for possible reasons not to use condoms and ask for possible responses to counter those excuses *(see Handout 20 in the Participant Handbook for possible reasons and responses)*. After soliciting a few responses, refer the participants to the list of "Condom Excuses and Responses" in Handout 20 in the Participant Handbook.

Activity C. Condom Races *(20 minutes; 30 minutes if the exercise is repeated using the female condom)*

1. Divide the participants into two or three groups of six to 10 people each, depending on the number of participants.

2. Explain that you will be distributing a set of 13 cards and that each card states one of the steps involved in using a condom. These cards have been mixed up, and the participants will be asked to place them in the correct order.
3. Inform the participants that their group's job is to:
   - Line the cards up on the floor so that the steps for using a condom are in the correct order
   - Complete the task faster than the other groups without making any mistakes

   The first group to finish with no mistakes will be the winner.

> **➳ Training Tips**
>
> This exercise is usually a lot of fun for the participants and can be used to build energy in the group. It also provides an excellent opportunity to get the participants to talk about using condoms, which will allow you to correct any incorrect ideas that they might have.
>
> As in any game, some participants might become very competitive about winning the contest. Some might want to argue about the order of the cards. If that happens, you can use the opportunity to review the steps, explaining each one in slightly more detail. Do not spend too much time defending the order.

4. Hand each group a set of cards and let the race begin.
5. Keep time for each group. Let all groups finish before judging finished lineups for accuracy.
6. Start by reviewing the lineup of the group that finished first. Call all groups to view the lineup and to correct any mistakes. If the first group does not have the right order, review other groups' lineups. Repeat the correct order of the steps out loud so that all of the participants can hear.
7. Announce the winning team. Distribute prizes to the members of the winning team.
8. Ask the participants to return to the large group.
9. Repeat Steps 1–7 for the female condom (optional).

Activity D. Condom Use Demonstration and Practice *(20 minutes; 35 minutes if the activity will be repeated for female condom)*

1. Tell the participants that providers tend to assume that clients can and will understand how to use a condom just by being told how. Many studies show that service providers do not demonstrate condom use to their clients. Helping clients build skills in using condoms deserves special attention. Whether condoms are being used for FP, for protection from STIs, or for dual protection, building clients' skills during counseling is very important.
2. Ask the participants if they have ever demonstrated condom use to their clients or service providers.
3. Ask them why most service providers do not do condom demonstrations with their clients. *Responses might include the following:*

- *They do not think it is necessary.*
- *They might not know how to do a demonstration.*
- *They might not have penis models.*
- *They might not know very well how condoms should be used.*
- *They might be embarrassed.*

4. Now announce to the participants that you will be demonstrating how to put a condom on a model of a penis. Tell them that this activity will give them an opportunity to practice using a condom and explaining the steps to clients. Refer them to "Steps for Using a Male Condom" on Handout 20 in the Participant Handbook. Reading each step (with their numbers) one by one, complete the demonstration. Make sure that everyone sees the demonstration clearly. Encourage the participants to ask questions during the demonstration.
5. At the end of the demonstration, ask the participants what "stored properly" means. Get a few answers and then give the correct answer. See Handout 20 in the Participant Handbook for the correct response.
6. Call for a volunteer to repeat the condom demonstration.
7. Ask the participants to work in pairs and do the condom demonstration for each other by explaining each step clearly. Distribute condoms, one to each participant, and penis models (or cucumbers or bananas, as needed), one to each pair. Tell the members of each pair to give feedback to each other as they practice.

> **➳ Training Tip**
>
> If you are not experienced with using a condom, it is a good idea to prepare for this exercise. You can take a condom and a penis model and go through the steps of placing the condom on the model. This will help you appreciate why the steps are listed in a specific order.

8. Repeat Steps 1–3 for the female condom (optional).
9. Finish the activity by asking the group this question:
   ✱ How did you feel when doing the condom demonstration? Was it easy? Was it difficult?

Activity E. Summary *(5 minutes)*

Summarize and close the session by asking:

✱ How can you incorporate counseling about dual protection into your practice?

✱ What barriers would need to be overcome?

✱ How would you overcome them?

Session 21:
Strengthening Partner Communication and Negotiation

Participants' Learning Objectives

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

- Identify possible reasons why clients might not talk with their partners about FP and SRH concerns
- List the deeper personal and social factors behind clients' difficulties in discussing FP and SRH issues with their partners
- Help clients discuss FP and SRH issues more effectively with partners (even in relationships marked by violence or a power imbalance between partners)

Time

55 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Partner scenarios (see Advance Preparation)
- Participant Handbook—Handout 21: Helping Clients Develop Skills in Partner Communication and Negotiation

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	2 mins.
B. Reasons for Not Talking to Partners about FP/SRH	Brainstorm/discussion	10 mins.
C. Helping Clients Strategize	Brainstorm	15 mins.
D. Demonstration Role Play	Role play	10 mins.
E. Practice and Feedback	Role play/discussion	15 mins.
F. Summary	Discussion	3 mins.

Adapted from: EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum*. New York: EngenderHealth.

Session 21

Advance Preparation

1. Prepare flipcharts for Steps B-2 and E-4 (already posted from Session 11).

[Flipchart for Step B-2]

BARRIERS TO TALKING WITH PARTNERS ABOUT FP AND SRH	
Clients' Reasons	Deeper Personal and Social Factors

[Flipchart for Step E-4]

GUIDELINES FOR FEEDBACK AFTER ROLE PLAYS

- [Ask the person playing the client]: How did you feel during the role play? Were your needs met (or not) by the "provider"?
- What did the provider do well? What improvements would you suggest?
- What communication skills did the provider use?
- How well did the provider accomplish all the tasks listed for this phase/step?

2. Learn about local resources for people in violent or abusive relationships. See the "Training Preparation" section in the Introduction for Trainers and Program Planners.
3. Decide which one of the client profiles to use for the demonstration role play (Activity D). Develop a role play based on that client profile. The role plays should start at the point where the client has already chosen a method and is identifying possible barriers to his or her use of the method. The counseling role play can also incorporate practicing with the client how to talk to the partner (i.e., a role play within a role play).
4. Develop "partner scenarios" for Step E-2 (see samples below). For this exercise, the participants will work in pairs, and each pair will need only one partner scenario. Because all pairs will be practicing simultaneously, they can all use the same partner scenario. Make sure that there are enough copies of the partner scenario for all pairs.

[Sample partner scenarios for Step E-2]

The partner is very suspicious of the client's intention to use condoms.

The violent partner is refusing to discuss anything related to FP.

The partner is objecting to the idea of FP for religious reasons.

Session 21
Activities

Activity A. Introduction *(2 minutes)*

1. Introduce this session by noting that even after attending a workshop like this, providers and trainers might still have trouble talking with their *own* partners about sexuality-related issues, FP, and RH concerns. Yet, talking with their partners is a key component of most clients' implementation plans. The last phase of REDI, **implementing the decision**, takes this important component into consideration. During this session, the participants will explore the difficulties that clients might have in talking openly with their partners about sexuality, FP, and RH. This session will also address the ways in which providers can help clients develop and improve their communication skills and strategies.
2. Review the session objectives with the participants.

Activity B. Reasons for Not Talking to Partners about FP/SRH *(10 minutes)*

1. Ask the participants to brainstorm responses to the following question (participants should not have their Participant Handbooks open during this activity):
   - ✱ What are some reasons why clients might not talk with their partners about FP and SRH?

2. Record the responses in the left-hand column of the prepared flipchart (see Advance Preparation). See the "Examples of Barriers to Talking with Partners about SRH Concerns" table in Handout 21 in the Participant Handbook for ideas for this activity.
3. Ask the participants to discuss the deeper personal issues (e.g., fears) and social factors behind each reason listed. After agreeing on each one, write the response in the right-hand column, next to the reason.
4. If fear of violence or abuse does not come up during the brainstorm, note that even in the best of circumstances, women might find it challenging to discuss sexuality-related issues with a partner. Ask how this is further complicated when there is a power imbalance or violence or abuse within the relationship (see "How Power Imbalances Affect FP Use" on Handout 21 in the Participant Handbook for discussion points). If you identified any local resources for people in abusive or violent relationships, give their names now.

Activity C. Helping Clients Strategize *(15 minutes)*

1. Ask the participants to brainstorm answers to the following questions:
   - ✱ What are some suggestions that providers can make to their clients about how to discuss sexuality-related issues and FP with their partners?
   - ✱ What are the options when a client says he or she absolutely cannot discuss FP with his or her partner? What would you say to him or her?

2. Record their suggestions on a separate flipchart, supplementing as necessary from Handout 21 in the Participant Handbook. Acknowledge that for clients who are in potentially violent situations, some of these suggestions might be about reducing the client's risk for harm (in other words, they are survival strategies).
3. Review Handout 21 with the participants.

Activity D. Demonstration Role Play *(10 minutes)*

1. Using members of the training team and one of the client profiles (see Advance Preparation), conduct a role play to demonstrate how to help the client develop partner communication and negotiation skills, using one of the client profiles. Try to incorporate some of the suggestions listed on the flipchart. Also, in your demonstration role play, include conducting a role play *with the client*. This will be a role play within a role play, where one trainer will play the partner and the other the client, so that the "provider" helps the "client" practice in a situation where the client talks to the partner about the issue of FP (see "Strategies for Detecting and Addressing Barriers" on Handout 21 in the Participant Handbook). *(5 minutes)*
2. After the role play, ask for feedback or questions from the participants and observers. *(5 minutes)*

Activity E. Practice and Feedback *(15 minutes)*

1. Tell the participants that they will be doing similar five-minute role plays in pairs. The idea is to counsel a client and help the client develop strategies or tactics for talking to his or her partner. Remind the participants about the strategies they reviewed on Handout 21 in the Participant Handbook. Each pair will base their role play on the partner scenario they will receive. The role plays will start at the point where the client has already chosen a method and is identifying possible barriers to his or her use of it. The client should start by raising the partner scenario given on the card as a possible barrier. In their counseling role play, pairs can incorporate practicing with the client how to talk to the partner (i.e., a role play within a role play like the one in the demonstration by the trainers in Activity A). The pairs will practice alone, and then the large group will discuss their experience with the role plays.
2. Divide the participants into pairs. Spread out the pairs across the room as much as possible to allow space and to minimize distractions. Distribute cards with partner scenarios to each pair (see Advance Preparation for sample partner scenarios). Ask each pair to decide who will play the client.
3. Have the training team monitor as many of the pairs as possible, moving around as necessary. Stop the role plays after five minutes.
4. 
Post the "Feedback Guidelines for Role Plays" flipchart and facilitate a discussion on all four bullets.
   - ✱ How did the "clients" feel? Were their needs met?
   - ✱ How well did the "providers" do? Is there any room for improvement?
   - ✱ What communication skills were used?
   - ✱ Did the providers accomplish all of the tasks?

Activity F. Summary *(3 minutes)*

Ask the participants what difference this session will make in their counseling practice when they go back to their work sites

Session 22:
Counseling Return Clients

Participants' Learning Objectives

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

- Describe how the counseling needs of returning clients differ from those of new clients
- List possible reasons for return visits
- Identify appropriate provider attitudes and approaches for addressing the concerns of return clients

Time

1 hour, 5 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Situation cards developed for each client profile (see Advance Preparation)
- Participant Handbook—Handout 22: Counseling Return Clients; and Participant Handbook Appendix B: Learning Guides for FP Counseling Skills

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Identifying Reasons for Return Visits	Brainstorm	5 mins.
C. Identifying Appropriate Counseling Approaches	Small-group work/ discussion	45 mins.
D. Summary	Discussion	10 mins.

Advance Preparation

1. Prepare flipcharts for Steps B-2 and C-2 (see page 22-2).

[Flipchart for Step B-2]

REASONS FOR CLIENTS' RETURN VISITS

[Flipchart for Step C-2]

CLIENTS' REASON FOR RETURNING
Counselor Responses and Approaches

2. Prepare situation cards with a reason to return for each returning client profile. Since there are only five client profile groups, make sure that you select at least one reason from each category listed below, so that the groups will practice with a variety of clients' reasons for returning. See the sample situation below and the other reasons, listed on page 22-3.

Sample situation cards

Yesterday, [client's name] learned that she is pregnant.

[client's name] comes back to the facility and says that she has decided to have a child.

Other reasons to include on situation cards

SIDE EFFECTS, COMPLICATIONS, AND CLINICAL PROBLEMS

- [client's name] comes back and complains of spotting four weeks after her first DMPA injection.
- [client's name] comes back and says that she missed a period while using oral contraceptives.
- [client's name] comes back and complains of vaginal discharge.
- [client's name] comes back and says that she learned that she developed high blood pressure while on oral contraceptives.
- [client's name] comes back and complains of excessive bleeding and feeling weak after using DMPA twice.
- [client's name] comes back and says that three weeks after insertion of an IUD, she found out that she is pregnant.

A CHANGE IN CLIENT'S CIRCUMSTANCES

- [client's name] comes back and says that he or she just learned that he or she is HIV-positive.
- [client's name] comes back and says that she is getting divorced.
- [client's name] comes back and says that she has decided to have a child.
- [client's name] finds out that her husband has another partner.

RESUPPLY AND ROUTINE FOLLOW-UP

- [client's name] comes back for a sperm count one week after a vasectomy.
- [client's name] comes back for a regular follow-up visit after her first period following IUD insertion.
- [client's name] comes back for condom resupply at the end of two months.
- [client's name] comes back for the second DMPA injection at the end of three months.
- [client's name] comes back just to express gratitude, to say how comfortable she is after having had female sterilization.

OTHER PROBLEMS

- [client's name] comes back and says that his or her partner objects to the use of [name of the FP method].
- [client's name] comes back and says that her neighbor told her that those who use the IUD cannot have children anymore.
- [client's name] comes back and says that she believes the pain in her stomach is the result of the oral contraceptives that she has been using.
- [client's name], an implant user, comes back and says that she heard on TV that implants cannot be removed easily.

Session 22
Activities

Activity A. Introduction *(5 minutes)*

1. Tell the participants that, starting with this session, you will be focusing on return clients, who constitute a significant portion of the clients whom the participants see in their facilities. Remind them of the categories of clients that you identified in Session 4: new clients with a method in mind, new clients with no method in mind, clients returning for resupply, and clients returning with problems. For clients initiating use of an FP method, return visits can be considered as part of the **implementing the decision** phase of the REDI counseling process. Support for implementation of the client's decision should not stop at the end of the initial counseling session. Rather, support should be continuous to ensure that the client is satisfied with the FP method, that he or she is using it safely, and that any other emerging SRH needs are met in a timely manner. Clients might be faced with other decisions (such as discontinuing a method and switching to another one) that would require the counselor and the client to go through all of the phases of REDI again. This session provides an overview of possible scenarios requiring return visits, and Sessions 23 and 24 examine in detail issues related to managing side effects and discontinuing and switching methods. At every return visit, the counselor should assess and address the client's needs (see Essential Ideas on Handout 22 in the Participant Handbook).
2. Review the session objectives with the participants.
3. Review the Essential Ideas on Handout 22 in the Participant Handbook with the participants. Answer any questions they have.

Activity B. Identifying Reasons for Return Visits *(5 minutes)*

1. Tell the participants to brainstorm the reasons for return visits.

2. Post the prepared "Reasons for Clients' Return Visits" flipchart and ask:
   - ✱ What are the reasons that clients come for return visits?
3. Write all answers on the flipchart.
4. Looking at the brainstormed reasons, distinguish between major categories: *clients who come for resupply or routine follow-up (no problems)* and *clients who come with problems or complaints (side effects, questions, or concerns)*. Then move on to the next activity.

Activity C. Identifying Appropriate Counseling Approaches *(45 minutes)*

1. Tell the participants that they will work in small groups to discuss and identify appropriate provider responses to the different reasons for clients' return for services. To do that, they will use the client profiles and work in the same client profile groups as before. Each group will be given a situation card that describes a change in the situation of their client. Based on the reason written on that situation card, they will discuss and identify

the best response and approach for the counselor to use. The task is to identify the best counselor response/approach to the reason for the visit described on the situation card and to present it to the larger group.

2. Post the prepared flipchart (see Advance Preparation, flipchart for Step C-2) and tell the participants that they will be describing the counselor response/approach on the flipchart and also demonstrating it through a short role play.
3. Tell them that they have 15 minutes to complete the task. At the end of the small-group work, each group will have three minutes to present their work to the whole group.
4. Ask them to go into their client profile groups.
5. Distribute the situation cards (see Advance Preparation) and flipchart paper to the groups and give them 15 minutes to complete the task and be ready to present.
6. When the time is up, ask the groups to present their role plays, one by one. After each group presents, take questions and comments from the larger group. See Handout 22 in the Participant Handbook for possible counselor responses and approaches to different reasons for clients' return visits. Add responses and attitudes that have not been mentioned by the groups. *(30 minutes total for presentations and discussions)*
7. If any of the reasons listed on Handout 22 were not covered by the presenting groups, review them and the appropriate counselor responses and approaches.

Activity D. Summary *(10 minutes)*

1. Review with the participants the Learning Guides for FP Counseling Skills (Appendix B in the Participant Handbook). Tell them that they should refer to these learning guides during activities in the upcoming sessions about return clients. Ask if they have any questions.
2. Ask the participants how this session will change their approach to counseling once they are back in their workplaces.

Session 23:
Managing Side Effects and Other Problems

Participants' Learning Objectives

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

- List the steps in managing side effects and other problems
- Describe the management of side effects and other problems for each FP method
- Demonstrate how to help clients cope with side effects and other problems

Time

1 hour, 35 minutes

Materials

- Flipchart paper, markers, and masking tape
- Participant Handbook—Handout 23: Managing Side Effects and Other Problems
- Flipcharts prepared with text (see Advance Preparation)
- Method-specific cue cards (Appendix F)
- Flipchart from Session 11, "Feedback Guidelines for Role Plays"

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	2 mins.
B. Managing Side Effects	Discussion/presentation	20 mins.
C. Practice	Small-group work/role play	1 hour, 10 mins.
D. Summary	Discussion	3 mins.

Advance Preparation

1. Prepare a flipchart or transparency on "Managing Side Effects and Other Problems" (see flipchart for Step B-2). If you are preparing a flipchart, include only the five main bullets, not the second-level bullets (see page 23-2).

[Flipchart for Step B-2]

MANAGING SIDE EFFECTS AND OTHER PROBLEMS

- Always acknowledge the clients' complaints
- Take clients' complaints seriously
- Gain a full understanding of the complaint: Ask and listen!
- Inform and reassure
- Discuss and/or offer medical management as appropriate

[Template for transparency for Step B-2]

MANAGING SIDE EFFECTS AND OTHER PROBLEMS

- Always acknowledge clients' complaints
- Take clients' complaints seriously
- Gain a full understanding of the complaint: Ask and listen! (Is it a side effect, a sign of a health risk/complication, or another problem?)
- Inform and reassure (for side effects):
  - Explain to the client why and how side effects occur
  - Assure the client that the side effect or complaint is benign and not a sign of a serious health problem
  - Determine whether the side effect will go away without treatment or should be treated
  - Explain what the client can do to cope with the inconvenience caused by the side effect
  - Remind the client of the warning signs of health risks/complications
  - Remind the client that he or she is always welcome to come back with any concerns or questions
  - Remind the client that he or she is always welcome to change methods
- Discuss and/or offer medical management as appropriate (for side effects and health risks/complications)
  - Discuss medical treatment options
  - Treat side effects or complications as per guidelines, or refer the client if treatment is not available at your facility
  - If the client is not satisfied with these options, offer the client the option of switching to another method

2. Identify the most common side effects that clients face with each method; see results of brainstorms from Step A-3 in Session 4 (on the reasons for clients' visits) and the flipchart for Step B-2 in Session 22 ("Reasons for Clients' Return Visits"). Choose up to five of these side effects for use in Activity C. If specific side effects have not been listed during the discussions in Sessions 4 and 22, ask the group, including the training team, to identify the side effects most commonly experienced by clients or those that providers most commonly have to address within their practice.

Session 23
Activities

Activity A. Introduction *(2 minutes)*

Review the objectives of the session and explain that one of the purposes of focusing on counseling for return clients is to better address the needs of clients who might be experiencing side effects or other problems. The provider can assist the client with deciding whether to continue with the current method or to switch to a different one. Continuing support for return clients leads to improved continuation of family planning use. Managing side effects and other problems is an aspect of supporting the client in implementing his or her initial decision; therefore, it is part of the **implementing the decision** of REDI. However, if the return client is faced with other decisions, he or she might need the counselor's support in going through all of the phases of REDI again.

Activity B. Managing Side Effects *(20 minutes)*

1. Start a discussion about side effects by asking the following question in the large group.
   - ✱ How do you manage a client's complaints about side effects; what do you say and do? Ask the participants to reflect upon their own experience.

2. Present the "Managing Side Effects and Other Problems" transparency or flipchart (see Advance Preparation) and refer the participants to Handout 23 in the Participant Handbook. Briefly review the Essential Ideas and the "Steps for Managing Side Effects and Other Problems" table.
3. Refer the participants to the table in Handout 23 that shows the side effects by method ("Management of Side Effects and Other Problems by Method"). To orient the participants to the content and template of the table, review the side effects/problems and corresponding management guidance for one or two of the methods listed.
4. Tell the participants that they can use this table as a job aid at work. Tell them to refer to other contraceptive technology resources[2] for detailed information about FP methods and the management of side effects and other problems related to each method.
5. Tell the participants that they will use this table to prepare for a role play in the next activity.

> **➳ Training Tip**
>
> Depending on the background of the participants and the knowledge assessment you have done in advance, you might wish to cover the entire "Management of Side Effects and Other Problems by Method" table in a discussion or question-and-answer session. This would provide the opportunity to update the participants' knowledge about management of side effects and other problems related to the use of FP methods, but it would add at least 30 minutes to the session duration.

[2] Such as: WHO and JHSPH/Center for Communication Programs. 2007. *Family planning: A global handbook for providers*. Baltimore, MD: The INFO Project.

Activity C. Practice *(1 hour, 10 minutes)*

1. Divide the participants into groups by asking them to count off, based on the number of trainers, so that each trainer can follow one group during the small-group work. You can have a maximum of five groups while making sure that each group is assigned one of the most common side effects identified in Session 4 or as a result of your consultation with other trainers or participants (see Advance Preparation).
2. Ask the groups to discuss and develop a plan to talk to the client coming with the assigned side effect (e.g., a client using injectables returns complaining of bleeding). The plan should reflect the flow in the "Steps for Managing Side Effects and Other Problems" table, and the content should be informed by the management recommended in the table listing side effects by method.
3. Give the groups 10 minutes for preparation. Ask each group to select two people to present a three-minute role play about a client coming to the facility with the assigned side effect and a provider managing the situation through counseling. To keep the role plays short and focused, the conversation will start at the point where both the client and the provider are already seated and the client brings up his or her complaint about the side effect. Tell the participants that the rest of the group will use the transparency/table on steps for managing side effects and other problems as a checklist on what to look for during the observation of the role plays.

4. Post the "Feedback Guidelines for Role Plays" flipchart (from Session 11). Allow three minutes for a role play, and after each role play, use 7–10 minutes for discussion. Start the discussion by asking the role players to comment on their own performance, then ask the large group to give feedback. The length of discussions may vary, depending on the total number of groups, but the total time spent on role plays and discussion should not exceed 60 minutes.
5. Make sure that the medical management of the side effects is handled correctly in the role plays. Ask if they have any questions about the management of side effects and other problems. Use the detailed table in Handout 23 or other resources[3] to correct any misinformation.

Activity D. Summary *(3 minutes)*

Ask for volunteers to summarize the steps involved in managing side effects.

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[3] Such as: WHO and JHSPH/Center for Communication Programs. 2007. *Family planning: A global handbook for providers*. Baltimore, MD: The INFO Project, and Geneva; and Hatcher, R.A., et al. 1997. *The essentials of contraceptive technology*. Baltimore, MD: Johns Hopkins Bloomberg School of Public Health, Population Information Program.

Session 24:
Helping Clients Continue or Switch Methods

Participants' Learning Objectives

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

- Identify possible reasons for method discontinuation
- Develop strategies to support clients in method continuation
- Describe when and how to support clients in switching methods

Time

50 minutes

Materials

- Flipchart paper, markers, and tape
- Flipcharts prepared with text (see Advance Preparation)
- Situation cards developed for this session
- Flipchart from Session 11, "Feedback Guidelines for Role Plays"

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	2 mins.
B. Reasons for Discontinuation and Support Strategies	Brainstorm/discussion	20 mins.
C. Practice	Small-group work/role play	25 mins.
D. Summary	Discussion	3 mins.

Advance Preparation

1. Prepare sample flipcharts for Steps B-2 and B-4 (see page 24-2).

[Flipchart for Step B-2]

REASONS FOR DECIDING TO DISCONTINUE

[Flipchart for Step B-4]

SUPPORTING CLIENTS WHO WANT TO DISCONTINUE

2. For each client profile, prepare a situation card describing a situation in which the client wants to discontinue an FP method (see sample situation cards in Advance Preparation section of Session 22). Ensure that different reasons for discontinuation are represented in the five situation cards by checking against the discontinuation reasons in Handout 24 of the Participant Handbook.

Examples of reasons for discontinuation, for use on situation cards:

- [client's name] comes back saying that she doesn't want to have the DMPA injection any more, because of the excessive irregular bleeding she has had in the last six months.
- [client's name] comes and asks to have her IUD removed because her husband feels the IUD during intercourse.
- [client's name] comes back asking for reversal of the vasectomy, saying that he and his new wife want to have a child.
- [client's name] comes and asks to have her implant removed because she wants to get pregnant now.
- [client's name] comes and says that she has been diagnosed with high blood pressure and that her doctor has told her to stop taking the pill.
- [client's name] comes and asks to have her IUD removed because of the headaches she has been having since it was inserted.
- [client's name] comes and asks for another method because she has heard that the DMPA injections she has been getting can cause infertility.

3. For the role play in Activity C, the groups will switch client profiles so that each group works with a new profile. Decide how you will switch the client profiles across groups.

Session 24
Activities

Activity A. Introduction *(2 minutes)*

1. Tell the participants that this session is about two key issues that service providers are faced with when providing FP services: *method discontinuation and method switching*. The provider's support for the client's efforts to continue or switch to another method fall under the **implementing the decision** phase of REDI.
2. Review the objectives of the session with the participants.

Activity B. Reasons for Discontinuation and Support Strategies *(20 minutes)*

1. Ask the participants what they think the terms *discontinuation* and *switching* imply. Note that they refer to "discontinuing a method" and "switching from one method to another."

2. Post the "Reasons for Discontinuation" flipchart (see Advance Preparation), and tell the participants to brainstorm the reasons for method discontinuation. Probe as needed to make sure that all reasons listed on Handout 24 of the Participant Handbook are covered.
3. Ask the participants the following questions:
   - ✱ How do you feel about clients discontinuing a method? (If needed, ask "Is this right or wrong? Why?")
   - ✱ How do you feel about clients switching from one method to another? (If needed, ask "Is this right or wrong? Why?")
   - ✱ When would clients' decisions to discontinue or switch to another method be inappropriate or unjustified?

   After soliciting answers, cover the key messages in the first three bullets of this session's Essential Ideas in the Participant Handbook.

4. Post the "Supporting Clients Who Want to Discontinue" Flipchart, and ask the participants to brainstorm the answers to the following question:
   - ✱ How can a provider support a client who wants to discontinue the method he or she has been using?

   Note all answers on the "Supporting Clients Who Want to Discontinue" flipchart (see Advance Preparation).
5. Ask the participants to open the Participant Handbook to Handout 24. Review the chart with the title "Supporting Clients Who Want to Discontinue."

Activity C. Practice *(25 minutes)*

1. Tell the participants that they will now practice counseling clients who wish to discontinue their FP method. This time they will be switching client profiles, so every group will be working with a new client profile.

2. They will work in their groups and prepare a five-minute role play based on the situation card that you will be giving to each group. The role play will be a return visit by a client who wants to discontinue the FP method that he or she had been using. To save time, the role play will start in the middle of a counseling session in which the client states that he or she wants to discontinue (e.g., asking to have her IUD or implant removed).
3. Remind the participants that, as they are preparing their role plays, they can refer to the FP cue cards (Appendix A in the Participant Handbook) for technical details on when and how safely clients using a specific method can switch to a new method..
4. Tell them to spend five minutes with the role play, followed by five minutes of feedback, as they did in the previous sessions. In each group, one person will play the provider, one person will play the client, and the remaining group member(s) will be observer(s). Following the role play, the observer will give feedback to the provider. If they have time left before all groups finish, they can shift roles and repeat the role play.
5. Tell them to start.
6. When all groups have finished, ask for a volunteer group to give their role play for the whole group.

7. After the role play, gather feedback from the large group using the "Guidelines for Feedback after Role Plays" flipchart from Session 11.

Activity D. Summary *(3 minutes)*

To wrap up, ask the participants to describe the correct and supportive attitude of a provider when faced with a client wishing to discontinue using an FP method.

Part III:

FP Counseling in Practice

Session 25:
Counseling Role Plays

Participants' Learning Objectives

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

- Demonstrate how to counsel FP clients, applying all of the counseling skills covered in this workshop and using the REDI model and profiled clients
- Describe *self-assessment and peer assessment* after counseling practice

Time

3 hours, 10 minutes

Materials

- Flipchart paper, markers, and masking tape
- New role play scenarios (see Advance Preparation)
- New role play scenarios with hidden information for second round of role plays (see Advance Preparation)
- Participant Handbook—Handout 25-A: Counseling Role Plays; Handout 25-B: Counseling Skills Observation Guide; and Participant Handbook Appendix B: Learning Guides for FP Counseling Skills

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Reviewing Tools and Job Aids before Counseling Practice	Presentation/discussion	15 mins.
C. Counseling Practice	Large-group role plays/ feedback	1 hour, 50 mins.
D. Concurrent Practice in Groups (Eliciting Hidden Information)	Role play in small groups/ feedback	55 mins.
E. Summary	Presentation	5 mins.

Advance Preparation

1. This session includes five large-group role plays and at least two rounds of concurrent role plays in small groups. Both in the full group and in small groups, all of the participants who play the service provider will get feedback on their performances. The purpose is to make sure that each participant gets a chance to practice counseling and get feedback in this session.

2. Decide how you will rearrange groups. Up to this point in the workshop, the participants have worked in the same groups in most of the sessions and exercises. To make the small-group work and role plays more interesting and challenging, rearrange the participants to form five new groups. You can also choose to have four or six groups, depending on the number of participants, with the aim of ensuring that each participant gets a chance to play the provider and get feedback.
3. For the plenary role plays in Activity C, pick five role play scenarios from the list below, one for each group. Make sure that there is an even representation of new clients and return clients among the five role-play scenarios that you choose. This is also an opportunity to cover client characteristics that have not been adequately discussed so far in the workshop (e.g., postabortion FP, postpartum FP, FP counseling during antenatal care, high individual risk for HIV and STIs, HIV-positive clients, clients with an STI, unmarried people, and adolescents). To facilitate your selection of role-play scenarios, you can refer to the keywords (in the first column below) that describe the theme and population group covered in the role-play scenario.

Client characteristics	Role play scenarios
New—female client— unmarried— no method in mind	**1.** [client's name] is 26 years old and will marry her boyfriend next month. They have not had sex so far, and she does not want a child until their income is sufficient to support the child. She comes in asking for FP. She does not have a method in mind.
New—female client— married— female sterilization	**2.** [client's name] is 31. She has one daughter and one son, ages 5 and 3 respectively. She and her husband have decided that she should have female sterilization. They love each other very much and do not have any problem. They come to the FP station asking for female sterilization.
Return—male client— vasectomy	**3.** [client's name] had vasectomy four months ago, and he returns to the facility saying that his wife is six weeks pregnant. In answer to the counselor's questions, he admits that they have had unprotected sex about one month after the vasectomy. He is concerned very much about the health of his wife, whom he loves very much and who has diabetes.
Return—female client— pill	**4.** [client's name], age 27, comes to the FP station saying that she forgot to take her last two pills (yesterday and the day before) while she was lying in bed sick with the flu. She has been married for one year, but she and her husband believe that they are not ready to have a child yet.
New—female client—IUD	**5.** [client's name], age 25, has just had a son and does not want to have another child. She is interested in having an IUD, like her colleagues at work. Her husband is very caring for her and the baby, and he believes that they should not have another child so as to take better care of their son.

Client characteristics	Role play scenarios
New—female client—postpartum	**6.** [client's name], age 35, has delivered her fifth child a week ago by cesarean section and has returned to the facility to have her stitches removed. The counselor asks if she has thought of FP. Already breastfeeding, she doesn't want any more children but is not sure about a permanent method.
Return—female client—IUD + pregnancy	**7.** [client's name], age 40, has been using an IUD for six months. She returns to the facility saying that she is pregnant. She wants to keep the child.
New—female client—postabortion	**8.** [client's name], age 32, comes to the facility with bleeding due to a miscarriage. After an uncomplicated procedure, she is about to leave the facility. A counselor explains that fertility returns quickly, within a few weeks, and asks her if she is interested in protection against pregnancy.
Return—male client—unmarried——condom—dual protection—emergency contraception	**9.** [client's name], age 26, is using condoms with his girlfriend and with other girls he meets occasionally. Last night the condom slipped during intercourse, and he is concerned his girlfriend might get pregnant.
Return—female client—married—injectables (DMPA)	**10.** [client's name], age 30, is married and has three children. She comes back to the clinic for sixth injection. She is very happy with DMPA, especially because her periods are less severe now.

4. For role plays in small groups in Activity D, pick at least two scenarios from the list below. Because the five groups will be practicing simultaneously, they can each work with the same role play scenarios.

Themes, population groups	Role play scenarios
New—female client—unmarried adolescent	**11.** She is worried about pregnancy and she wants to prevent it. She has a boyfriend. She does not know anything about STIs, and she has not even thought about her possible risk for contracting one. **Hidden information:** She had vaginal sex with her boyfriend, but she became very scared of getting pregnant. For this reason, they started practicing anal sex, but she does not enjoy it.
Return—female client—married—STIs—unsafe abortion	**12.** She presents with vaginal discharge and itching. She is on the pill. She has heard of STIs. Now she is convinced that she has got one and that it is her husband's fault. **Hidden information:** She did not take the pill correctly. She got pregnant, but she did not tell anybody. She had an unsafe abortion. The discharge and itching started after she had the abortion.
New—male client—married—vasectomy—STI risk—multiple partners	**13.** He wants a vasectomy because he and his wife already have a child. They do not want to be worried about pregnancy any longer. **Hidden information:** He has sex with other women. He wants a vasectomy to avoid getting them pregnant. He is not thinking of HIV or other STIs.

Themes, population groups	Role play scenarios
Return—female client—postabortion woman—pill	**14.** She has a history of repeat abortions and says that this happened because of method failure (the pill). **Hidden information:** Her husband wants to have a male child, and he put pressure on her to have the abortions.
Return—female client—IUD—STI/HIV risk	**15.** She complains that she has prolonged periods and pain. She blames the IUD for the prolonged periods. **Hidden information:** She has noticed that her husband has lost interest in her since she got the IUD, but she is too shy to discuss this with the provider.

Session 25
Activities

Activity A. Introduction *(2 minutes)*

1. Explain that in this session, the participants will work on synthesizing the skills they have learned in a counseling session following all of the phases and steps of REDI. So far, they have practiced the phases and steps of counseling separately. This session will give them the opportunity to practice counseling and receive feedback on their performance and to use tools and job aids that support counseling.
2. Review session objectives with the participants.

Activity B. Reviewing Tools and Job Aids before Counseling Practice *(15 minutes)*

1. Tell the participants that they will review tools and job aids that will help them with FP counseling practice during the workshop and later at their workplaces.
2. Refer them to Appendix B in the Participant Handbook. Remind them that they have already covered the phases and steps of REDI in previous sessions. The learning guides list the essential steps that need to be accomplished in counseling, so they will be useful as a reference. They can also be used as a self-assessment tool. Service providers can assess their own performance by scoring themselves on the learning guide. The learning guides help providers identify gaps in their performance and remind them what to do to improve their skills.
3. Briefly review the learning guides for new clients and for return clients (just by going through titles and orienting the participants to the template), and answer any questions that the participants have.
4. Refer the participants to the Essential Ideas in Handout 25A of the Participant Handbook and explain how "self assessment" and "peer assessment" can be done. Then refer them to Handout 25-B (Counseling Skills Observation Guide) in the Participant Handbook. The participants are seeing this guide for the first time. Tell them that this guide is intended for use during observation of a counseling session. Trainers, supervisors, and peers can use this guide to record and give feedback to a provider observed during counseling.
5. Tell the participants that they will be using this Counseling Skills Observation Guide to provide feedback to the role players in the role plays that will follow.
6. Orient the participants to the flow and content of the guide by reviewing it briefly, and tell them that explanations of the items in this guide can be found in the learning guides in Appendix B of the Participant Handbook.
7. Give the participants five minutes to review the items in the guide, and answer any questions they have.

Activity C. Counseling Practice *(1 hour, 50 minutes)*

1. Tell the participants that they will do role plays using new role-play scenarios. They also will work in new groups.
2. Explain that they will work in their new groups to prepare for and practice all phases of REDI, from **rapport building** through **implementing the decision**. Groups will have 10 minutes to prepare for the role play, and then each group will be asked to perform in front of the large group. They will choose one group member to play the provider and another to play the client. The other members of the groups will help with the preparation for the role play. Each group will have a maximum of 20 minutes to do the counseling role play in the large group and then get feedback from the large group. All of the participants in the large group will be observers, and they will base their feedback on the Counseling Skills Observation Guide. *(10 minutes for each role play and 10 minutes for feedback for each group)*
3. Divide the participants into new groups and hand each group a new role play scenario (see Advance Preparation). Then give the groups 10 minutes to prepare for the first role play.
4. Ask the groups, one by one, to do the role play in front of the large group. Have the provider and client from the first group role play for 10 minutes. Then spend 10 minutes on feedback based on the Counseling Skills Observation Guide (Handout 25-B). Repeat with all five groups.

> **➳ Training Tip**
>
> You will notice that the role plays will improve as you approach the end of the practice session, and both the role plays and the feedback will take less time as the participants become more efficient.

Activity D. Concurrent Practice in Groups (Eliciting Hidden Information) *(55 minutes)*

1. Tell the participants that they will continue doing the role plays concurrently in their groups. They will repeat the same process of role playing and giving feedback for two more rounds in their small groups. With each new role play, members of the group will switch roles. By the end of the practice session (Activities C and D), each participant will have assumed each role at least once. Each group will be given two new scenarios. For a change of pace and to make the activity more challenging, the role-play scenarios will be given only to the person playing the client. In each role-play scenario, there will be a piece of hidden information. The "client" should not reveal this hidden information unless specifically asked or probed by the "provider." The challenge for the person playing the provider is to explore the client's circumstances to elicit the hidden information—that is, all factors that would affect the client's decision (the social context and background, relationships, other RH needs and problems, and so on). Each role play will last no longer than 10 minutes and will be followed by 10 minutes of feedback from the group, led by the observer. The observer will fill in the Counseling Skills Observation Guide for each role play, and the feedback will be based on this guide.

2. Tell the participants to go back to their groups; then hand the "clients" the first role-play scenario. Tell them to start practicing.
3. Go around the groups to make sure that they understand the task and are all on track—that they are switching to the feedback and to the second role play in a timely manner, that they are switching roles, and that they are using the Counseling Skills Observation Guide correctly.
4. When groups finish the first role play, hand the second role play scenarios to the group members who will assume the role of the client and tell them to continue practicing the role play and feedback. *(40 minutes total for two rounds of role plays, Steps 1–4)*
5. Ask the participants to come back into the large group.
6. Ask those who assumed the client role in the last two role plays:
   - ✱ How did you feel during and at the end of counseling?
   - ✱ Were your needs met? If not, what else did you need?
   - ✱ Did you have any other questions to be answered? If yes, what questions?
7. Ask those who assumed the provider role in the last two role plays:
   - ✱ What did you find easy and what did you find difficult to do as the counselor?
   - ✱ What would you do differently if you had one more chance to counsel this client?
8. Ask those who assumed the observer role in the last two role plays:
   - ✱ What did you observe in general as points to be improved?
   - ✱ How useful was the Counseling Skills Observation Guide in observing counseling? *(15 minutes total for large-group discussion, Steps 5–8)*

Activity E. Summary *(5 minutes)*

Wrap up by saying that the participants will improve their counseling skills and become more efficient through further practice and feedback. Once they are back in their facilities, they can use the Learning Guides for FP Counseling Skills to assess their own performance and identify the gaps they should work on. The participants can also seek feedback from peers who are trained in counseling. Peers should use the Counseling Skills Observation Guide while observing and should base their feedback on the findings they have marked in the guide (see Essential Ideas on Handout 25-A in the Participant Handbook).

Session 26:
Action Plans to Apply New Learning

Participants' Objectives

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

- Identify three changes to make in their work as a result of what they learned in the course
- Develop action plans for implementing the changes identified

Time

1 hour, 35 minutes (Option 1—Individual work)
2 hours, 5 minutes (Option 2—Work in groups)

Materials

- Flipchart paper, markers, and masking tape
- Flipcharts prepared with text (see Advance Preparation)
- Flipchart ("Principles of Good Client-Provider Interaction") from Step B-4 in Session 3
- Index cards
- Participant Handbook—Handout 26-A: Applying What Was Learned; Handout 26-B: Action Plan; and Handout 1: Goal and Objectives from Session 1
- All daily wrap-up flipcharts (see the explanation under Training Implementation in the Introduction for Trainers and Program Planners [page xx] and in Appendix C: Daily Warm-Ups and Wrap-Ups)

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	10 mins.
B. Review of Training Goal and Objectives	Reading/discussion	15 mins.
C. Introducing the Action Plan Framework	Presentation	10 mins.
D. Preparing and Presenting Action Plans (Option 1/Option 2)	Individual/small-group work/presentation in large group	45 mins./ 1 hour, 15 mins.
E. Review of Action Plans	Discussion	15 mins.

Session 26

Advance Preparation

1. Decide whether you want the participants to prepare their action plans individually or in groups (see Training Tip).

> **➳ Training Tip**
>
> If the participants can be divided into groups according to their work places (those coming from the same facility or the same unit in a facility), or based on a close day-to-day working relationship (such as participants who work at a number of sites under the same administrative division or members of a task force summoned from different organizations), they can work in small groups. Group members will develop a joint action plan on a flipchart and report as a group at the full-group session (see Activity D, Option 2: Work in groups).
>
> If the participants cannot be divided into such groups, they can work individually. In this case, the presentations to the large group will be limited to one action per participant. Reporting will be done orally, by reading from the Action Plan worksheet (Handout 26-A), and the participants will not repeat actions already reported by other participants. They will report only different actions or different aspects of actions already reported (see Activity D, Option 1: Individual work).

2. Post all of the daily wrap-up flipcharts together where the participants can see them. If you have opted for having the participants write their "identified actions from the day's learning" in their notebooks, you do not need to post any flipcharts. When you get to Activity C, just refer the participants to their own notes.
3. Prepare flipcharts for Step C-2 and Activity D (at least five flipcharts for Step D-3 under Option 1 or one sample flipchart for Step D-2 under Option 2) (see below).

[Flipchart for Step C-2]

QUESTIONS FOR ACTION PLAN:

- What will you do differently in counseling?
- How can you help make counseling more client centered in your facility (among your colleagues)?

[Flipchart for Step D-3 (Option 1) and D-2 (Option 2)]

Actions	Barriers	Strategies

Session 26
Activities

Activity A. Introduction *(10 minutes)*

1. Explain the following points to the participants:
   - Implementing what you have learned is important to you and your clients. Thinking about impact and results makes you ask yourself, Why am I doing this? Do I think this is valuable? What difference will it make for clients? What difference will it make for myself and my colleagues? Even a minor improvement in the quality of the counseling service you provide might mean a lot to your clients—for example, it might mean more satisfied clients, clients who continue longer, or clients who trust you and your facility more.
   - To facilitate taking concrete steps for improving the quality of counseling services, you will develop an action plan in this session. At the end of every day, you have been picking out one activity that you could implement as soon as you return to work. This action plan is meant to remind you of those ideas and to give you a framework for focusing on them. The action plan will be inspired by those ideas.
   - To ensure your co-workers' and supervisors' buy-in to the changes you will be making (actions you will be taking), you will need to provide information and coordinate closely with them—especially with colleagues from your site or your district who are attending this workshop. You might need to be prepared to overcome resistance within your facility.
   - Being clear about *why* you are carrying out these action plans will help you if and when you encounter people who are curious or concerned about the changes they see or whose work is also affected by the changes.
   - Finally, to maximize the support you receive from your institution, you will need to coordinate with your colleagues. You will design activities for informing your managers about the outcomes and implications of this workshop and for getting their endorsement and support, and you will work together to implement those activities.
   - *Include this paragraph only if it has been discussed and negotiated with the managers in advance:* Last but not least, the organizers of this workshop have already engaged your managers (specify the level of managers—i.e., either site level or higher) in making decisions about this workshop, and they will also report back to your managers after the workshop to describe the kind of support and endorsement the managers can and should provide at your workplace.

Activity B. Review of Training Goal and Objectives *(15 minutes)*

1. Tell the participants that before moving on to the action plan, it will be good to review the goal and objectives of the workshop as well as what has been accomplished so far.
2. Ask them to refer to Handout 1 in the Participant Handbook, and ask a volunteer to read the goal and objectives of the workshop.

3. Next, refer back to the objectives one by one, and for each objective ask the participants the following question:
   - ✱ How (through which sessions or activities) has this objective been addressed and achieved?
4. Ask the participants:
   - ✱ What are the key messages of this workshop?
   - ✱ What are the new ideas or tasks that this training course brings to FP counseling?

Activity C. Introducing the Action Plan Framework *(10 minutes)*

1. Refer the participants to the "Principles of Good Client-Provider Interaction" flipchart from Session 3. Tell them that these principles describe the ideal situation. In their action plans, they will be identifying the changes they want to make to the way they provide counseling or the actions they want to take in order to achieve that ideal situation.

2. Post the "Questions for Action Plan" flipchart (see Advance Preparation) and refer the participants to Handout 26-A in the Participant Handbook. Read the two questions and tell them that they will write their answers to these two questions in the first column of the Action Plan table:
   - ✱ What will you do differently in counseling?
   - ✱ How can you help make counseling more client centered in your facility (and among your colleagues)?
3. Orient the participants to the table and to the task:
   - Column 1: Specific changes or actions that the participants can implement immediately; write the answers to the two questions here.
   - Column 2: Barriers that might be encountered; for each proposed change or action, write the possible barriers to the implementation of that change or action in the corresponding cell.
   - Column 3: Strategies for overcoming barriers; for each barrier identified, write at least one strategy for overcoming that barrier here.

4. Review the flipcharts from the daily wrap-up sessions, with the participants' ideas about how they can apply what they have learned. Or, if you have instructed the participants to take notes (as part of the daily wrap-up) about what they have learned each day that they could apply in their work, ask them to find those notes in their notebooks. Tell them that they can use these ideas or develop new actions for the first column of the table.

Activity D. Preparing and Presenting Action Plans

(Option 1—Individual Work) (45 minutes)

1. Ask the participants to identify (to themselves) three concrete actions they would like to implement when they get back to their workplace, based on what they have learned in this training. As they choose their actions they should prioritize those actions that are (1) feasible with their own resources, (2) important in terms of service quality, and (3) realistic.

2. Ask them to start filling in all three columns of the Action Plan framework. Give them 15 minutes to complete the task.
3. Post the "Actions, Barriers, Strategies" flipchart (see Advance Preparation).

4. Ask the participants to volunteer to share the actions they listed in the first column of their action plans and record them in the first column of the flipchart. Get one action at a time from each participant and then move on to another participant. With each action that you record, ask how many other participants have the same action. Ask everybody to volunteer the barriers they have identified for that action and record them on the flipchart. Do the same for strategies to overcome the barriers.
5. Encourage the participants to write down in their individual action plans the barriers and strategies that the group has identified collectively for their specific actions.
6. Repeat the same process, going through actions, barriers, and strategies until there is no action left. Tell the participants not to repeat the same or similar actions but to share only those actions not yet listed on the flipchart.

(Option 2—Work in Groups) (1 hour, 15 minutes)

1. Divide the participants into groups (see Advance Preparation on how to do this). Ask the groups to identify (to themselves) three concrete actions they would like to implement when they get back to their workplace, based on what they have learned in this training. As they choose their actions, they should prioritize those actions that are (1) agreed on by the group members, (2) feasible with their own resources, (3) important in terms of service quality, and (4) realistic.

2. Post the "Actions, Barriers, Strategies" flipchart (see Advance Preparation). Ask the groups to start filling in all three columns of the action plan framework. Give them 25 minutes to complete the task and prepare for reporting on a flipchart.
3. Ask the groups to volunteer to present their action plans. After each group presents their plan, ask if the other participants have questions or anything to add. Ask if the plan is feasible and realistic.
4. Spend no more than 10 minutes on the presentation and discussion of each action plan, and continue until all groups have reported.
5. Encourage the groups to add to their action plans any additional points or any changes they think they should make as a result of the discussion.
6. Before closing, remind all of the groups to give you their site action plans for copying or typing. They will need to keep their own copy for reference back at their workplaces.

Activity E. Review of Action Plans *(15 minutes)*

1. Provide an overview of the action plans, including the most common actions, the most common barriers, and ideas for strategies for overcoming the barriers.
2. Ask if the participants have questions and answer them.
3. Refer the participants to Handout 26-B in the Participant Handbook for a list of possible barriers and suggested strategies.

Session 27:
Follow-Up Plans and Workshop Closing

Facilitator's Objectives

- To administer the postcourse knowledge assessment
- To solicit the participants' thoughts and impressions about the training and their suggestions for improving future workshops
- To describe the follow-up plans of the institution organizing the workshop, of the participants' own institutions, and of the trainers

Time

1 hour, 25 minutes

Materials

- Postcourse knowledge assessment (Appendix B)
- Copies of the participants' precourse knowledge assessment
- Participants' workshop evaluation form (Appendix G)
- Certificates of participation

Session Outline

Training Activities	Methodology	Time
A. Introduction	Presentation	5 mins.
B. Postcourse Assessment	Written test/presentation of correct answers	40 mins.
C. Course Evaluation	Written evaluation	15 mins.
D. Review of Follow-Up Plans	Lecture/Q&A	10 mins.
E. Closing Ceremony	Presentation/distribution of certificates	15 mins.

Advance Preparation

1. Identify and invite guests from the organizing institution and/or the participants' institution(s) for the closing ceremony. If possible, invite them to attend the afternoon session beginning after the first hour. This will allow them to listen and contribute to the action plan presentations as well.
2. Make enough copies of the postcourse knowledge assessment to have one for each participant.

3. Make enough copies of the evaluation form to have one for each participant.
4. If follow-up plans were not made before the start of the workshop (see the "Training Preparation" section in the Introduction for Trainers and Program Planners), discuss follow-up plans for this training with the institution organizing the workshop and with the participants' institution(s), and determine what follow-up will be conducted, by whom, and when. See Trainer's Tool No. 7 (Session 27).
5. If follow-up plans have already been made, arrange for a representative of the institution(s) to inform the group about the follow-up plans.
6. Prepare a certificate of participation for each participant (as appropriate for each setting).
7. *Optional:* Identify one of the participants to give closing remarks on behalf of the participants. (Preferably, this would be done earlier in the day or the day before.)
8. Summarize the workshop for any guests attending the closing ceremony (this can be done by a participant as well), and prepare the guests to give brief comments.

Session 27
Activities

Activity A. Introduction *(5 minutes)*

1. Open the session by saying that this is the final session and the closing of the course.
2. Provide an overview of the activities that will take place during the session.

Activity B. Postcourse Knowledge Assessment *(40 minutes)*

1. Administer the postcourse knowledge assessment. (30 minutes)
2. When everyone is finished, collect the papers.
3. Distribute the scored precourse assessments. (Each participant will get his or her own paper, distinguishing it by the number marked on it.)
4. Provide the answers to the assessment aloud in front of the group while the participants correct their own precourse assessment papers. *(10 minutes)*
5. Remind the participants of your commitment to keeping scores confidential. (Participants can keep the pretests.)

Activity C. Course Evaluation *(15 minutes)*

1. Distribute the evaluation forms.
2. Allow 15 minutes for the participants to complete them.
3. Collect all copies of the evaluation.

Activity D. Review of Follow-Up Plans *(10 minutes)*

> **➳ Training Tip**
>
> The trainer should have discussed the follow-up plan with the institution organizing the workshop and the participants' institution(s) in advance, or before this session at the latest. Ideally, a representative from one of these institutions should explain the plans for follow-up activities. If such a person is not available or the trainer will be conducting the follow-up activities, the trainer should go ahead and explain the plans for follow-up.

1. Invite and introduce the representative from the organizing institution or from the participants' organization to describe the training follow-up plan. This might include follow-on or inservice workshops to focus on specific content areas for FP counseling. It might also include technical assistance site visits—to see how the participants are doing in implementing their action plans, to provide guidance and support for further development of skills, and to assist with problem solving. See Trainer's Tool No. 7 (Session 27).

2. Have the representative answer the participants' questions about follow-up.
3. Remind the participants of mechanisms such as self-assessment, peer feedback, and client feedback as means of getting feedback on one's performance as a counselor. Remind them of the three tools in the curriculum that they can use for the above mentioned activities: the Learning Guides for FP Counseling, for self-assessment; the Counseling Skills Observation Guide, for peer feedback; and the Client Interview Form, to solicit feedback from clients.
4. Ask if the participants have any questions.

Activity E. Closing Ceremony *(15 minutes)*

Conduct a closing ceremony that is appropriate for the setting. This might include closing remarks by the representative(s) of the organizing institution or the participants' institution and the distribution of certificates. Thank the participants and announce the completion of the course. *Optional:* Have one participant give closing remarks (see Advance Preparation).

Trainer's Tool No. 7 (Session 27)

Discussion Guide for Planning Follow-Up

Follow-up is a set of activities for supporting the participants in a training event and reinforcing their learning. Follow-up can be done by the trainers and supervisors from the institution that has organized the training event, or it can be conducted by the participants' institution, as long as they have been trained and understand the principles, step, and behaviors to look for. Follow-up involves direct observation of the provider conducting the particular skill; feedback on the application of acquired skills, knowledge, and attitudes; guidance on further development of skills; assistance with problem solving; monitoring how action plan implementation is progressing; and assistance in soliciting the support that the participants need from their supervisors, colleagues, and organization. It is one of the ways of ensuring transfer of learning to the work environment.

Why is follow-up essential?

- It takes more than attending a training to become an expert at conducting FP counseling. Skill development occurs through practice. Facilitative feedback from supervisors and trainers about how the trainees are doing is intended to provide support and promote the learning process once the participants have returned to their home facilities and have begun using their newly acquired skills.
- A common weakness of trainings like this is insufficient posttraining follow-up. Making changes on your own in your work setting can be difficult, and many people give up after a while, no matter how enthusiastic they were after the training. That is why the trainers and the organizing institution are committed to providing follow-on trainings and site visits, so that the trainees will have the needed technical and emotional support to change the way they work.

How can follow-up be done?

Major responsibility for developing mechanisms for and conducting follow-up rests with the organization or institution in which the newly trained participants work. Institutions and those organizing training events should plan and budget for follow-up along with planning for the training event. Supervisors, trainers, and peers can all provide follow-up. Clients also can provide valuable feedback through exit interviews, and their input can be used as a follow-up mechanism. Below is a list of possible follow-up activities:

- Follow-on meetings or inservice workshops with the participants
- Follow-up visits (technical assistance site visits)
- Phone calls to and among the participants
- Newsletters, email groups, and web sites to share achievements, problems, remedies
- On-the-job sharing of experiences among peers
- Peer feedback using the Counseling Skills Observation Guide (see Session 25)
- Self-assessment using Learning Guides for FP Counseling Skills (Appendix B in the Participant Handbook)
- Client interviews and focus group discussions to monitor improvement of service quality *(See Appendix C: Client Interview Form*

Appendixes

Appendix A

Sample Training Agendas

Agenda for the Training of Providers: Six Days

DAY AND TIME	SESSION	TIME
Day 1		
Morning	1 Welcome and Introduction 2 Supporting Clients' Informed and Voluntary Decision Making 3 The Difference That Counseling Makes **Total time**	1 hour, 20 mins. 1 hour, 20 mins. 1 hour, 35 mins. **4 hours, 30 mins.**[1]
	Lunch Break	
Afternoon	After-Lunch Warm-Up[2] 4 Who Are Our Clients? 5 Factors Influencing Clients' Decisions Daily Wrap-Up **Total time**	15 mins. 1 hour, 30 mins. 1 hour, 5 mins. 15 mins. **3 hours, 20 mins.**[1]
Day 2		
Morning	Daily Warm-Up 6 Bringing in the Client Perspective 7 Providers' Beliefs and Attitudes 8 Introduction to the REDI Framework 9 Sexuality **Total time**	15 mins. 1 hour, 5 mins. 45 mins. 1 hour, 5 mins. 1 hour, 15 mins. **4 hours, 40 mins.**[1]
	Lunch Break	
Afternoon	10 Ensuring Optimal Communication Daily Wrap-Up **Total time**	2 hours, 50 mins. 15 mins. **3 hours, 20 mins.**[1]

continued

Agenda for the Training of Providers: Six Days *(continued)*

DAY AND TIME	SESSION	TIME
Day 3		
Morning	Daily Warm-Up	15 mins.
	11 Addressing Misconceptions	1 hour
	12 Filling Clients' Knowledge Gaps	1 hour, 45 mins.
	13 Using Simple Language and Visual Aids during Counseling	1 hour, 5 mins.
	Total time	**4 hours, 20 mins.**[1]
Lunch Break		
Afternoon	14 Exploring Clients' Sexual Relationships	1 hour, 35 mins.
	15 The Risk Continuum	55 mins.
	Daily Wrap-Up	15 mins.
	Total time	**3 hours**[1]
Day 4		
Morning	Daily Warm-Up	15 mins.
	16 Risk Assessment: Improving Clients' Perception of Risk	50 mins.
	17 Helping Clients Make or Confirm Decisions	1 hour, 45 mins.
	18 Decision Making for Permanent Methods	1 hour, 5 mins.
	Total time	**4 hours, 10 mins.**[1]
Lunch Break		
Afternoon	19 Helping Clients Implement Their Decisions	1 hour, 15 mins.
	20 Dual Protection and Condom Use	1 hour, 10 mins.
	Daily Wrap-Up	15 mins.
	Total time	**2 hours, 55 mins.**[1]

continued

Agenda for the Training of Providers: Six Days *(continued)*

DAY AND TIME	SESSION	TIME
Day 5		
Morning	Daily Warm-Up	15 mins.
	21 Strengthening Partner Communication and Negotiation	55 mins.
	22 Counseling Return Clients	1 hour, 5 mins.
	23 Managing Side Effects and Other Problems	1 hour, 5 mins.
	Total time	**4 hours, 5 mins.**[1]
Lunch Break		
Afternoon	24 Helping Clients Continue or Switch Methods	50 mins.
	25 Counseling Role Plays	1 hour, 10 mins.
	Daily Wrap-Up	15 mins.
	Total time	**2 hours, 30 mins.**[1]
Day 6		
Morning	Daily Warm-Up	15 mins.
	25 Counseling Role Plays (continued)	2 hours
	26 Action Plans to Apply New Learning	1 hour, 35 mins.
	Total time	**4 hours, 5 mins.**
Lunch Break		
Afternoon	27 Follow-Up Plans and Workshop Closing	1 hour, 25 mins.
	Total time	**1 hour, 25 mins.**[1]

[1] All "total times" include time for a 15-minute break. Trainers will decide when to schedule these breaks, based on local preferences.

[2] An after-lunch warm-up is scheduled for the first day, to help "break the ice" and encourage communication among participants. You can select one of your favorite warm-ups for this session. There are no other after-lunch warm-ups scheduled on the following days, because all of the after-lunch sessions are highly interactive and include group activities. If you want to conduct additional warm-ups after lunch, you will need to adjust the schedule and extend the time allotted for the afternoon sessions.

Appendix A

Agenda for the Training of Providers: Five Days

DAY AND TIME	SESSION	TIME
Day 1		
Morning	1 Welcome and Introduction 2 Supporting Clients' Informed and Voluntary Decision Making 3 The Difference That Counseling Makes **Total time**	1 hour, 20 mins. 1 hour, 20 mins. 1 hour, 35 mins. **4 hours, 30 mins.**[1]
	Lunch Break	
Afternoon	4 Who Are Our Clients? 5 Factors Influencing Clients' Decisions 6 Bringing in the Client Perspective Daily Wrap-Up **Total time**	1 hour, 30 mins. 1 hour, 5 mins. 35 mins. 15 mins. **3 hours, 20 mins.**[1]
Day 2		
Morning	Daily Warm-Up 7 Providers' Beliefs and Attitudes 8 Introduction to the REDI Framework 9 Sexuality 10 Ensuring Optimal Communication *(Short version)* **Total time**	15 mins. 1 hour, 15 mins. 1 hour, 5 mins. 1 hour, 15 mins. 35 mins. **4 hours, 40 mins.**[1]
	Lunch Break	
Afternoon	10 Ensuring Optimal Communication *(Short version) (continued)* 11 Addressing Misconceptions 12 Filling Clients' Knowledge Gaps Daily Wrap-Up **Total time**	25 mins. 1 hour 1 hour, 45 mins. 15 mins. **3 hours, 40 mins.**[1]

continued

Agenda for the Training of Providers: Five Days *(continued)*

DAY AND TIME	SESSION	TIME
Day 3		
Morning	Daily Warm-Up	15 mins.
	13 Using Simple Language and Visual Aids during Counseling	1 hour, 5 mins.
	14 Exploring Clients' Sexual Relationships	1 hour, 35 mins.
	15 The Risk Continuum	55 mins.
	Total time	**4 hours, 5 mins.**[1]
Lunch Break		
Afternoon	16 Risk Assessment: Improving Clients' Perception of Risk	50 mins.
	17 Helping Clients Make or Confirm Decisions	1 hour, 45 mins.
	18 Decision Making for Permanent Methods	1 hour, 5 mins.
	Daily Wrap-Up	15 mins.
	Total time	**3 hours, 55 mins.**[1]
Day 4		
Morning	Daily Warm-Up	15 mins.
	19 Helping Clients Implement Their Decisions	1 hour, 15 mins.
	20 Dual Protection and Condom Use	1 hour, 10 mins.
	21 Strengthening Partner Communication and Negotiation	55 mins.
	Total time	**3 hours, 50 mins.**[1]
Lunch Break		
Afternoon	22 Counseling Return Clients	1 hour, 5 mins.
	23 Managing Side Effects and Other Problems	1 hour, 35 mins.
	24 Helping Clients Continue or Switch Methods	50 mins.
	Daily Wrap-Up	15 mins.
	Total time	**4 hours**[1]
Day 5		
Morning	Daily Warm-Up	15 mins.
	25 Counseling Role Plays	3 hours, 10 mins.
	Total time	**3 hours, 40 mins.**[1]
Afternoon	26 Action Plans to Apply New Learning	1 hour, 35 mins.
	27 Follow-Up Plans and Workshop Closing	1 hour, 25 mins.
	Total time	**3 hours, 15 mins.**[1]

[1] All "total times" include time for a 15-minute break. Trainers will decide when to schedule these breaks, based on local preferences.

Appendix A

Appendix B

Precourse and Postcourse Knowledge Assessment

Appendix B

Precourse and Postcourse Knowledge Assessment

Number: _____ Date: _____

1. Which of the following is **not** required for a client to be able to make an informed choice?
   a. Service provider's recommendation
   b. Availability of appropriate information
   c. Voluntary decision-making process
   d. Availability of adequate service options

2. Which one of the following is **not** a principle of good client-provider interaction?
   a. Providing the client's preferred method
   b. Using and providing memory aids
   c. Giving all the available information about all reproductive health issues
   d. Providing information on fewer topics, which are directly relevant to the client's expressed needs, concerns, and circumstances.

3. Which one of the following statements about counseling is **incorrect**?
   a. Counseling is one of the safeguards of clients' right to informed choice.
   b. Counseling about side effects scares clients away and decreases method continuation.
   c. Counseling enables clients to use their chosen method correctly.
   d. Clients who receive the method they want are more likely to continue using it.

4. Which one of the following statements about counseling is **correct**?
   a. New clients with a method in mind should be given full information about all methods.
   b. New clients with no method in mind should receive information on all methods that respond to their expressed needs.
   c. Satisfied return clients do not need counseling.
   d. Dissatisfied return clients should be discouraged from discontinuing their method.

5. Which one of the following is **incorrect** about counseling?
   a. Assessing and addressing the needs of the client is more important than following the steps of REDI or any other counseling framework.
   b. Clients have the right and responsibility to make decisions and carry them out.
   c. The steps of REDI or any other counseling framework have to be followed in sequential order for a successful counseling session.
   d. An important role for family planning (FP) counselors is to assist clients in anticipating and strategizing about how to overcome the barriers that might prevent them from implementing their decisions.

6. Which one of the following is **correct**?
   a. The counselor should not discuss sexuality with clients unless the client raises the issue.
   b. The counselor should inform the client that certain sexual practices are right or that some are wrong.
   c. Sexuality is mostly about sexual intercourse.
   d. The counselor should explore clients' sexual practices and relationships.

7. Which one of the following is **incorrect** in describing the communication between clients and health care staff?
   a. Body language and tone of voice are as important as words in conveying messages.
   b. Praise and encouragement should be used to encourage clients to continue talking.
   c. Counselors should use only open-ended questions in order to get information from the client as quickly as possible.
   d. Opinions and feelings of clients are best elicited by open-ended questions.

8. Client says, *"People say injection makes cancer."*
   Provider says, *"I see you are concerned about it."*
   Which communication technique has the provider used here?
   a) paraphrasing b) reflecting c) clarification d) active listening

9. Which of the following is **incorrect** about giving information to clients?
   a. Information should be tailored to clients' needs.
   b. First the counselor should explore what the client already knows.
   c. The counselor should start with the method used most frequently in the country.
   d. The counselor should check whether the client understands the information given during the counseling session.

10. Which one of the following statements is **incorrect** when discussing sexuality with clients?
    a. Counseling should start with discussion of sexuality first, because it is the basis and reason for FP and for transmission of sexually transmitted infections (STIs).
    b. The counselor should warn the client that personal and sensitive questions might be asked during counseling.
    c. The client should be assured of confidentiality.
    d. The clients' sexual relationships should be explored to the extent that the client is comfortable revealing information about them.

11. Which of the following statements is **incorrect**?
    a. Condoms offer less protection against other STIs than against HIV.
    b. Anal sex is riskier than vaginal sex for transmission of HIV and other STIs.
    c. Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if exposed.
    d. Men who are not circumcised are less likely to become infected with HIV if they are exposed than are men who are circumcised.

12. Which of the following statements is **incorrect**?
    a. Counselors should help clients consider their risk for HIV and other STIS while choosing a FP method.
    b. Married women's sense of safety from contracting HIV and other STIs might be false.
    c. Self risk assessment for STIs complements but does not replace risk assessment conducted jointly by the client and provider.
    d. STI risk assessment needs to be done only with clients who belong to groups at high risk.

13. Which one of the following statements is **incorrect**?
    a. Women with a history of an STI in the last two months can generally use an IUD.
    b. Clients with AIDS who are well and on treatment (e.g., antiretroviral therapy) can continue using the IUD.
    c. Breastfeeding women who are six weeks to six months postpartum should not use combined oral contraceptives.
    d. Breastfeeding women generally should not use progestin-only injectables (such as depot medroxyprogesterone acetate (DMPA) within the first six weeks postpartum.

14. Which one of the following **is not** among the information elements of informed consent for permanent methods?
    a. Temporary methods of contraception are available to the client and his or her partner.
    b. The procedure to be performed on the client is a surgical procedure.
    c. The client can have the procedure reversed if he or she decides to have children again.
    d. The procedure does not protect the client or the partner from infection with HIV or other STIs.

15. Which one of the following **is not** among the tasks of a counselor after the client makes a decision?
    a. Assisting the client in making a concrete and specific plan for carrying out the decision
    b. Helping the client perceive his or her risk for HIV and other STIs
    c. Identifying and practicing skills that will be needed by the client
    d. Developing strategies to overcome the barriers identified with the client

16. Which of the following **cannot be considered** as a form of dual protection?
    a. The use of a condom (male or female) alone for both pregnancy and STI prevention
    b. Mutual monogamy between uninfected partners, combined with a contraceptive method
    c. The use of a condom plus another contraceptive method for extra protection against pregnancy
    d. Emergency contraception

17. Which one of the following **is not** a part of the services for satisfied return clients?
    a. Checking how satisfied the client is with the FP method
    b. Inquiring if the client is using the method correctly
    c. Telling the client about the side effects of the method that he or she is using
    d. Providing resupply or follow-up services (like checking the IUD)

18. Mark the statements that reflect the **incorrect** management of side effects or problems.
    a. Amenorrhea seen with progestin-only injectables (like DMPA) should be treated with a cycle of combined oral contraceptives so that the client can have regular periods again.
    b. For clients using combined oral contraceptives, mild side effects can be relieved by switching to a lower-dose pill or a progestin-only pill.
    c. When an IUD client is diagnosed with an STI, the IUD can stay in place during the treatment.
    d. In case of a pregnancy of less than 13 weeks gestation with an IUD in place, the IUD should be removed if its strings are visible.

19. Mark the statement that is **incorrect**.
    a. Clients who come back frequently to switch methods should be discouraged from doing so.
    b. Clients who want to discontinue their method should be offered the option of switching to another FP method.
    c. When a client brings up a misconception or rumor during counseling, the provider should explain why it is not true and give the correct information.
    d. The provider should give full information on side effects to a new FP client, regardless of whether the client asks.

20. *For this question, review the activities below and write the phase of REDI to which the activity corresponds in the space provided at the end of the activity (R for Rapport Building; E for Exploration; D for Decision Making; and I for Implementing the Decision).*

    a. Help the client consider how his or her family might react to his or her choice of actions. __ ___
    b. Offer ideas for improving communication and negotiation with the client's partner. __ ___

Precourse and Postcourse Knowledge Assessment: Key

Number: _____ Date: _____

1. Which of the following is **not** required for a client to be able to make an informed choice? (Session 2)
   a. Service provider's recommendation
   b. Availability of appropriate information
   c. Voluntary decision-making process
   d. Availability of adequate service options

2. Which one of the following is **not** a principle of good client-provider interaction? (Session 2)
   a. Providing the client's preferred method
   b. Using and providing memory aids
   c. Giving all the available information about all reproductive health issues
   d. Providing information on fewer topics, which are directly relevant to the client's expressed needs, concerns, and circumstances.

3. Which one of the following statements about counseling is **incorrect**? (Session 3)
   a. Counseling is one of the safeguards of clients' right to informed choice.
   b. .Counseling about side effects scares clients' away and decreases method continuation.
   c. Counseling enables clients to use their chosen method correctly.
   d. Clients who receive the method they want are more likely to continue using it.

4. Which one of the following statements about counseling is **correct**? (Session 4)
   a. New clients with a method in mind should be given full information about all methods
   b. New clients with no method in mind should receive information on all methods that respond to their expressed needs
   c. Satisfied return clients do not need counseling
   d. Dissatisfied return clients should be discouraged from discontinuing their method

5. Which one of the following is **incorrect** about counseling? (Session 8)
   a. Assessing and addressing the needs of the client is more important than following the steps of REDI or any other counseling framework.
   b. Client's have the right and responsibility to make decisions and carry them out.

c. The steps of REDI or any other counseling framework have to be followed in sequential order for a successful counseling session.

d. An important role for FP counselors is to assist clients in anticipating and strategizing about how to overcome the barriers that might prevent them from implementing their decisions.

6. Which one of the following is **correct**? (Session 9)
   a. The counselor should not discuss sexuality with clients unless the client raises the issue.
   b. The counselor should inform the client that certain sexual practices are right or that some are wrong.
   c. Sexuality is mostly about sexual intercourse.
   d. The counselor should explore clients' sexual practices and relationships.

7. Which one of the following is **incorrect** in describing the communication between clients and health care staff? (Session 10)
   a. Body language and tone of voice are as important as words in conveying messages.
   b. .Praise and encouragement should be used to encourage clients to continue talking.
   c. Counselors should use only open-ended questions in order to get information from the client as quickly as possible.
   d. Opinions and feelings of clients are best elicited by open-ended questions.

8. Client says *"People say injection makes cancer."* (Session 10)
   Provider says *"I see you are concerned about it."*
   Which communication technique has the provider used here?
   a) paraphrasing **b) reflecting** c) clarification d) active listening

9. Which of the following is **incorrect** about giving information to clients? (Session 12)
   a. Information should be tailored to clients' needs.
   b. First the counselor should explore what the client already knows.
   c. The counselor should start with the method used most frequently in the country.
   d. The counselor should check whether the client understands the information given during the counseling session.

10. Which one of the following statements is **incorrect** when discussing sexuality with clients? (Session 14)
    a. Counseling should start with discussion of sexuality first, because it is the basis and reason for FP and for transmission of sexually transmitted infections (STIs).
    b. Counselor should warn the client that personal and sensitive questions might be asked during counseling.

c. The client should be ensured of confidentiality.

d. Clients' sexual relationships should be explored to the extent the client is comfortable revealing.

11. Which of the following statements is **incorrect**? (Session 15)

a. Condoms offer less protection against STIs than against and other HIV.

b. Anal sex is riskier than vaginal sex for transmission of HIV and other STIs.

c. Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if they are exposed.

d. Men who are not circumcised are less likely to become infected with HIV if exposed than are men who are circumcised.

12. Which of the following statements is **incorrect**? (Session 16)

a. Counselors should help clients consider their risk for HIV and other STIS while choosing a FP method.

b. Married women's sense of safety from contracting HIV and other STIs might be false.

c. Self risk assessment for STIs complements but does not replace risk assessment conducted jointly by the client and provider.

d. STI risk assessment needs to be done only with clients who belong to groups at high risk.

13. Which one of the following statements is **incorrect**? (Session 17)

a. Women with a history of an STI in the last two months can generally use an IUD.

b. Clients with AIDS who are well and on treatment (e.g., ARVs) can continue using the IUD.

c. Breastfeeding women who are six weeks to six months postpartum should not use combined oral contraceptives.

d. Breastfeeding women generally should not use progestin-only injectables (such as DMPA) within the first six weeks postpartum.

14. Which one of the following **is not** among the information elements of informed consent for permanent methods? (Session 18)

a. Temporary methods of contraception are available to the client and his or her partner.

b. The procedure to be performed on the client is a surgical procedure.

c. The client can have the procedure reversed if he or she decides to have children again.

d. The procedure does not protect the client or the partner from infection with HIV or other STIs.

15. Which one of the following **is not** among the tasks of a counselor after the client makes a decision? (Session 19)
    a. Assisting the client in making a concrete and specific plan for carrying out the decision
    b. Helping the client perceive his or her risk for HIV and other STIs.
    c. Identifying and practicing skills that will be needed by the client
    d. Developing strategies to overcome the barriers identified with the client

16. Which of the following **cannot be considered** as a form of dual protection? (Session 20)
    a. The use of a condom (male or female) alone for both pregnancy and STI prevention
    b. .Mutual monogamy between uninfected partners, combined with a contraceptive method
    c. The use of a condom plus another contraceptive method for extra protection against pregnancy
    d. Emergency contraception

17. Which one of the following **is not** a part of the services for satisfied return clients? (Session 22)
    a. Checking how satisfied the client is with the FP method
    b. Inquiring if the client is using the method correctly
    c. Telling the client about the side effects of the method that he or she is using
    d. Providing resupply or follow-up services (like checking the IUD)

18. Mark the statements that reflect the **incorrect** management of side effects or problems. (Session 23)
    a. Amenorrhea seen with progestin-only injectables (like DMPA) should be treated with a cycle of combined oral contraceptives so that the client can have regular periods again.
    b. For clients using combined oral contraceptives, mild side effects can be relieved by switching to a lower-dose pill or a progestin-only pill.
    c. When an IUD client is diagnosed with an STI, the IUD can stay in place during the treatment.
    d. In case of a pregnancy of less than 13 weeks gestation with an IUD in place, the IUD should be removed if its strings are visible.

19. Mark the statement that is **incorrect**. (Session 24)
    a. Client, who come back frequently to switch methods should be discouraged from doing so.
    b. Clients who want to discontinue their method should be offered the option of switching to another FP method.

c. When a client brings up a misconception or rumor during counseling, the provider should explain why it is not true and give the correct information.

d. The provider should give full information on side effects to a new FP client, regardless of whether the client asks.

20. *For this question, review the activities below and write the phase of REDI to which the activity corresponds in the space provided at the end of the activity (R for Rapport Building; E for Exploration; D for Decision Making; and I for Implementing the Decision).*

a. Help the client consider how his or her family might react to his or her choice of actions. **D**

b. Offer ideas for improving communication and negotiation with the client's partner. **I**

c. Ask about the client's relationships and behaviors that might put him or her at risk for an unintended pregnancy or a sexually transmitted infection. **E**

d. Assure the client of confidentiality. **R**

Appendix B

Appendix C

Daily Warm-Ups and Daily Wrap-Ups

Appendix C

Daily Warm-Ups

Facilitator's Objectives

- To help the participants refocus on their participation in the workshop
- To review the previous day's discussions and learning in terms of the client's perspective
- To preview the day's sessions and learning objectives

Time

15 minutes

Materials

- Flipchart paper, markers, and tape

Session Outline

Training Activities	Methodology	Time
A. Welcome/Logistics		2 mins.
B. Icebreaker		5 mins.
C. Review of Previous Day	Discussion/presentation	8 mins.

Advance Preparation

1. Prepare to conduct your favorite icebreakers or other warm-up activities in a five-minute timeframe. Short games, songs, or physical activities can help participants get energized and focused on being back in the workshop setting and interacting with fellow participants. You can also ask the participants to lead the group in songs or short group activities.
2. Starting from the second day of the workshop, prepare one or two questions to ask the participants to help them think about the profiled clients' perspectives, based on the previous day's sessions and discussions. For example, on the day after the sessions on the topics of introducing the topic of sexuality with clients, using language that clients can understand, or using visual aids, you might ask the "clients" (i.e., those participants selected to assume the role of the client on that day) the following relevant questions:
   - ✱ How did you feel when the "providers" (the participants who were playing the role of the provider) here were discussing sexuality? Describe your feelings.
   - ✱ How would you feel if they spoke to you about sexuality?
   - ✱ How would you like them to discuss these issues with you?
   - ✱ How did you feel when you heard words about reproductive organs and sexual practices?

Similar questions can be asked about rights to family planning services and methods, attitudes and beliefs, and clients' reactions to any of the exercises on counseling skills and steps later in the training.

In addition, general questions such as the following can be asked:

- ✱ How did you feel yesterday in this room as you observed these "providers"?
- ✱ What do you think about what they are doing here?
- ✱ How do you feel about the training they are going through?

3. For more information on how to use client portraits, see the Introduction for Trainers and Program Planners and Session 6: Bringing in the Client Perspective.
4. Starting from the fourth day of the workshop, prepare situation cards to reflect a change in each client's situation. The idea is to allow for the discussion of topics not covered so far in the discussions. These might include discontinuing a method, desiring to have a child, worrying about a rumor, getting married, getting divorced, having vaginal discharge, hearing about HIV and AIDS, complaining of a side effect of a method, having a problem using a method (e.g., missed pills), having a partner who objects to use of family planning, or wanting to switch methods. Situation cards will be needed for Sessions 19, 21, 22, and 24. In those sessions, there are sample situation cards that you can use and more instructions and examples on how to use them. You might choose to give out the situation cards during the morning warm-up, when you assign new participants to client portraits, or you can give out the situation cards at the beginning of the sessions in which they will be used.
5. Decide how to preview the day's sessions.

Daily Warm-Up Activities

Activity A. Welcome and Logistics *(2 minutes)*

1. Welcome the participants back to the workshop.
2. Make announcements and address any "housekeeping" or logistical issues that need to be discussed.

Activity B. Icebreaker *(5 minutes)*

Conduct a short icebreaker.

Activity C. Review of Previous Day *(8 minutes)*

1. Briefly review the sessions of the previous day.
2. Call on the participants who were assigned to the five client roles the previous day. Introduce them to the large group by just telling their names. (Note: For day 2, there will not be any client role assigned from the previous day, and the reporting on clients' experiences will start on day 3.)
3. To help the participants think about the profiled clients' perspectives, ask them the prepared question(s) based on the previous day's sessions (see Advance Preparation).

> **➳ Training Tip**
>
> When assigned to a client role, participants tend to report on what problem they were experiencing and what happened. Discourage them from telling the story, and ask them to talk about their feelings and thoughts.

4. Preview the day's sessions (as you determined during Advance Preparation).
5. Assign client roles to new participants for the rest of the day. This group will report on their experience as the "client" during the following day's warm-up. (***Note:*** You may give the situation cards to the newly assigned participants for days 4 and 5 at this point.)

> **➳ Training Tip**
>
> - The numerous role plays and practice sessions in this curriculum focus on the knowledge, attitudes, and skills of the participant who is playing the provider. But equally important learning can happen for the person who is playing the client. Role playing the client involves thinking about a client as a whole person and being able to understand how the lives of clients outside the facility influence communication within the service-delivery setting.
> - Thinking about the client's perspective can help providers identify similarities between themselves and their clients. Paying attention to similarities between clients and providers can be as helpful as noticing the differences, because the things that we share help build a bridge of understanding and communication between clients and providers.

Appendix C

Daily Wrap-Ups

Facilitators' Objectives

- To recap the information and ideas covered during the day
- To identify one thing that each participant could do in his or her work to apply what he or she learned today
- To provide feedback to the facilitator about how well the workshop is going, issues that remain unclear, and ways to improve the workshop

Time

15 minutes

Materials

- Flipchart paper, markers, and tape

Session Outline

Training Activities	Time
A. Discussion	15 mins.

Advance Preparation

1. Before the first wrap-up session, create a flipchart entitled "Needs More Discussion."
2. *Optional:* Create a flipchart entitled "How Can I Apply in My Work What I Have Learned Today?"

Appendix C

Daily Wrap-Up Activities

Activity A. Discussion (15 minutes)

1. Briefly review the topics covered in the day's sessions.
2. Ask the participants the following question (encourage everyone to say something, but do not write their responses on a flipchart):

   ✱ What was the most important thing you learned from today's sessions?
3. Post the flipchart entitled "Needs More Discussion." Ask if there are any areas that remain unclear or that need more discussion. Note these areas on the flipchart.
4. Ask the participants the following question:

   ✱ What suggestions do you have for making things go well tomorrow?

   Do not write their answers on a flipchart, but thank the participants for their comments and note that you will try to follow their recommendations as much as possible.

➳ Training Tip

- After the first day, the "Needs More Discussion" flipchart will be revisited each day. Before asking if any areas remain unclear from the day, briefly review the list from the preceding days and ask which (if any) areas have been covered adequately by now. These can be crossed out; the others will remain on the list.
- Try to address the unclear issues at some point during the workshop. These wrap-up sessions are not intended to be used for that purpose, unless you find that there is enough time at the end of the day to do so.

5. ***Option A:*** Post the flipchart entitled "How Can I Apply in My Work What I Have Learned Today?" Then ask the participants:

   ✱ What is one thing that you could do when you get back to your work site to apply what you learned from today's sessions?

   List the participants' responses on the flipchart. Do not write the same answers more than once, but make tally marks alongside each to indicate how many times each answer was given.

➳ Training Tip

Save the "How Can I Apply…" flipchart sheets from each day. At the end of the workshop, during Session 26, refer back to these sheets to help the participants start working on their action plans.

When you ask for one idea from each participant about how to apply what he or she has learned, a participant might have an idea to which everyone else will say, "Yes, I would do the same thing." While such a response could in theory be accurate and significant, encourage people to think independently. Thus, on the first day, you might put participants into pairs to discuss this issue briefly and ask each pair to report. If you feel that this is not necessary to get a range of answers, then brainstorming works well too.

Option B: Tell participants to open the last page of their notebooks and write their answers to the following question on that last page. Then ask the participants:

- What is one thing that you could do when you get back to your work site to apply what you learned from today's sessions?

Tell them to make sure they write the answers in a place where they will be able to find later. They will need their answers on the last day of the workshop.

➳ Training Tip

This daily recap is meant to help the participants focus on realistic changes they can make immediately (i.e., as soon as they return to work) to enhance their communications and counseling with clients.

Too often, trainings end with action plans that never get applied because participants identify potential changes that are too many or too big, or that require the approval of others before they can happen. By asking the participants in this training to identify one thing in each day's learning that they really think they can do when they return to their work site, we hope to provide a foundation for real and lasting change and for application of the ideas and approaches presented in this training.

It is important to be realistic about what is expected from providers. We often talk about providers and what is expected of them as if they were superhuman and should be able to provide quality counseling to all clients at all times, even under the most adverse conditions. This daily exercise encourages providers to have more realistic expectations, which should help them avoid becoming discouraged about implementing the approaches they learn in training.

Appendix D

The Difference That Counseling Makes (PowerPoint Presentation)

The Difference That Counseling Makes

The Difference That Counseling Makes

Appendix D

Counseling for Effective Use of Family Planning
2008

USAID | ACQUIRE project

What Is Counseling?

Counseling is:

Two-way communication between a client and a health care staff member for the purpose of confirming or facilitating a decision by the client or of helping the client address problems or concerns.

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Counseling Tasks

During counseling, health care staff:

- Help clients assess their health care and informational and emotional support needs
- Provide personalized information *(i.e., appropriate to clients' identified problems and needs)*
- Help clients make their own informed and voluntary decisions by enabling them to weigh the options
- Help clients plan how to carry out that decision effectively *(by identifying possible barriers and developing skills and strategies to overcome them)*
- Answer questions and address concerns

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Two Experts in the Room

Knowledge of:

- Healthy timing and spacing of pregnancy (HTSP)
- FP methods and services available
- Other RH areas and services

Skills to:

- Build trust
- Empathize with clients
- Communicate
- Assess needs
- Tailor information to clients' needs
- Help clients weigh options and decide

Thoughts, Feelings, and Opinions about:

- Fertility plans
- Past experience
- Relationship with partner(s)
- Social circumstances
- Sexual relationships
- Other unexpressed needs

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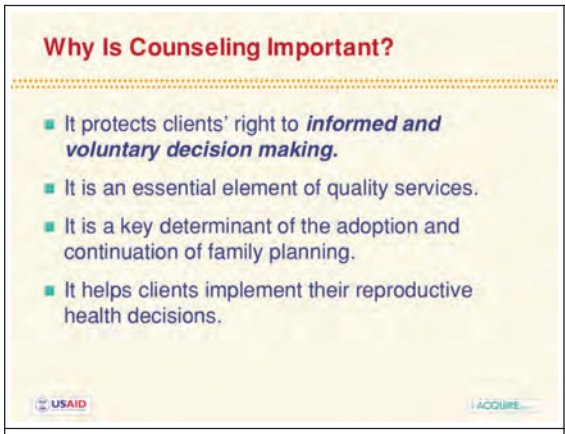
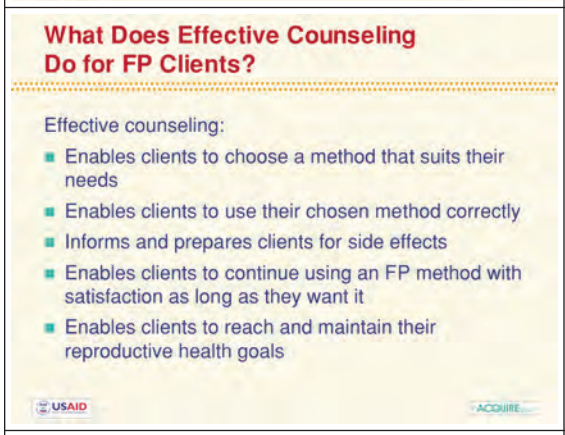
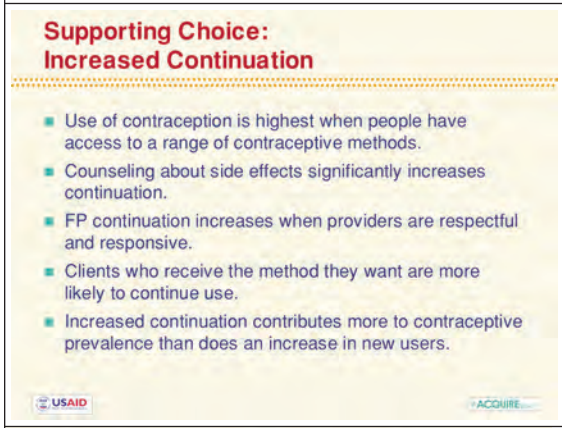
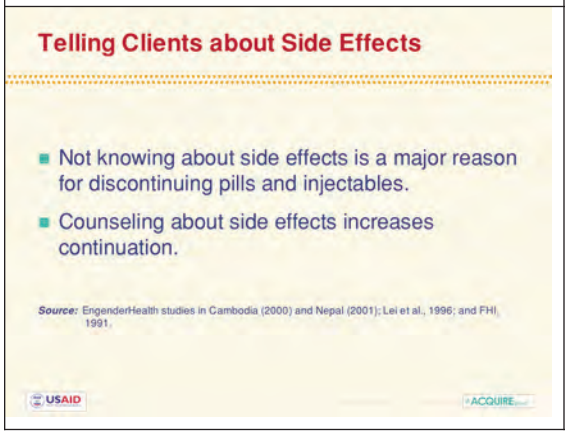
The Difference That Counseling Makes *(continued)*



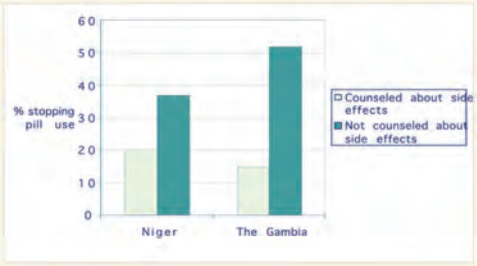






The Difference That Counseling Makes *(continued)*

Counseling for Side Effects Reduces Early Discontinuation



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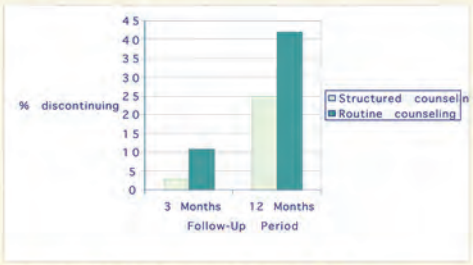
Effect of Structured Counseling* on Injectable Continuation



*Structured counseling included details on hormonal effects and side effects.

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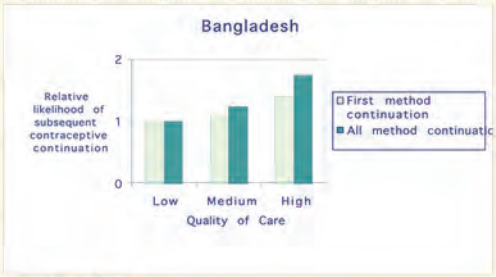
FP Continuation Increases When Providers Are Respectful, Responsive



Source: Koenig et al., 1997

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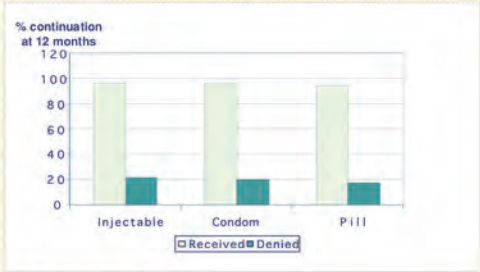
Clients Who Receive the Method They Want Are More Likely to Continue Use



Source: Pariani et al., 1991

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The Difference That Counseling Makes *(continued)*

Consequences of Poor Counseling

Effect	Outcome
Improper method use	Unwanted pregnancy
Fear and dissatisfaction with side effects	Discontinuation
Failure to recognize serious warning signs	Health risks
Dissatisfaction with services or method	▪ Dropout ▪ Poor word of mouth ▪ Low utilization

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However…

The Reality Often Falls Short of the Ideal

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Under What They Call "Counseling"…

Many providers often:

- Fail to explore clients' concerns, preferences, and informational needs
- Provide inappropriate or incomplete information or information overload
- Provide little or no preparation for side effects

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Many Providers:

- Believe they know what is best for clients
- Direct the choice of FP methods
- Lack:
  - Good communication skills
  - A client-centered approach
  - Knowledge needed for effective counseling
  - Comfort in discussing sexual and reproductive health
  - Adequate management and supervisory support
- Tell, tell, and tell …(they tend to do most of the talking)

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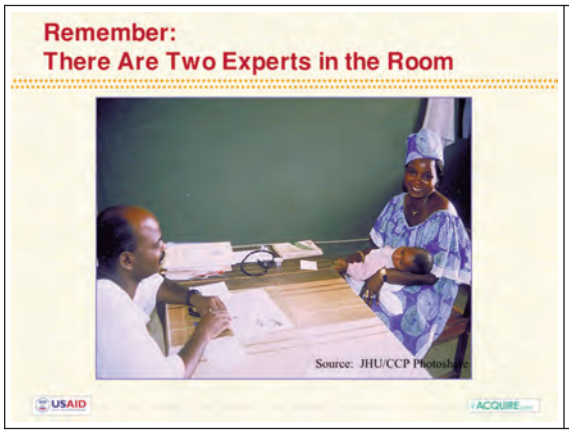
The Difference That Counseling Makes *(continued)*



Appendix E

Counseling Skills Observation Guide

Appendix E

Counseling Skills Observation Guide

Instructions: This observation guide was developed for use by trainers/supervisors, to regularly observe family planning (FP) counselors in their program and provide ongoing support. The trainer/supervisor, marks the following scores according to the performance level for each client-provider interaction observed:

2 = Competently performed (step performed correctly)

1 = Needs improvement (step performed partially or incorrectly)

0 = Step omitted (step not done)

NA = Not applicable

Any area that is scored less than 2 needs improvement (except when it is not applicable).

For a more complete description of each task, the trainer/supervisor, can use the "Learning Guides for FP Counseling Skills; *New Clients, Satisfied Return Clients, Dissatisfied Return Clients*" in the Participant Handbook Appendix B. The supervisor completes one form for each provider observed over one or more observations or supervisory visits.

Name: _____ **Service Site:**_____

Supervisor:_____ **Date(s):** _____

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	**Clients/Rating**		
	1	**2**	**3**
Rapport Building (Items 3, 5, 6, 7, and 8 should be observed during all phases of REDI. Please mark scores for them only after observing the entire counseling session.)			
1. Did the provider greet the client politely, according to local custom?			
2. Did the provider offer the client a seat?			
3. Did the provider ensure **privacy** throughout the session, with no interruptions?			
4. Did the provider explain that he or she asks personal and sometimes embarrassing questions of all clients to better help them select and use FP and stress that everything is **confidential** (i.e., that no one outside the counseling room will learn what is discussed)?			
5. Did the provider **ask open-ended questions** to encourage the client to speak?			
6. Did the provider **listen** to the client without interruptions?			
7. Did the provider give correct information to the client, using clear and simple language to ensure **informed choice**?			
8. Did the provider use visual aids (brochures, flipcharts, contraceptive samples, posters, etc.)?			

Counseling Skills Observation Guide (*cont.*)

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients/Rating		
	1	2	3
Exploration			
9. Did the provider ask the client questions to identify the type of visit? (*Circle type of client and go to the appropriate category of client below.*) • New client with a method in mind • New client with no method in mind • Satisfied return client with no problems (routine follow-up visit or resupply) • Dissatisfied return client/client with problem/side effects/concerns			
FOR NEW CLIENTS ONLY: If return client, **skip to** ⇛⇛ ***15***			
10. Did the provider ask about the client's past experience with FP and assess the client's knowledge about FP?			
11. Did the provider ask questions about: • The client's sexual relationship(s) and habits? • Communication with partner(s) about sex, FP, and sexually transmitted infections (STIs), including HIV and AIDS? • Support from partner and family to use FP? • Possible domestic violence? • Socioeconomic circumstances?			
12. Did the provider explain STI/HIV prevention and help the client perceive his or her risks for STI/HIV transmission?			
13. Did the provider give appropriate information to the client based on the client's needs (i.e., tailored to the need of the client)?			
14. Did the provider screen client for FP use according to standard (medical conditions and history)?			
FOR RETURN CLIENTS ONLY: If new client, **skip to** ⇛⇛ ***18***			
15. Did the provider ask if the client has any problems or concerns with the method?			
16. Did the provider ask about possible **changes in client's life**? • New health-related problems or concerns • New partner(s)/possible exposure to STIs/HIV • Change in fertility plans			
FOR DISSATISFIED RETURN CLIENTS ONLY: If satisfied return client, **skip to** ⇛⇛ ***18***			
17. Did the provider appropriately **address the concerns or problems** raised by the client and help the client to develop possible solutions?			

Counseling Skills Observation Guide (*cont.*)

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients/Rating		
	1	2	3
Decision Making			
18. Did the provider help the client consider his or her different options **or** reconfirm his or her choice? • Select an FP method based on correct knowledge about side effects, health benefits, and health risks of suitable methods, considering her/his preferences and needs for FP and STI/HIV prevention (**new client with no method in mind**) • Reconfirm her choice of method based on correct knowledge about its side effects, health benefits, and health risks, including the level of STI/HIV protection it offers (**new client with a method in mind AND satisfied return client**) • Options related to discontinuation and method switching (**dissatisfied return client**)			
Implementing the Decision (the provider often does not need to cover all of these tasks with satisfied return clients)			
19. Did the provider help the client make a plan for implementing the decision by asking about next steps and the timeline for implementation?			
20. Did the provider help the client consider ways to overcome potential barriers to implement his or her decision(s)?			
21. Did the provider ensure that the client has adequate knowledge and skills to implement the decision(s) (e.g., how to use the method, condom demonstration/practice, communication and negotiation skills, provision of information about safer sex practices)			
22. Did the provider ensure that the client understands what **follow-up** is required (return visits, referral, and/or resupply)?			
23. Did the provider ensure that the client understands what the possible **side effects** of the method are and what to do about side effects?			
24. Did the provider ensure that the client knows the warning signs of the method and that he or she needs to return to the facility immediately if he or she experiences warning signs?			
25. Did the provider assure the client that he or she is welcome to return to the facility any time that he or she has concerns or problems or thinks he or she might prefer to switch to another method?			
TOTAL			
Additional comments:			

Appendix E

Counseling Skills Observation Guide

Instructions: This observation guide was developed for use by supervisors and staff to regularly observe family planning (FP) counselors in their program and provide ongoing support. It is based on the GATHER counseling framework.

Observation Guide

Instructions: Evaluate the performance of the provider in implementing each task or activity, using the following codes:

1 = Needs improvement
2 = Adequate
3 = Competent
N = Not applicable

Name: _____ **Service Site:** _____

Supervisor:_____ **Date(s):** _____

Task/Activity	**Rating per client-provider interaction**			
General skills and establishment of positive client-provider interaction				
Demonstrates respect for the client; does not judge the client				
Shows friendliness by smiling				
Ensures privacy in the consultation room				
Uses simple and clear language				
Asks open-ended questions				
Asks the client to paraphrase, as necessary, to ensure that the client understands his or her questions and explanations				
Encourages the client to ask question and express concerns				
Answers all of the client's questions				
Indicates throughout the consultation that he or she is listening to the client				
Paraphrases the client to ensure understanding of the client's message				
Does not interrupt the client unless absolutely necessary				
Greets the client with respect and kindness, introduces himself or herself, and offers the client a seat				
Asks what he or she can do for the client; determines the purpose of the visit				
Explains what will happen during the visit				
Assures the client of the confidentiality of all information that is shared				
Encourages and responds to the client's questions				

Observation Guide (*cont.*)

Task/Activity	Rating per client-provider interaction			
Asks the client about himself/herself and his or her concerns				
Assists the client in:				
• Clarifying his or her reproductive health needs, concerns, and problems				
• Asking questions				
• Determining decisions or actions that the client needs or wants to make during this visit				
Obtains the client's medical and social history (as appropriate to the client's needs and concerns, using the checklist for the corresponding service):				
• Asks simple and brief questions				
• Explains terms as need				
• Explains the routine nature and purpose of risk-assessment questions regarding pregnancy, sexually transmitted infections (STIs), and HIV or AIDS, among others				
Asks about the client's:				
• Reproductive health plans (desired number of children, spacing of births, etc.)				
• Perception of risk (regarding pregnancy or STIs, and HIV and AIDS)				
• Risk behaviors as pertinent to the client's concerns (e.g., pregnancy and STIs and HIV)				
• Other health, interpersonal, or social concerns				
• Feelings about his or her concerns, risks, etc. (as appropriate)				
Explains the purpose of the questions (as appropriate)				
Looks at the client while the client or service provider speaks				
Encourages and responds to the client's questions				
Tells the client information appropriate to his or her sexual and reproductive health (SRH) needs and knowledge				
Begins the discussion with the client's preference or most urgent need				
Asks what the client already understand about his or her SRH situation and desired course of action				
Tailors information to the client's needs, knowledge, and personal situation				
Uses words familiar to the client				
Uses appropriate information, education, and communication materials in an effective manner				
Asks open-ended questions to verify client's understanding of important information				
Encourages and responds to the client's questions				
Corrects false information and rumors, as needed				

Observation Guide (*cont.*)

Task/Activity	Rating per client-provider interaction			
Helps client to make decisions to meet his or her SRH needs				
Through active listening, including asking open-ended questions, helps the client:				
• Take "ownership" of his or her problem and responsibility for his or her decisions				
• Identity options and the pros and cons of each				
• Make decisions based on weighing pros and cons of all options (including side effects and the possibility of complications), relative to the client's values and social context				
• Act on decisions taken:				
➤ By asking concrete, specific questions about steps to be taken				
➤ By encouraging the client in terms of steps taken				
Confirms the client's decision				
Assists the client to identity:				
• Possible barriers to implementing the decision				
• Ways to overcome these barriers				
Helps the client practice skills (e.g., communication skills) to overcome barriers (if appropriate)				
For the client who declines treatment or chooses not to practice any behavior change:				
• Explains possible complications or consequences of unmanaged condition or unchanged behavior				
• Offers his or her services if the client wishes to use them later				
Explains instructions for managing SRH problems/implementing decisions				
Explains how to use the chosen method or treatment option				
Reviews common side effects, the warning signs or symptoms of more serious complications, and what to do if they occur				
Provides written instructions and reviews them with the client				
Asks open-ended questions to verify the client's understanding of important information				
Encourages and responds to the client's questions				
Return visit/referral				
Sets up follow-up visit, as needed				
Invites the client to come back at any time for any reason				
Refers the client for needed or requested services unavailable onsite				
Thanks the client for coming				

Appendix F

Family Planning Cue Cards

Appendix F

HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

For more detailed guidance, refer to: Extending Service Delivery Project. 2007. *A pocket guide for health practitioners, program managers and community leaders.* Washington, DC: Pathfinder International.

Discuss reproductive intentions with your clients whenever there is an opportunity—do they wish to delay or space the births of children, or do they want to limit the number of children they have?

- During antenatal care (checkups before delivery)
- During postpartum care (checkups after delivery)
- During well-baby clinics and services for children under 5 (such as immunizations)
- During family planning (FP) services (especially services for *engaged couples, HIV-positive women who wish to become pregnant, newlyweds, young couples, married couples with children, single mothers, and women who have experienced a miscarriage or abortion)*
- During postabortion care
- During services related to sexually transmitted infections (STIs) and HIV and AIDS
- During youth services
- During men's health services
- During community outreach

The following information is not relevant for those clients who have completed their family size and wish to use a contraceptive method or procedure to limit. Be sure to establish what the client's reproductive intentions are before discussing healthy timing and spacing.

What is healthy timing and spacing of pregnancy?

Healthy timing and spacing of pregnancy (HTSP) is a way of achieving healthier pregnancies and deliveries and reducing pregnancy-related risks to the health of the mother and babies. HTSP has 3 **key messages** that should be discussed with couples and individuals "taking into consideration health risks and benefits and other circumstances such as their age, fecundity, fertility aspirations, access to health care services, child-rearing support, social and economic circumstances, and personal preferences." Those key messages are:

- **After a live birth:**
  To achieve the healthiest pregnancy outcomes, couples can use an effective FP method of choice continuously for at least 2 years, but not more than 5 years after the last birth, before trying to become pregnant again.
- **After a miscarriage or abortion:**
  To achieve the healthiest pregnancy outcomes, couples can use an effective FP method of choice continuously for at least 6 months after a miscarriage or abortion, before trying to become pregnant again.
- **For adolescents:**
  To achieve the healthiest pregnancy outcomes, adolescents need to use an effective FP method of their choice continuously until they are 18 years of age before trying to become pregnant.

HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP) *(cont.)*

What happens when HTSP messages are not taken into consideration?

- **When pregnancies are too close together:**
  Less than 24 months from the last live birth to the next pregnancy:
  - Newborns can be born too soon, too small, or with a low birth weight.
  - Infants and children may not grow well and are more likely to die before the age of 5.

  Less than 6 months from the last live birth to the next pregnancy:
  - Mothers may die in childbirth.
  - Newborns can be born too soon, too small, or with a low birth weight.
  - Infants and children may not grow well and are more likely to die before the age of 5.
- **When pregnancies are too far apart (more than 5 years):**
  - Mothers are at a higher risk of developing preeclampsia, a potentially life-threatening complication of pregnancy.
  - Newborns can be born too soon, too small, or with a low birth weight.
- **When pregnancies occur too soon (less than 6 months) after a miscarriage or abortion:**
  - Mothers are at a higher risk of developing anemia or premature rupture of membranes.
  - Newborns can be born too soon, too small, or with a low birth weight.
- **When first pregnancies occur to adolescents less than 18 years old:**
  - Adolescents are at a higher risk of developing pregnancy-induced hypertension, anemia, and prolonged or obstructed labor.
  - Newborns may die, be born too soon, too small, or with a low birth weight.
  - Additionally, the potential health risks associated with short pregnancy spacing intervals and/or having a pregnancy too early in life are exacerbated for women who already have pre-existing health problems, such as HIV, anemia, malnutrition, malaria, tuberculosis, heart disease, and diabetes.

Counseling clients for HTSP

1. Explain the HTSP messages to clients clearly, in language that they understand
2. Explain that to time and space pregnancies, the couple can use an effective FP method of their choice
3. Mention the wide range of FP methods available to the couple, including fertility awareness-based methods
4. Explain how to obtain and use FP methods
5. Emphasize the health, social, and economic benefits of practicing HTSP
6. Remind the clients that HTSP benefits the whole family and the community
7. Encourage clients to ask questions and share the information with partners, family members, and friends

PREGNANCY CHECKLIST

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to ***any question***, stop, and follow the instructions.

NO	1. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3. Have you had a baby in the last 4 weeks?	YES
NO	4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	5. Have you had a miscarriage or abortion in the past 7 days?	YES
NO	6. Have you been using a reliable contraceptive method consistently and correctly?	YES

If the client answered **NO** to ***all of the questions***, pregnancy cannot be ruled out. Client should await menses or use a pregnancy test.

If the client answered **YES** to ***at least one of questions*** and she is free of signs or symptoms of pregnancy, provide client with desired method.

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Appendix F

COMBINED ORAL CONTRACEPTIVES (COCs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Combined Oral Contraceptives?

- Combined oral contraceptives (COCs) are pills that are taken once a day to prevent pregnancy. They contain the hormones estrogen and progestin.
- COCs are also called "the Pill," low-dose combined pills, oral contraceptive pills (OCPs), and oral contraceptives (OCs).
- COCs work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective Are COCs?

The effectiveness of COCs depends on the user:

- As commonly used, in the first year, about 8 pregnancies occur per 100 women using COCs.
- When no pill-taking mistakes are made, in the first year, less than 1 pregnancy occurs per 100 women using COCs (3 per 1,000 women).
- *Return of fertility after COCs are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns, including:
  - Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, no monthly bleeding
- Headaches
- Dizziness
- Nausea
- Breast tenderness
- Weight change
- Mood changes
- Acne (can improve or worsen, but usually improves)
- Increase in blood pressure (by a mm Hg)

Health Benefits

Help protect against:

- Pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Cancer of the ovary
- Symptomatic pelvic inflammatory disease

May help protect against:

- Ovarian cysts
- Iron deficiency anemia

Reduce incidence of:

- Menstrual cramps
- Menstrual bleeding problems
- Painful ovulation
- Excess hair on face or body
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

Health Risks and Their Warning Signs

Very rare:

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). Warning signs include a sharp pain in the leg or abdomen.

Extremely rare:

- Stroke—Warning signs include severe headache with vision problems.
- Heart attack—Warning signs include severe chest pain or shortness of breath.

COCs and cancer:

- Research findings about COCs and breast cancer are difficult to interpret. Current users of COCs and those who have used COCs within the past 10 years are more likely to be diagnosed with breast cancer, but the cancers are less advanced than cancers diagnosed in other women.
- Use of COCs for 5 years or more appears to speed development of persistent HPV infection into cervical cancer. Only a very small number of such can-cers are thought to be associated with COC use.

Why Some Women Say They Like COCs

- They are controlled by the woman.
- They can be stopped at any time, without a provider's help.
- They do not interfere with sex.

Correcting Misunderstandings

- COCs do not build up in a woman's body.
- COCs do not collect in the stomach; instead, they dissolve each day.
- Women do not need a "rest" from taking COCs.
- COCs must be taken every day, whether or not a woman has sex that day.
- COCs do not make women infertile.
- COCs do not cause birth defects or multiple births.
- COCs do not change women's sexual behavior.
- COCs do not disrupt an existing pregnancy.

COMBINED ORAL CONTRACEPTIVES (COCs) *(cont.)*

Who Can Use COCs?

Women of any reproductive age or parity can use COCs, including women who:

- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes—if under 35 years old
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not taking antiretroviral medications

Women can begin using COCs without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant –see Pregnancy Checklist cue card)

Who Cannot Use COCs?

Women who have the following conditions (contraindications) cannot use COCs:

- Breastfeeding fully (or nearly fully) a baby less than 6 months old
- Having had a baby in the last 3 weeks
- Having a current or history of breast cancer
- Having a liver tumor, liver infection, or cirrhosis, or having developed jaundice while using COCs
- Being age 35 or older and smoking
- Having blood pressure 140/90 mmHg or higher
- Having current gallbladder disease
- Having diabetes for more than 20 years, or damage to arteries, vision, kidneys or nervous system caused by diabetes
- Having current or history of stroke, blood clot in legs or lungs, heart attack or serious heart problems
- Migraines with aura or migraines without aura at age 35 or older
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin)
- Planning major surgery that will keep her from walking for 1 week

When to Start Using COCs?

- Any time (during the menstrual cycle) it is reasonably certain that the client is not pregnant (see cue card titled Pregnancy Checklist)
- Within 5 days after the start of her monthly bleeding
- Immediately when stopping IUD or another hormonal method. No need to wait for her next monthly bleeding.
- Postpartum:
  - 6 months after giving birth if using LAM
  - At 6 weeks if partially breastfeeding
  - At least after 3 weeks if not breastfeeding (on days 21–28)
  - Beyond those dates, pregnancy has to be ruled out.
- Postabortion (after induced abortion or miscarriage), immediately or within 7 days

How Are COCs Used?

- The client should always take 1 pill each day.
- *For 28-pill packets* (21 hormonal pills and 7 reminder pills containing iron)—When the client finishes 1 packet, she should take the first pill from the next packet on the **very next day.**
- *For 21-pill packets*—After the client takes the last pill from 1 packet, she should wait **7 days** and then take the first pill from the next packet.
- If the client forgets to take a pill or pills (all instructions for pills containing 30–35 µg estrogen):
  - Missed 1 or 2 hormonal pills or started a new pack 1 or 2 days late—Take a hormonal pill as soon as possible and then continue taking pills daily, 1 each day.
  - Missed 3 or more hormonal pills in the first 2 weeks or started a pack 3 or more days late—Take a hormonal pill as soon as possible and continue taking pills daily, 1 each day. Use a back-up method (condoms or abstain from sex) until you have taken hormonal pills for 7 days in a row. If missed 3 or more pills in the third week, finish the hormonal pills in your current pack and start a new pack the next day. You should not take the 7 nonhormonal pills. Use a back-up method for 7 days. You may miss a period. This is okay.
  - Missed 1 or more of any nonhormonal pills—Throw the missed pills away. Take the rest of the pills as usual, 1 each day. Start a new packet as usual on the next day.
    *For pills with **20 _g of estrogen or less,** women missing 1 pill should follow the same guidance as missing 1 or 2 30–35 _g pills. Women missing 2 or more pills should follow the same guidance as missing 3 or more 30–35 _g pills.*
- The client should also be told about the **warning signs for health risks** (see on first page).

PROGESTIN-ONLY PILLS (POPs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Progestin-Only Contraceptive Pills?

Progestin-only pills (POPs) are pills that are taken once a day to prevent pregnancy.

- Unlike COCs, POPs, do not contain any estrogen, and therefore they can be used throughout breastfeeding and by women who cannot use methods with estrogen.
- POPs are also called "minipills" and progestin-only oral contraceptives.
- POPs work primarily by:
  - Thickening cervical mucus (this blocks sperm from meeting an egg)
  - Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation)

How Effective Are POPs?

Effectiveness depends on the user. For breastfeeding women:

- As commonly used, about 1 pregnancy per 100 women using POPs over the first year.
- When taken everyday, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000).
- They are less effective for women not breastfeeding: as commonly used, 3–10 pregnancies per 100 women and when pills are taken every day, less than 1 pregnancy per 100 women (9 per 1,000 women). Women not breastfeeding should take pills at the same time every day (no later than 3 hours) for pills to be effective.
- *Return of fertility after POPs are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side effects (which are temporary and not dangerous)

- Changes in bleeding patterns including:
  - Frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding, and, for breastfeeding women, lengthened postpartum amenorrhea
- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea
- For women not breastfeeding, enlarged ovarian follicles).

Health Benefits and Health Risks

Help protect against risks of pregnancy.

Why Some Women Say They Like POPs

- Can be used while breastfeeding
- Can be stopped any time without a provider's help
- Do not interfere with sex
- Controlled by the woman

Correcting Misunderstandings

Progestin-only pills:

- Do not cause a breastfeeding woman's milk to dry up.
- Must be taken every day, whether or not a woman has sex that day. They don't require a "rest" period between packs.
- Do not make women infertile.
- Do not cause diarrhea in breastfeeding babies.
- Reduce the risk of ectopic pregnancy.
- Do not build up in a woman's body. That's why they have to be taken everyday to maintain their effectiveness.
- Do not cause birth defects.

Who Can Use POPs?

Women of any reproductive age or parity can use POPs, including women who:

- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have or have not had children
- Are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, regardless of whether they are taking antiretroviral medications

Women can begin using POPs without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see cue card titled Pregnancy Checklist).

PROGESTIN-ONLY PILLS (POPs) *(cont.)*

Who Cannot Use POPs?

Women who have the following conditions cannot use POPs:

- Breastfeeding a baby less than 6 weeks old
- Liver tumor, liver infection, or cirrhosis
- Current serious problem with blood clots in legs or lungs
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

When to Start Using POPs?

- **Any time** it is reasonably certain that the client is not pregnant. See Pregnancy Checklist cue card.
- **No monthly bleeding**—Any time it is reasonably certain that the client is not pregnant. A back-up method needed for the first 2 days of taking pills.
- Immediately when **switching from copper-bearing IUD or another hormonal method,** if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding.
- The day after the client finishes taking emergency contraceptive pills.
- **Having menstrual cycles or switching from a nonhormonal method**—within 5 days after the start of her monthly bleeding and no back-up method; or more than 5 days after the start of monthly bleeding—any time it is certain that the client is not pregnant, and a back-up method Is used for the first 2 days of taking pills.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding*—Six weeks after giving birth, and any time between 6 weeks and 6 months, if her monthly bleeding has not returned
  - *Partially breastfeeding*—At 6 weeks after giving birth; if less than 6 weeks and monthly bleeding has returned, a back-up method should be used until 6 weeks have passed since giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant, and a back-up method should be used for the first 2 days.
  - *Breastfeeding and monthly bleeding has returned*—As advised for women having menstrual cycles.
  - *Not breastfeeding*—Any time within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned, then any time it is reasonably certain that client is not pregnant, plus a back-up method should be used for the first 2 days of taking pills; if monthly bleeding has returned, then as advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage)—Immediately or within 7 days, no back-up method is needed; more than 7 days after, any time it is reasonably certain that client is not pregnant, and a back-up method should be used for the first 2 days of taking pills.

How Are POPs Used?

- The client should always take 1 pill each day. When she finishes 1 packet, she should take the first pill from the next packet on the **very next day**. There is no wait between packets.
- **IMPORTANT:** It is best to take the pill at the same time each day, if possible. This helps remembering and ensures effectiveness. Taking a pill more than 3 hours late increases the risk of pregnancy.
- If the client **forgets to take a pill or pills** or **is 3 or more hours late taking a pill:**
  - **Having monthly bleeding (including those who are breastfeeding):** She should take 1 pill as soon as possible, continue taking the pills as usual, 1 each day and use a back-up method for the next 2 days. If she had sex in the past 5 days, she can also consider taking emergency contraceptive pills (ECP).
  - **Breastfeeding AND no monthly bleeding:** She should take 1 pill as soon as possible and continue taking the pills as usual, 1 each day. This may mean that she takes 2 pills at the same time or on the same day.
- The client should also be told about the **warning signs for complications,** such as severe abdominal pain (a warning sign for ectopic pregnancy).

EMERGENCY CONTRACEPTIVE PILLS (ECPs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Emergency Contraceptive Pills (ECPs)?

- Emergency contraceptive pills (ECPs) are pills that contain a progestin alone, or a progestin and an estrogen together—hormones like the natural hormones progesterone and estrogen in a woman's body. ECPs help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.
- ECPs are sometimes called "morning after" pills or postcoital contraceptives.
- They provide an opportunity for women to start using an ongoing family planning method.
- ECPs work primarily by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant.
- Use of copper-bearing IUDs for ***emergency contraception*** is described on the Copper-Bearing Intrauterine Device cue card.

What Pills Can Be Used as Emergency Contraceptive Pills?

- A special ECP product with the progestin levonorgestrel
  - 1.5 mg of levonorgestrel in a single dose
- A special ECP product with estrogen and levonorgestrel
  - 0.5 mg levonorgestrel + 0.1 mg ethinyl estradiol, followed with same dose 12 hours later.
- Progestin-only pills with levonorgestrel or norgestrel
  - 1.5 mg levonorgestrel in a single dose or 3 mg norgestrel in a single dose
- Combined oral contraceptives with estrogen and a progestin (levonorgestrel, norgestrel, or norethindrone)
  - 0.5 mg levonorgestrel + 0.1 mg ethinyl estradiol followed with same dose 12 hours later
  - 1 mg norgestrel + 0.1 mg ethinyl estradiol followed with same dose 12 hours later
  - 2 mg norethindrone + 0.1 mg ethinyl estradiol followed with same dose 12 hours later

When Should ECPs Be Taken?

- *As soon as possible* after unprotected sex. The sooner ECPs are taken after unprotected sex, the better they prevent pregnancy.
- ECPs can prevent pregnancy when taken any time up to 5 days after unprotected sex.

How Effective Are ECPs?

- If 100 women each had sex once in the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
- If all 100 women used progestin-only ECPs, 1 would likely become pregnant.
- If all 100 women used estrogen and progestin ECPs, 2 would likely become pregnant.
- *Return of fertility after taking ECPs:* No delay (A woman can become pregnant immediately after taking ECPs. Taking ECPs will not protect a woman from pregnancy from acts of sex after she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once.)
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous) • Changes in bleeding patterns, including: ◦ Light vaginal bleeding for 1–2 days after taking ECPs ◦ Monthly bleeding that starts earlier or later than expected	In the week after taking ECPs: • Nausea • Abdominal pain • Fatigue • Headache • Breast tenderness • Dizziness • Vomiting (less frequent with progestin-only formulations)
Health Benefits Help protect against risks of pregnancy.	***Health Risks*** None

EMERGENCY CONTRACEPTIVE PILLS (ECPs) *(cont.)*

Why Some Women Say They Like ECPs

- Offer a second chance at preventing pregnancy
- Are controlled by the woman
- Reduce seeking out abortion in the case of contraceptive errors or if contraception is not used
- Can have on hand in case an emergency arises

Correcting Misunderstandings

Emergency contraceptive pills:

- Do not cause abortion.
- Do not cause birth defects if pregnancy occurs.
- Are not dangerous to a women's health.
- Do not promote sexual risk-taking.
- Do not make women infertile.

Who Can Use ECPs?

All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Tests and examinations are not necessary for using ECPs. They may be appropriate for other reasons—especially if sex was forced.

Who Cannot Use ECPs?

Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

When Can ECPs Be Used?

ECPs can be used at any time within 5 days after unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are. ECPs can be used any time a woman is worried that she might become pregnant. For example, after:

- Sex was forced (rape) or coerced
- Any unprotected sex
- Contraceptive mistakes, such as:
  - Condom was used incorrectly, slipped, or broke.
  - Fertility awareness method was used incorrectly (e.g., couple failed to abstain or to use another method during the fertile days).
  - Man failed to withdraw, as intended, before he ejaculated.
  - Woman missed 3 or more combined oral contraceptive pills, or starts a new pack 3 or more days late, or is too late for a repeat injection.
  - IUD has come out of place.

How Are ECPs Used?

- The client takes the pills at once, or if she is using the 2-dose regimen, she takes the next dose in 12 hours.
- Women who have had nausea with previous ECP use or with the first dose of a 2-dose regimen can take antinausea medication.
- If the woman vomits within 2 hours after taking ECPs, she should take another dose. (She can use anti-nausea medication with this repeat dose.) If vomiting continues, she can take the repeat dose by placing the pills high in her vagina. If vomiting occurs more than 2 hours after taking ECPs, she does not need to take any extra pills.
- No routine return visit is required

Counseling Clients:

- **Explain:**
  - How to take the pills
  - Most common side effects and what to do if they occur (especially nausea and vomiting)
  - That ECPs will not protect the client from pregnancy for any future sex acts—even the next day.
- **Discuss** ongoing contraception options and, if the client is at risk, protection from STIs and HIV
  - If the client does not want to start a contraceptive method now, give her condoms or oral contraceptives in case she changes her mind and invite her to come back any time if she wants another method.
- **Invite the client** to come back for any questions or problems or if she wants to switch to another method, if she experiences any major change in her health status, or if she thinks she might be pregnant.

PROGESTIN-ONLY INJECTABLES

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Progestin-Only Injectables?

- To prevent pregnancy, a shot is given into the muscle (intramuscular injection) every 2 or 3 months, depending on the type of injectable. The 2-monthly injectable contains norethisterone enantate (NET-EN—Noristerat®, Syngestal®), and the 3-monthly injectables contain depot medroxyprogesterone acetate (DMPA—Depo-Provera®, Megestron®, Petogen®).
- Progestin-only injectable contraceptives contain no estrogen. Therefore, they can be used throughout breast-feeding and by women who cannot use methods with estrogen.
- Progestin-only injectables work primarily by preventing the release of eggs from the ovaries (ovulation).
- A new subcutaneous formulation of DMPA has been developed specifically for injection into the tissue just under the skin (subcutaneously). Called DMPA-SC, this new formulation will be available in prefilled syringes and will contain 30% less hormone than typical DMPA (104 mg instead of 150 mg). Thus, it may cause fewer side effects, with an injection every 3 months which clients can deliver themselves. It has been approved in the United States under the name "Depo-subQ provera 104."

How Effective Are Progestin-Only Injectables?

- As commonly used, injectables have a failure rate of 3 pregnancies per 100 women over the first year of use.
- When women have injections on time, the failure rate is less than 1 pregnancy per 100 women over the first year (3 per 1,000 women).
- *Return of fertility after progestin-only injectables are stopped:* An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods.
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns including:
  - With DMPA first 3 months: irregular bleeding, prolonged bleeding
  - With DMPA at 1 year: no monthly bleeding, infrequent bleeding, irregular bleeding
  - NET-EN affects bleeding patterns less than DMPA. Fewer days of bleeding in the first 6 months and less likely to cause no bleeding after 1 year
- Weight gain (about 1–2 kg per year)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive
- Loss of bone density

Health Risks

None

Health Benefits

DMPA:

- Helps protect against
  - Risks of pregnancy
  - Cancer of the lining of uterus (endometrial cancer)
  - Uterine fibroids
- May help protect against
  - Symptomatic pelvic inflammatory disease
  - Iron deficiency anemia
- Reduces:
  - Sickle cell crisis among women with sickle cell anemia
  - Symptoms of endometriosis (pelvic pain, irregular bleeding)

NET-EN

- Helps protect against iron deficiency anemia
- May also offer many of the health benefits as DMPA

Correcting Misunderstandings

Progestin-only injectables:

- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.
- Do not cause birth defects.

Why Some Women Say They Like Progestin-Only Injectables

- Do not require daily action
- Do not interfere with sex
- Private: No one else can tell that a woman is using contraception
- No monthly bleeding (for many women)
- May help women to gain weight

PROGESTIN-ONLY INJECTABLES *(cont.)*

Who Can Use Progestin-Only Injectables?

Women of any reproductive age or parity, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have just had abortion or miscarriage
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Are infected with HIV, whether or not they are taking antiretroviral medications

Women can begin using progestin-only injectables without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when the woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see Pregnancy Checklist cue card).

Who Cannot Use Progestin-Only Injectables?

Women who have the following conditions:

- Breastfeeding a baby less than 6 weeks old
- Active liver disease (severe cirrhosis of the liver, a liver infection, or liver tumor)
- Systolic blood pressure 160 or higher or diastolic blood pressure 100 or higher
- Diabetes for more than 20 years or with damage to the arteries, vision, kidneys, or nervous system
- History of heart attack, heart disease due to blocked or narrowed arteries, or stroke or current blood clot in the deep veins of the leg or in the lung
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition.
- Current or history of breast cancer

When to Start Using Progestin-Only Injectables?

- At **any time** that it is reasonably certain that the client is not pregnant (If it has been more than 7 days since the last monthly bleeding started, a back-up method [such as abstinence, male or female condoms, spermicides, or withdrawal] is needed for the next 7 days.)
- **Having menstrual cycles or switching from a nonhormonal method:** If within 7 days after the start of monthly bleeding, there is no need for a back-up method. If more than 7 days after the start of monthly bleeding, a back-up method is needed for the first 7 days after the injection.
- **Switching from another hormonal method:** Immediately, if the client has been using the previous method consis-tently and correctly. There is no need to wait for a first period and no need for a back-up method. The day after, when the client finishes taking emergency contraceptive pills; a back-up method is needed for the first 7 days after the injection.
- **No monthly bleeding** (not related to childbirth or breastfeeding): Any time it is reasonably certain that the client is not pregnant. A back-up method is needed for the first 7 days after the injection.
- **Postabortion** (after abortion or miscarriage): Immediately or within 7 days. No back-up method needed. Beyond 7 days, any time it is reasonably certain the client is not pregnant; a back-up method is needed for the first 7 days after injection.
- **Postpartum:**
  - Fully or nearly fully breastfeeding: Six weeks after giving birth, and any time between 6 weeks and 6 months if her monthly bleeding has not returned. If more than 6 months, need to be certain that she is not pregnant, and a back-up method is needed for the first 7 days after the injection.
  - Partially breastfeeding: At 6 weeks after giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after injection.
  - Breastfeeding and monthly bleeding has returned: As advised for women having menstrual cycles.
  - Not breastfeeding: Any time, within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned, any time it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after the injection. If monthly bleeding has returned, as advised for women having menstrual cycles.

How Are Progestin-Only Injectables Used?

- The client should not massage the injection site, should be told the name of the injection, and should return in **3 months (13 weeks) for her next DMPA injection** and in **2 months (8 weeks) for NET-EN** on the day agreed upon.
- The repeat injection for DMPA and NET-EN can be given up to **2 weeks early,** or up to **2 weeks late** without the need for additional contraceptive protection, but it is best to return on time.
- If the client is **more than 2 weeks late** for the DMPA or NET-EN repeat injection, she can have the injection, if it is reasonably certain that she is not pregnant. She will need to use a back-up method for the first 7 days after the injection. She may consider emergency contraception if she has had unprotected sex in the past 5 days.

MONTHLY INJECTABLES

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use. 3rd ed.* Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Monthly Injectables?

- Monthly injectables contain 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body. (Combined oral contraceptives also contain these 2 types of hormones.) They are administered by intramuscular injection once a month.
- Monthly injectables also are called combined injectable contraceptives (CICs). Information in this cue card applies to medroxyprogesterone acetate + estradiol cypionate (MPA/E2C, which is marketed under the trade names Cyclofem®, Ciclofem®, Ciclofemina®, Cyclo-Provera®, Feminena®, Lunelle®, Lunella®, and Novafem®) and to norethisterone enanthate + estradiol valerate (NET-EN/E2V, which is marketed under the trade names Mesigyna® and Norigynon®). It may also apply to older formulations, about which less is known. The most widely available CICs are Cyclofem® (25 mg depot-medroxyprogesterone acetate and 5 mg estradiol cypionate) and Mesigyna® (50 mg norethindrone enanthate and 5 mg estradiol valerate).
- Monthly injectables work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective Are Monthly Injectables?

- As commonly used, the failure rate is about 3 pregnancies per 100 women over the first year.
- When women have injections on time, the failure rate is less than 1 pregnancy per 100 women over the first year (5 per 10,000 women).
- Return of fertility after injections are stopped: An average of about 1 month longer than with most other methods.
- Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns, including:
- Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding
- Weight gain
- Headaches
- Dizziness
- Breast tenderness

Health Benefits and Health Risks

Long-term studies of monthly injectables are limited, but researchers expect that their health benefits and health risks are similar to those of combined oral contraceptives (see the cue card Combined Oral Contraceptives, Health Benefits and Health Risks).

Why Some Women Say They Like Monthly Injectables

- Private; no one else can tell that a woman is using contraception
- Do not require daily action
- Injections can be stopped at any time
- Good for spacing births

Correcting Misunderstandings

Monthly injectables:

- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman's body.
- Are not in experimental phases of study. Government agencies have approved them.
- Do not make women infertile.
- Do not cause early menopause.
- Do not cause birth defects or multiple births.
- Do not cause itching.
- Do not change women's sexual behavior.

Who Can Use Monthly Injectables?

Women of any reproductive age and parity, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion or miscarriage
- Smoke any number of cigarettes and are younger than 35
- Smoke fewer than 15 cigarettes daily and are older than 35
- Have anemia now or had anemia in the past
- Have varicose veins
- Are infected with HIV, whether or not they are taking antiretroviral medications

Women can begin using monthly injectables without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see Pregnancy Checklist cue card).

MONTHLY INJECTABLES *(cont.)*

Who Cannot Use Monthly Injectables?

Women who have the following conditions (contraindications):

- Fully or nearly fully breastfeeding a baby less than 6 months old
- Partially breastfeeding a baby less than 6 weeks old
- Have had a baby in the last 3 weeks
- Smoking 15 or more cigarettes a day and being age 35 or older
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor); women with mild cirrhosis or gall bladder disease can use monthly injectables.
- Systolic blood pressure 140 mm Hg or higher or diastolic blood pressure 90 or higher
- Diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes
- Current or history of stroke, blood clot in legs or lungs, heart attack, or serious heart problems
- Current or history of breast cancer
- Migraines with aura or migraines without aura at age 35 or older
- Planning major surgery that will keep her from walking for 1 week or more

When to Start Using Monthly Injectables?

- **Any time** it is reasonably certain that the client is not pregnant. If it has been more than 7 days since menstrual bleeding stared, a back-up method (such as abstinence, male or female condoms, spermicides, or withdrawal) is needed for the next 7 days.
- **Having menstrual cycles or switching from a nonhormonal method:** If within 7 days after the start of monthly bleeding, there is no need for a back-up method. If more than 7 days after the start of monthly bleeding, a back-up method is needed for the first 7 days after the injection.
- **Switching from another hormonal method,** immediately if the client has been using the previous method consistently and correctly. No need to wait for a first period. No need for a back-up method. **After using emergency contraceptive pills** (ECPs), the same day as the client finishes taking pills; a back-up method is needed for the first 7 days after the injection.
- **No monthly bleeding:** Any time when it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after the injection.
- **Postabortion** (after abortion or miscarriage): Immediately or within 7 days. No back-up method is needed. Beyond 7 days after abortion or miscarriage, any time it is reasonably certain as the client is not pregnant; a back-up method is needed for the first 7 days after the injection.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding*—6 months after giving birth or when breast milk is no longer the baby's main food, whichever comes first. After 6 months and if her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more than 6 months and monthly bleeding has returned, as advised for women having menstrual cycles.
  - *Partially breastfeeding*—At 6 weeks after giving birth, at the earliest. After 6 weeks and if her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more 6 weeks and her monthly bleeding has returned, as advised for women having menstrual cycles.
  - *Not breastfeeding*—On days 21–28 after giving birth (within fourth week). If more than 4 weeks after giving birth and her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more than 4 weeks and her monthly bleeding has returned, as advised for women having menstrual cycles.

How Are Monthly Injectables Used?

- The injection should be given every 4 weeks.
- The client should not massage the injection site, and she should be told the name of the injection.
- Subsequent injections can be given up to 7 days earlier and 7 days later than the scheduled injection day.
- For ease of use, the injections can be scheduled for the same day of each month.
- If the client comes more than 7 days late, she should abstain from sex or use condoms, spermicides, or withdrawal until she can get an injection. She can also consider emergency contraceptive pills if she has had unprotected sex in the past 5 days.
- The client should also be told about the **warning signs for health risks** (see the cue card on Combined Oral Contraceptives).

IMPLANTS

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Implants?

- Implants are small plastic rods or capsules, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body. A specifically trained provider performs a minor surgical procedure to place the implants under the skin on the inside of a woman's upper arm.
- Implants do not contain estrogen, and so they can be used throughout breastfeeding and by women who cannot use methods containing estrogen.
- There are many types of implants: *Jadelle* consists of 2 rods and lasts 5 years; *Implanon* consists of 1 rod and lasts 3 years. (Studies are underway to see if it lasts f4our years); *Norplant* consists of 6 capsules and is labeled for 5 years of use (large studies found it effective for 7 years); *Sinoplant* consists of 2 rods and lasts 5 years.
- Implants work primarily by thickening cervical mucus (which blocks the sperm from meeting an egg) and by disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

How Effective Are Implants?

- Pregnancy rates are less than 1 pregnancy per 100 women using implants over the first year (5 per 10,000 women).
- Pregnancy risk continues beyond first year of use. Over 5 years of Jadelle use, the rate is about 1 pregnancy per 100 women; over 3 years of Implanon use, the rate is less than 1 pregnancy per 100 women (1 per 1,000 women); over 7 years of Norplant use, the rate is about 2 pregnancies per 100 women.
- Jadelle and Norplant implants begin to lose effectiveness sooner in heavier women.
- *Return of fertility after implants are removed:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side effects (which are temporary and not dangerous)

- Changes in bleeding patterns including:
  - In first several months, lighter bleeding and fewer days of bleeding, Irregular bleeding that lasts more than 8 days, irregular bleeding, no monthly bleeding
  - After about 1 year, lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding
- Headaches
- Abdominal pain
- Acne (can improve or worsen)
- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea
- Enlarged ovarian follicles

Health Benefits

- Help protect against
  - Risks of pregnancy
  - Symptomatic pelvic inflammatory disease
  - Uterine fibroids
- May help protect against
  - Iron deficiency anemia

Health Risks

None

Complications and Their Warning Signs

Uncommon:

- Infection at insertion site (mostly within the first 2 months)—Warning signs include arm pain and pus or bleeding at the insertion site.
- Difficult removal (rare if properly inserted and the provider is skilled at removal)

Rare:

- Expulsion of implant (mostly within the first 4 months)

Correcting Misunderstandings

Implants:

- Stop working once they are removed. Their hormones do not remain in a woman's body.
- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Substantially reduce the risk of ectopic pregnancy.
- Do not make women infertile.
- Do not move to other parts of the body.

Why Some Women Say They Like Implants

- Do not require the user to do anything once they are inserted
- Prevent pregnancy very effectively for many years
- Convenient
- Do not interfere with sex

IMPLANTS *(cont.)*

Who Can Use Implants?

Women of any reproductive age or parity, including women who:

- Have or have not had children, or are not married.
- Are of any age, including adolescents and women older than 40.
- Have just had an abortion, a miscarriage, or an ectopic pregnancy.
- Smoke cigarettes, regardless of age or number of cigarettes smoked.
- Are breastfeeding (starting as soon as 6 weeks after childbirth).
- Have anemia, now or in the past.
- Have varicose veins.
- Have HIV infection, whether or not they are taking antiretroviral medications.

Women can begin using implants without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see the Pregnancy Checklist cue card).

Who Cannot Use Implants?

Women cannot use implants if they have the following conditions:

- Breastfeeding a baby less than 6 weeks old
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor)
- Current problem with a blood clot in legs or lungs
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

How Are Implants Used?

- Implants are inserted and removed by trained health care providers. Insertion takes a few minutes.
- The woman receives an injection of local anesthetic under the skin to prevent pain in her arm.
- The implant(s) are inserted through an incision made on the inside of the upper arm. Implanon does not require an incision. It is inserted through its applicator. The woman stays fully awake throughout the procedure.
- The incision is closed with an adhesive bandage. Stitches are not needed.
- For removal, the same steps of injection and incision are completed, and the provider pulls out the implants with the help of an instrument. The client may feel slight pain ore soreness for a few days after removal. Stitches are not needed. An adhesive bandage is used to close the incision.
- The client should also be told about the **warning signs for complications** (see the first page).

When to Start Using Implants?

- **Any time** it is reasonably certain that the client is not pregnant. (See Pregnancy Checklist cue card.)
- **No monthly bleeding**—Any time it is reasonably certain that the client is not pregnant. A back-up method is needed for the first 7 days after insertion.
- Immediately when **switching from another hormonal method,** if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding. No need for a back-up method.
- **After taking emergency contraceptive pills (ECPs),** within the first 7 days (5 days for Implanon) after next monthly bleeding, or any time it is reasonably certain the client is not pregnant. Will need to use a back-up method or the pill the day after taking ECPs, until implant insertion.
- **Menstruating or switching from nonhormonal method,** within 7 days (5 for Implanon) after start of monthly bleeding and no back-up method, or more than 7 days after start of monthly bleeding—any time it is certain client is not pregnant; use back-up method for first 7 days after insertion.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding*—Six weeks after giving birth, and any time between 6 weeks and 6 months, if her monthly bleeding has not returned. If more than 6 months after giving birth and her monthly bleeding has returned, any time it is reasonably certain that she is not pregnant; a back-up method should be used for the first 7 days after insertion.
  - *Partially breastfeeding*—At 6 weeks after giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant; a back-up method should be used for the first 7 days.
  - *Breastfeeding, monthly bleeding has returned*—As advised for women with menstrual cycles.
  - *Not breastfeeding*—Any time within 4 weeks after giving birth; If beyond 4 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant; a back-up method is needed for the first 7 days of taking pills. If monthly bleeding has returned, as advised for women having menstrual cycles
- **Postabortion** (after abortion or miscarriage)—If immediately after or within 7 days, no back-up method is needed. If more than 7 days after, any time it is reasonably certain that she is not pregnant; a back-up method is needed for the first 7 days after insertion.

COPPER-BEARING INTRAUTERINE DEVICE (IUD)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is the Intrauterine Device (IUD)?

- The IUD is a small, flexible plastic device with copper sleeves or wire around it. A specially trained health care provider inserts it into a woman's uterus through her vagina and cervix. Almost all types of IUDs have 1 or 2 strings, or threads, tied to them. The strings hang through the cervix into the vagina.
- The most commonly used IUD in family planning programs is the copper-bearing TCu-380A IUD, which is effective for up to 12 years of use. Other copper-bearing IUDs are the MLCu-375 (Multiload) and Nova T, which are effective for 5 years.
- The IUD works primarily by causing a chemical change that damages sperm and egg before they can meet.

How Effective Are IUDs?

- IUDs are highly effective in providing long-term, reversible contraception. For the TCu-380A, the pregnancy (failure) rate during the first year of use is less than 1 pregnancy for 100 women (6–8 per 1,000 women). Over 10 years of IUD use, the failure rate is about 2 pregnancies per 100 women.
- *Return to fertility after IUD is removed:* No delay
- *Protection against sexually transmitted diseases (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

Changes in bleeding patterns (especially in the first 3–6 months), including:

- Prolonged and heavy monthly bleeding
- Irregular bleeding
- More cramps and pain during monthly bleeding

Health Benefits

- Helps protect against risks of pregnancy.
- May help protect against cancer of the lining of the uterus (endometrial cancer).

Health Risks and Warning Signs

- **Uncommon:** May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
- **Rare:** Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhea at the time of IUD insertion. Warning signs include increasing or severe pain in the lower abdomen, pain during intercourse, unusual vaginal discharge, fever, chills, nausea, and/or vomiting.

Complications

- **Rare:** Puncturing (perforation) of the wall of the uterus by the IUD or an instrument used for insertion may occur. This usually heals without treatment.

Why Some Women Say They Like the IUD

- Highly effective protection from pregnancy
- Long-lasting
- Relatively inexpensive at the start, and no further costs
- Does not require the user to do anything once the IUD is inserted

Correcting Misunderstandings

Intrauterine devices:

- Rarely lead to PID after insertion.
- Do not increase the risk of contracting STIs, including HIV.
- Do not increase the risk of miscarriage when a woman becomes pregnant after IUD removal.
- Do not make women infertile.
- Do not cause birth defects.
- Do not cause cancer.
- Do not move to the heart or brain.
- Do not cause discomfort or pain for the woman during sex.
- Do not require a "rest period" after several years of use.
- Substantially reduce the risk of ectopic pregnancy.

Who Can Use an IUD?

Most women can use IUDs safely and effectively, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion or miscarriage (if there is no evidence of infection)
- Are breastfeeding
- Do hard physical work
- Have had an ectopic pregnancy
- Have had PID
- Have vaginal infections
- Are infected with HIV or are taking antiretroviral medications and doing well

Women can begin using an IUD without STI testing, without an HIV test, without any blood tests or other routine laboratory tests, without cervical cancer screening, and without a breast examination.

COPPER-BEARING INTRAUTERINE DEVICE (IUD) *(cont.)*

Who Cannot Use an IUD?

The IUD should not be used by women who have the following conditions:

- Gave birth more than 48 hours ago but less than 4 weeks ago
- Had an infection following childbirth or abortion
- Experienced unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition
- Have female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis
- Have current cervical, endometrial, or ovarian cancer
- Have AIDS and are clinically not well or are not using antiretroviral therapy (If the woman is at risk of HIV or is infected with HIV but does not have AIDS, she can use an IUD; if a woman who has an IUD in place develops AIDS, she can keep the IUD.)
- Are at very high individual risk for chlamydial infection or gonorrhea *(see below)*
- Might be pregnant

Assessing a client's risk of STIs; Women who are at ***high individual risk*** of infection should not have an IUD inserted. Steps to take:

1. Tell the client that a woman who faces a very high individual risk of some STIs usually should not use an IUD.
2. Ask the woman to consider her own risk and to think about whether she might have an STI. Risky situations include: a sexual partner with STI symptoms (pus coming from penis, pain or burning during urination, open sore in the genital area); she or a sexual partner diagnosed with an STI recently; and she or her sexual partner having had more than 1 sexual partner recently. The provider also can mention other high-risk situations that exist locally.
3. Ask if she thinks she is a good candidate for an IUD or would like to consider other methods.

When Can the IUD Be Inserted?

- **Having menstrual cycles:** If starting within 12 days after start of monthly bleeding, there is no need for a back-up method. If it is more than 12 days after the start of monthly bleeding, client can have IUD inserted whenever it is reasonably certain she is not pregnant; there is no need for a back-up method.
- **Switching from another method:** Immediately, if client has been using previous method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. There is no need to wait for next monthly bleeding. There is no need for a back-up method.
- For **emergency contraception:** Within 5 days after unprotected intercourse. After taking **emergency contraceptive pills** (ECPs), the same day that she finishes taking ECPs. There is no need for a back-up method.
- **No monthly bleeding:** Any time, if it can be determined she is not pregnant. There is no need for a back-up method.
- **Postpartum:**
  - Any time within 48 hours of giving birth (requires a provider with specific training in postpartum insertion), or 4 weeks after giving birth (in all other cases)
  - *Fully or nearly fully breastfeeding:* If monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth; if more than 6 months after giving birth, any time it is reasonably certain she is not pregnant. There is no need for a back-up method.
  - *Partially breastfeeding or not breastfeeding:* If more than 4 weeks since giving birth and monthly bleeding has not returned, if it can be determined she is not pregnant. There is no need for a back-up method.
  - *Breastfeeding and monthly bleeding has returned:* As advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage): Immediately or within 12 days, if no infection is present. No back-up method is needed. Beyond 12 days after abortion or miscarriage, any time it is reasonably certain she is not pregnant. No back-up method is needed. If infection is present, after infection has completely cleared. IUD insertion ***after a second-trimester abortion or miscarriage*** requires specific training. If specifically trained health care provider is not available, insertion should be delayed until 4 weeks after abortion or miscarriage.

How Are IUDs Used?

- IUDs are inserted and removed by trained health service providers. The client should be told the type of the IUD, the date to return, for how long it protects from pregnancy, and when it will need to be removed or replaced.
- For **insertion**, to assess the client's eligibility for the IUD, the provider first conducts a bimanual exam, followed by the speculum exam to inspect the vagina and the cervix). The provider cleans the cervix and then holds the cervix by closing the tenaculum. Then the provider passes the uterine sound through the cervix to measure the depth and position of the uterus. Finally, the provider inserts the IUD slowly through the cervix and cuts its strings at 3 cm.
- The client can expect some cramping and pain for a few days after insertion. She can use ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever, as needed. Also, she can expect some bleeding or spotting immediately after insertion. This may continue for 3–6 months.
- A follow-up visit after her first monthly bleeding or 3–6 weeks following insertion is recommended.
- (If she wants) the client can check the IUD strings to confirm that her IUD is in place.
- The client should also be told about the **warning signs for health risks and complications** (see the first page) and to return to the clinic if she feels the strings are missing or feels the hard plastic of an IUD that has come out.
- For **removal**, the provider inserts a speculum to see the IUD and its strings, cleans the cervix and the vagina with an antiseptic, asks the woman to take slow, deep breaths to relax, and using a narrow forceps pulls the IUD strings slowly.

LEVONORGESTREL INTRAUTERINE DEVICE (LNG-IUD)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is the Levonorgestrel Intrauterine Device (LNG-IUD)?

- The LNG-IUD is a T-shaped plastic device that steadily releases small amounts of levonorgestrel each day. (Levonorgestrel is a progestin widely used in implants and oral contraceptive pills.) It is effective for 5 years.
- A specifically trained health care provider inserts it into a woman's uterus through her vagina and cervix.
- The LNG-IUD is also called the levonorgestrel-releasing intrauterine system (LNG-IUS) or the hormonal IUD. It is marketed under the brand names *Mirena* and *LevoNova*. Other IUDs are available with progesterone (*Progestasert*) and other progestins, such as etonogestrel. Information provided in this cue card pertains to the LNG-IUD, but it may be applicable to other hormonal IUDs.
- The LNG-IUD works primarily by suppressing the growth of the lining of uterus (endometrium).

How Effective Is the LNG-IUD?

- The LNG-IUD's failure rate is less than 1 pregnancy per 100 women over the first year (2 per 1,000 women). Over 5 years of LNG-IUD use, the failure rate is less than 1 pregnancy per 100 women (5 to 8 per 1,000).
- *Return to fertility after LNG-IUD is removed:* No delay
- *Protection against sexually transmitted diseases (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns (especially in the first 3–6 months), including:
  - Lighter bleeding and fewer days of bleeding
  - Infrequent bleeding, Irregular bleeding
  - No monthly bleeding
  - Prolonged bleeding
- Acne
- Headaches
- Breast pain or tenderness
- Nausea
- Weight gain
- Dizziness
- Mood changes
- Ovarian cysts

Health Benefits

- Helps protect against risks of pregnancy and iron deficiency anemia.
- May help protect against pelvic inflammatory disease (PID).

Health Risks:

None

Complications:

Rare: Puncturing (perforation) of the wall of the uterus by the LNG-IUD or an instrument used for insertion may occur. This usually heals without treatment.

Who Can Use the LNG-IUD?

Nearly all women can use the LNG-IUD safely and effectively.

Who Should Not Use the IUD?

The LNG-IUD should not be used by women who have the following conditions:

- Gave birth less than 4 weeks ago
- Infection following childbirth or abortion
- Unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition
- Female conditions or problems (gynecologic or obstetric conditions or problems) such as genital cancer or pelvic tuberculosis
- Known current cervical, endometrial or ovarian cancer
- AIDS and clinically not well or are not on antiretroviral therapy (If she is at risk of HIV or infected by HIV but does not have AIDS, she can use an LNG-IUD. If a woman who has an LNG-IUD in place develops AIDS, she can keep the LNG-IUD.)
- Very high individual risk for chlamydial infection or gonorrhea *(see Assessment of Individual Risk on the Copper-Bearing IUD cue card)*
- Might be pregnant
- Current blood clot in the deep veins of legs or lungs
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor)
- Current or history of breast cancer

LEVONORGESTREL INTRAUTERINE DEVICE (LNG-IUD) *(cont.)*

When Can the LNG-IUD Be Inserted?

- **Having menstrual cycles or switching from a nonhormonal method:** If starting within 7 days after the start of her monthly bleeding, no back-up method is needed. If it is more than 7 days after the start of her monthly bleeding, she can have the LNG-IUD inserted any time it is reasonably certain she is not pregnant. A back-up method is needed for the first 7 days after insertion.
- **Switching from a hormonal method:** Immediately, if she has been using the previous method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for next monthly bleeding. No back-up method is needed.
- After taking **emergency contraceptive pills** (ECPs): The LNG-IUD can be inserted within 7 days after the start of the client's next monthly bleeding or any other time it is reasonably certain that the client is not pregnant. A back-up method is needed until the LNG-IUD is inserted.
- **No monthly bleeding:** Any time it can be determined she is not pregnant; a back-up method is needed for the first 7 days after insertion.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding:* If monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth. No back-up method is needed. If more than 6 months after giving birth and her monthly bleeding has not returned, any time it is reasonably certain she is not pregnant; a back-up method is needed for the first 7 days after insertion.
  - *Partially breastfeeding or not breastfeeding:* If more than 4 weeks since giving birth and her monthly bleeding has not returned, LNG-IUD can be inserted anytime it can be determined she is not pregnant. A back-up method is needed for the first 7 days after insertion.
  - *Breastfeeding and monthly bleeding has returned:* As is advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage): Insert immediately, or within 7 days if no infection is present; no back-up method is needed. Beyond 7 days after abortion or miscarriage, insert any time it is reasonably certain she is not pregnant; no back-up method is needed. If infection is present, insert after infection has completely cleared. LNG-IUD insertion ***after second-trimester abortion or miscarriage*** requires specific training. If specifically trained health care provider is not available, insertion should be delayed until after 4 weeks following the abortion or miscarriage.

How Is LNG-IUD Used?

- LNG-IUDs are inserted and removed by trained health service providers. The client should be told the type of the LNG-IUD, the date to return, for how long it protects from pregnancy, and when it will need to be removed or replaced.
- For **insertion**, to assess the client's eligibility for the IUD, the provider first conducts a pelvic exam (a bimanual exam, followed by the speculum exam to inspect the vagina and the cervix). The provider cleans the cervix and then holds the cervix by closing the tenaculum. Then the provider passes the uterine sound through the cervix to measure the depth and position of the uterus. Finally the provider inserts the LNG-IUD slowly through the cervix and cuts its strings at 3 centimeters. After the insertion the client can rest on the examination table until she feels ready to get dressed.
- The client should return within the first 3 months to make sure that the LNG-IUD is in the right place.
- (If she wants) the client can check the LNG-IUD strings to confirm that her LNG-IUD is in place.
- The client should also be told about the **warning signs for complications** (see the first page) and to return to the clinic if she feels the strings are missing or feels the hard plastic of an LNG-IUD that has come out.
- For **removal**, the provider inserts a speculum to see the LNG-IUD and its strings. After cleaning the cervix and the vagina with an antiseptic solution, the provider asks the woman to take slow, deep breaths to relax, and using a narrow forceps pulls the LNG-IUD strings slowly.

FEMALE STERILIZATION

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is Female Sterilization?

- Permanent contraception for women who will not want more children.
- The 2 surgical approaches most often used:

Minilaparotomy involves making a small incision in the abdomen, and the fallopian tubes are brought to the incision to be cut or blocked.

Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen.

- Also called tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and "the operation."
- Works because the fallopian tubes are blocked or cut. Eggs released from the ovaries cannot move down the tubes, and so they do not meet sperm. It is immediately effective.

How Effective Is Sterilization?

- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1,000).
- Over 10 years of use: About 2 pregnancies per 100 women (18 to 19 per 1,000).
- *Fertility does not return because sterilization generally cannot be stopped or reversed.* The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy.
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects None

Health Benefits

- Helps protect against risks of pregnancy and pelvic inflammatory disease (PID).
- May help protect against ovarian cancer

Health Risks

- **Uncommon to extremely rare:** Complications of surgery and anesthesia

Complications of Surgery

- **Uncommon to extremely rare:** Serious complications are uncommon and death due to procedure or anesthesia is extremely rare. The risk of complications with local anesthesia is significantly lower than with general anesthesia. Complications can be kept to a minimum if appropriate techniques are used and if procedure is performed in an appropriate setting.

Why Some Women Say They Like Female Sterilization

- No side effects
- No need to worry about contraception again
- Easy to use, nothing to do or remember

Correcting Misunderstandings

Female sterilization:

- Does not make women weak
- Does not cause lasting pain in back, uterus, or abdomen.
- Does not remove a woman's uterus or lead to a need to have it removed.
- Does not cause hormonal imbalances.
- Does not cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- Does not cause any changes in weight, appetite, or appearance.
- Does not change women's sexual behavior or sex drive.
- Substantially reduces the risk of ectopic pregnancy.

Who Can Have Female Sterilization?

With proper counseling and informed consent, any woman can have female sterilization safely, including women who:

- Have no children or few children or are not married
- Do not have husband's permission
- Are young
- Just gave birth (within the last 7 days)
- Are breastfeeding
- Are infected with HIV, whether or not on antiretroviral medications

Women can have female sterilization without any blood tests or routine laboratory tests, without cervical cancer screening and even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see cue card titled **Pregnancy Checklist**).

Who Cannot Have Female Sterilization? *No medical condition prevents a woman from using female sterilization.* Some medical conditions may limit when, where, or how the female sterilization procedure should be performed. In such situations one should use ***caution***, ***delay*** the procedure or make ***special*** arrangements.

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition (e.g., past PID, previous abdominal or pelvic surgery, hypothyroidism, moderate iron deficiency anemia).

continued

FEMALE STERILIZATION *(cont.)*

- *Delay* means postpone female sterilization. These conditions must be treated and resolved before female sterilization can be performed. The client should be given a back-up method* to use until the procedure can be performed (e.g., current pregnancy, pelvic inflammatory disease, malignant trophoblast disease, active viral hepatitis).
- *Special* means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other back-up medical support (e.g., AIDS, endometriosis, severe cirrhosis of the liver).

For a complete list of medical conditions that necessitate caution, delaying of the procedure, and making special arrangements, see the *Family Planning: A Global Handbook for Providers* or see WHO Medical Eligibility Criteria, 2004.

When Can Female Sterilization Be Performed?

- **Having menstrual cycles or switching from another method**—If procedure is performed within 7 days after the start of her monthly bleeding, no need to use another method before the procedure. If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant.
- **No monthly bleeding**—Any time it is reasonably certain she is not pregnant.
- After using **emergency contraceptive pills** (ECPs), woman can have sterilization procedure done within 7 days after the start of her next monthly bleeding or, any other time it is reasonably certain she is not pregnant. She should be given a back-up method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.
- **After childbirth (Postpartum):**
  - Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance.
  - Any time 6 weeks or more after childbirth, if it is reasonably certain she is not pregnant.
- **After abortion or miscarriage (postabortion)** Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance.

How Is Female Sterilization Performed?

- The client should be counseled and have decided after having fully understood the 7 points of informed consent (see Participant Handbook, p. 109).
- **Before the procedure** the client should not eat anything for 8 hours and should not take any medication for 24 hours.
- The most common approaches used are minilaparotomy and laparoscopy. It can also be done during caesarean section. Based on the surgical approach and type of anesthesia, the client should be told about what to expect during the procedure.
- The procedure can be performed under local or **general anesthesia**. If the procedure will be done under local anesthesia, the woman receives light sedation (with pills or into a vein) to relax her. Local anesthetic is injected at the incision site.
- **Minilaparotomy** involves a 2–5 centimeter incision just above the pubic hairline (for interval female sterilization) or a 1.5–3 cm incision at the lower edge of the navel (for postpartum female sterilization). Inserting a special instrument (uterine elevator) into the vagina, through the cervix, and into the uterus, the provider raises each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort. Through the incision, the provider grasps the tubes and occludes them, by tying and cutting them or by closing them with a clip or ring. The incision is then closed with stitches and covered with an adhesive bandage.
- **Laparoscopy** starts with the insertion of a special needle into the women's abdomen. Through the needle, the provider inflates (insuflates) the abdomen with gas or air. The provider makes a small incision (about 1 cm) and inserts a long, thin tube (laparoscope) with which to visualize the tubes. Then another instrument is inserted through the laparoscope to close the fallopian tubes by applying a clip or ring or by using electric current (electrocoagulation) to block the tube. The provider then removes the instrument and the laparoscope, the gas or air is let out, and the provider closes the incision with stitches and covers it with an adhesive bandage. A laparoscope is not used in the immediate postpartum period because of the risk of injury to the large vascular uterus.
- Local anesthesia is safer than spinal, epidural, or general anesthesia, lets the client leave the clinic or hospital sooner (in a few hours), allows faster recovery, and makes it possible to perform female sterilization in more facilities.
- **After the procedure,** the client is observed for 2–6 hours at the clinic or hospital. She receives instructions on what to do after she leaves. She should:
  - Rest for 2 days and avoid vigorous work and heavy lifting for a week.
  - Keep the incision clean and dry for 1–2 days.
  - Not have sex for at least 1 week.
- The client should be told about the warning signs of complications of surgery, such as:
  - Bleeding, pain, pus, heat, swelling, or redness of the wound that becomes worse or does not go away
  - High fever (greater than 38°C/101°F)
  - Fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks
- The client should return within 7 days to have the incision site checked and any stitches removed, and any time soon after the procedure if signs of infection are present.

VASECTOMY

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is Vasectomy?

- Vasectomy is permanent contraception for men who will not want more children.
- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carry sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery).
- Vasectomy is also called male sterilization and male surgical contraception.
- Vasectomy works by closing off each vas deferens, keeping sperm out of semen. Semen is ejaculated, but it cannot cause pregnancy.
- There is a 3-month delay in vasectomy's taking effect. Therefore, the man or couple must use condoms or another contraceptive method for 3 months after vasectomy.

How Effective Is Vasectomy?

- Where men cannot routinely have their semen examined to see if it still contains sperm, pregnancy rates are about 2 or 3 per 100 women over the first year after their partners have had a vasectomy. Where men can have their semen examined after vasectomy, pregnancy rates are less than 1 per 100 women over the first year after their partners have had vasectomies (2 per 1,000).
- Some pregnancies occur within the first year because the couple does not use condoms or another effective method correctly and consistently in the first 3 months, before the vasectomy is fully effective.
- Over 3 years of use: About 4 pregnancies per 100 women
- *Fertility does not return because vasectomy generally cannot be stopped or reversed.* The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects, Health Benefits, and Health Risks

- None

Complications of Surgery

- ***Uncommon to rare:*** Severe scrotal or testicular pain that lasts for months or years
- ***Uncommon to very rare:*** Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with no-scalpel technique)
- ***Rare:*** Bleeding under the skin that might cause swelling or bruising (hematoma)

Correcting Misunderstandings

Vasectomy:

- Does not remove the testicles. In vasectomy, the tubes carrying sperm from the testicles are blocked. The testicles remain in place.
- Does not decrease sex drive.
- Does not affect sexual function. A man's erection is as hard, it lasts as long, and he ejaculates the same as before.
- Does not cause a man to grow fat or become weak, less masculine, or less productive.
- Does not cause any diseases later in life.
- Does not prevent transmission of STIs, including HIV.

Why Some Women Say They Like Vasectomy

- Safe, permanent, and convenient
- Fewer side effects and complications than many methods for women
- Man takes responsibility for contraception—takes burden off woman
- Increases enjoyment and frequency of sex

VASECTOMY *(cont.)*

Who Can Have a Vasectomy?

With proper counseling and informed consent, any man can have a vasectomy safely, including men who:

- Have no children or few children
- Are not married
- Do not have wife's permission
- Are young
- Have sickle cell disease
- Are at high risk of HIV or other STI infection
- Are infected with HIV, whether or not on antiretroviral medications

In some of these situations, especially careful counseling is important to make sure the man will not regret his decision.

Men can have a vasectomy without any blood tests or routine laboratory tests, without having their blood pressure checked, without a hemoglobin test, without having their cholesterol or liver function checked, and even if they cannot have their semen examined by microscope later to see if there are still sperm in it.

Who Cannot Have a Vasectomy?

No medical condition prevents a man from using vasectomy. Some medical conditions may limit when, where, or how the vasectomy procedure should be performed. In such situations, one should use ***caution***, ***delay*** the procedure, or make ***special*** arrangements.

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition (e.g., previous scrotal injury, large varicocele or hydrocele, undescended testicle [one side only], diabetes, depression).
- *Delay* means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. The client should be given a back-up method* to use until the procedure can be performed (e.g., active STI, scrotal skin infection, a mass in the scrotum, systemic infection).
- *Special* means that special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other back-up medical support (e.g., hernia in the groin, undescended testicles [both sides], AIDS, coagulation disorders [blood fails to clot]).

For a complete list of medical conditions that necessitate caution, delaying of the procedure, and making special arrangements, see the sources cited on the front of this cue card.

When Can Vasectomy Be Performed?

Vasectomy can be performed any time a man requests it (if there is no medical reason to delay).

How Is Vasectomy Performed?

- The client should be counseled and have decided after having fully understood the 7 points of informed consent (see Participant Handbook, p. 109).
- Male sterilization is performed through either **no-scalpel vasectomy (NSV)** or **conventional vasectomy**. NSV is the preferred method, because it uses a smaller puncture instead of incisions, it causes less pain and bruising, recovery time is shorter, and it reduces the operating time. Based on the approach used, the client should be told about what to expect during the procedure and how to prepare for the procedure.
- The man receives an injection of local anesthetic in his scrotum to prevent pain. He stays awake throughout the procedure.
- In **NSV**, the skin is punctured with a special instrument and each vas deferens is reached and occluded through the puncture. As the puncture is so small, it can be covered with adhesive bandage.
- In **conventional vasectomy**, the clinician makes 1–2 cm incision(s) in the scrotal skin. Through the incision(s), each vas deferens is reached and occluded. The skin is then closed with stitches.

Both conventional vasectomy and NSV are performed almost exclusively under **local anesthesia** only.

- **After the procedure**, the client receives clear instructions about postoperative care. Following the procedure, the client can leave within a few hours, often in less than 1 hour. He should:
  - Rest for 2 days, if possible
  - Apply cold compresses on the scrotum for the first 4 hours, if possible
  - Wear snug underwear or pants for 2–3 days
  - Not have sex for at least 2–3 days
  - (If his wife is not using an effective contraceptive,) use condoms to use for 3 months, until sperm are cleared from his system.
  - Return in 3 months for semen analysis, if available
- The client should be told about the warning signs of complications of surgery, such as:
  - Bleeding, pain, pus, heat, swelling, or redness in the genital area that becomes worse or does not go away

MALE CONDOM

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Male Condoms?

- A male condom is a thin sheath usually made of rubber (latex) that is placed on an erect penis before intercourse. It is the only method of contraception that also provides protection from sexually transmitted infections (STIs), including HIV.
- Male condoms are also called rubbers, "raincoats," "umbrellas," skins, and prophylactics, and are known by many different brand names.
- Male condoms form a barrier that keeps sperm out of the vagina, preventing pregnancy; they also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

How Effective Are Condoms?

Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used with every act of intercourse.

- As commonly used, the failure rate is about 15 pregnancies per 100 women whose partners use male condoms over the first year.
- When used correctly with every sex act, the male condom has a failure rate of about 2 pregnancies per 100 women whose partners use male condoms over the first year.
- *Return of fertility after use of condoms is stopped:* No delay
- *Protection against HIV and other STIs:*
  - When used consistently and correctly, the male condom prevents 80–95% of HIV transmission that would have occurred without condoms.
  - Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly.
    - ⇒ They are most effective for preventing STIs spread by discharge, such as HIV, gonorrhea, and chlamydia.
    - ⇒ They reduce the risk of becoming infected with STIs spread by skin-to-skin contact, such as herpes and human papillomavirus.

Side Effects, Health Benefits, and Health Risks

Side Effects None

Health Benefits

Condoms help protect against:

- Risk of pregnancy
- STIs, including HIV
- They may help protect against conditions caused by STIs:
- Recurring pelvic inflammatory disease and chronic pelvic pain
- Cervical cancer
- Infertility (male and female)

Health Risks

Extremely rare: Severe allergic reaction (among people with latex allergy)

Why Some Men and Women Say They Like Male Condoms

- No hormonal side effects
- Can be used as a temporary back-up method
- Can be used without seeing a health care provider
- Are sold in many places and are generally easy to obtain
- Help protect against both pregnancy and STIs, including HIV

Correcting Misunderstandings

Male condoms:

- Do not make men sterile, impotent, or weak, or decrease their sex drive.
- Cannot get lost in the woman's body.
- Do not have holes that HIV can pass through.
- Are not laced with HIV.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.
- Do not cause illness in men because sperm "backs up."
- Are used by many married couples. They are not only for use outside of marriage.

Who Can Use Male Condoms?

All men and women can safely use male condoms, except for those with severe allergy to latex rubber. Also, condoms can be used by:

- Men and women needing a **temporary** method while waiting for a regular one
- Couples needing a **back-up** method
- Men and women who have intercourse infrequently
- Couples who need contraception **immediately**
- Couples in which either partner has **more than 1 sexual partner**, even if using another method

MALE CONDOM *(cont.)*

When to Start Using Male Condoms?
Use of male condoms can start any time the client wants.

How Are Male Condoms Used?
IMPORTANT: Whenever possible, show the client how to put on a condom. Use a model of a penis, if available, or some other item, like a banana, to demonstrate.

1. **Use a new condom for each sex act.**
   - Check the condom package. Do not use if torn or damaged.
   - Tear open the package carefully. Do not use finger nails, teeth or anything that could damage the condom.

2. **Before any physical contact, place the condom on the tip of the erect penis with the rolled side out.**
   - For the most protection, put the condom before the penis makes any genital, oral or anal contact.

3. **Unroll the condom all the way to the base of the erect penis.**
   - The condom should unroll easily. Forcing it on could cause it break during use.
   - If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom.
   - If the condom is on backwards and a new one is not available, turn it over and unroll it onto penis.

4. **Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.**
   - Withdraw the penis.
   - Slide the condom off, avoiding spilling semen.
   - If having sex again or switching from one sex act to another, use a new condom.

5. **Dispose of the used condom safely.**
   - Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.

Also:
- Explain about use of emergency contraceptive pills (ECPs), in case there are errors in condom use.
- Discuss skills and techniques for negotiating condom use with partners.

FEMALE CONDOM

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What Are Female Condoms?

- Female condoms are sheaths, or linings, made of thin, transparent, soft plastic film that fit loosely inside a woman's vagina.
  - They have flexible rings at both ends. One ring, at the closed end, helps the woman to insert the condom, and the ring at the open end holds part of the condom outside the vagina
  - They are lubricated inside and out with a silicone-based lubricant.
- Different brand names of female condoms include FC Female Condom, Reality, Femidom, Dominique, Femy, Myfemy, Protectiv', and Care. In some countries, latex female condoms may be available.
- They work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy; they also keep infections in the semen, on the penis, or in the vagina from infecting the other partner.

How Effective Are Female Condoms?

Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used with every act of intercourse.

- As commonly used, the failure rate for the female condom is 21 pregnancies per 100 women over the first year of use.
- When used correctly with every sex act, female condoms have a failure rate of about 5 pregnancies per 100 women over the first year.
- *Return of fertility after use of female condom is stopped:* No delay
- *Protection against HIV and other sexually transmitted infections (STIs):* Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every sex act.

Side Effects, Health Benefits, and Health Risks

Side Effects

None

Health Benefits

Female condoms help protect against

- Risk of pregnancy
- STI, including HIV

Health Risks

None

Correcting Misunderstandings

Female condoms:

- Cannot get lost in the woman's body.
- Are not difficult to use, but correct use needs to be learned.
- Do not have holes that HIV can pass through.
- Are used by many married couples; they are not only for use outside marriage.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.

Why Some Women Say They Like Female Condoms

- Women can initiate their use.
- Female condoms have a soft, moist texture that feels more natural during sex.
- Female condoms protect against pregnancy and STIs, including HIV.
- The outer ring provides added sexual stimulation for some women.
- Female condoms can be used without the need to see a health care provider.

Why Some Men Say They Like Female Condoms

- Female condoms can be inserted ahead of time so that use does not interrupt sex.
- They are not tight or constricting like male condoms.
- They do not dull the sensation of sex, like male condoms do.
- Female condoms do not have to be removed immediately after ejaculation.

Who Can Use Female Condoms?

Any women can use female condoms. No medical conditions prevent the use of this method.

When to Start Female Condoms?

Female condom use can begin anytime the client wants.

FEMALE CONDOM *(cont.)*

How Are Female Condoms Used?

IMPORTANT: Whenever possible, show the client how to insert the female condom. Use a model or picture, if available, or your hands to demonstrate. You can create an opening similar to a vagina with one hand and show how to insert the female condom with the other hand. Basic steps and important details are of using a female condom are as follows.

1. **Use a new female condom for each act of intercourse.**
   - Check the condom package. Do not use the product if the packaging is torn or damaged.
   - If possible, wash your hands with mild soap and clean water before inserting the condom.

2. **Before any physical contact, insert the condom into the vagina.**
   - The female condom can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes into contact with the vagina.
   - Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down.
   - Rub the sides of the female condom together to spread the lubricant evenly.
   - Grasp the ring at the closed end, and squeeze it so that it becomes long and narrow.
   - With the other hand, separate the outer lips (labia) and locate the opening of the vagina.
   - Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2–3 cm of the condom and the outer ring should remain outside the vagina.

3. **Ensure that the penis enters the condom and stays inside the condom.**
   - The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again.
   - If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.

4. **After the man withdraws his penis, he should hold the outer ring of the condom, twist it to seal in fluids, and gently pull it out of the vagina.**
   - The female condom does not need to be removed immediately.
   - Remove the condom before standing up, to avoid spilling semen.
   - If the couple has sex again, they should use a new condom.
   - Reuse of female condoms is not recommended.

5. **Dispose of the used condom safely.**
   - Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.

Also:

- Explain about use of emergency contraceptive pills (ECPs), in case there are errors in condom use.
- Discuss skills and techniques for negotiating condom use with partners.

SPERMICIDES

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What Are Spermicides?

- Spermicides are sperm-killing substances inserted deep in the vagina, near the cervix, shortly before sex.
  - Nonoxynol-9 is most widely used spermicide.
  - Others include benzalkonium chloride, chlorhexidine, menfegol, octoxynol-9, and sodium docusate.
- Spermicides are available in foaming tablets, melting or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream. Jellies, creams, and foam from cans can be used alone, with a diaphragm, or with condoms. Films, suppositories, and foaming tablets or suppositories can be used alone or with condoms.
- Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.

How Effective Are Spermicides?

The effectiveness of spermicides depends on the user. The risk of pregnancy is greatest when spermicides are not used with every act of intercourse.

- Spermicides are one of the least effective family planning methods.
- As commonly used, spermicides have a failure rate of about 29 pregnancies per 100 women over the first year.
- When used correctly with every act of intercourse, spermicides have a failure rate of about 18 pregnancies per 100 women over the first year.
- *Return of fertility after spermicides are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None. Frequent use may increase risk of HIV infection.

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Irritation in or around the vagina or penis
- Vaginal lesions

Health Benefits

Help protect against risk of pregnancy.

Health Risks

- ***Uncommon:*** Urinary tract infection, especially when spermicides are used 2 or more times a day
- ***Rare:*** Frequent use of nonoxynol-9 may increase risk of HIV infection.

Why Some Women Say They Like Spermicides

- Controlled by the woman
- No hormonal side effects
- Increase vaginal lubrication
- Can be used without seeing a health care provider
- Can be inserted ahead of time, so they do not interrupt sex

Correcting Misunderstandings

Spermicides:

- Do not reduce vaginal secretions or make women bleed during sex.
- Do not cause cervical cancer or birth defects.
- Do not protect against STIs.
- Do not change men's or women's sex drive or reduce sexual pleasure for most men.
- Do not stop women's monthly bleeding.

SPERMICIDES *(cont.)*

Who Can Use Spermicides?
Spermicides are safe and suitable for nearly all women.

Who Cannot Use Spermicides?
All women can safely use spermicides, except for those who:
- Are at high risk for HIV infection
- Have HIV infection
- Have AIDS

When to Start Using Spermicides?
Spermicides can be started at any time the client wants.

How Are Spermicides Used?
- Spermicides should be inserted before sex.
  - Foam or cream: Any time less than 1 hour before sex.
  - Tablets, suppositories, jellies, film: Between 10 minutes and 1 hour before sex.
- The client checks the expiration date and washes her hands with mild soap and clean water, if possible.
- The client applies the spermicide by:
  - ***Foam or cream:*** Shaking can of foam hard, squeezing spermicide from the can or tube into a plastic applicator, inserting the applicator deep into the vagina, near the cervix, and pushing the plunger.
  - ***Tablets, suppositories, jellies:*** Inserting the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.
  - ***Film:*** Folding film in half and inserting with dry fingers (or else the film will stick to the fingers and not the cervix).
- The client should insert additional spermicide before each act of vaginal sex.
- Douching is not recommended, because it will wash away the spermicide and will also increase the risk of STIs. If the client must douche, she should wait for at least 6 hours after sex before doing so.
- Explain about emergency contraceptive pills (ECPs), in case the spermicide is not used at all or is not used properly.

DIAPHRAGM

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is the Diaphragm?

- The diaphragm is a soft latex cup that covers the cervix. It is placed deep in the vagina before sex. The rim contains a firm, flexible spring that keeps the diaphragm in place.
- The diaphragm comes in different sizes and requires fitting by a specifically trained provider.
- This method requires correct use with every act of intercourse for greatest effectiveness.
- The diaphragm is used with spermicidal cream, jelly, or foam to improve its effectiveness.
- The diaphragm blocks sperm from entering the cervix; spermicides kill or disable sperm. Both keep sperm from meeting an egg.

How Effective Is the Diaphragm?

The effectiveness of the diaphragm depends on the user. The risk of pregnancy is greatest when the diaphragm with spermicides is not used with every act of intercourse.

- As commonly used, the diaphragm has a failure rate of about 16 pregnancies per 100 women over the first year.
- When used correctly with every act of intercourse, the diaphragm has a failure rate of about 6 pregnancies per 100 women over the first year.
- *Return of fertility after use of the diaphragm is stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* The diaphragm may provide some protection against certain STIs, but clients should not rely on it for STI prevention.

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Irritation in or around the vagina or penis
- Vaginal lesions

Health Benefits

- Helps protect against risks of pregnancy
- May help protect against
  - Certain STIs (chlamydia, gonorrhea, pelvic inflammatory disease, trichomoniasis)
  - Cervical precancer and cancer

Health Risks

- ***Common to uncommon:*** Urinary tract infection
- ***Uncommon:*** Bacterial vaginosis, candidiasis
- ***Rare:*** Increased risk of HIV infection, from frequent use of nonoxynol-9
- ***Extremely rare:*** Toxic shock syndrome

Why Some Women Say They Like the Diaphragm

- Controlled by the woman
- No hormonal side effects
- Can be inserted ahead of time, so does not interrupt sex

Correcting Misunderstandings

Diaphragms:

- Do not affect the feeling of sex. (A few men report feeling the diaphragm during sex, but most do not.)
- Cannot pass through the cervix, and cannot go into the uterus or otherwise get lost in the woman's body.
- Do not cause cervical cancer.

Who Can Use the Diaphragm?

Nearly all women can use the diaphragm safely and effectively.

Who Cannot Use the Diaphragm?

Women cannot use the diaphragm if they:

- Have had a baby or a second-trimester abortion in the past 6 weeks.
- Are allergic to latex rubber.
- Are at high risk for HIV infection.
- Have an HIV infection.
- Have AIDS.

When to Start Using the Diaphragm?

A client can begin using the diaphragm any time she wants, except within 6 weeks of a full-term delivery or a second-trimester spontaneous or induced abortion.

DIAPHRAGM *(cont.)*

How Is the Diaphragm Used?
A pelvic examination is needed before starting use. The provider determines the correct diaphragm size and checks that it fits properly and does not come out easily. With a properly fitted diaphragm, the client should not be able to feel anything inside her vagina, even when she walks or when she has intercourse.
IMPORTANT: Whenever possible, show the woman the location of the pubic bone and cervix with a model or picture. Explain that the diaphragm is inserted behind the pubic bone and covers cervix.

1. **Squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim.**
   - Wash hands with mild soap and clean water if possible.
   - Check the diaphragm for holes, cracks, or tears by holding it up to the light.
   - Check the expiration date of the spermicide and avoid using any beyond its expiration date.
   - Insert the diaphragm less than 6 hours before having sex.

1

2. **Press the rim together; push the diaphragm into the vagina as far as it goes.**
   - Choose a position that is comfortable for insertion—squatting, raising one leg, sitting, or lying down.

2

3. **Feel the diaphragm to make sure that it covers the cervix.**
   - Through the dome of the diaphragm, the cervix feels like the tip of the nose.
   - If the diaphragm feels uncomfortable, take it out and insert it again.

4. **Keep the diaphragm in place for at least 6 hours after sex.**
   - Keep the diaphragm in place at least 6 hours after having sex, but no longer than 24 hours.
   - *Leaving the diaphragm in place for more than 1 day may increase the risk of toxic shock syndrome.* It can also cause a bad odor and vaginal discharge.
   - For multiple sex acts, make sure that the diaphragm is in the correct position, and insert additional spermicides in front of the diaphragm before each act.

3

5. **To remove the diaphragm, slide a finger under the rim to pull it down and out.**
   - Wash hands with mild soap and clean water, if possible.
   - Insert a finger into the vagina until the rim of the diaphragm is felt.
   - Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail.
   - Wash the diaphragm with mild soap and clean water, and dry it after each use.

Also:
- Explain emergency contraceptive pill (ECP) use, in case the diaphragm moves out of place or is not used properly.
- Explain when to replace the diaphragm (when it gets thin, develops holes, or becomes stiff, or about every 2 years).

FERTILITY AWARENESS METHODS

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Fertility Awareness Methods?

- "Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)
- This approach is also called periodic abstinence or natural family planning. These methods can be used alone or in combination and can be grouped into:
  - ***Calendar-based methods.*** These methods involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time. Examples: *Standard days method and calendar rhythm method.*
  - ***Symptoms-based methods.*** These methods depend on observing signs of fertility.
    - ⇒ Cervical secretions: When a woman sees or feels cervical secretions, she may be fertile.
    - ⇒ Basal body temperature (BBT): A woman's resting body temperature goes up slightly near the time of ovulation (release of an egg), when she could become pregnant.
    - ⇒ Examples: Two-Day Method, BBT method, ovulation method, and the symptothermal method
- Fertility awareness methods require partner's cooperation for abstaining or using another method on fertile days.
- Fertility awareness methods work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms or a diaphragm. Some couples use spermicides or withdrawal, but these are among the least-effective methods.
- Clients should be told about emergency contraceptive pills (ECPs), in case there are errors in identifying fertile days.

How Effective Are Fertility Awareness Methods?

Effectiveness depends on the user. Pregnancy risk is greatest when couples have unprotected sex on the fertile days.

- As commonly used, periodic abstinence has a failure rate in the first year of about 25 pregnancies per 100 women.
- Pregnancy rates with correct and consistent use vary for different types of fertility awareness methods—5 pregnancies per 100 women over the first year of use of the standard days method, 9 per 100 women over the first year of use of the calendar rhythm method, 4 per 100 women over the first year of use of the Two-Day method, 1 per 100 women over the first year of use of the basal body temperature (BBT) method, 3 per 100 women over the first year of use of the ovulation method, and 2 per 100 women over the first year of use of the symptothermal method.
- *Return of fertility after fertility awareness methods are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects and Health Risks

None

Correcting Misunderstandings

Fertility awareness methods:

- Can be very effective if used consistently and correctly.
- Do not require literacy or advanced education.
- Do not harm men who abstain from sex.
- Do not work when a couple is mistaken about when the fertile time occurs, such as thinking it occurs during monthly bleeding.

Why Some Women Say They Like Fertility Awareness Methods

- Have no side effects.
- Do not require procedures and usually do not require supplies.
- Help women learn about their bodies and fertility.
- Allow some women to adhere to their religious or cultural norms about contraception.
- Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy.

Who Can Use Calendar-Based Methods and Symptoms-Based Methods?

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively and necessitate using caution or delaying their use. Caution means that additional or special counseling may be needed to ensure correct use of the method. Delay means that use of a particular fertility awareness method should be delayed until a condition is evaluated or corrected.

Calendar-Based Methods

- *Caution*—Menstrual cycles have just started or have become less frequent or stopped due to older age.
- *Delay*—The woman recently gave birth or is breastfeeding, recently had an abortion or miscarriage, is having irregular vaginal bleeding, is using drugs that may delay ovulation)

Symptoms-Based Methods

- *Caution*—Woman may have recently had an abortion or miscarriage, menstrual cycles may have just started or may have become less frequent or stopped due to older age, or woman may have a chronic condition that raises her body temperature (for BBT and symptothermal methods)
- *Delay*—The woman recently gave birth or is breastfeeding, has an acute condition that raises her body temperature [for BBT and symptothermal methods], is having irregular vaginal bleeding, is experiencing abnormal vaginal discharge, or is using drugs that may affect cervical secretions, raise body temperature, or delay ovulation).

FERTILITY AWARENESS METHODS *(cont.)*

When to Start Using Fertility Awareness Methods?
Once trained, a woman or couple usually can begin using fertility awareness methods at any time.

- **Having regular menstrual cycles**—Any time of the month. No need to wait for the next monthly bleeding.
- **No monthly bleeding**—Calendar-based methods cannot be used. Delay symptoms-based methods until monthly bleeding returns.
- **After childbirth** (whether or not breastfeeding)—Delay standard days method until woman has had 3 menstrual cycles; she can start symptothermal methods once normal secretions have returned.
- **After miscarriage or abortion**—Delay standard days method until the start of woman's next monthly bleeding. Start symptothermal methods immediately, with special counseling and support.
- **When switching from a hormonal method**—Delay standard days method until the start of her next monthly bleeding. Start symptothermal methods in the next menstrual cycle after stopping a hormonal method.
- **After taking emergency contraceptive pills** – Delay standard days method until the start of her next monthly bleeding. Start symptothermal methods once normal secretions have returned.

How Are Symptoms-Based Methods Used?

Two-Day Method
(If the woman has a vaginal infection or another condition that changes cervical mucus, the Two-Day method will be difficult to use.) The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. As soon as she notices any secretions of any type, color, or consistency, she considers herself fertile that day and the following day. The couple avoids unprotected sex or uses condoms or a diaphragm on each day that she considers herself fertile and the following day. The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any type) in a row.

Basal Body Temperature (BBT) Method
(If a woman has fever or other changes in body temperature, the BBT method will be difficult to use.) The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph. She watches for her temperature to rise slightly—0.2° to 0.5°C (0.4° to 1.0°F)—around the time of ovulation (usually about midway through the menstrual cycle). The couple avoids vaginal sex, or uses condoms or a diaphragm from the first day of monthly bleeding until 3 days after the woman's temperature has risen above her regular temperature. The couple can have unprotected sex on the 4th day and until her next monthly bleeding.

Symptothermal Method
Users identify fertile and nonfertile days by combining BBT and ovulation method instructions. Women may also identify the fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around the time of ovulation). The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later. Some women who use this method have unprotected sex between the end of monthly bleeding and the beginning of secretions, but not on 2 days in a row.

***Ovulation Method** (also known as the Billings method or cervical mucus method):*
(If a woman has a vaginal infection or another condition that changes cervical mucus, this method may be difficult to use.) The woman checks every day for any cervical secretions on her finger, underwear, or tissue paper or by sensation in the vagina. The couple avoids unprotected sex on days of heavy bleeding that makes mucus difficult to observe. Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding intercourse on the second day allows time for semen to disappear and for cervical mucus to be observed.) As soon as she notices any secretions, the woman considers herself fertile and avoids unprotected sex. She continues to check her cervical secretions each day. The secretions have a "peak day"—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex. The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

Standard Days Method (SDM)
Can be used if most of the cycles in a year are between 26 to 32 days long. A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1. Avoids unprotected sex or uses condoms or a diaphragm on days 8–19 that are considered fertile days for all users of the SDM. The couple can have unprotected sex on all other days of the cycle. They can use color-coded beads or calendar as memory aid.

Calendar Rhythm Method
Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1. The woman estimates the fertile time by subtracting 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time. The couple avoids unprotected sex or uses condoms or a diaphragm during the fertile time. She updates these calculations each month, always using the 6 most recent cycles.

LACTATIONAL AMENORRHEA METHOD (LAM)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is LAM?

- The lactational amenorrhea method (LAM) is a temporary family planning method based on the natural effect of breastfeeding on fertility. ("Lactational" means related to breastfeeding. "Amenorrhea" means not having monthly bleeding.) LAM provides contraception for the mother and the best approach for feeding for the baby.
- LAM is effective as long as all 3 of the following conditions are met:
  - The mother's monthly bleeding has not returned.
  - The baby is fully or nearly fully breastfed, and is fed often, day and night.
  - The baby is less than 6 months old.
- "Fully breastfeeding" includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).
- "Nearly fully breastfeeding" means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.
- LAM works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

How Effective Is LAM?

Effectiveness depends on the user: With LAM, the risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant.

- As commonly used, LAM has a failure rate of about 2 pregnancies per 100 women in the first 6 months after childbirth.
- When used correctly, LAM has a failure rate of less than 1 pregnancy per 100 women in the first 6 months after childbirth.
- *Return of fertility after LAM is stopped:* This depends on how much the woman continues to breastfeed.
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects
None

Health Benefits
- LAM helps protect against the risk of pregnancy.
- LAM encourages the best breastfeeding patterns, with health benefits for both mother and baby.

Health Risks
None

Why Some Women Say They Like LAM
- It is a natural family planning method.
- LAM supports optimal breastfeeding, providing health benefits for the baby and the mother.
- There is no direct cost for family planning or for feeding the baby.

Correcting Misunderstandings
LAM:
- Is highly effective when a woman meets all 3 criteria.
- Can be used by a woman with viral hepatitis.

LACTATIONAL AMENORRHEA METHOD (LAM) *(cont.)*

Who Can and Cannot Use LAM?

All women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Has HIV infection, including AIDS (Important: Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding—5–20 of every 100 infants breastfed by mothers with HIV will become infected. Women taking antiretroviral medications [ARVs] can use LAM. In fact, ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk. Rapid weaning also decreases the risk of HIV transmission. She should stop breastfeeding over 2 days to 3 weeks. Replacement feeding poses no risk of HIV transmission. Replacement feeding is recommended for the first 6 months after childbirth if—*and only if*—replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.)
- Is using certain medications during breastfeeding (including mood altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants)
- The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, being unable to digest food normally, or having deformities of the mouth, jaw, or palate)

When to Start Using LAM?

The woman should start breastfeeding immediately (within 1 hour) or as soon as possible after the baby is born. LAM can be initiated at any time within 6 months after childbirth if the woman has been fully or nearly fully breastfeeding her baby since birth and her monthly bleeding has not returned.

How Is LAM Used?

- ***Ask the mother these 3 questions:***
  - Has your monthly bleeding returned?
  - Are you regularly giving the baby other food besides breast milk or allowing long periods without breastfeeding, either day or night?
  - Is your baby more than 6 months old?

  If the answer to all of these 3 questions is no, she can use LAM.
- An ideal pattern is feeding on demand (that is, whenever the baby wants to be fed) and at least 10–12 times a day in the first few weeks after childbirth and 8–10 times a day thereafter, including at least once at night in the first months. Daytime feedings should be no more than 4 hours apart, and nighttime feedings should be no more than 6 hours apart.
- She should start giving other foods in addition to breast milk when the baby is 6 months old. At this age breast milk can no longer fully nourish a growing baby.

POSTPARTUM FAMILY PLANNING

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and Republic of Turkey Ministry of Health General Directorate of MCHFP and EngenderHealth. 1999. *Postpartum family planning counseling.* Ankara.

What Is Postpartum Family Planning?

Postpartum family planning is the initiation of family planning method use within the 6 weeks following childbirth. There are important considerations in helping pregnant women and new mothers decide how they will avoid pregnancy after childbirth. These are:

- **Timing of counseling:** Ideally, family planning counseling should start ***during antenatal care***. This allows sufficient time for clients to be counseled and to make their decisions free of the stress associated with the delivery. It also helps to ensure that clients can receive their method of choice immediately after giving birth or just following (*immediate postpartum*)—e.g., the postpartum IUD or female sterilization. Usually, it is not appropriate to counsel the client ***just before delivery***. In this case, the stress that she is experiencing may impair sound decision making. The provider has the responsibility to confirm that such clients are making an informed, voluntary, and sound decision. If there are signs of stress, counseling and the client's decision making should be postponed. The next appropriate opportunity for counseling the client is ***after delivery*** but before the client leaves the facility. At this point, it may be too late to provide the client's method of choice during or at the end of the delivery or procedure, but this may help to ensure that the client gets his or her method of choice *before discharge* or returns later to get it at *follow-up*.
- **Healthy timing and spacing of pregnancy (HTSP) messages:** To achieve healthiest pregnancy outcomes for the baby and the mother, a woman should wait until her baby is at least 2 years old before trying to become pregnant again. See the HTSP cue card for details.
- **Breastfeeding status:** Since about 99% of women breastfeed their infants for some period of time, providers need to consider the impact of contraceptive methods on breast milk, breastfeeding, and infant health when helping clients choose a method. Within this context, the following 3 points should be taken into consideration when discussing use of contraceptive methods after childbirth:
  - All women should be encouraged to breastfeed.¨
  - Breastfeeding should continue when use of a family planning method is initiated.
  - The family planning method should not have any adverse effects on breastfeeding or infant health.
- **Return of fertility:** To make an informed decision, a woman needs to know when she will become fertile again following childbirth.
  - If not fully or nearly fully breastfeeding, she is able to become pregnant as soon as 6 weeks after childbirth.
  - If fully or nearly fully breastfeeding, she is able to become pregnant as soon as 6 months postpartum (see the LAM cue card).

For maximum protection, a woman should not wait until the return of monthly bleeding to start a contraceptive method, but should instead start as soon as guidance allows (see table below).

* Detailed breastfeeding guidance for HIV-positive women is provided in Handout 15-C of the Participant Handbook, p. XX.

Earliest Time That a Woman Can Start a Family Planning Method after Childbirth

Family Planning Method	Fully/Nearly Fully Breastfeeding	Partially/Not Breastfeeding
Lactational amenorrhea method (LAM)	Immediately	Not applicable
Vasectomy	Immediately or during partner's pregnancy†	
Male or female condoms	Immediately	
Spermicide		
Copper-bearing IUD	Within 48 hours, otherwise wait 4 weeks	
Female sterilization	Within 7 days, otherwise wait 6 weeks	
LNG-IUD	4 weeks after childbirth	
Diaphragm	6 weeks after childbirth	
Fertility awareness methods	Start when normal secretions have returned (symptoms-based methods) or when she has had 3 regular menstrual cycles (calendar-based methods). This is later for breastfeeding women than for those are not breastfeeding.	
Progestin-only pills	6 weeks after childbirth‡	Immediately if not breastfeeding; 6 weeks after childbirth if partially breastfeeding
Progestin-only injectables		
Implants		

† If a man has a vasectomy during the first 6 months of his partner's pregnancy, it will be effective by the time she delivers her baby.

‡ Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.

POSTPARTUM FAMILY PLANNING *(cont.)*

Counseling Clients for Postpartum Family Planning

During Antenatal Care (Check-Ups before Delivery)	*During Postpartum Care (Check-Ups after Delivery)*
• Emphasize the importance of breastfeeding, which benefits both mothers and newborns. • Explain the benefits for future births of healthy timing and spacing of pregnancy (HTSP) • Discuss family planning methods, including: ◦ LAM ◦ Methods that can be started during or immediately after delivery (IUD, female sterilization) ◦ Methods that can be used while breastfeeding and afterwards ◦ Discuss ways of reducing transmission risk of HIV and other sexually transmitted infections (STIs)	• Provide counseling about the benefits of delaying the next pregnancy for 2 years (HTSP) • Emphasize the benefits of breastfeeding, which can delay the next birth if the infant is exclusively breastfed • Explain that using exclusive breastfeeding as a temporary family planning method (LAM) protects women from pregnancy for up to 6 months • Discuss when to start using family planning methods (including when to switch from LAM to another method) • Discuss ways of reducing risk of HIV and STI transmission

Invite the client to come back for any questions or problems, when she thinks she is ready to start using a method, to switch from LAM to another family planning method, or if she has any problems with the method she has just started using.

POSTABORTION FAMILY PLANNING

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes and to the method-specific cue cards.

What Is Postabortion Family Planning?

Access to family planning counseling and methods is an important aspect of postabortion care, to ensure that women are able to avoid a future unplanned pregnancy or successfully achieve a planned pregnancy following a miscarriage. Important considerations in helping women avoid pregnancy in this period include:

- **Timing of counseling:** Postabortion clients have particular needs related to their personal circumstances—their recent pregnancy, in this case—(e.g., worries, stress, pain they may be experiencing, hurry to return home). The provider needs to assess the best timing for family planning counseling for these clients. For postabortion clients, counseling ***before the procedure*** can only be an option if the client is not under stress. Usually, counseling the client just before a procedure to address abortion complications is not appropriate. In this case, sound decision making may be impaired by the stress the client is experiencing. If there are signs of stress, the counseling and decision making of the client should be postponed. The next appropriate opportunity to counsel the client is ***after the procedure*** to address abortion complications, but before the client leaves the facility. At this point, it may be too late to provide the client's method of choice immediately at the end of the procedure (e.g., an IUD), but this may help ensure that the clients get their method of choice *predischarge* or return later to get it at *follow-up*.
- **Timing of pregnancy:** To achieve the healthiest pregnancy outcomes for the baby and the mother, the woman should wait at least 6 months after a miscarriage or abortion before trying to become pregnant again. See the cue card on **Healthy Timing and Spacing of Pregnancy (HTSP)** for details.
- **Return of fertility:** Fertility returns very quickly postabortion. A woman can become pregnant as early as within the first 2 weeks following a first-trimester miscarriage or abortion, and within 4 weeks after a second-trimester abortion. Therefore, she needs protection from pregnancy almost immediately.

For maximum protection, a woman should not wait until her next monthly bleeding to start a contraceptive method, but instead she should start as soon as guidance allows (see table on page F-42).

Counseling Clients for Postabortion Family Planning

Before Abortion Procedure

- Explain the benefits of healthy timing and spacing of pregnancy for expected newborns (HTSP)
- Discuss family planning methods, including:
  - Methods that can be started immediately after the procedure (see table above)
  - IUD (which can be inserted after a procedure to address abortion complications, providing there is no infection present)
  - Back-up method options for methods that can be provided later
- Discuss ways of reducing risk of HIV and sexually transmitted infection (STI) transmission

After Abortion Procedure

- Provide counseling about the benefits of delaying the next pregnancy for 2 years (HTSP)
- Discuss family planning methods (see table above):
  - When to start using them
  - Back-up method options for methods that can be provided later
- Discuss ways of reducing risk of HIV and STI transmission

Invite the client to come back for any questions or problems, when she thinks she is ready to start using a method, or if she has any problems with the method she has just started using.

POSTABORTION FAMILY PLANNING *(cont.)*

Earliest Time That a Woman Can Start a Family Planning Method after Abortion/Miscarriage		
Family Planning Method	**When to Start**	**Special Considerations**
Oral contraceptives (combined or progestin-only)	Immediately	
Injectables (combined or progestin-only)		
Implants		
Combined patch		
Male or female condom		
Withdrawal		
Combined vaginal ring	Immediately	Once any injury to the genital tract is healed.
Spermicide		
Cervical cap		
Diaphragm	Immediately	Once any injury to the genital tract is healed. Must be refitted after uncomplicated first-trimester miscarriage. After uncomplicated second-trimester miscarriage, use should be delayed 6 weeks.
IUDs	Immediately	Provided there is no infection and any injury to the genital tract is healed. IUD insertion after a second-trimester abortion requires a specially trained provider.
Female sterilization	Immediately	Provided there is no infection any injury to the genital tract is healed. Must be decided upon in advance, not while the woman is sedated, under stress, or in pain.
Vasectomy	Any time, regardless of the timing of miscarriage or abortion	
Fertility awareness methods	Delay until there are no noticeable secretions or bleeding related to injury or infection.	Provided there is no infection any injury to the genital tract is healed. For calendar-based methods, delay until the woman has had at least one monthly bleed after all such secretions and bleeding has stopped.

FAMILY PLANNING FOR PEOPLE LIVING WITH HIV

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2006. *Reproductive choices and family planning for people living with HIV: Counseling tool.* Geneva.

People living with HIV:
- **Can enjoy a healthy sexual life** (see "Ways of lowering risk")
- **Have options for preventing unwanted pregnancy and further transmission of HIV** (See "Contraceptives for clients with STIs, HIV, and AIDS" as well as **Dual Protection** in Handout 20 in the Participant Handbook.)
- **Can have a healthy baby** (See "Thinking about pregnancy," next page)

Ways of Lowering Risk

- **Mutual faithfulness**—Two partners faithful to each other
- **Limited number of sexual partners**
- **Safer sex**—For example, using condoms or avoiding penetrative sex
  - **Examples of acts with no risk:** Pleasuring self, massage, hugging, kissing on lips
  - **Examples of low-risk acts:** vaginal or anal intercourse using condom, oral sex (safer with condoms or other barrier)
  - **Examples of high-risk acts:** anal intercourse without a condom, vaginal intercourse without a condom
  - These apply whether client's partner(s) is/are same or opposite sex.

- **Early treatment of sexually transmitted infections (STIs) and avoidance of sex if client or partner has an STI**
- **Not having sex**—Need to be prepared to use condoms if client returns to sexual activity

Contraceptives for Clients with STIs, HIV, and AIDS

People with STIs, with HIV and AIDS, or on ARV therapy can start and continue to use most contraceptive methods safely. There are a few limitations, however. See the table below and each cue card on contraceptive methods for more information and for considerations for clients with HIV, including those taking ARV medications.

- **Male and female condoms** are the only methods that prevent both pregnancy and infection. It is important to use them correctly with every act of vaginal or anal intercourse.
- All **hormonal methods** (combined and progestin-only pills, injectables, implants) can be safely used. Rifampicin taken for tuberculosis usually reduces the effectiveness of contraceptive pills and implants. Some antiretrovirals (protease inhibitors and nonnucleoside reverse transcriptase inhibitors [NNRTIs]) may lower the effectiveness of hormonal methods. This is not known for sure. (Nucleoside reverse transcriptase inhibitors [NRTIs] are not a concern.)
- **Fertility awareness-based methods** can be safely used. In case of infection that causes vaginal discharge or fever, fertility awareness–based methods may be difficult to use.
- The **lactational amenorrhea method** (LAM) risks passing HIV to the baby. Women with HIV should be counseled to choose the feeding option that best suits their situation. (Important: Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding—5–20 of every 100 infants breastfed by mothers with HIV will become infected. Women taking antiretroviral medications [ARVs] can use LAM. In fact, ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk. Rapid weaning also decreases the risk of HIV transmission. She should stop breastfeeding over 2 days to 3 weeks. Replacement feeding poses no risk of HIV transmission. Replacement feeding is recommended for the first 6 months after childbirth if—*and only if*—replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.)
- For **IUDs, female sterilization, vasectomy,** and **spermicides,** there are special considerations (see table, page F-44).

In general, contraceptives and ARV medications do not interfere with each other. It is not certain whether some antiretroviral medications make low-dose hormonal contraceptives less effective. Even if they do, condom use can make up for that.

FAMILY PLANNING FOR PEOPLE LIVING WITH HIV *(cont.)*

Special Family Planning Considerations for Clients Who Have STIs, Who Have HIV, or Who Are Receiving Antiretroviral Therapy (ART)

METHOD	HAS STI	HAS HIV OR AIDS	RECEIVES ART
Intrauterine Device (copper-bearing or hormonal)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or pelvin inflammatory disease (PID). (A current IUD user who becomes infected with gonorrhea or chlamydia or who develops PID can safely continue using an IUD during and after treatment.)	• A woman with HIV but not AIDS can have an IUD inserted. • A woman with AIDS should not have an IUD inserted unless she is clinically well on ARV therapy. (A woman who develops AIDS while using an IUD can safely continue using the method.)	Do not insert an IUD if the client is not clinically well.
Female Sterilization	If the client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Delay sterilization if the client is currently ill with an AIDS-related illness.	
Vasectomy	If the client has a scrotal skin infection, an active STI, balanitis, epididymitis, or orchitis, delay sterilization until the condition is treated and cured.	Delay sterilization if the client is currently ill with an AIDS-related illness.	
Spermicides	Can be safely used, including when used with diaphragm or cervical cap	Should not be used if the client is at high risk of HIV, is infected with HIV, or has AIDS.	

Thinking about Pregnancy: What the Client Needs to Know

It's your decision about getting pregnant.
Pregnancy risks and risks of infecting the baby are not as high as many people think.

Risks to baby:
- If the mother is living with HIV, the baby may get HIV during pregnancy, childbirth, or breastfeeding (3 out of 10 babies). Most babies do not get infected. Treatment lowers this risk to 1 of 10 babies who will get infected.
- If the mother is living with HIV, there is greater chance of stillbirth, premature birth, or low birth weight.

Risks to mother:
- HIV infection raises the risk of childbirth complications such as fever and anemia, particularly with delivery by caesarean section.
- Pregnancy will not speed up the course of HIV infection, but it is best to avoid pregnancy in some health situations (see under "What the client needs to consider before getting pregnant").

Risks to partner:
- If the woman is uninfected and her partner is infected, she may have to risk getting HIV to become pregnant.
- If the man is uninfected and the woman is infected, he can avoid HIV risk by using artificial insemination.

What the Client Needs to Consider before Getting Pregnant

Her health now:
- *Pregnancy is possible,* if her health is good, if her CD4 count is greater than 200 (consider starting women with CD4 counts of 200–350 on antiretrovirals before pregnancy), if she is at clinical Stage 1 or 2 (where CD4 count is not available), if she is on prophylaxis to prevent opportunistic infections or is on antiretrovirals (if eligible), and if she has no sign or symptoms of tuberculosis.
- *If pregnancy may cause problems* now, delay pregnancy and reevaluate later (e.g., if her health is worsening, if her CD4 count is less than 200, if her tuberculosis status is unknown, if she is taking no prophylaxis to prevent opportunistic infections, or if she is in her first 6 weeks of antiretrovirals).
- *Pregnancy* is not a good idea now if her health is poor (e.g., if she is in clinical Stage 3 or 4, if she is on tuberculosis treatment, if her CD4 count is less than 100, or if she is waiting to start antiretrovirals).

Medical care for her and her baby: Are services available? Where?

Her partner's support:
- Has she got a steady partner? Does her partner know her HIV status?
- Is her partner supportive, and will her partner help with the baby? Does her partner know his own status or is he willing to be tested? What is her partner's health status?

Family support:
- Is her family supportive? Or would they reject a child with HIV? Are family members close by, and can they help?

Telling others her HIV status:
- Has she told others? Is she planning to? Who cannot be told?

Feeding her baby: Is she able to feed her infant in the recommended way to lower the chances of transmitting HIV?

Appendix G

Participant Workshop Evaluation Form

Appendix G

Participant Workshop Evaluation Form

Please answer all sections of this evaluation form, using the reverse side for comments, if needed. Your responses will assist the training organizers in determining what modifications, if any, should be made to this program.

I. Overall Evaluation

Select the choice that best reflects your overall evaluation of this training:
____ Very good ____ Good ____ Fair ____ Poor ____ Very poor

II. Achievement of Objectives

The general objectives of the training are to ensure that you have the knowledge, attitudes, and skills necessary to carry out the key tasks of family planning (FP) counseling. For each objective (below), please circle the number that reflects the degree to which you feel that objective was achieved (or the task described in the objective was mastered):

5 = totally achieved
4 = mostly achieved
3 = somewhat achieved
2 = hardly achieved
1 = not at all achieved

For any objectives given a rating of 1, 2, or 3, please indicate in the Comments/Suggestions column why you feel that it was somewhat, hardly, or not at all achieved, and please offer any suggestions you might have to improve it.

Objective	Score					Comments/ Suggestions
1. Explain the importance of quality, client-centered counseling for improving family planning uptake and continuation	5	4	3	2	1	
2. Effectively communicate with clients	5	4	3	2	1	
3. Assess clients' individual FP needs, knowledge, and concerns, and fulfill their needs for information, services, and emotional support						
4. Identify the key decisions clients need to make or confirm, and assist them through this process by considering various options and their consequences	5	4	3	2	1	
5. Assist clients in carrying out their FP decisions, including making a plan for implementation and coping with side effects	5	4	3	2	1	
6. Identify the barriers to conducting "ideal" counseling and develop a plan to overcome them in your own practice setting	5	4	3	2	1	

III. Other Aspects of the Workshop

For each of the following questions, check the response that best represents your opinion. Please add any other comments you have.

1. How relevant to your work was the overall workshop?

   ❑ Extremely Well ❑ Mostly ❑ Moderately ❑ Minimally ❑ Not at all

   What aspects of the workshop were most relevant to your work? Why?

   What aspects of the workshop were least relevant to your work? Why?

   Additional comments:

2. How well did the course content meet your expectations?

   ❑ Totally ❑ Mostly ❑ Moderately ❑ Minimally ❑ Not at all

   Comments:

3. How well did the overall training methods contribute to achieving the workshop objectives?

   ❑ Extremely Well ❑ Mostly ❑ Moderately ❑ Minimally ❑ Not at all

   Comments:

   The *most* effective training methods were: (please check below)

   ( ) Illustrated lectures (presentations) ( ) Question and answer
   ( ) Large-group discussion ( ) Small-group work
   ( ) Role plays ( ) Case studies
   ( ) Games ( ) Other: _____(Please specify)

   The *least* effective training methods were: (please check below)

   ( ) Illustrated lectures (presentations) ( ) Question and answer
   ( ) Large-group discussion ( ) Small-group work
   ( ) Role plays ( ) Case studies
   ( ) Games ( ) Other: _____(Please specify)

4. How well did the materials (session handouts in Participant Handbook, FP cue cards) distributed in the workshop contribute to your learning?

   ❑ Extremely Well ❑ Mostly ❑ Moderately ❑ Minimally ❑ Not at all

   Comments:

   Which materials were most useful?

For the next two questions, please refer to your agendas for the names of the sessions (topics) in this workshop.

5. Which three sessions were the *most* useful, and why?

   a)

   b)

   c)

6. Which three sessions were the *least* useful, and why?

   a)

   b)

   c)

7. What was the most important new information or skill you learnt?

   _____

   _____

   _____

8. What knowledge or skill needs were not met?

   _____

   _____

   _____

9. What did you think about the length of the course?

_____

_____

_____

10. What did you think about the depth of the course topics? Please explain.

_____

_____

_____

11. Please check any of the following that you feel could have improved the workshop.

_____ a. Use of more realistic examples and applications
_____ b. More time to become familiar with theory and concepts
_____ c. More time to practice skills and techniques
_____ d. More effective group interaction
_____ e. More effective training methods: _____ (please specify)
_____ f. Concentration on a more limited and specific topic
_____ g. Consideration of a broader and more comprehensive topic:
_____ (please specify)
_____ h. Other: _____ (please specify)

Comments:

Appendix H

Provider Interview Form

Appendix H

Outcome Evaluation Using Provider Interviews

The true test of the success of family planning (FP) counseling training is whether the participants begin conducting such counseling at their service sites and how well they do it. This appendix and appendixes G and I offer tools for evaluating the outcome of this training through observation of client-provider interaction, interviews with providers, and anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in the "Training Evaluation" section of the Introduction for Trainers and Program Planners, trainers should determine the evaluation plan with program planners and site administrators before conducting the course.

The Provider Interview Form gives a template for exploring the individual provider's perspective on how well he or she has been able to apply what he or she learned in the training and on what challenges have been encountered. It is meant to complement the information provided in the Counseling Skills Observation Guide and to answer the question "Why not?" if the provider is not implementing FP counseling up to standards. It also requests suggestions for improving the training.

Who Can Conduct Outcome Evaluation?

Because competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as consistent as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should not conduct the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Provider Interviews Be Conducted?

Because provider interviews reflect on the providers' experience following the training, it should only be carried out at the time of the posttraining observations.

Specific Instructions

- The evaluator should fill out one form for each provider interviewed.
- To encourage candor in the provider's comments, the interviewer must maintain confidentiality. Therefore, the provider's name should not be recorded on the form. The site name also should not be recorded on the form because there might be only one provider interviewed at any site, and this would allow the individual provider to be identified.
- The evaluator should compile a summary of the providers' interviews after at least four have been conducted in at least two sites. The summary should be shared only with supervisors, site or program managers, and a representative of the training team. This should be explained to the provider before the interview is started.

If the provider answers Question 1 by saying he or she has "not found it appropriate to initiate reproductive health counseling with clients," make notes on why this is so, and then skip to Question 5 and complete the rest of the interview. Questions 5 through 8 ask specific questions about problems that have been encountered, and these questions would definitely be relevant for a trainee who has not done any reproductive health (RH) counseling with clients.

Provider Interview Form

Interviewer:_____ **Date:**_____

Instructions

Obtain a copy of the participant's action plan (from Session 26 of the training) ahead of time (for Question 7).

Introduce yourself. Explain the following points to the service provide:

- The purpose of the counseling training that you participated in was intended to improve your counseling skills to address the range of clients' reproductive health (RH) needs and concerns.
- The purpose of this interview is to learn how you have been able to apply your training to the provision of RH services, the challenges you might have encountered in doing so, and how the training might be modified to better prepare participants for counseling tasks in RH service provision.
- Many of the questions are open-ended questions that enable you (the service provider) to share your responses and reactions without being confined to a predetermined range of answers.
- The results of this interview with you and other participants will be shared with program managers, supervisors, and trainers to make improvements at your work site and in the training itself. If there is only one trainee from your work site, it might be difficult (if not impossible) to ensure confidentiality. However, candor will be appreciated and will yield the most helpful responses.

Questions

Check off the service provider's response to each question, or fill in with additional explanation, as appropriate.

1. What has been your experience in counseling clients using the REDI framework?

_____

_____

_____

(If the provider has not yet used the REDI counseling framework, ask him or her to explain why not and go to Question 2.)

_____

_____

_____

2. What do you do to establish rapport and trust with clients?

_____

_____

_____

3. What has been the reaction of clients when you have initiated discussion on sexuality with them? (check as many as apply)
   a. Clients seem to have welcomed the discussions (have been open and interested in discussing their issues).
   b. Clients have seemed uncomfortable but have answered questions when asked.
   c. Clients have been mostly closed or resistant to discussing anything beyond the primary reason they came to the facility.

4. Consider the various areas of counseling that were emphasized in the training.
   a. Helping clients identify and address their individual FP/RH needs, including the social and sexual context
   - Describe your approach.

_____

_____

_____

   - How effective do you feel this approach has been? Explain.

_____

_____

_____

   - What obstacles have you encountered in using this approach?

_____

_____

_____

   - What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

b. Giving essential information to clients

- Describe your approach.

_____

_____

_____

- How effective do you feel this approach has been? Explain.

_____

_____

_____

- What obstacles have you encountered in using this approach?

_____

_____

_____

- What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

c. Helping clients perceive or determine their own and their partners' risk of unintended pregnancy or HIV and other sexually transmitted infections (STIs)

- Describe your approach.

_____

_____

_____

- How effective do you feel this approach has been? Explain.

_____

_____

_____

- What obstacles have you encountered in using this approach?

_____

_____

_____

- What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

d. Helping clients reduce their risk for HIV and other STIs

- Describe your approach.

_____

_____

_____

- How effective do you feel this approach has been? Explain.

_____

_____

_____

- What obstacles have you encountered in using this approach?

_____

_____

_____

- What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

e. Helping clients make their own decisions

- Describe your approach.

_____

_____

_____

- How effective do you feel this approach has been? Explain.

_____

_____

_____

- What obstacles have you encountered in using this approach?

_____

_____

_____

- What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

f. Helping clients implement their own decisions

- Describe your approach.

_____

_____

_____

- How effective do you feel this approach has been? Explain.

_____

_____

_____

- What obstacles have you encountered in using this approach?

_____

_____

_____

- What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

g. Helping clients communicate with a partner about FP/RH issues or concerns

- Describe your approach.

_____

_____

_____

- How effective do you feel this approach has been? Explain.

_____

_____

_____

- What obstacles have you encountered in using this approach?

_____

_____

_____

- What have you done when confronted by these obstacles? What support or assistance do you need?

_____

_____

_____

5. Remind the provider that the general objective of the training was to enable participants to carry out the following tasks:
   - Effectively communicate with clients
   - Assess clients' individual FP needs, knowledge, and concerns, and fulfill their needs for information, services, and emotional support
   - Identify the key decisions clients need to make or confirm, and assist them through this process by considering various options and their consequences
   - Assist clients in carrying out their FP decisions, including making a plan for implementation and coping with side effects.

Ask him or her to consider the following questions in terms of his or her ability to carry out these tasks.

a. In what ways has REDI been useful in carrying out these counseling tasks (i.e., the tasks listed above)?

_____

_____

_____

b. What problems have you encountered in applying REDI?

_____

_____

_____

6. What types of clients, clients' attitudes, or clients' behaviors do you find most challenging in FP counseling?

   a. In what ways are they challenging to you?

   _____

   _____

   _____

   b. What do you do when confronted by these clients, attitudes, or behaviors?

   _____

   _____

   _____

7. How would you describe your progress in implementing your action plan?

   _____

   _____

   _____

   a. What obstacles have you encountered in implementing your action plan?

   _____

   _____

   _____

   b. What success have you had in overcoming these obstacles? What additional support or assistance do you need?

   _____

   _____

   _____

8. What suggestions do you have for improving the training to better prepare participants to carry out the tasks of integrated RH counseling?

   _____

   _____

   _____

Appendix H

Appendix I

Client Interview Form

Appendix I

Outcome Evaluation Using Client Interviews

The true test of the success of family planning (FP) counseling training is whether the participants begin conducting such counseling at their service sites and how well they are doing it. This appendix, along with Appendix E (Counseling Skills Observation Guide) and Appendix H (Provider Interview Form), and offers a tool for evaluating the outcome of this training through observation of client-provider interaction, interviews with providers, and anonymous interviews with clients. All three perspectives should be considered to get a complete picture of the possible impact of the training on providers and clients. As noted in the "Training Evaluation" section of the Introduction for Trainers and Program Planners, trainers should determine the evaluation plan with program planners and site administrators before conducting the course.

The Client Interview Form included here is to be used to gather feedback from clients about their perception of the quality of the counseling services they have received. Again, it is best used in conjunction with the Counseling Skills Observation Guide and Provider Interview Form.

Who Can Conduct Outcome Evaluation?

Because competency in counseling is evaluated through observation of counseling and through interviews with participants and clients, such evaluations are necessarily somewhat subjective. To make the observation process as consistent as possible from one evaluation to another, the same individuals should conduct the evaluations each time, and these evaluators should be competent in the skills being evaluated. The trainers should not conduct the evaluations, although they can help orient local evaluators to the desired outcomes of the training.

When Should Client Interviews Be Conducted?

Client interviews can be conducted both before and after the training, to get some sense of the clients' perceptions of change over time. Because other factors might influence the quality of care and clients' perceptions of it, changes in quality (from the client's perspective) cannot be directly attributed to the training. However, these interviews might yield valuable insights into the client's experience, which can be addressed in future trainings or training follow-up.

How Can This Information Be Used?

The results of this outcome evaluation can be used in many ways:

- *Program planners and administrators* will want to know whether the training had the desired effect on service delivery (i.e., establishing effective FP counseling services). If it did not, evaluations provide clues about what the barriers are and whether they are related to training or can be traced to other aspects of service delivery.
- *Providers* will want to know how clients respond to this approach to counseling and how they can improve their skills.
- *Trainers* will want to know whether their training approaches were effective in imparting appropriate knowledge, attitudes, and skills for effective FP counseling and how these approaches can be strengthened.

Specific Instructions

- The client's name should not be recorded on the interview form, to maintain confidentiality and to encourage the client to be comfortable giving feedback that he or she might believe is critical of the provider or the service site.
- The site name *should* be recorded, however, because this feedback will be valuable to providers and supervisors at each site.
- The evaluator should compile a summary of the providers' interviews after at least four have been conducted in at least two sites. Copies of this summary should be given to providers and supervisors at each site and to a representative of the training team.

Client Interview Form

Interviewer: _____ **Date:** _____

Site: _____

Instructions

Introduce yourself to the client and explain the following:

- You are interviewing clients about their experience in seeking and obtaining reproductive health and family planning services at this facility.
- The purpose of your interviewing clients is to get feedback about their perceptions of the quality of services they received. This will enable facility staff to continue to improve the quality of their services.
- In this context, you would like to ask the client some questions about the services he or she just received. The client's answers will be "yes" or "no." You will not be asking any questions about the client himself or herself.
- To help facility personnel improve, it is important that the client be frank about his or her impressions. The client's feedback will be anonymous—that is, no names will be connected with his or her responses.
- Participation is completely voluntary, and their choice to participate or not will not affect their access to care at this facility.
- The client may refuse to answer any of the questions and may choose to stop participating at any time.
- Ask the client for his or her permission to be interviewed for this purpose.
- This will take about 15 to 20 minutes.

If the client agrees, proceed with the interview using the following questions. Record the client's answers in the spaces provided. Check the column "NA" if the question is not applicable to the client you are interviewing.

CLIENT INTERVIEW FORM	Yes	No	NA
General skills and establishment of positive client-provider interaction			
In general, did the staff with whom you met: Show you respect (did not judge you, what you think, or what you have done)?			
Ensure your privacy in the consultation room?			
Talk in a language and use terms that you could easily understand?			
Ask you to repeat some of the explanations to reinforce your understanding?			
Listen to you without interrupting and show interest in what you had to say?			
Encourage you to talk about yourself and to ask questions?			
Answer your questions clearly?			

CLIENT INTERVIEW FORM (cont.)	Yes	No	NA
Rapport building			
Did the staff with whom you met: Welcome you with kindness and with respect?			
Make you feel comfortable?			
Introduce himself or herself?			
Ask what he or she could do for you?			
Explain why he or she would be asking sensitive and personal questions?			
Assure you that whatever you said would not be shared with others?			
Explain what would happen during the visit?			
Exploration			
Did the staff with whom you met: Ask you about:			
○ Your sexual relationships?			
○ How you communicate with your partner (or partners) about sexuality, family planning, HIV, and other sexually transmitted infections (STIs)?			
Ask you about your:			
○ Previous pregnancies and the outcomes of those pregnancies?			
○ Use of family planning methods, including condoms?			
○ Own HIV and STI history			
○ Knowledge of your partner's (or partners') history of HIV or STIs?			
Ask you what you know about:			
○ Family planning?			
○ HIV?			
○ Other STIs?			
Provide you with information about any of the above (as appropriate)?			
Explain your possible risks for:			
○ HIV and other STIs?			
Help you determine your (or your partner's) risk for:			
○ HIV or other STI transmission?			
Ask you about other health needs or concerns?			

CLIENT INTERVIEW FORM (cont.)	Yes	No	NA
Decision making			
Did the staff with whom you met: Explain the importance of making your own decisions?			
Ask if you already made a decision?			
Help you consider all of your options?			
Help you consider the advantages and disadvantages of each option (including common side effects of family planning methods being considered)?			
Help you consider how your partner or family might react to your choice of options?			
Help you confirm or make the decision that you feel best fits your medical and personal circumstances?			
Help you receive the service or method you wanted or understand why a different option would be considered better for you?			
Implementing the decision			
Did the staff with whom you met: Encourage you to think about how you would put your decisions into practice?			
Ask you:			
○ How you would communicate your plan to your partner?			
○ Whom you could count on to support you in your decision?			
○ Who might create obstacles for you, and what you can do about that if it happens?			
○ To offer ideas for improving communication and negotiation with your partner?			
Help you make an alternate plan if this one does not work out?			
Demonstrate how to use a condom (if applicable) and have you repeat the demonstration to reinforce your understanding?			
Give you samples of condoms and tell you where and how to obtain more?			
Give clear instructions about how to use the medical treatment recommended for you			
or the family planning method that you chose?			
Invite you back for a follow-up visit (for ongoing support with decision making, negotiation, or condom use, as appropriate)?			
Tell you about other services available elsewhere and how to access them?			
Were you happy with the service you received?			
Would you refer a friend or relative to this service provider?			
What other comments would you like to share that we have not covered in these questions?			
Is there anything that the provider could have done differently to better meet your needs? (If the client says “yes,” ask for his or her suggestions and write those here.)			

Appendix A

Appendix J

Contraceptive Technology Update (CTU) (PowerPoint Presentation)

Contraceptive Technology Update (CTU): What's New Out There, and What Are the Implications?

Roy Jacobstein, M.D., M.P.H.
EngenderHealth
James Shelton, M.D., M.P.H.
USAID

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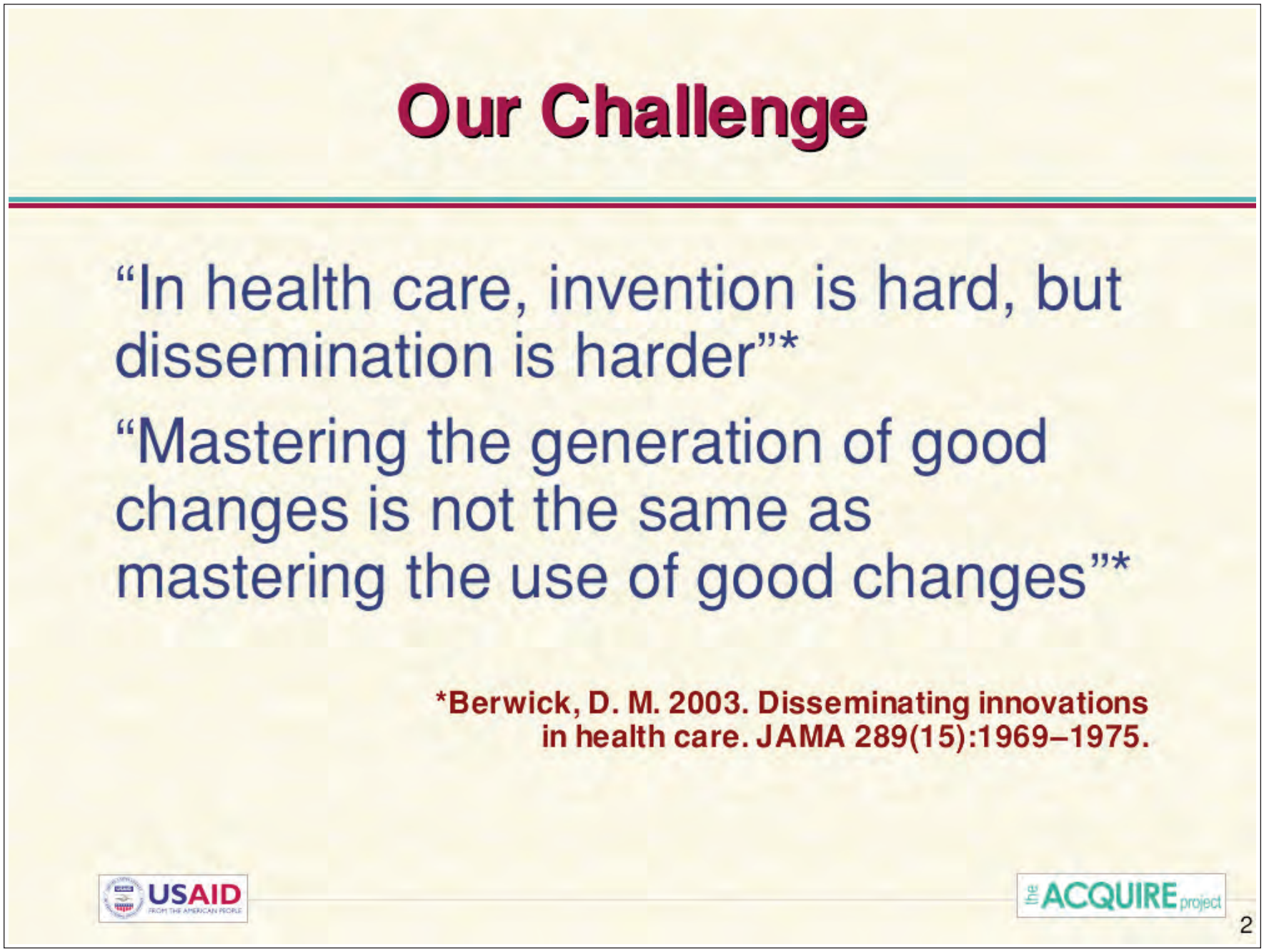
Our Challenge
"In health care, invention is hard, but dissemination is harder"*
"Mastering the generation of good changes is not the same as mastering the use of good changes"*
*Berwick, D. M. 2003. Disseminating innovations in health care. JAMA 289(15):1969–1975.
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Contraceptive Technology Update (CTU) *(continued)*

Outline of Presentation

I. World Health Organization (WHO) evidence-based guidance for contraceptive use (Medical Eligibility Criteria)

II. Latest information/thinking/new developments about FP methods

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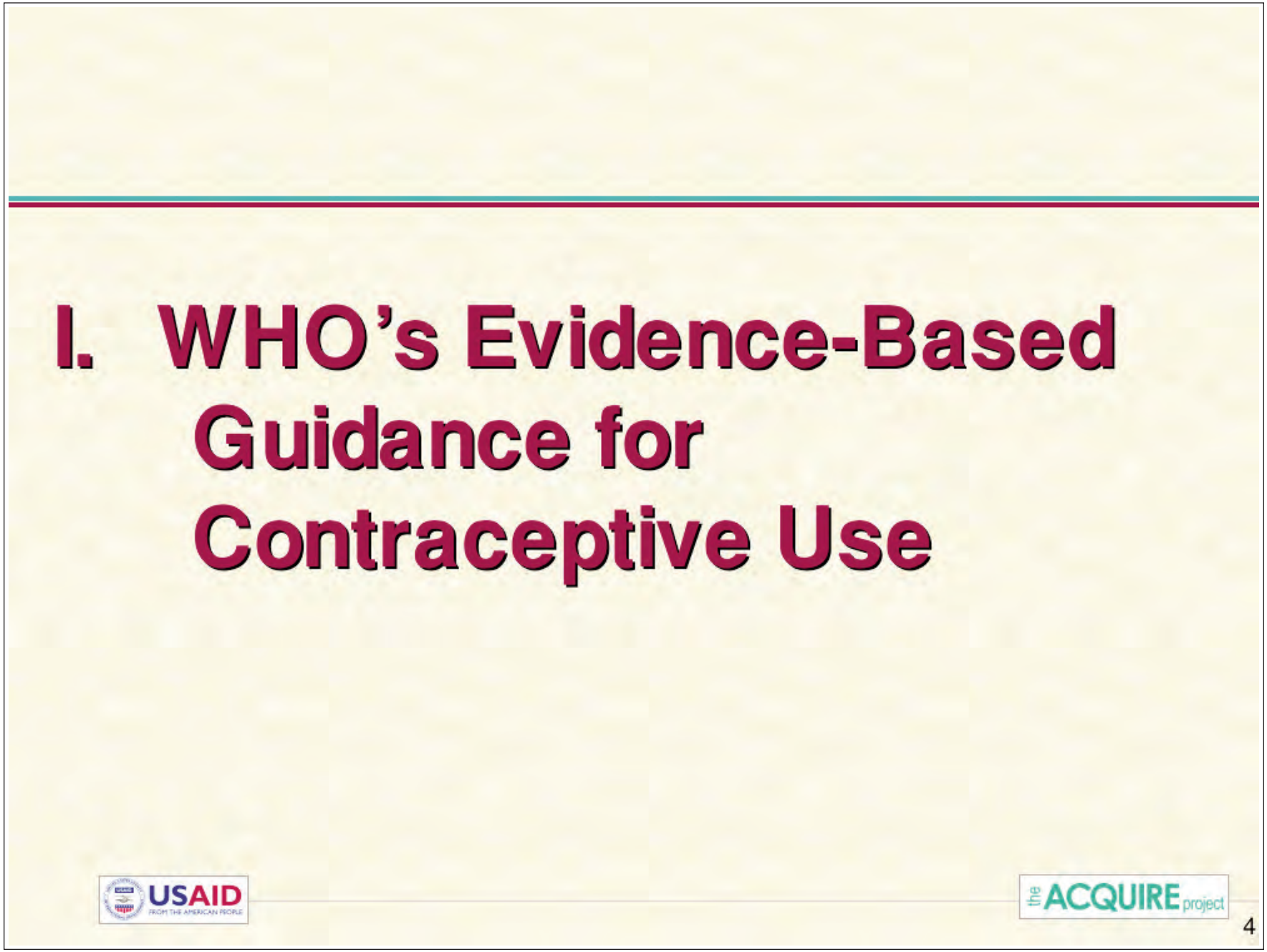
I. WHO's Evidence-Based Guidance for Contraceptive Use
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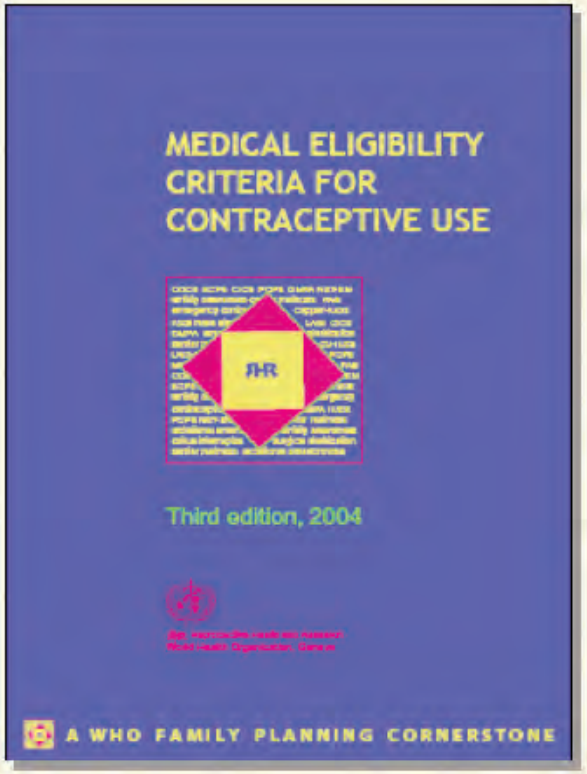
Contraceptive Technology Update (CTU) *(continued)*

Medical Eligibility Criteria for Contraceptive Use (MEC, 2004)



- Covers 19 methods, 120 medical conditions
- ~ 1700 recommendations on who can use various contraceptive methods
- Gives guidance to programs and providers for clients with medical problems or other special conditions
- Informs national guidelines, policies, and standards with best available evidence
- Helps reduce medical policy and practice barriers
- Helps lead to improved quality and use of FP methods and services

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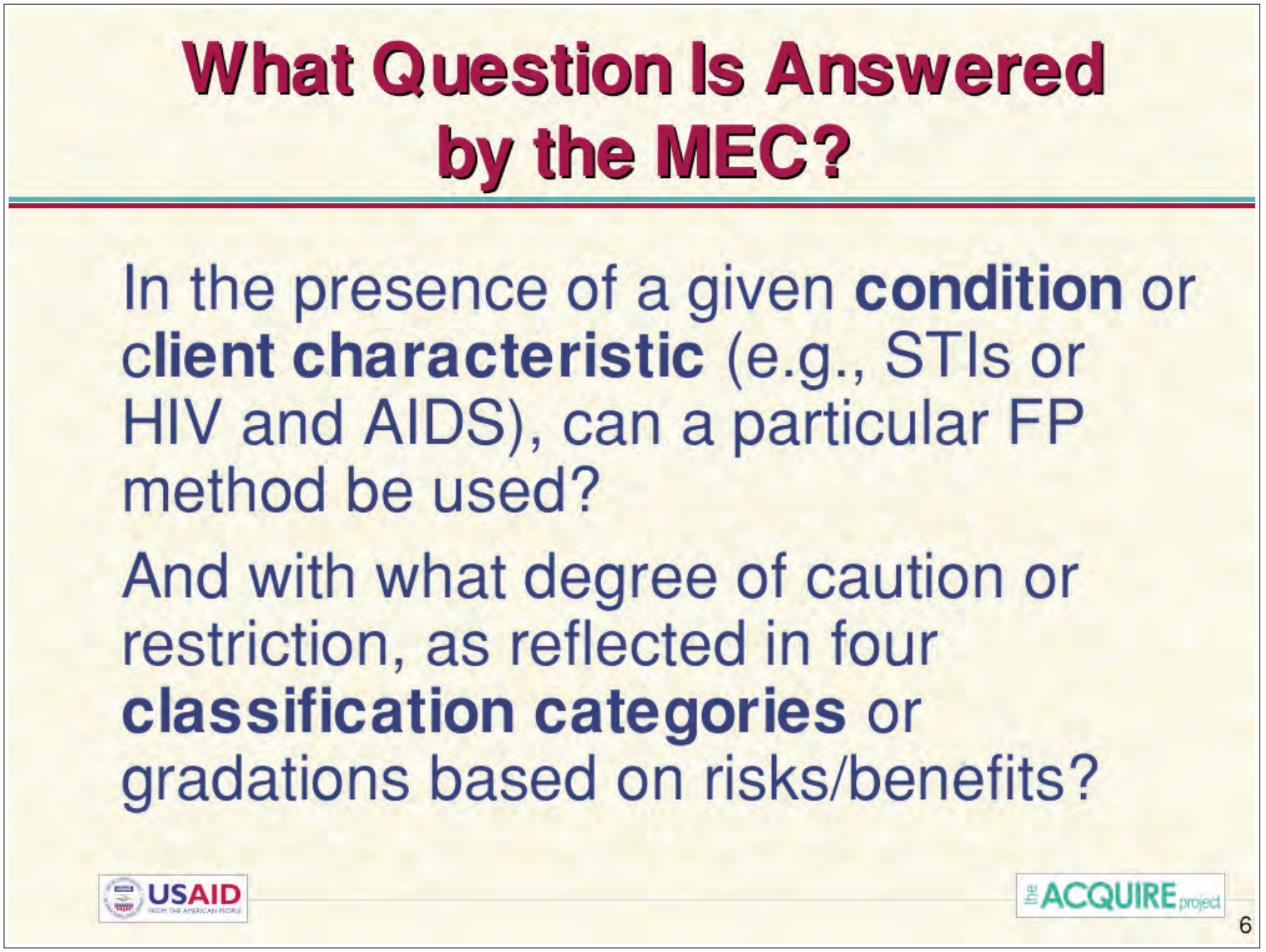
What Question Is Answered by the MEC?
In the presence of a given **condition** or **client characteristic** (e.g., STIs or HIV and AIDS), can a particular FP method be used?
And with what degree of caution or restriction, as reflected in four **classification categories** or gradations based on risks/benefits?
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Contraceptive Technology Update (CTU) *(continued)*

WHO Medical Eligibility Criteria, Classification Categories

Classification Category	With Clinical Judgment	With Limited Clinical Judgment
1	No restriction: Use method in any circumstances	Yes Use the method
2	Generally use: Benefits generally outweigh risks	Yes Use the method
3	Generally do not use: Risks outweigh benefits	No Do not use the method
4	Unacceptable health risk: Method is not to be used	No Do not use the method

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II. New Findings and Thinking about Specific FP Methods
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Contraceptive Technology Update (CTU) *(continued)*

Methods to Be Considered:

1. Sterilization (female sterilization/ vasectomy)
2. IUD
3. Implant
4. Injectable
5. Emergency contraception
6. Standard days method

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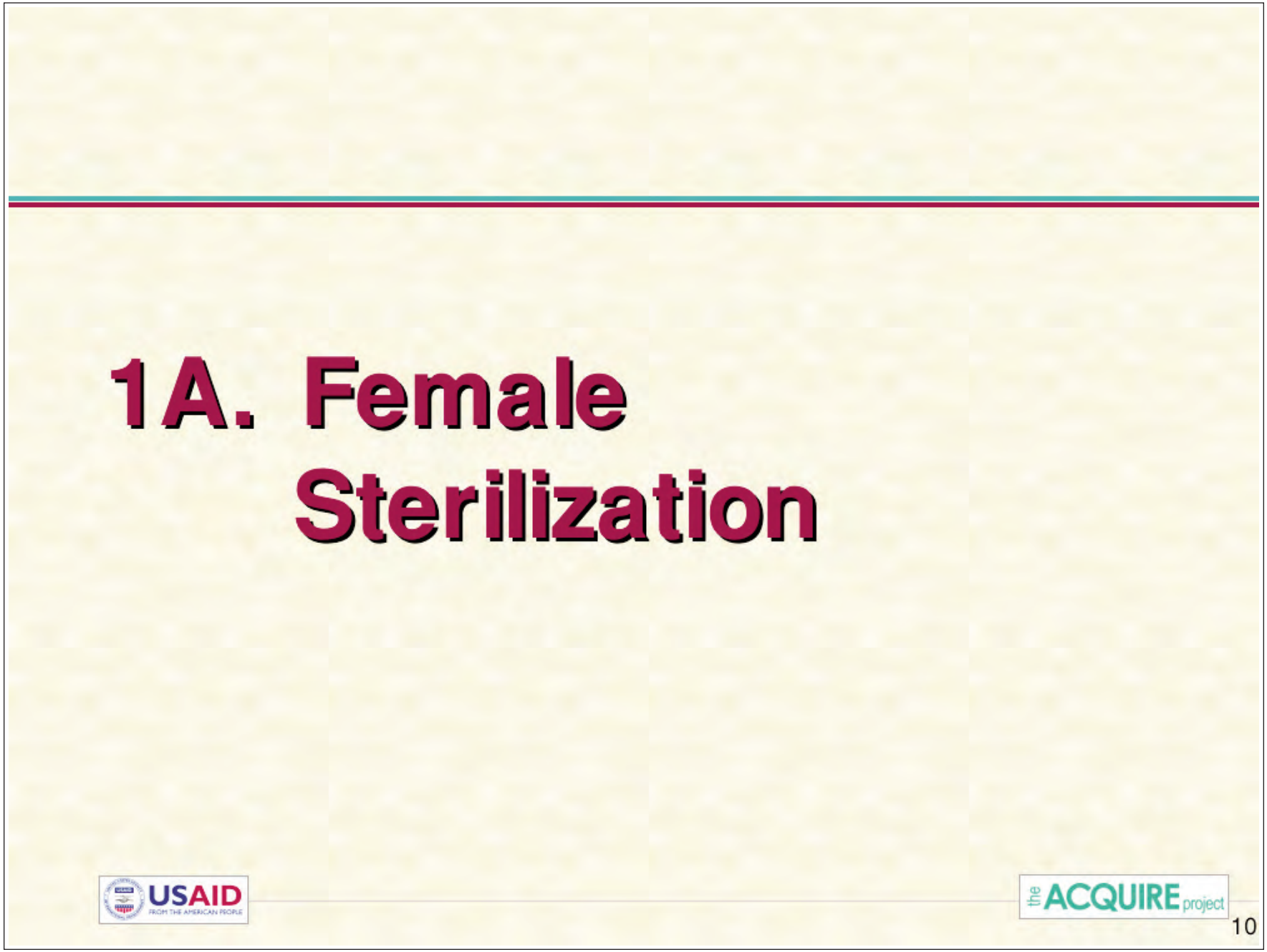
1A. Female Sterilization
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Female Sterilization

- Highly effective, comparable to vasectomy, implant, IUD
- Risk of failure (pregnancy), while low:
  - Continues for years after the procedure (18.5/1000 at 10 years; almost 2/100)
  - Does not diminish with time
  - Is higher in younger women
- No medical condition absolutely restricts a woman's eligibility for sterilization

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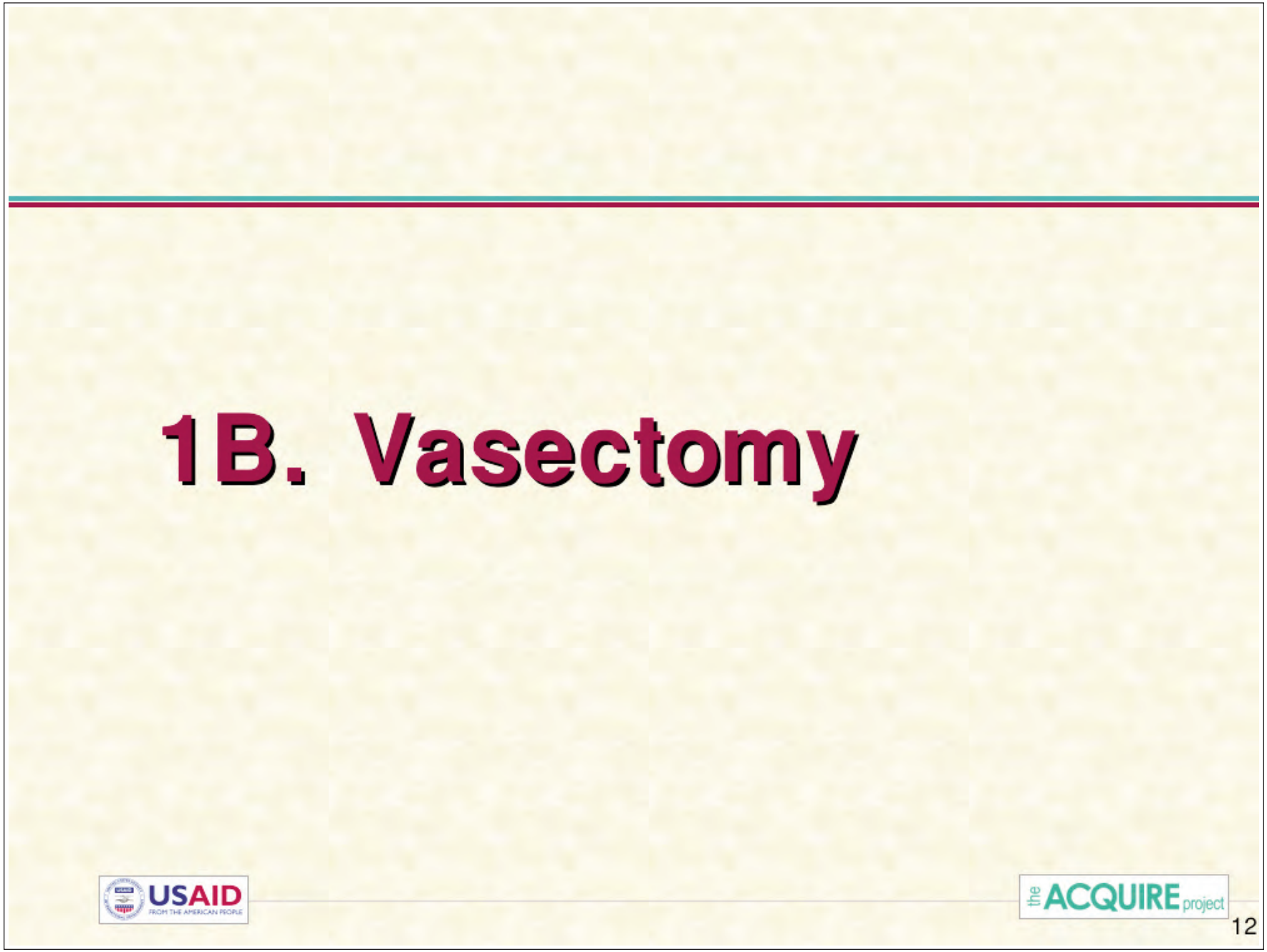
1B. Vasectomy
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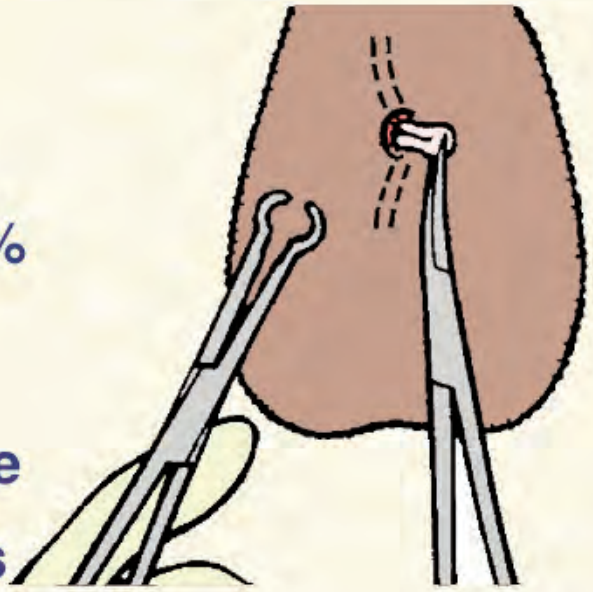
Contraceptive Technology Update (CTU) *(continued)*

No-Scalpel Vasectomy (NSV): Characteristics

- Small puncture; *vas deferens* is pulled through skin
- Very safe; few restrictions
- Minor complications (post-operative and chronic pain, infection and bleeding): 5-10%
- Less with NSV than with incisional technique
- Major morbidity/mortality rare
- No adverse long-term effects
- NSV not "new" (1972)—yet only got to 51% in U.S. in 2004



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Vasectomy (cont.)

- Effectiveness is comparable to female sterilization, implant, IUD.
- Not effective immediately—WHO recommends use of back-up method for 3 months after procedure (i.e., no longer "… or 20 ejaculations").
- Failure (pregnancy) is commonly quoted at from 0.2–0.4%, but rates as high as 3–5% have been reported. This has counseling implications….

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2. IUD (TCu 380A)

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IUD: Effectiveness and Safety

- Highly effective, comparable to sterilization
  - "Reversible sterilization"
    - 12–13 yrs with TCu (FDA labels for 10)
    - Cheaper and easier to provide than sterilization
    - Quickly and easily reversible, with immediate return to fecundability
- Very safe for almost all women (including: postpartum, postabortion, or interval; breastfeeding; HIV-infected; young; nulliparous; women who cannot use hormonal methods)

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IUD: Other Considerations

- More service cadres can provide (because it is nonsurgical)
- Good for both "spacers" and "limiters"
- Greater availability = greater choice
- Good option for HIV-positive women
- Most cost-effective method (after 2 years), yet …
- "The IUD has the worst reputation of all methods … except among those using it."

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Not Only Clients Have "Myths": Latest Evidence about Providers' Concerns
The "Big Three" provider concerns:
1. Pelvic Inflammatory Disease (PID)
2. Infertility
3. HIV and AIDS
New evidence is reassuring
Challenge: "dissemination," "acceptance," appropriate behavior change by providers
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Concern: Does IUD Cause PID?

- We know the IUD needs an accomplice—sexually transmitted organisms such as *Chlamydia* and *gonococcus* (i.e., PID is not caused by the device itself or by its string)
- 2 possible mechanisms, raises 2 questions:

  Q 1: Risk from IUD insertion process? &/or

  Q 2: Risk from postinsertion bacterial exposure (i.e., does having IUD in place facilitate later PID)?

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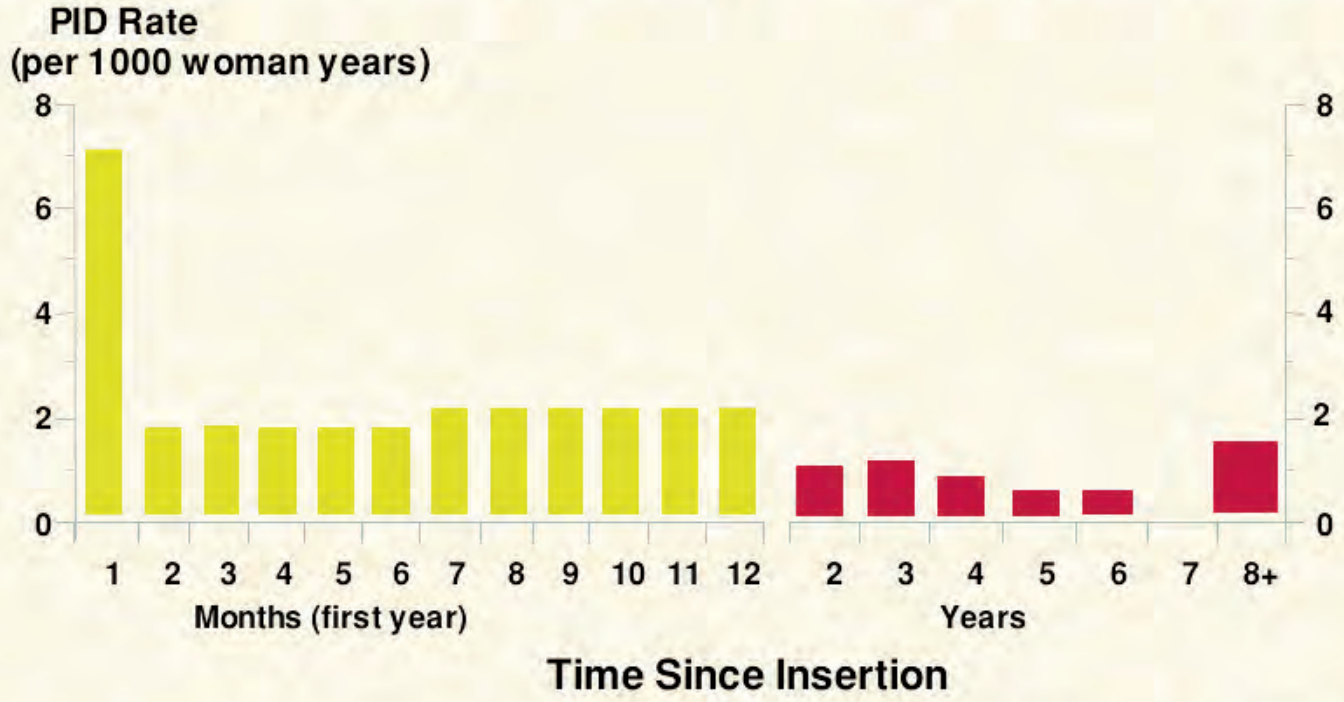
Risk of PID: Very Low and Far Lower Than Many Providers Erroneously Believe

PID Incidence Rate by Time Since Insertion



Source: Farley et al, 1992, in FHI 2004

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But What About Risk of PID in High-Prevalence STI Settings?

- Perhaps WHO data included only low-risk women? (study done in Thailand and Latin America)
- What about in low-resource settings, where STI testing is not feasible?
- But no prospective studies exist, thus we need to (can only) estimate risks

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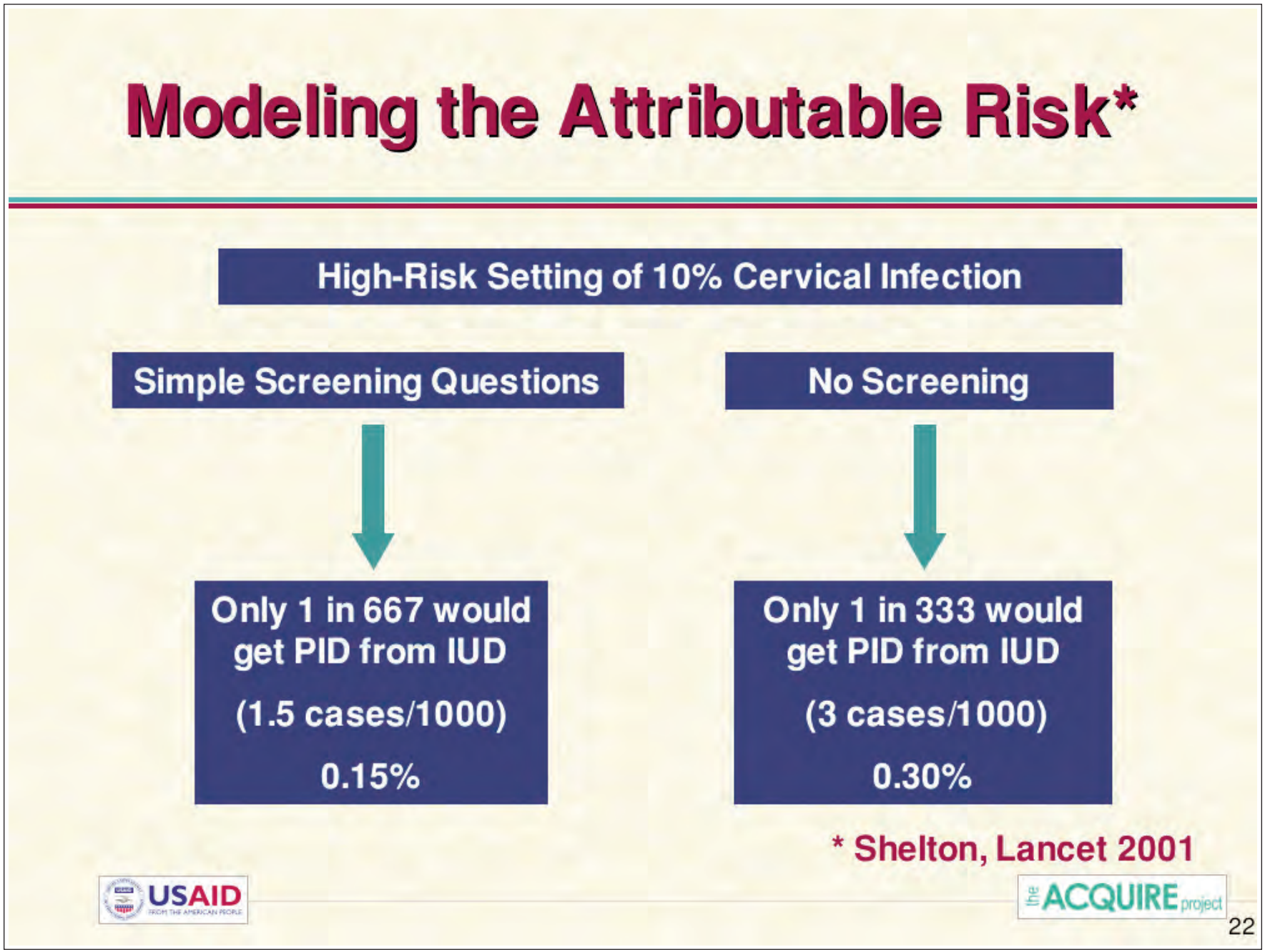
Modeling the Attributable Risk*
High-Risk Setting of 10% Cervical Infection
Simple Screening Questions
No Screening
Only 1 in 667 would get PID from IUD
(1.5 cases/1000)
0.15%
Only 1 in 333 would get PID from IUD
(3 cases/1000)
0.30%
* Shelton, Lancet 2001
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Summary: Emerging View on IUD and PID

- Insertion process, due to presence of sexually transmitted bacteria, increases short-term risk of PID in some women (those at high risk of STIs)
- IUD does not appear to facilitate development of PID in postinsertion period
- Overall risks are **very small**
- Even in high-STI settings, risks appear **small (and much smaller than typically believed)**
- Our challenge: These facts are not widely known; and it is hard to change preexisting "truths."

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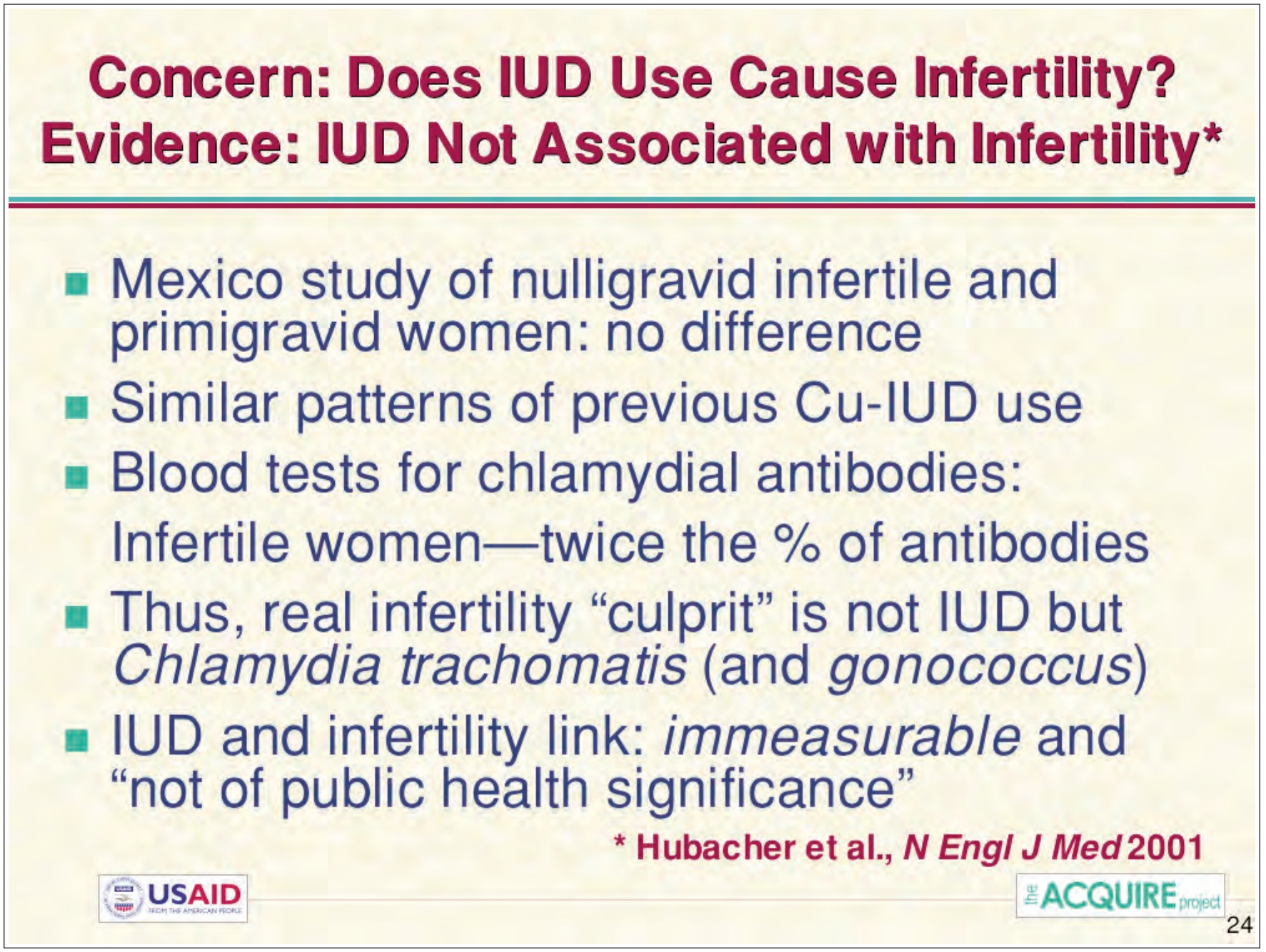
Concern: Does IUD Use Cause Infertility?
Evidence: IUD Not Associated with Infertility*
Mexico study of nulligravid infertile and primigravid women: no difference
Similar patterns of previous Cu-IUD use
Blood tests for chlamydial antibodies:
Infertile women—twice the % of antibodies
Thus, real infertility "culprit" is not IUD but Chlamydia trachomatis (and gonococcus)
IUD and infertility link: immeasurable and "not of public health significance"
* Hubacher et al., N Engl J Med 2001
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Concern: Is IUD Use by HIV-Infected Women Safe? Evidence: Yes

- Cohort studies in Kenya
- Compared HIV-infected and noninfected women using IUDs
- Findings: Same **low rates** of **overall** (7–10%) and **infectious** (0.2–2%) complications
- Conclusion: HIV does not appear to increase risk of IUD-related adverse events, inc. PID

Sinei et al, *Lancet*, 1998
Morrison et al., *Br J Obstet Gynaecol* 2001

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Concern: IUD in HIV-Positive Woman Might Raise Risk for HIV-Negative Male Partner

- Ancillary study to Kenyan cohort
- Asks: Does presence of IUD increase cervical shedding of HIV? (Increased shedding is a proxy for increased risk of being infective.)
- Finds cervical shedding of HIV is not increased with IUD use
- Inferential conclusion: IUD use by HIV-positive women appears safe for HIV-negative partner

Richardson et al., *AIDS* 1999

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Contraceptive Technology Update (CTU) *(continued)*

Changes in the WHO MEC for Use of Copper IUD in HIV/AIDS Clients

HIV/AIDS	2nd Ed. Category	2004 Category	
		I	C
High Risk of HIV	3	2	2
HIV-infected	3	2	2
AIDS	3	3	2
Clinically well on ARV therapy		2	2

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Overview: Current (2004) Medical Eligibility Criteria for IUD Use in Clients with STIs or HIV/AIDS

Condition	Category	
	Initiation	Continuation
Increased general risk of STI (high prevalent setting)	2	2
High *individual* risk of STI	3	2
Current chlamydial or GC infection, or purulent cervicitis	4	2
HIV positive	2	2
AIDS	3	2
AIDS and clinically well on ARV	2	2

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Progesterone-Releasing Intrauterine Systems (IUS)

- Mirena®—continuous release of a small amount of the progestin, levonorgestrel (same hormone in Norplant and Jadelle)
- Effective 5 years; failure rate in 1 year: ~0.1–0.2%
- Same benefits and side effects of progestins
- May reduce menstrual cramps and flow
- Reduced flow may reduce iron deficiency anemia
- Foundations considering supporting it
- USAID: too expensive, trying to develop generic

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3. Implant (Norplant, Jadelle, Implanon)

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Norplant vs. Jadelle vs. Implanon

Norplant (6 capsules)

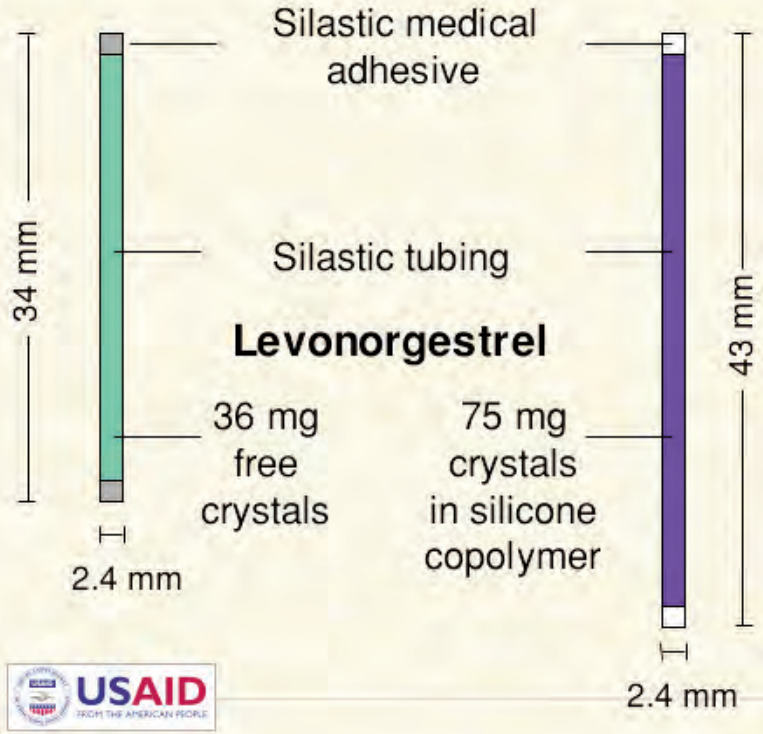
216 mg LNG

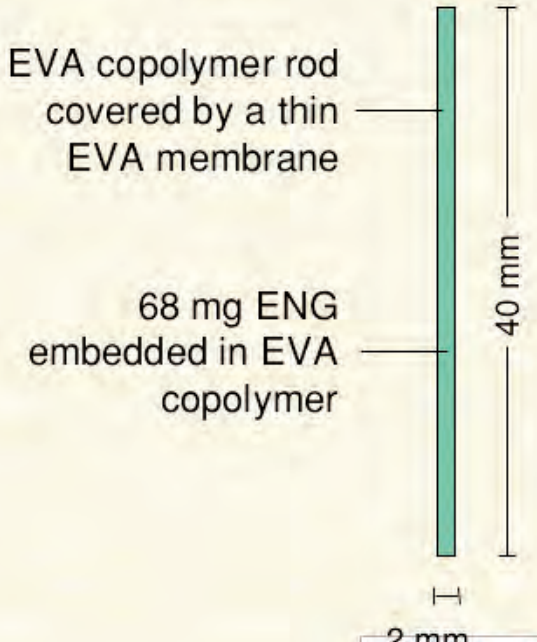
Jadelle (2 rods)

150 mg LNG

Implanon (1 rod)

68 g etonogestrel
(ENG, 3-ketodesogestrel)





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Comparison of Norplant®, Jadelle®, and Implanon®

Norplant®

- 6 capsules
- Effective 7 yrs
- 1-yr. failure: 0.05% (1 in 20,000); 5-yr. failure 1.6%
- Regulatory approval in 62 countries
- Insertion time: 4.3 min (0.8–18.0)
- Removal time: 10.2 min (1.3–50m)
- Cost: $27

Jadelle®

- 2 rods
- Effective 5 years
- 1-yr. failure: 0.05% (1 in 20,000); 5-yr. failure 1.1%
- Regulatory approval in 11 countries
- Insertion time: 2 min
- Removal time:4.9 min ± 3.5 minutes
- Cost: $29

[Sinoplan: $5]

Implanon®

- 1 rod
- Effective 3 years
- Regulatory approval in 25 countries
- Insertion time: 1.1 min (0.03—5.0)
- Removal time:2.6 min (0.2–20.0)
- Cost: comparable; AID RFA out now

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Contraceptive Technology Update (CTU) *(continued)*

Injectable: Names, Lengths, Content

- Progestin-only injectables:
  - Depot-medroxyprogesterone acetate (DMPA; Depo-provera; Megestron®)
    - 150 mg given intramuscularly every three months
    - also subcutaneous formulation, lower dose (104 mg); CBD …
  - NET-EN: norethindrone (or norethisterone) enanthate, Noristerat®) given every two months
- Combined injectable contraceptives (progestin plus estrogen)—given monthly:
  - Cyclofem® (MPA, 25 mg plus estradiol, 5 mg)
  - Mesigyna® (50 mg Norethindrone enanthate, plus 5 mg estradiol)

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Depo-Provera

- Women of any age and parity can use it (MEC Cat. 1, age 18–45; Cat. 2, if younger or older)
- Start first 7 days after LMP, or can use any time reasonably sure woman not pregnant
- Usable immediately postpartum if not breastfeeding; or 6th week postpartum if breastfeeding
- Usable immediately postabortion
- No association of Depo use with HIV acquisition (2005, FHI/NICHD Study)
- Bone density: WHO consultation, July 2005

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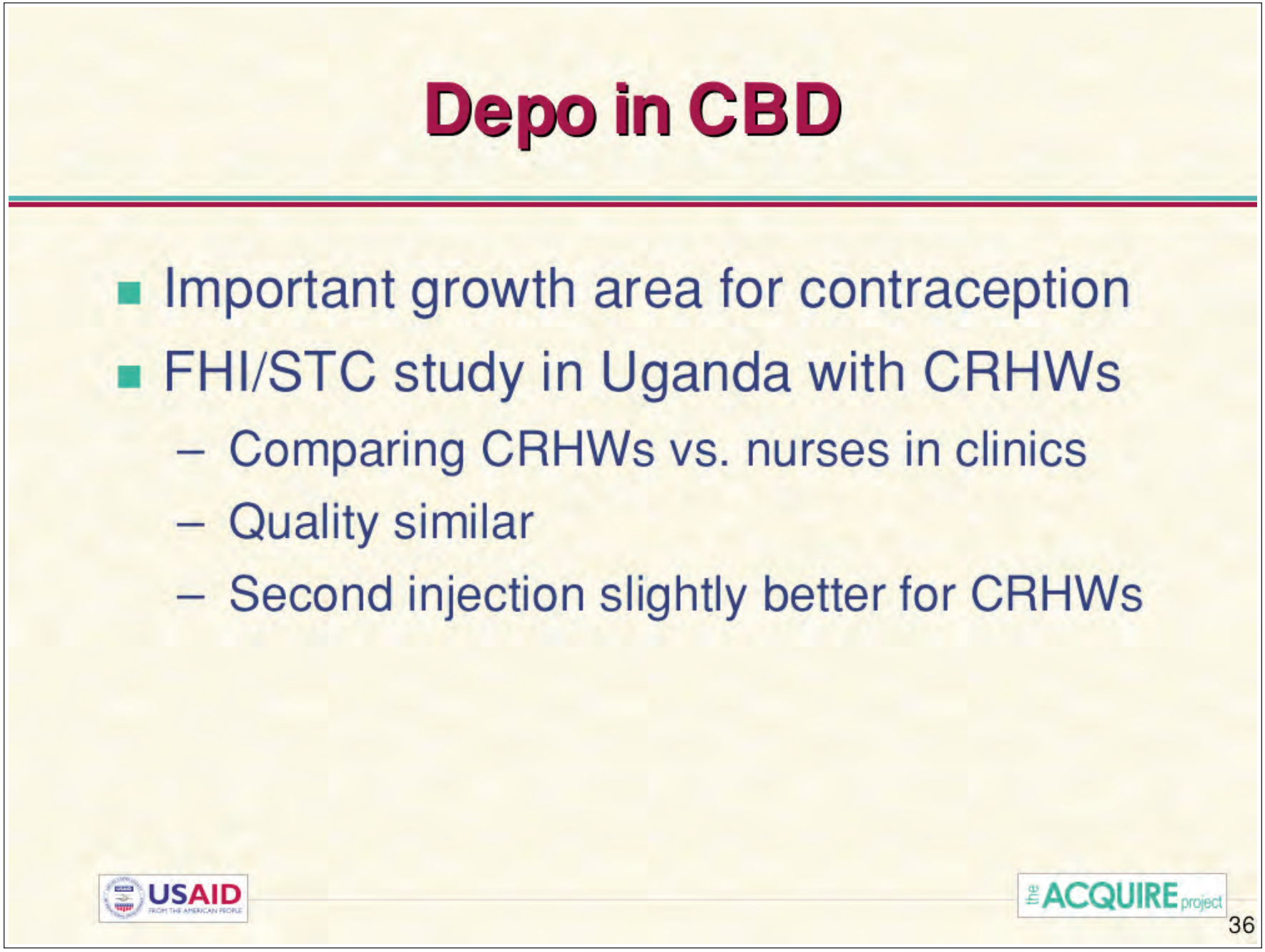
Depo in CBD
Important growth area for contraception
FHI/STC study in Uganda with CRHWs
– Comparing CRHWs vs. nurses in clinics
– Quality similar
– Second injection slightly better for CRHWs
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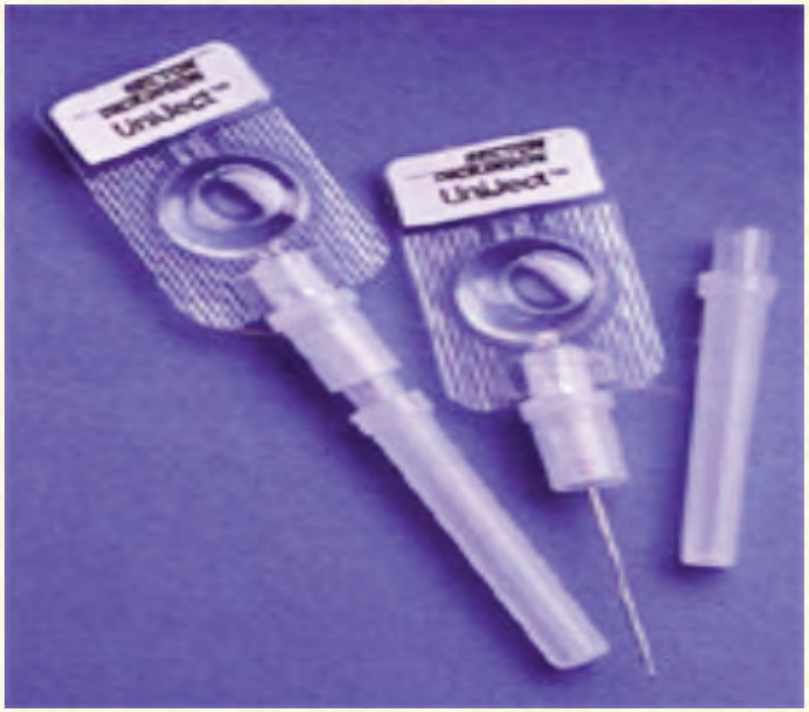
Depo in Uniject



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5. Standard Days Method (SDM)

Simple Fertility Awareness–Based Approach to Family Planning

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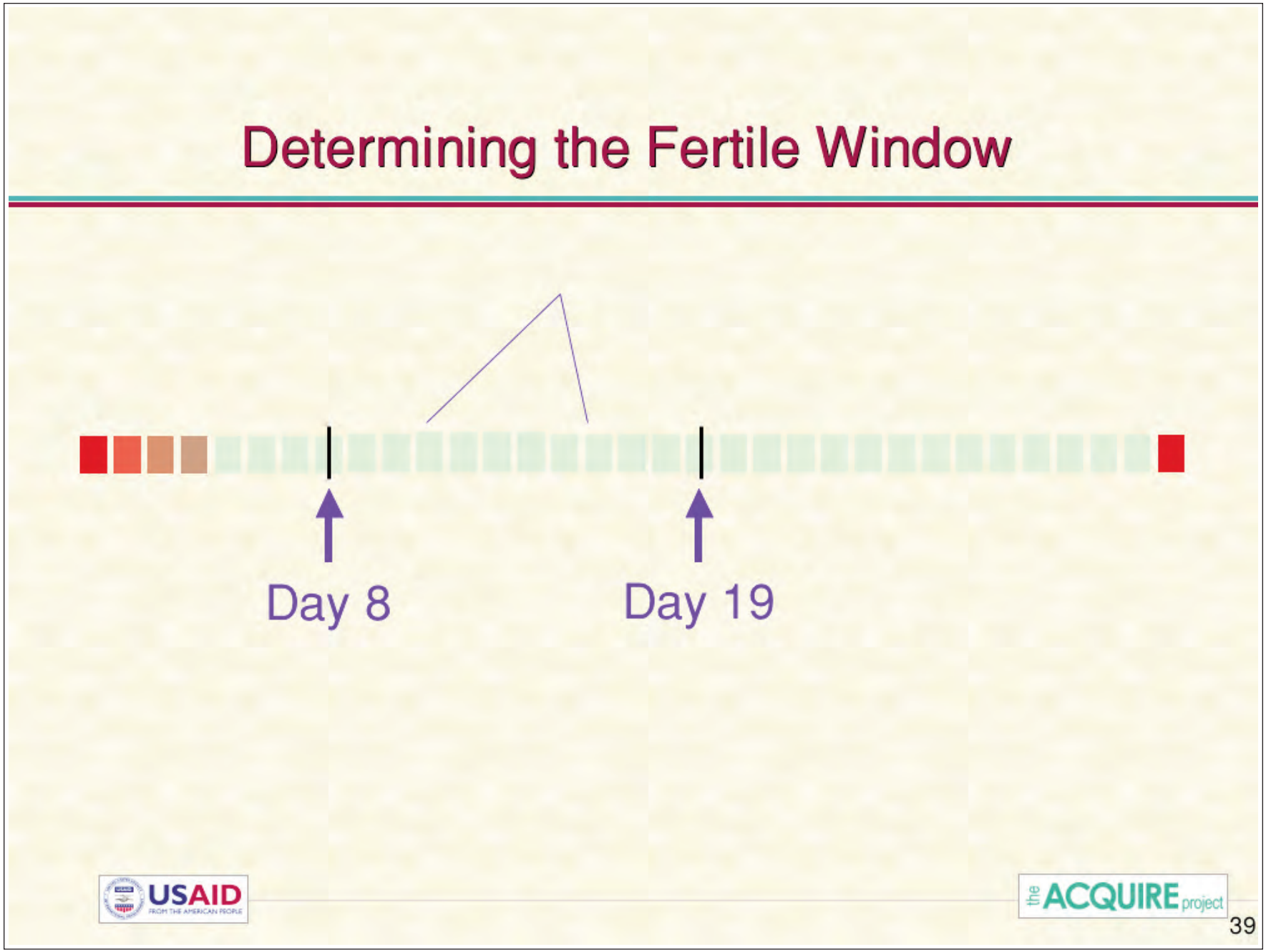
Contraceptive Technology Update (CTU) *(continued)*




Standard Days Method
Identifies days 8–19 of the cycle as fertile
Is appropriate for women with menstrual cycles between 26 and 32 days long
Helps a couple plan or prevent pregnancy by knowing which days they should or should not have unprotected sex
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Standard Days Method

Is used with CycleBeads®, a color-coded string of beads that can help a woman:

- Track her cycle days
- Know when she is fertile
- Monitor her cycle length

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Contraceptive Failure of User-Directed Methods

% of women who became pregnant during 1st year of use

	Correct Use	Typical Use
No Method	85	85
Spermicides	18	29
Diaphragm	6	16
Condom	2	15
Oral Contraceptive	.3	8
Standard Days Method	5	12

Source: Adapted from Contraceptive Technology, 18th edition, 2004

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Contraceptive Technology Update (CTU) *(continued)*

SDM - What does it cost?

- Less expensive than most other methods (only IUD is less per CYP)*
- Counseling takes about 20 minutes
- Training: in-service contraceptive updates, preservice curricula
- USAID working with manufacturer to ensure best price, efficient procurement and delivery for CycleBeads
- CycleBeads can be included in IEC budgets for bilaterals, centrally funded projects
- Technical assistance from AWARENESS (Georgetown Institute for Reproductive Health)

* Gribble, James N. "Mind the gap." *Journal of Family Planning and Reproductive Health Care* 2004; 30(3): 155–157.

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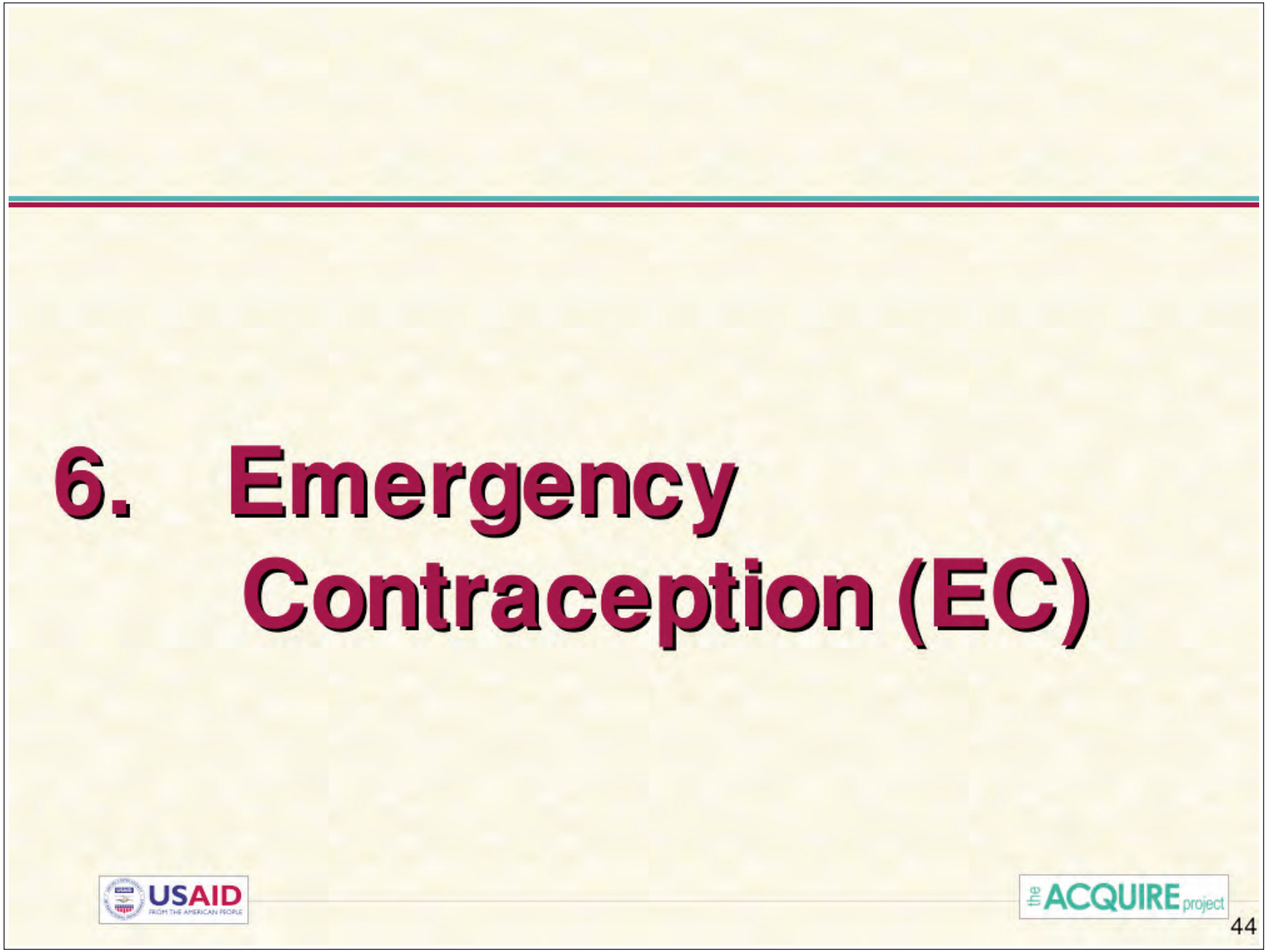
6. Emergency Contraception (EC)
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What Is Emergency Contraception (EC)?

- Method of *preventing* pregnancy *after* unprotected sexual intercourse
- Mechanism of action: Predominantly and probably only affects ovulation.
- Hormones of regular oral contraceptives, used:
  - In a special higher dosage
  - Within 120 hours (5 days) of unprotected sex
- EC pills (ECPs) do *not* interrupt an established pregnancy
- (IUDs can also be used for up to 7 days after unprotected sex)
- Not RU-486

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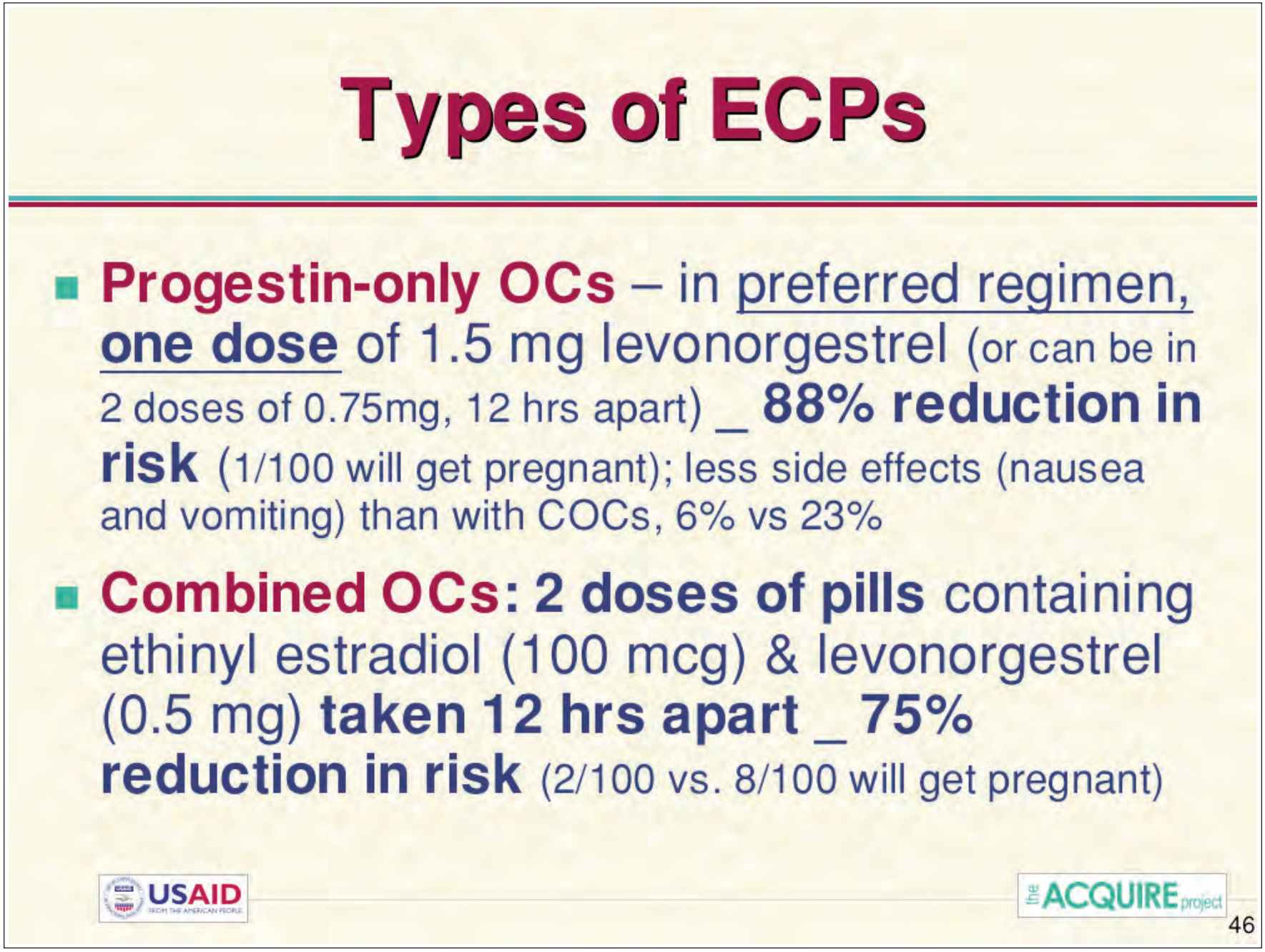
Types of ECPs
Progestin-only OCs – in preferred regimen, one dose of 1.5 mg levonorgestrel (or can be in 2 doses of 0.75mg, 12 hrs apart) _ 88% reduction in risk (1/100 will get pregnant); less side effects (nausea and vomiting) than with COCs, 6% vs 23%
Combined OCs: 2 doses of pills containing ethinyl estradiol (100 mcg) & levonorgestrel (0.5 mg) taken 12 hrs apart _ 75% reduction in risk (2/100 vs. 8/100 will get pregnant)
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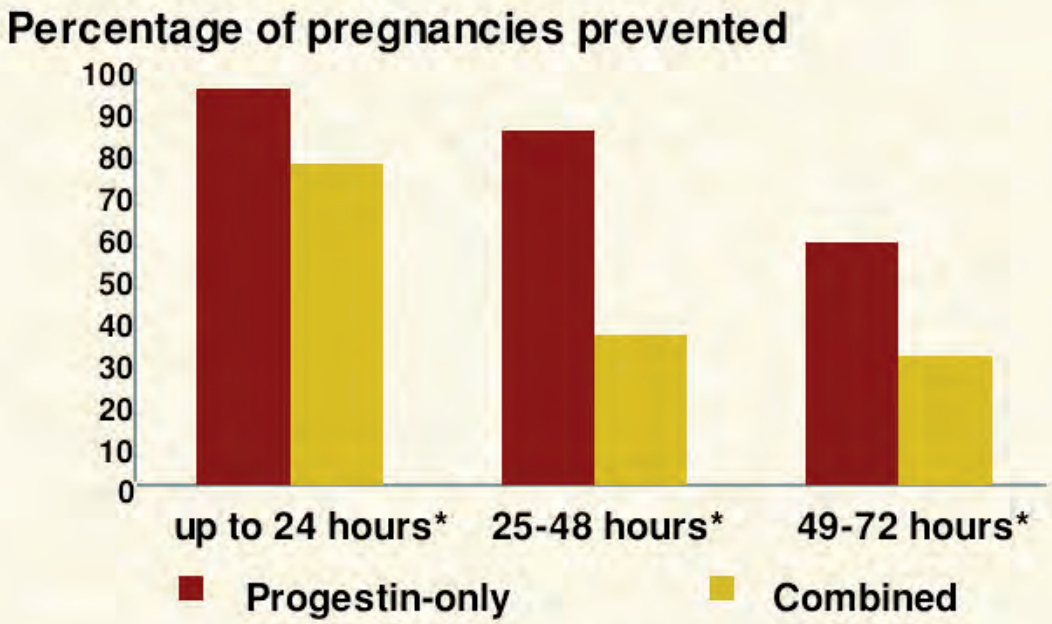
Contraceptive Technology Update (CTU) *(continued)*

ECPs Are Most Effective When Taken Early



***Source*: WHO Task Force, *Lancet*, 1998; 352: 428-33.**

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Counseling for Effective Use of Family Planning

Participant Handbook

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Contents

Preface

In the public health community at large—and among many of EngenderHealth's country and global programs in particular, including The ACQUIRE Project and Action for the West Africa Region–Reproductive Health (AWARE–RH)—health workers have expressed a need for a new approach to family planning (FP) counseling. Several countries have reached a plateau in contraceptive prevalence rates as well as high discontinuation rates in the use of contraceptives. And counseling needs to be reoriented and refocused to:

- Offer a tailored approach to meeting clients' individual needs
- Address the needs of returning clients
- Strengthen the management of side effects
- Strengthen integration with other areas of sexual and reproductive health (including HIV and sexually transmitted infections, postabortion care, and sexuality)

Many colleagues in the field find existing counseling materials either outdated or insufficient in terms of FP information and the needs of FP clients. For this reason, The ACQUIRE Project has developed a new FP counseling curriculum.

The curriculum builds on EngenderHealth's previous work in counseling, including *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*. At the same time, it responds to the identified gap in existing materials and fills the needs expressed by those in the field.

The intended audiences for this curriculum are health care providers, their supervisors, and the managers of the programs in which they work. The counseling skills addressed here are expected to be relevant to the provision of both preventive and curative health services through the workshop participants' national health systems. Finally, the curriculum's participatory approach to defining terms and to generating profiles of potential clients is designed to assist trainees in addressing the realities and exploring the reproductive health priorities of their communities in a culturally appropriate manner.

Acknowledgments

Counseling for Effective Family Planning Use represents the work of many teams and country programs at EngenderHealth, The ACQUIRE Project, and AWARE-RH. It is the culmination of a process that began in 2002 with the initial development and field testing of EngenderHealth's counseling curriculum, *Comprehensive Counseling for Reproductive Health: An Integrated Curriculum*. Based on pilot tests in the field and the growing need to strengthen family planning counseling in particular, the concept for this curriculum emerged. The original concept for this curriculum was developed by John Pile, Jill Tabbutt, Jan Kumar, and Levent Cagatay; the latter was the lead writer and was the cofacilitator of all but one of the field tests. Subsequent field tests yielded input from the following staff and consultants: Gebeyehu Mekonnen in Ethiopia in 2002, Nirmala Selvam in Nepal in 2003, Nisreen Bitar and Huda Murad in Jordan in 2004, Nirmala Selvam in Kenya in 2006, Akif Hasanov in Azerbaijan in 2006, and 29 experienced counseling trainers representing nine countries (Azerbaijan, Bangladesh, Cameroon, Ethiopia, the Gambia, Ghana, Nepal, Sierra Leone, and Tanzania) who all participated in a counseling standardization workshop in Ghana in 2007.

Over the years, internal reviewers at EngenderHealth have included Karen Beattie, Dr. Carmela Cordero, Maj-Britt Dohlie, Dr. Roy Jacobstein, Edna Jonas, Anna Kaniauskene, Jan Kumar, Erin Mielke, Feddis Mumba, John Pile, Mizanur Rahman, and Damien Wohlfahrt.

Revisions of the curriculum based on each of the field tests were written mainly by Levent Cagatay, with assistance from Edna Jonas, Erin Mielke, and Elizabeth Oliveras.

We thank our U.S. Agency for International Development reviewers, Patricia MacDonald and Carolyn Curtis.

The curriculum was edited by Sandra J. Crump and was formatted by Robert Vizzini. Michael Klitsch provided overall editorial management.

Part I:

Getting to Know Our Clients

In Part I of the counseling curriculum, you consider the context in which reproductive health and family planning decisions are made, identify categories of clients who seek services, and develop "client profiles" that will be used for case studies and role plays throughout the rest of your training. Because counseling focuses on facilitating decision making, the training sessions here explore the client's decision-making process from the perspective of rights to family planning services and methods, informed and voluntary decision making, and the client's rights in the service setting. Principles of client-provider interaction and counseling provide the foundation for developing key counseling skills, attitudes, and knowledge in the rest of the training. This part also sets the stage for discussions about providers' attitudes, values, and beliefs and their impact on clients.

HANDOUT 1 Goals and Objectives

The overall **goal** of this training is to improve your knowledge, attitudes, and skills in assessing and addressing clients' family planning (FP) needs through individualized counseling that considers the clients' circumstances and broader reproductive health (RH) needs and their impact on the choice and use of FP.

Overall Course Objectives: By the end of the training, you will be able to

1. Explain the importance of quality client-centered counseling for improving FP uptake and continuation
2. Effectively communicate with clients
3. Better assess clients' individual FP needs, knowledge, and concerns, and meet these needs in an effective and efficient manner
4. Identify the key decisions clients need to make or confirm, and assist and support them through this process by considering various options and their consequences
5. Assist clients in strategizing how to carry out their FP decisions
6. Identify the barriers to conducting "ideal" counseling that exist in your practice setting, and develop a plan to overcome them

Essential Ideas—Session 1

The objectives of the training will be achieved through the following approaches:

- Increasing your awareness of the different types of clients you serve and their varying needs
- Preparing you to rapidly assess clients' needs and appropriately tailor counseling to meet them
- Increasing your awareness of and comfort with issues related to sexuality
- Updating your knowledge of FP methods

By focusing on the client as an individual and considering factors that influence his or her decision making, providers are better able to assess and meet the client's informational, decision-making, and emotional needs. This will help the client make decisions and plans that he or she will be more likely to carry out. Focusing on clients' ongoing and evolving needs enables providers to support them in using their chosen method successfully and in coping with common side effects.

HANDOUT 2A

Supporting Clients' Informed and Voluntary Decision Making

By the end of this session, you should be able to:

- Name three rights recognized by international conventions and explain their relevance for FP counseling
- Define *informed and voluntary decision making* and explain its importance in FP and RH
- List at least four of the seven "rights of clients" and explain how they apply to FPservices
- Describe the roles of providers and other health care staff in supporting clients' informed and voluntary decision making

Essential Ideas—Session 2

- Rights to family planning services and methods are recognized by international conventions signed by most countries of the world and include the right to decide on the number, spacing, and timing of children; the right to have the information to do so; the right to attain the highest standards of sexual and reproductive health; and the right to make these decisions without discrimination, coercion, or violence.
- Including women's "right to exercise control over their own sexuality" as a component of health rights is an important breakthrough. The right to decide about reproduction and the right "to attain the highest standard of sexual and reproductive health" have little meaning if women cannot decide whether, when, and with whom they will have sex.
- Rights to family planning services and methods are only effective when people feel entitled to these rights and empowered to exercise them. Yet, everyday constraints—such as power imbalances between social groups, between men and women, or between health care staff and clients; physical and social accessibility of services; cost and quality of services; and quality of client-provider interaction —can pose barriers to the exercise of these rights.
- Individuals and couples have the right to make key decisions that significantly affect their health status in every area of sexual and reproductive health (SRH), including FP. The ability and means to make informed decisions in each of these areas is a fundamental expression of one's rights to sexual and reproductive health.
- At the same time, rights related to access to information and services regardless of age, sex, marital status or ethnic group—for example, the right to information for unmarried people or to SRH services for adolescents—must exist before individuals can make informed decisions and act on them.
- The clients' rights are a way to operationalize reproductive and sexual rights through the quality of services provided. They describe aspects of service delivery that are essential to ensuring quality of care.
- Many facility staff play a role in supporting clients' rights—or in undermining them. It is important to consider the impact of *all* people with whom the client comes into contact and to determine the role that each person can play in ensuring that clients' rights and needs are respected and addressed.

Session 2

HANDOUT 2B

A Rights-Based Approach to Family Planning and Sexual and Reproductive Health

The ***rights-based approach*** to FP and SRH assumes that health and rights are inseparable and that individuals have the right and the capacity to make decisions about their lives. Basic elements of this approach include:

- Gender equity and equality
- Rights to sexual and reproductive health
- Client-centered sexual and reproductive health care

Rights-Based Approach

The **rights-based approach** was adopted at the 1994 United Nations–hosted International Conference on Population and Development (ICPD), which was held in Cairo, Egypt. The countries assembled there developed and ratified the following description of reproductive rights:

> Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights documents, and other consensus documents. These rights rest on the recognition of the basic rights of all couples and individuals to decide freely and responsibly the number, spacing, and timing of their children, to have the information necessary to do so, and to attain the highest standard of sexual and reproductive health . . . [and] the right to make decisions concerning reproduction free of discrimination, coercion, and violence.
>
> *ICPD Program of Action, 1995, Paragraph 7.3*

In 1995, the Fourth World Conference on Women was held in Beijing. The conference platform for action stated, among other things, that women's human rights include "their right to have control over and decide freely and responsibly on matters related to their sexuality, including sexual and reproductive health, free of coercion, discrimination, and violence."

Fourth World Conference on Women Platform for Action, 1995, Paragraph 96

Much of the language of rights to sexual and reproductive health, including family planning services and methods, focuses on the right to make decisions "freely and responsibly . . . without coercion, discrimination, and violence." Thus, one of the most concrete and significant ways in which we can support the rights associated with SRH is to ensure informed and voluntary decision making by individuals and couples.

Adapted from: Family Care International (FCI). 2000. *Sexual and reproductive health briefing cards*. New York.

Session 2

HANDOUT 2C

Informed and Voluntary Decision Making in Sexual and Reproductive Health

Informed choice is an individual's well-considered, voluntary decision based on options, information, and understanding.

When applied to decisions about FP, the concept of informed choice means that individuals freely choose whether to use a contraceptive method and which one, based on their awareness and understanding of accurate information about the methods. Although informed choice could apply to any SRH service, some providers have difficulty understanding informed choice in non–FP services, because often there is only one treatment option available (e.g., only one medication for syphilis) and thus no real choice to make, or an individual's medical condition might require the provider to make emergency decisions for the client (e.g., in postabortion or emergency obstetric care).

The concept of *informed and voluntary decision making* applies broadly to any health care decision and assumes that individuals have both the right and the ability to make their own health care decisions in a voluntary manner and with full information and understanding of the consequences of each option. How does this concept relate to other similar concepts, such as informed consent and informed choice?

Informed consent is a medical, legal, and rights-based construct whereby clients agree to receive medical treatment, such as surgery for FP method or to take part in a study, ideally as a result of the client's informed choice. Unfortunately, there are many instances in which a client signs an informed consent form without adequate information and without feeling that he or she has had any choice in the matter.

We use the term *informed and voluntary decision making* to underscore the importance of the decisions that individuals make in every area of SRH, even when options are limited and their need is urgent. Examples of decisions that people make concerning their SRH include the following:

- *For FP:* whether to use contraception to delay, space, or end childbearing; which method to use; whether to continue using contraception when side effects occur; whether to switch methods when the current method is unsatisfactory; and whether to involve one's partner(s) in decision making about FP
- *For HIV and other sexually transmitted infections (STIs):* whether to use a condom with every act of sexual intercourse; whether to use a dual-protection strategy (to prevent both unintended pregnancy and STIs); whether to limit the number of sexual partners; whether to seek treatment for apparent infection; whether to inform partner(s) if an infection is diagnosed; whether to delay sexual intercourse until the infection is completely treated, and whether to be tested for HIV

- *For maternal health care:* whether to seek antenatal care during pregnancy, whether to improve one's nutrition during pregnancy; whether and when to have sex during pregnancy; whether and when to go to a health care setting for assistance with delivery; whether to breastfeed exclusively and for how long; and whether and when to use contraception after delivery
- *For postabortion care:* when to seek care following signs of spontaneous abortion; whether and when to seek care for complications of abortion; and whether to use contraception to prevent or delay future pregnancies

Several conditions support informed and voluntary decision making in SRH, including:

- Service options being available
- A voluntary decision-making process
- Having all the appropriate information (i.e., having an understanding of all options and their consequences)
- Good client-provider interaction, including counseling
- Respect for rights at the community and program level

Adapted from: EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum*. New York.

HANDOUT 2D Clients' Rights

The Rights of Clients

Information: Clients have a right to accurate, appropriate, understandable, and unambiguous information related to reproductive health and sexuality and to health overall. Educational materials for clients should be made available in all parts of the health care facility.

Access to services: Services must be affordable and available at times and places that are convenient to clients, without physical barriers to the health care facility, without inappropriate eligibility requirements for services, and without social barriers such as discrimination based on gender, age, marital status, fertility, nationality or ethnicity, belief, social class, caste, or sexual orientation.

Informed choice: A voluntary, well-considered decision that an individual makes on the basis of options, information, and understanding represents his or her informed choice. The decision-making process begins in the community, where people get information even before coming to a facility for services. It is the provider's responsibility either to confirm a client's informed choice or to help him or her reach one.

Safety of services: Safe services require skilled providers, attention to infection prevention, and appropriate and effective medical practices. This right also refers to the proper use of service-delivery guidelines, the existence of quality assurance mechanisms within the facility, counseling and instructions for clients, and recognition and management of complications related to medical and surgical procedures.

Privacy and confidentiality: Clients have a right to privacy and confidentiality during delivery of services—for example, during counseling and physical examinations and in the way staff handle clients' medical records and other personal information.

Dignity, comfort, and expression of opinion: All clients have the right to be treated with respect and consideration. Providers must ensure that clients are as comfortable as possible during procedures. Clients should be encouraged to express their views freely, especially when their views differ from those of service providers.

Continuity of care: All clients have a right to continuity of services and supplies, follow-up, and referral.

Adapted from: Huezo, C., and Diaz. S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129-139.

HANDOUT 3 The Difference That Counseling Makes

By the end of this session, you should be able to:

- Define good *client-provider interaction* and its role in ensuring informed and voluntary decision making
- Describe strategies to improve client-provider interaction and support clients' rights more effectively in the health care facility setting
- Define good *counseling* and its role in informed and voluntary decision making
- Explain how counseling supports clients' rights and makes a difference
- Identify specific tasks that need to be carried out in counseling
- Explain the counseling-related role of various staff
- List the needs of health care staff that must be addressed for improved client-provider interaction and counseling

Essential Ideas—Session 3

- *Client-provider interaction* refers to interpersonal communications (both verbal and nonverbal) between health care staff and the people who seek health care services. *Provider* includes everyone in the health care setting with whom the client interacts. This definition recognizes the importance of nonmedical staff to clients' impressions of the health care setting and messages that they associate with the health care setting.
- A client's first impressions of a health care facility are usually made through interactions with frontline staff. The client's sense of trust and confidence that he or she has made the right decision to seek services can be reinforced or completely undermined by frontline staff.
- *Counseling* is a type of client-provider interaction that involves two-way communication between a health care staff member and a client for the purpose of confirming or facilitating a decision by the client, or helping the client address problems or concerns.
- Quality counseling is the main safeguard for the client's right to informed and voluntary decision making. In addition, counseling can support each of the other clients' rights.
- Although clinical providers are usually responsible for the final stages of counseling, frontline staff can perform many preliminary steps, such as giving information about the options, methods, and services available and gathering basic information about the client's condition. These preliminary steps allow providers to spend more time with the client on individual considerations and the actual decision-making process.
- For quality client-provider interaction and counseling to occur, the needs of all types of health care staff must be addressed. To perform at their best, staff need facilitative supervision and management, information, training and development, supplies, equipment, and infrastructure.

Client-Provider Interaction

Definition

Client-provider interaction is person-to-person communication (verbal and nonverbal) between clients and health care staff. (*Health care staff* can include anyone associated with a service site—e.g., medical and paramedical staff, outreach staff, receptionists, cleaners, and drivers.)

The client interacts with facility staff from the moment he or she enters a service site. All staff should use good communication skills and be sensitive to clients' needs when clients are skeptical or distrustful of sexual and reproductive health services. Experience has shown that clients are more satisfied and more likely to continue using services when they are treated with respect.

Principles[1]

The key principles for cultivating good client-provider interaction include the following:

- Treat all clients with respect.
- Tailor the interaction to the individual client's needs, circumstances, and concerns.
- Interact with the client, and elicit his or her active participation.
- Avoid information overload.
- Provide or refer the client for their preferred FP method or address the client's primary concern (for other SRH issues).
- Use and provide memory aids.

Counseling

Definition and Tasks

Definition. Counseling is a type of client-provider interaction that involves two-way communication between a health care staff member and a client for the purpose of confirming or facilitating a decision by the client or helping the client address problems or concerns.

Tasks. When providing counseling, health care staff are responsible for:

- Helping clients to assess their own needs for services, information, and emotional support
- Providing information appropriate to clients' identified problems and needs
- Assisting clients in making their own voluntary and informed decisions by helping them weigh the options
- Helping clients explore possible barriers to the implementation of their decisions and helping them develop the strategies and skills to overcome those barrier, and carry out their decisions
- Answering questions and addressing concerns, and making sure the client understands all the information they have received

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[1] These key principles for client-provider interaction are adapted from: U.S. Agency for International Development (USAID) and World Health Organization (WHO). 1997. *Recommendations for updating selected practices in contraceptive use, Volume II*. Washington, DC, pp. 187–190.

Essentials

Few SRH or FP programs can afford to pay staff whose only responsibility is to be a counselor. In addition, few sites have private spaces designated only for counseling. Thus, *all* staff need to develop counseling skills and approaches to incorporate into *all* of their interactions with clients, always respecting physical and auditory privacy and including the following essentials:

- Compassion
- Common sense
- Communication skills
- Comprehensive, understandable information

Principles

Because counseling is a form of client-provider interaction, the key principles for cultivating good client-provider interaction also apply to counseling. In addition, providers should follow these guidelines when counseling clients:

- Create an atmosphere of privacy, respect, and trust.
- Engage in two-way communication with the client.
- Ensure confidentiality.
- Remain nonjudgmental about values, behaviors, and decisions that differ from your own.
- Show empathy for the client's needs.
- Demonstrate comfort in addressing sexual and gender issues.
- Remain patient with the client during the interaction and express interest.
- Provide reliable and factual information tailored to the needs of the client.
- Support the client's rights to sexual and reproductive health.

(See also the accompanying PowerPoint presentation, "The Difference That Counseling Makes.")

Addressing Staff Needs to Improve Client-Provider Interaction and Counseling

Most of the interventions aimed at improving the quality of client-provider interaction and counseling focus on training. Yet training is only one of the prerequisites of excellence in staff performance. All of the staff needs listed below must be addressed in order to improve the quality of client-provider interaction and counseling they provide.

Needs of Health Care Staff[2]

Facilitative supervision and management: Health care staff function best in a supportive work environment with facilitative management and supervision to motivate and enable them to perform their tasks well and better meet the needs of external clients.

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[2] Huezo, C., and Diaz, S. 1993. Quality of care in family planning: Clients' rights and providers' needs. *Advances in Contraception* 9(2):129–139.

Information, training, and development: For a facility to provide quality health services, staff must possess and continuously acquire the knowledge, skills, and attitudes needed to provide the best family planning and overall health services possible.

Supplies, equipment, and infrastructure: In order for health care staff to provide good services, they need reliable and sufficient supplies, equipment in working order, and adequate infrastructure.

The Difference That Counseling Makes

The Difference That Counseling Makes

Appendix D

Counseling for Effective Use of Family Planning
2008

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What Is Counseling?

Counseling is:

Two-way communication between a client and a health care staff member for the purpose of confirming or facilitating a decision by the client or of helping the client address problems or concerns.

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Counseling Tasks

During counseling, health care staff:

- Help clients assess their health care and informational and emotional support needs
- Provide personalized information *(i.e., appropriate to clients' identified problems and needs)*
- Help clients make their own informed and voluntary decisions by enabling them to weigh the options
- Help clients plan how to carry out that decision effectively *(by identifying possible barriers and developing skills and strategies to overcome them)*
- Answer questions and address concerns

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Two Experts in the Room

Knowledge of:

- Healthy timing and spacing of pregnancy (HTSP)
- FP methods and services available
- Other RH areas and services

Skills to:

- Build trust
- Empathize with clients
- Communicate
- Assess needs
- Tailor information to clients' needs
- Help clients weigh options and decide

Thoughts, Feelings, and Opinions about:

- Fertility plans
- Past experience
- Relationship with partner(s)
- Social circumstances
- Sexual relationships
- Other unexpressed needs

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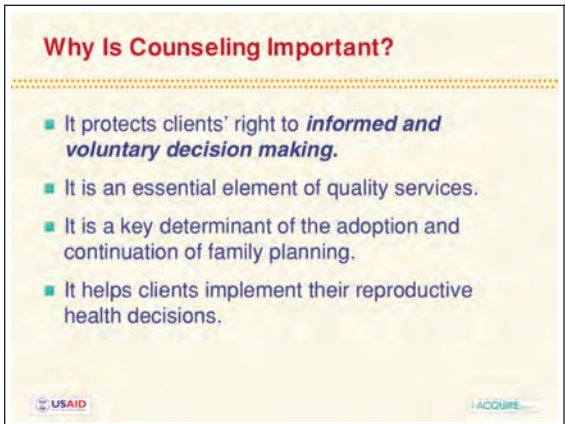
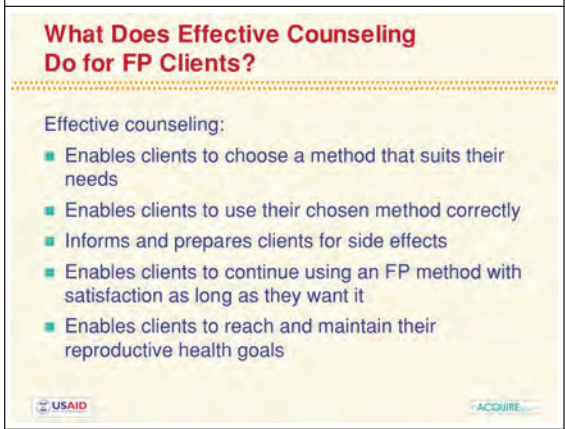
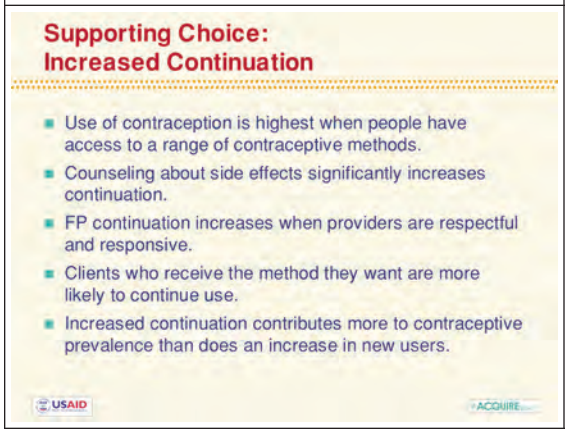
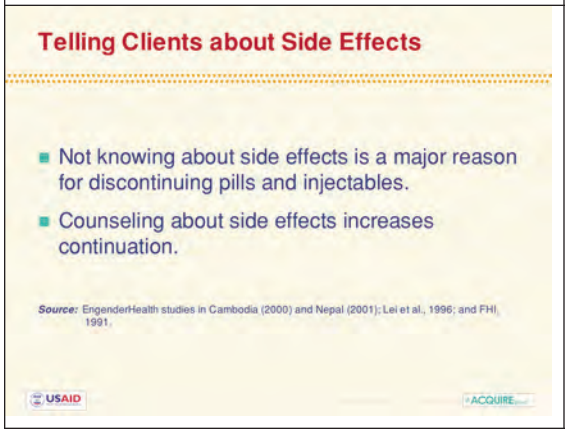
The Difference That Counseling Makes *(continued)*



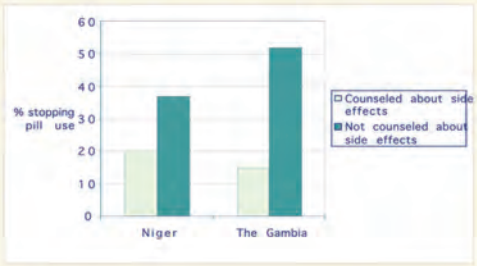






The Difference That Counseling Makes *(continued)*

Counseling for Side Effects Reduces Early Discontinuation



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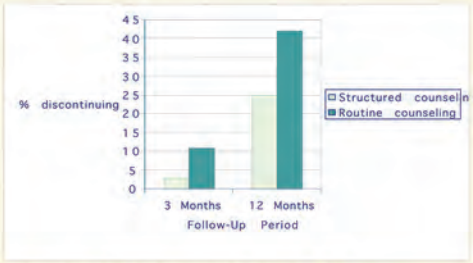
Effect of Structured Counseling* on Injectable Continuation



*Structured counseling included details on hormonal effects and side effects.

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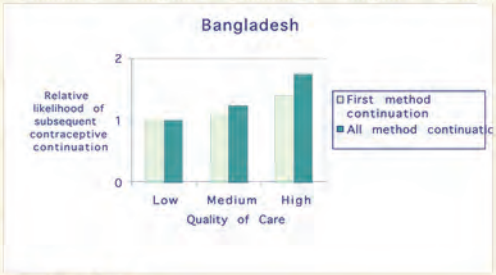
FP Continuation Increases When Providers Are Respectful, Responsive



Source: Koenig et al., 1997

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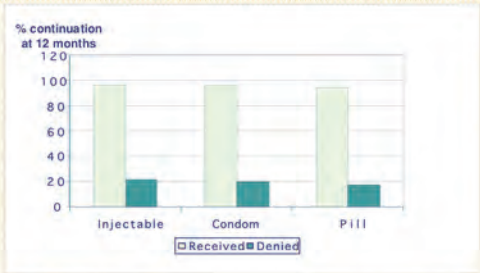
Clients Who Receive the Method They Want Are More Likely to Continue Use



Source: Pariani et al., 1991

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The Difference That Counseling Makes *(continued)*

Consequences of Poor Counseling

Effect	Outcome
Improper method use	Unwanted pregnancy
Fear and dissatisfaction with side effects	Discontinuation
Failure to recognize serious warning signs	Health risks
Dissatisfaction with services or method	▪ Dropout ▪ Poor word of mouth ▪ Low utilization

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However…

The Reality Often Falls Short of the Ideal

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Under What They Call "Counseling"…

Many providers often:

- Fail to explore clients' concerns, preferences, and informational needs
- Provide inappropriate or incomplete information or information overload
- Provide little or no preparation for side effects

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Many Providers:

- Believe they know what is best for clients
- Direct the choice of FP methods
- Lack:
  - Good communication skills
  - A client-centered approach
  - Knowledge needed for effective counseling
  - Comfort in discussing sexual and reproductive health
  - Adequate management and supervisory support
- Tell, tell, and tell …(they tend to do most of the talking)

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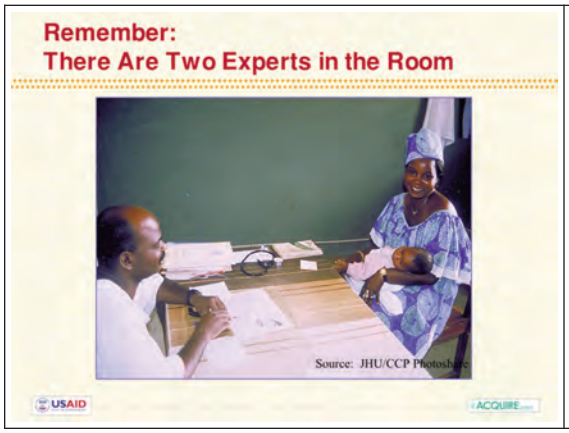
The Difference That Counseling Makes *(continued)*



HANDOUT 4A Who Are Our Clients?

By the end of this session, you should be able to:

- Identify the most common reasons why clients come for FP services
- Identify different categories of FP clients
- Explain why it is important to become familiar with each client's situation and reproductive health needs
- Identify the different information and emotional support needs of all FP clients and specific population groups (e g., men, adolescents, HIV-positive clients)

Essential Ideas—Session 4

- Providers need to quickly assess individual clients' needs so they can serve them in an efficient manner. Understanding who the client is and what his or her needs are helps the provider tailor the counseling accordingly. This reduces the provider's work, optimizes the amount of information to be given to the client, and shortens the time needed for counseling. Client-centered counseling also reduces the number of return visits and the likelihood of discontinuation of FP use that sometimes results from poor counseling, misunderstandings, or incorrect use of the chosen method.
- Most FP clients are either **return clients** who are already using a method or **new clients** who have a method in mind. Very few FP clients see a provider for assistance in choosing a method.
- Different **population groups** (e.g., men, women, adolescents, married, unmarried, HIV-positive clients) have different information and emotional support needs.
- Likewise, clients' informational and emotional support needs vary according to their **fertility plans** (wishing to delay, space, or limit their childbearing), the **timing and outcome of their last pregnancy** (e.g., postpartum, postmiscarriage, or postabortion), their **medical history and condition,** and their **individual risk for HIV and other sexually transmitted infections (STIs)**. All of these factors must be taken into consideration, and they have implications for counseling and the choices available to the client.

Increasing the Efficacy of Counseling

FP counseling curricula usually focus on helping the new client choose a FP method. This curriculum is designed to encourage you to think about FP clients more broadly and to consider their individual counseling needs. Clients can be categorized in several different ways that can facilitate your understanding of their needs and your ability to tailor counseling. For example:

- New versus returning clients
- Clients returning for resupply and/or routine follow-up versus those returning with problems
- Clients wishing to limit childbearing versus those wishing to space births

- Clients with special needs associated with a recent pregnancy (e.g., postabortion and postpartum)
- Special population groups (e.g., adolescents, men, people who are HIV-positive)

Understanding who the client is in relation to theses categories can help to guide the counselor in:

- Identifying needs and concerns
- Determining the knowledge clients have as well as any gaps in knowledge
- Ascertaining what information to elicit from the client and to impart to the client
- Providing reassurance and support
- Ensuring and instructing clients in correct method use

To facilitate good client-provider interaction, providers should rapidly assess clients' needs, tailor their counseling accordingly, and use their time efficiently. Taking these steps will allow more time for individuals who need help in choosing a method, resolving a problem, or addressing a concern.

New versus Returning Clients[1]

The traditional approach to FP counseling focuses primarily on new clients who need to choose a method, but the majority of new clients already know which method they want to use. Most returning clients come for follow-up or supplies, and most of these clients are satisfied users who have no particular problems or concerns. Some clients return with side effects or other method-related problems. These clients face different kinds of decisions when they come for services. The table below shows one way to categorize the reasons for FP clients' visits; it can be helpful in considering counseling needs.

Four Types of FP Clients and Decisions They Face		
New Client	Method in mind Decision: Is this method the best choice and can he or she use it effectively?	No method in mind Decision: Which method to use
Returning Client	Concerns about method Decision: Should he or she continue to use the method or switch to a new method?	No major concerns Decision: No decision to make

Even among new clients, most already have a method in mind. Only a small proportion need help selecting a method. For example, a study in Indonesia found that 93% of new clients had a method in mind.[2] **The provider's role in working with these clients is to ensure that they understand all aspects of their chosen method, including correct use and possible side effects.**

[1] *Adapted from:* Shelton, J., Kumar, J., and Kim, Y. 2005. Client-provider interaction: Key to successful family planning. *Global Health Technical Briefs*. Baltimore: INFO Project.

[2] Kim, Y. M., et al. 2003. Participation by clients and nurse midwives in family planning decision making in Indonesia, *Patient Education and Counseling* 50(3): 295–302.

Fertility Plans

Clients have different plans at different stages of their lives regarding having children. Those who do not have any children and wish to delay their first pregnancies can be thought of as *delayers*. Similarly, clients who have a child and want to delay their next pregnancy can be thought of as *spacers*. Clients should be encouraged to wait three years between pregnancies in order to reduce maternal and child health risks. Finally, some clients do not want any more children; they can be considered limiters. Of course, there are also clients who *want to get pregnant* right away. Family planning counseling is a good opportunity to give clients key messages about the healthy timing and spacing of pregnancies (HTSP). (For more information, see the cue card on HTSP in the Appendix A of this handbook.)

Special Population Groups

In many FP programs, services focus on married women. However, other individuals, including unmarried people, adolescents (married or unmarried), and single men, also need and have the right to access FP services, and their particular needs should be considered and addressed. Minority groups, people who do not speak the national language, refugees, and people who are HIV-positive often have needs that require special consideration and accommodation.

FP Counseling Related to a Recent Pregnancy

To achieve the healthiest pregnancy outcomes, couples should wait at least two years after a live birth and at least six months after a miscarriage or abortion before trying to become pregnant again.

Postpartum and postabortion clients have particular needs related to initiation of FP use, as well as emotional needs related to their personal circumstances (e.g., worries, stress or pain they might be experiencing). The provider should assess the best timing for FP counseling for these clients.

The ideal time to initiate counseling for **postpartum FP** is during the antenatal period. Early counseling allows sufficient time for the clients to make their decisions without the stress associated with the delivery. It also helps to ensure that clients receive their method of choice immediately after giving birth (*immediately postpartum*) should they choose postpartum intrauterine device (IUD) use or female sterilization. Counseling clients just before delivery is not appropriate. In such a case, sound decision making may be impaired by the stress the client is experiencing. With such clients, a provider has the responsibility to confirm that they are making an informed, voluntary, and sound decision. If there are signs of stress, the provider should postpone the client's counseling and decision making. The next appropriate opportunity to counsel the client is after delivery but before she leaves the facility. At this point, it may be too late to provide the client's method of choice during or at the end of the delivery, but this may help ensure that the client gets her method of choice *before discharge* or that she returns later to get it at *follow-up*. Another consideration is the types of FP methods that are appropriate at different times following delivery. For postpartum women, an important factor to consider is breastfeeding. Most methods can be used by breastfeeding women. For detailed information on FP methods and their use during the postpartum period, please refer to the method-specific FP cue cards, particularly the cue card on postpartum FP (Appendix A).

Providing FP counseling and methods also is one of the key elements of postabortion care. The provider should decide about the best timing to initiate counseling for **postabortion FP**. For postabortion clients, counseling before the procedure can only be an option if the client is not under stress related to the procedure. This allows the client to receive her method of choice immediately after the procedure (*immediate postabortion*) should she choose a postabortion IUD. However, in this case, the stress that the client is experiencing may impair sound decision making. With such clients, the provider has the responsibility to confirm that they are making an informed, voluntary, and sound decision. If there are signs of stress, the provider should postpone the client's counseling and decision making. The next appropriate opportunity to counsel such a client is after the procedure but before she leaves the facility. At this point, it may be too late to provide some methods (such as the IUD) at the end of the procedure, but this may help ensure that a client gets her method of choice *before discharge* or returns later to get it at *follow-up*. Use of any FP method can be initiated immediately postabortion. For more information on postabortion use of FP methods, see method-specific FP cue cards and the cue card on postabortion FP (Appendix A).

HANDOUT 4B

Providers' Role in Supporting Clients with Differing Needs

Cross-Cutting Needs of All Types of FP Clients

Information Need	Emotional Support Need	Provider's Role
Healthy timing and spacing of pregnancy (HTSP) Need for protection against HIV and other sexually transmitted infections (STIs) Proper use, effectiveness, associated benefits (e.g., protection from HIV and other STIs), cost, and side effects of various methods of FP Signs of possible health risks and complications]	Understanding of individual circumstances Encouragement to express needs Appreciation Trust Feeling of being welcome Confidence Reassurance about concerns, doubts Privacy, respect	Eliciting client's circumstances, medical and FP history, and preferences Listening to client's concerns and questions Providing correct information about methods and concerns Correcting misperceptions Answering any questions Validating concerns/fears Reassuring and referring as needed Giving emotional support

Clients Categorized by Reason for Visit

Type of Client	Special Information Need	Special Emotional Support Need*	Provider's Role
New client—no method in mind	Information on appropriate methods, including possible side effects, health benefits, and health risks Method-specific information once client makes a decision (see New client—method in mind)	Feeling of being welcome (X) Encouragement to express needs Appreciation (X) Trust (X)	Explore client's situation, intentions, and method preference Discuss methods suited to the client's needs Help client weigh options, considering implications of each option Provide information on how to use method, cope with side effects, and when to seek care

* *Emotional support needs* (marked with an X) represent a need that applies to all types of clients, but is more significant for that specific client type.

(continued)

Clients Categorized by Reason for Visit *(cont.)*

Type of Client	Special Information Need	Special Emotional Support Need*	Provider's Role
New client—no method in mind	Information on chosen method How to use Common side effects Warning signs of health risks and complications	Feeling of being welcome (X) Encouragement to express needs (X) Appreciation (X) Trust (X)	Explore and confirm the client's decision by ensuring that it is well considered Ascertain whether client wants to explore or consider other options Quickly review alternatives, if the client is unsure about the chosen method and/or interested in exploring other options Support client's choice Provide information to help with using the method, coping with side effects, and knowing when to seek care
Returning client—satisfied		Appreciation (X) Feeling of being welcome (X) Confidence (X)	Confirm whether or not client is using method correctly Check to be sure the client has no problems, health conditions, or concerns Provide services or supplies Ask about changes in circumstances that could affect risk for HIV and other STIs, the potential need for dual-method use, or the appropriateness of the current method
Returning client—concerns or problem	Information about side effects (causes, how long they might last, need to treat), whether the client's problem might be a sign of a complication How to manage the side effect, complication, or problem	Attentiveness to the problem Reassurance Trust (X) Encouragement to express needs (X) Flexibility in addressing the problem	Explore concerns about method and confirm correct use Help manage problems or side effects Confirm correct method use Assist the client in deciding whether to switch to another method If desired, provide or refer client for a new method of FP

* *Emotional support needs* (marked with an X) represent a need that applies to all types of clients, but is more significant for that specific client type.

Clients Categorized by Fertility Plans

Type of Client	Special Information Need	Special Emotional Support Need*	Provider's Role
Delayer	Information on long-acting methods Information on method chosen, including side effects	Reassurance about doubts, concerns Encouragement to express needs (X)	Explore client's situation, intentions, and method preference Discuss methods suited to the client's needs Help client weigh options, considering the implications of each Provide information about method use, managing side effects, and when to seek care for problems
Spacer	Information on temporary FP methods, including long-acting methods Information on method chosen, including possible side effects, health benefits, health risks, and complications	Encouragement to express needs (X)	Explore client's situation, intentions, and method preference Discuss methods suited to the client's needs Help client weigh options, considering the implications of each option Provide information on method use, how to manage side effects, and when to seek care for problems
Limiter	Information on all methods, with additional information on long-acting and permanent methods, including side effects, health benefits and health risks Information on method chosen, especially if surgical, emphasizing that it should be considered permanent and irreversible	Encouragement to express needs (X) Reassurance about concerns, doubts (X)	Explore and confirm that client's decision is well considered Discuss methods suited to the client's needs Help client weigh options, considering the implications of each Provide information on method use, how to manage side effects, and when to seek care for problems Help clients communicate, discuss, and negotiate with partner about use of the method (X)
Wanting to get pregnant	Information on how to discontinue the FP method (if the client is still using one) Information on recommended three-year spacing between pregnancies (if applicable) Information on preconception care and antenatal care	Encouragement about the client's decision Reassurance about concerns and doubts about pregnancy	Explore if the client is aware of the recommended three-year spacing between pregnancies (if applicable) Help client discontinue the method (if provider's help is needed) Provide information on preconception care and antenatal care

* *Emotional support needs* (marked with an X) represent a need that applies to all types of clients, but is more significant for that specific client type.

Clients Categorized by Population Group

Type of Client	Special Information Need	Special Emotional Support Need*	Provider's Role
Men	Concrete information on methods and reproductive physiology	Trust (X) Assertiveness from the provider (i.e., willingness to talk in a convincing way, in concrete and actionable terms)	Explore information needs Affirm appropriate behaviors Ensure knowledge of how to use FP method Do not make him feel ignorant
Unmarried adolescents	Reliable, factual information	Privacy, respect, and trust (X)	Serve as a reliable source of information Avoid being judgmental
Clients with high individual risk for STIs	Information on all methods and how they relate to individual risk for contracting STIs or are protective against STIs Information on condoms, dual protection Information on risk reduction	Privacy (X) Trust (X)	Help client weigh options, considering his or her situation Address need for protection against STIs, including dual-method use (or dual protection) as an option
Clients living with HIV	Information on all methods and how they relate to presence of HIV Information on condom use Information on risk reduction	Privacy (X) Trust (X)	Help client weigh options, considering his or her condition Address the client's need for protection against STIs, including dual-method use (or dual protection) as an option

* *Emotional support needs* (marked with an X) represent a need that applies to all types of clients, but is more significant for that specific client type.

Clients Categorized by Timing of Last Pregnancy

Type of Client	Special Information Need	Special Emotional Support Need	Provider's Role
Postabortion (or miscarriage)	Timing of return to fertility Need to wait at least six months before getting pregnant again, for HTSP Methods available for postabortion use	Understanding of physical and psychological distress	Explore underlying reasons for the miscarriage, abortion, or unwanted pregnancy (if applicable) to tailor counseling accordingly Help client understand immediate return of fertility and consequent need for FP, if pregnancy is not desired Help client weigh options (choose a method), considering her condition and situation
Postpartum	Timing of return to fertility Need to wait at least two years before getting pregnant again, for HTSP Issues related to FP use and breastfeeding Methods available for use in the postpartum period Effect of FP methods on baby and breast milk	Understanding of physical and psychological distress Reassurance about concerns, doubts	Help client understand the relationship between breastfeeding and contraception, including the lactational amenorrhea method (LAM) as an option for FP Help client weigh options (choose a method) considering her condition and situation
Interval	See ***Clients Categorized by Reason for Visit***		

HANDOUT 5 Factors Influencing Client Decisions

By the end of this session, you should be able to:

- Describe factors that influence clients' FP decisions, including other RH considerations, and their effects on counseling
- Explain how the characteristics of different contraceptive methods may affect clients' FP decisions
- Describe different FP needs that the client may have at different stages in life

Essential Ideas—Session 5

- Counseling requires focusing on the circumstances, values, and needs that affect the client's decisions about fertility. Although individuals make their own choices, counselors must be aware that a client's choices may be influenced by his or her spouse, family relationships, and/or community.
- **If the client wishes**, the client's partner should be included in the decision about contraception and in part of the counseling session because the use of contraception affects them both. Partners might be more supportive of contraceptive use if they are informed and involved in discussions early on. But in every case, each client should have some time alone with the counselor.
- Clients have different reproductive goals at different times in their lives. There is no right or wrong sequence or path for clients to take. The provider should learn about the client's current and planned reproductive intentions, because some methods might be more appropriate than others in helping the client achieve his or her current goals. The provider should tell the client about the healthy timing and spacing of pregnancy (HTSP) and, when appropriate, indicate that contraceptive methods and procedures like tubal ligation and vasectomy can also be used to limit the number of children, if one's desired family size has been achieved.
- For a client to use contraception consistently and to be reasonably satisfied with the method chosen, the method must be compatible with the client's lifestyle, including his or her sexual relationships and behaviors.
- **Individual factors** that might influence decision making include the age, number, and gender of the client's children; the client's health status; the client's risk for STIs and HIV; the client's socioeconomic and education background; previous contraceptive use and experiences; nature of the client's relationship(s) with partner(s) (including existence of sexual coercion or abuse); the client's sexual life; and religious and personal beliefs.
- **Service factors** include provider attitudes, knowledge, and skills; quality of counseling; availability of FP methods and information, education, and communication (IEC) materials; accessibility of service; and supervision to ensure that all of these elements are in place and working well.
- **Community influences** can have a major impact on the clients' knowledge and choice of FP method. Word of mouth and gossip play an important role and sometimes reflect misinformation, cultural norms, religion, politics, societal pressures, legal issues/considerations, and gender roles.

(continued)

Essential Ideas—Session 5 *(cont.)*

- In offering FP and reproductive health services, providers must be sensitive to the possibility that clients have needs beyond those they initially identify as the reason for their visit. Nothing that affects a client's reproductive health happens in isolation. For example, issues like HIV status and being immediately postpartum must be considered when choosing a FP method.
- **Method characteristics** include factors such as whether the method is provider controlled, partner controlled, or user controlled, whether it requires partner cooperation, whether it requires application/use with every instance of sexual relations, common side effects, and whether it offers dual protection from STIs (including HIV) and from pregnancy.

Contraceptive Methods and Sexual Practices

People use contraception because they are sexually active or plan to be. Clients' use of and satisfaction with contraceptive methods are often related to the real or perceived effect of contraceptives on their sexual practices and enjoyment.

Clients must think about which FP methods will meet their needs and which ones might cause problems for them. If problems occur, they might lead to discontinuation or incorrect and/or irregular use of the method. For example:

- If spontaneity is important, methods that are tied directly to intercourse, such as condoms or other barrier methods might not work as well.
- Women considering hormonal methods or the IUD should think about whether menstrual changes will cause problems for them or their partners.
- For some, frequency of sexual relations will be a factor in choosing contraceptives. Individuals who have sex occasionally or infrequently might prefer a method that can be used as needed, such as condoms, rather than a method like the pill that requires doing something every day.
- Clients with multiple partners should consider their need for both FP and protection from HIV and other STIs. Individuals with more than one partner have a higher risk for STIs and might want to consider dual-method use (using one method for contraception and one method for STI protection) or condoms alone for both purposes (keeping in mind that condoms are a less effective FP method).
- For clients whose partners will not cooperate with FP use, methods like condoms and natural family planning might not be ideal choices.
- Clients who need to conceal their sexual activities (e.g., unmarried adolescents) or their use of contraception (e.g., clients whose partners do not approve) might want to consider methods that do not require obtaining supplies or daily use.

More effective methods give some people a greater sense of security; without the fear of pregnancy, these people might enjoy sex more.

- Whether a client is at risk for or has HIV or another STI might affect the type of contraception he or she uses.
- Clients who strongly associate fertility with their sexuality or self-esteem might not be comfortable with permanent methods.

HANDOUT 6 Bringing in the Client Perspective

By the end of this session, you should be able to:

- Develop client profiles that reflect the range of clients who might seek FP services[1]
- Identify decisions that clients have to make and the information they need to make those decisions
- Identify the emotions that clients experience

Essential Ideas—Session 6

- The client profiles developed in this session will be used throughout the workshop as part of exercises, case studies, and role plays. Instead of using ready-made case studies, you will develop the client profiles to make them as realistic and relevant as possible to the range of clients and problems you see at your workplace.
- The second use of client profiles is for reflecting on the feelings, thoughts, and impressions of the portrayed clients as part of a structured exercise. This exercise will help you empathize with those clients and puts the client perspective at the center of the workshop.

[1] The client profiles are descriptions of typical clients; they are used throughout the training for role plays and reflections on the client perspective.

HANDOUT 7 Providers' Beliefs and Attitudes

By the end of this session, you should be able to:

- Explain how providers' beliefs and attitudes can affect their interactions with clients, both positively and negatively
- Explain the importance of being aware of our own beliefs and attitudes so we can avoid imposing them on clients or having them become barriers to communication

Essential Ideas—Session 7

- *Beliefs* are concepts and ideas that are accepted and thought to be true.
- Our beliefs shape our attitudes and thus the way we think about and act toward people and ideas. Our beliefs and attitudes are often so ingrained that we are unaware of them until we confront a situation that challenges them.
- How we communicate our beliefs and attitudes (both verbally and nonverbally) is an important part of our interactions with clients. Every interaction between a client and health care staff, from the moment he or she enters the health care setting until he or she leaves, affects the client's willingness to trust and share personal information and concerns, ability to listen and retain important information, capacity to make decisions that appropriately address his or her situation and meet his or her needs, and ability to commit to appropriate use of FP, follow treatment regimens, or implement new health behaviors.
- Everyone has a right to his or her own beliefs. However, as service providers, we have a professional obligation to provide health care and to do so in a respectful and nonjudgmental manner. Being aware of our beliefs and how they may affect others—both positively and negatively—will help us to do that.

Beliefs and Attitudes in FP Counseling

Beliefs are important to individuals. They help us to explain how things work in the world, what is right, and what is wrong. They usually reflect our values, which are influenced by religion, education, culture, and family and personal experiences.

Our beliefs and values shape our **attitudes** and the way that we think about and act toward people and ideas. Each interaction between clients and health care staff is influenced by the attitudes of both the client and the provider. Every interaction that a client has with a health care worker—from the time he or she enters the health care system until he or she leaves—affects the client's satisfaction with his or her care, how well he or she carries out decisions made during the counseling session, and whether he or she comes back for follow-up if problems arise.

How we communicate our own beliefs, values, and attitudes (both verbally and nonverbally) is an important part of our interactions with clients. Our beliefs often are so ingrained that we are unaware of them until we confront a situation that challenges them.

Our beliefs, attitudes, and values might affect how we treat clients and respond to their problems, needs, and concerns. For example, our private reaction to the client's appearance, social class, or reason for seeking health care might determine the gentleness or harshness with which we treat them, how soon we serve them, and whether we consider their full range of health care needs. Being aware of our values and attitudes can help us be more tolerant of those whose values differ from our own by helping us separate our personal beliefs and attitudes from theirs. Effective counselors are able to overcome their biases and provide services in a nonjudgmental manner for all types of clients. When the counselor's beliefs make him or her uncomfortable talking about a particular FP method or SRH issue with clients, he or she should refer the client to another service provider and try to overcome the discomfort by learning more about the issue.

Part II:

Building Communication and Counseling Skills

Part II introduces the REDI framework for FP counseling, and helps you build communication and counseling skills to carry out effective FP counseling.

Good counseling requires good communication skills. Counselors need the ability to establish rapport, elicit information, and provide information effectively in order to support clients' informed and voluntary decision making. To effectively assess clients' needs, providers must couple open-ended questions that encourage clients to talk about themselves with active listening skills and effective paraphrasing to ensure comprehension. To give appropriate information, providers must be able to effectively communicate their knowledge about RH/FP issues. They must have the ability to explain things in language and terms that the client understands (with or without the help of visual aids), and they must be comfortable talking about issues related to sexuality.

The sessions on counseling skills are organized by tasks that you are expected to accomplish in a counseling session. For each counseling task, the sessions first cover the theory behind the task and then use the client profiles created in Part I to give participants the opportunity to practice the skills and receive feedback. The Learning Guides for FP Counseling Skills introduced in Session 8 provide guidance throughout the training on how you are expected to perform the counseling tasks.

HANDOUT 8 Introduction to the REDI Framework

By the end of this session, you should be able to:

- Explain the importance of addressing clients' social context when assisting them in making decisions about FP
- Describe how counseling supports clients' informed and voluntary decision making
- Explain the importance of using a counseling framework flexibly
- Describe REDI, a framework for FP counseling
- Identify similarities and differences between REDI and GATHER (if optional activity involving GATHER is used in the session)

Essential Ideas—Session 8

- REDI stands for **rapport building, exploration, decision making,** and **implementing the decision.** The REDI framework:
  - Emphasizes the client's right and responsibility for making decisions and carrying them out
  - Provides guidelines to help the counselor and client consider the client's circumstances and social context
  - Identifies the challenges a client may face in carrying out their decision
  - Helps clients build skills to address those challenges
- A framework is an aid—a means to an end, not the end in itself. Counseling should be client centered. The REDI framework provides a structure and guidance for talking with clients, so that providers do not miss important steps in the counseling process. However, too often providers focus more on following the steps than on listening to the client and responding to what he or she is saying. The bottom line in counseling is to understand what the client needs and then help him or her meet those needs as efficiently as possible.
- No matter which framework is used for counseling, it is important to personalize counseling sessions by exploring each client's individual situation, as opposed to talking generally about family planning methods or transmission and prevention of STIs. By personalizing the discussion and applying it to the client's specific situation, you can help clients better understand their own risks so that they do not think of unintended pregnancy and HIV and AIDS as "things that happen to other people."
- Understanding and exploring the social context of decisions is critical in helping clients accurately assess their risks of pregnancy and HIV and other STIs and make well-considered, appropriate decisions. Social context encompasses the people (partners, family members, and friends) and the factors that influence a client's decisions, including the client's power to make autonomous decisions about sexual intercourse and about reproduction. Consideration of the client's social context also includes anticipating the ramifications of decisions for the client's social network (e.g., whether suggesting condom use to one's husband could lead to violence and/or marital problems).

(continued)

Essential Ideas—Session 8 *(cont.)*

- The REDI framework moves away from traditional FP counseling that relies on routinely giving detailed information about every FP method. It avoids overloading clients with unnecessary information and instead emphasizes the client's preferences, individual circumstances, and sexual relationships and knowledge. In this way, the provider can help clients narrow down their FP method choices more quickly and better tailor the information to clients' needs. This not only saves time, it also meets clients' needs more effectively.
- REDI provides a useful framework but does not need to be followed in a scripted or strict manner during a counseling session. REDI is merely a suggested guide for the steps and topics to cover while the provider and client engage in an interactive discussion of the client's needs, desires, and risks.
- This framework fosters informed and voluntary decision making based on understanding one's situation and the risks of pregnancy and contracting STIs; and it considers the options available for spacing or limiting childbearing.
- The REDI framework helps address the differing needs of clients: those who are new and have already chosen a method and those who have not, and those who are returning clients, whether they are experiencing problems or changes in personal circumstances or are merely visiting the facility for a resupply of contraceptives.

PHASES AND STEPS OF REDI

Phase 1: Rapport Building

1. Greet client with respect

2. Make introductions (identify category of the client—i.e., new, satisfied return, or dissatisfied return)

3. Assure confidentiality and privacy

4. Explain the need to discuss sensitive and personal issues

Phase 2: Exploration

1. Explore in depth the client's reason for the visit

(This information will help determine the client's counseling needs and the focus of the counseling session.)

FOR NEW CLIENTS:

2. Explore client's future RH-related plans, current situation, and past experience

a. Explore client's reproductive history and goals, while explaining healthy timing and spacing of pregnancy (HTSP)

b. Explore client's social context, circumstances, and relationships

c. Explore issues related to sexuality

d. Explore client's history of STIs, including HIV

e. Explain STI risk and dual protection, and help the client perceive his or her risk for contracting and transmitting STIs

3. Focus your discussion on the method(s) of interest to client: discuss the client's preferred method, if any, or relevant FP options if no method is preferred, give information as needed, and correct misconceptions

4. Rule out pregnancy and explore factors related to monthly bleeding, any recent pregnancy and medical conditions

FOR RETURNING CLIENTS:

2. Explore the client's satisfaction with the current method used

3. Confirm correct method use

4. Ask the client about changes in his or her life (i.e., plans about having children, STI risk and status, and so on)

For dissatisfied clients only: explore the reasons for the client's dissatisfaction or the problems, including the issue, causes, and possible solutions such as switching methods as well as other options *(if the client decides to switch methods, continue with Phase 3, Steps 2–5)*

Phase 3: Decision Making

1. Identify the decisions the client needs to confirm or make
(for satisfied clients, check if client needs other services; if not, go to Phase 4, Step 5)

2. Explore relevant options for each decision

3. Help the client weigh the benefits, disadvantages, and consequences of each option (provide information to fill any remaining knowledge gaps)

4. Encourage the client to make his or her own decision

Phase 4: Implementing the Decision

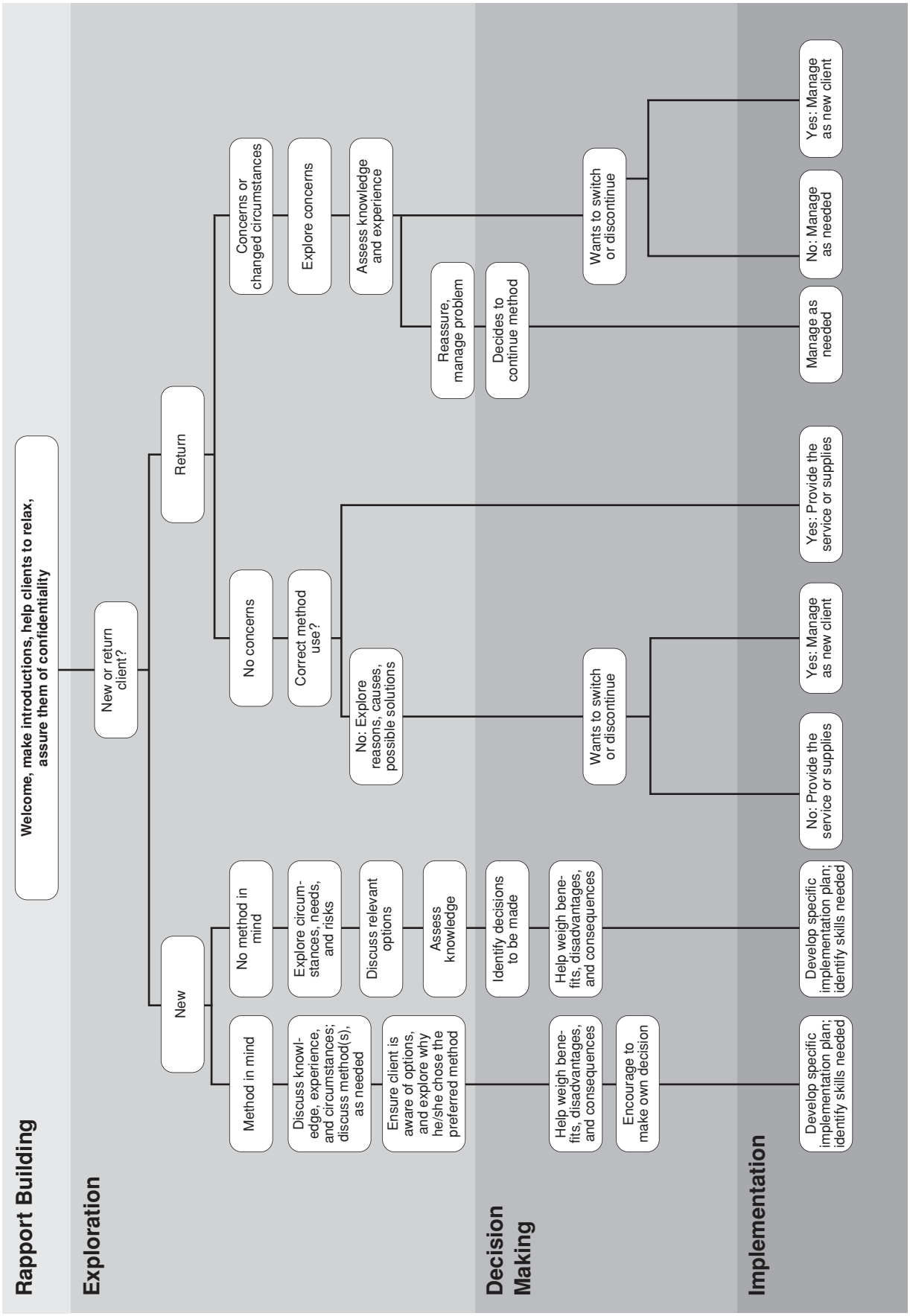
1. Assist the client in making a concrete and specific plan for carrying out the decision(s) (obtaining and using the FP method chosen, risk reduction for STIs, dual protection, and so on)

2. Have the client develop skills to use his or her chosen method and condoms

3. Identify barriers that the client might face in implementing his or her decision

4. Develop strategies to overcome the barriers

5. Make a plan for follow-up and/or provide referrals as needed


REDI Algorithms
Rapport Building
Welcome, make introductions, help clients to relax, assure them of confidentiality
Exploration
New or return client?
New
Method in mind
Discuss knowledge, experience, and circumstances; discuss method(s), as needed
Ensure client is aware of options, and explore why he/she chose the preferred method
No method in mind
Explore circumstances, needs, and risks
Discuss relevant options
Assess knowledge
Return
No concerns
Correct method use?
No: Explore reasons, causes, possible solutions
Concerns or changed circumstances
Explore concerns
Assess knowledge and experience
Reassure, manage problem
Decision Making
Identify decisions to be made
Help weigh benefits, disadvantages, and consequences
Encourage to make own decision
Wants to switch or discontinue
Yes: Provide the service or supplies
Decides to continue method
Manage as needed
Implementation
Develop specific implementation plan; identify skills needed
Develop specific implementation plan; identify skills needed
Wants to switch or discontinue
No: Provide the service or supplies
Yes: Manage as new client
Yes: Provide the service or supplies
Wants to switch or discontinue
No: Manage as needed
Yes: Manage as new client

HANDOUT 9 Sexuality

By the end of this session, you should be able to:

- Define the terms sex and *sexuality*
- Explain how sexual preferences and practices relate to the choice and use of FP methods
- Identify their personal biases and attitudes about various sexual behaviors
- Recognize that there are differences in perspectives on sexual behavior, including differences in what is considered normal or acceptable
- Explain why it is important to be nonjudgmental about sexual behaviors when counseling clients

Essential Ideas—Session 9

- Sexuality can have an influence on clients' choice of FP methods and continued use of the method they choose.
- Discussing sexuality might reveal underlying issues and concerns that affect clients' FP needs and decisions. Sexuality is closely related to one's individual risk for contracting STIs and ways of reducing that risk.
- Discussing sexuality can improve the overall quality of care by fostering comfort and trust between clients and providers.
- Providers often shy away from discussions of sexuality because of their own discomfort or because they fear that such discussions might be culturally inappropriate or offensive to clients.
- The provider is responsible for being comfortable with introducing the subject of sexuality and helping clients feel comfortable enough to respond to questions concerning their sexual behavior. The provider should not question or judge sexual behaviors or practices. Rather, providers should recognize the behaviors that clients might engage in and help clients' consider those behaviors when they are making decisions about FP.

Sexuality

Sexuality is an expression of who we are as human beings. Sexuality includes all of the feelings, thoughts, and behaviors related to being male or female, to being attractive and being in love, and to being in relationships that include intimacy and physical sexual activity.

Sexuality begins before birth and lasts throughout a person's life. Our sexuality is shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, religion, and all of the ways in which we have been socialized. Consequently, the ways in which an individual expresses his or her sexuality are influenced by ethical, spiritual, cultural, and moral factors.

Sexuality:

- Is an expression of who we are
- Involves the mind and the body
- Is shaped by our values, attitudes, behaviors, physical appearance, beliefs, emotions, personality, likes and dislikes, and the ways we have been socialized
- Is influenced by social norms, culture, and religion
- Involves giving and receiving sexual pleasure as well as enabling human reproduction
- Spans our lifetimes

Sexuality includes:

Sex

- The biological characteristics that make us male or female (anatomical, physiological, and genetic)
- Sexual activity, including sexual intercourse

Gender

- Gender: how an individual or society defines being female or male
- Gender roles: socially and culturally defined attitudes, behaviors, expectations, and responsibilities attributed to males and females
- Gender identity: the personal, private conviction each of us has about being male or female

Aspects of Sexuality

1. ***Sensuality*** is how our bodies derive pleasure. It is the part of our experience that deals with the five *senses*: touch, sight, hearing, smell, and taste. Any of these senses, when enjoyed, can be "sensual." Sensuality is also part of the sexual response cycle; it is the mechanism that enables us to enjoy and respond to sexual pleasure.

   Body image also is a part of sensuality. Feeling attractive and proud of one's body influences many aspects of life.

   The desire to be touched, held, or caressed is an essential aspect of healthy development because it is about appreciating one's body and understanding how it functions. Puberty and adolescence are critical stages in the development of sexuality, and during this time young people often develop strong pleasurable feelings about other people whom they may or may not know—for example, pop stars, celebrities, or peers. The desire to hug, kiss, or be physically intimate with others is an important step in young people's sexual development. This does not mean that young people act out such desires continually or that they should be encouraged to do so, but experiencing such emotions and desires is part of healthy sexual development.

2. ***Intimacy*** is the part of sexuality that deals with the emotional aspect of *relationships*. Our ability to love, trust, and care for others is based on our experience of intimacy. We learn about intimacy from our relationships with those around us, particularly relationships within our families.

   Emotional risk taking is part of intimacy. To be truly intimate with others, a person must open up and share feelings and personal information. We take a risk when we do this, but intimacy is not possible otherwise.

3. Every individual has his or her own personal ***sexual identity***. Sexual identity has four main components:
   - *Biological sex* is our physical status of being either male or female.
   - *Gender identity* is how we feel about being male or female. Gender identity starts to form at about age 2, when a little boy or girl realizes that he or she is different from people of the opposite sex.
   - *Gender roles* are the behaviors that society expects us to exhibit that are associated with our biological sex. What behaviors do we expect of men and what behaviors do we expect of women? And when did we learn to expect these behaviors? These sets of behaviors are gender roles, and they begin to form very early in life.
   - *Sexual orientation* is the final element of sexual identity. Sexual orientation refers to the biological sex to which we are sexually and romantically attracted. Our orientation can be heterosexual (attracted to the opposite sex), bisexual (attracted to both sexes), or homosexual (attracted to the same sex). People often confuse sexual orientation and gender roles. For example, if a man is very feminine or a woman is very masculine, people often assume that these individuals are homosexual. However, they actually are expressing different gender roles: Their masculine or feminine behavior has nothing to do with their sexual orientation. A homosexual man may be very feminine, very masculine, or neither; the same applies to heterosexual men. Also, a person may engage in same-sex sexual behavior and yet not consider himself or herself homosexual.

4. ***Sexual health*** is the integration of the physical, emotional, intellectual, and social aspects of being sexual in ways that enrich and enhance us—our personality, communication, and love. It involves our behavior related to producing children, enjoying sexual relationships, and maintaining our sexual and reproductive organs. Issues like sexual intercourse, pregnancy, and STIs are part of our sexual health. Sexual health also refers to the rights to exercise control over one's sexuality free of coercion or violence and to receive information about sex.

Power Imbalances and Sex

Unfortunately, sometimes power is used to force someone to engage in sex when they do not want to. This is not healthy and is often penalized by laws. Sometimes people misuse their power to manipulate or sexually violate someone. Rape is a clear example of the abuse of power to force someone to engage in sex. It is against human rights and outlawed in almost all countries. Sexual abuse and prostitution are other examples of the use of power to control others.

How Sexuality Relates to FP Counseling

(Why is it important to address sexuality as a part of FP counseling?)

- Pregnancy is one possible outcome of sexual activity; STIs are another.
- Sexuality and sexual practices can have implications for a client's decisions about contraceptive method use and STI risk reduction.
- People might stop using a contraceptive method if they perceive it as interfering with the sexual act or decreasing their sexual pleasure.
- Clients might feel reluctant to try a certain method (e.g., vasectomy or condoms) out of fear that it will affect sexual pleasure or response (for themselves, their partner, or both).
- Clients might have underlying concerns about sexuality that are the real reason for a facility visit or that are more important than the stated reason for their visit.
- A client's needs might be related to sexual abuse or coercion, rape, or incest—issues that need to be addressed in order to provide effective services.
- Discussing STI prevention must include discussing the specific sexual practices that place a person at risk as well as sexual practices that are safer.
- Taking sexuality into consideration during counseling might help improve client satisfaction with services and thus help to attract new clients and retain them.
- Exploring clients' sexuality—rather than making assumptions about it—enables providers to better tailor counseling to clients' circumstances (e.g., frequency of sex, number of partners, ability to discuss/negotiate with the partner, and so on).

HANDOUT 10A Ensuring Optimal Communication

By the end of this session, you should be able to:

Section I: Respect for Clients

- Explain the importance of showing respect for clients
- Describe at least two ways of showing respect for clients

Section II: Praise and Encouragement

- Explain how praise and encouragement can help to build rapport between providers and clients

Section III: Nonverbal Communication

- Describe nonverbal behaviors (such as gestures and body language) and explain how they can affect the client-provider interaction during counseling
- Demonstrate the effect of tone of voice on communication

Section IV: Eliciting Information

- Describe two types of questions to use when attempting to elicit information from clients
- Explain the use and importance of open-ended (and feeling/opinion) questions in assessing clients' needs and knowledge
- Demonstrate how to convert closed-ended questions into open-ended questions

Section V: Listening and Paraphrasing

- Describe at least two purposes of listening as a key communication skill for counseling
- List at least three indicators of active listening
- Name at least two purposes of paraphrasing during counseling
- Demonstrate paraphrasing

Section VI: Challenging Moments in Counseling

- Describe the appropriate provider attitudes when faced with challenging moments in counseling

Session 10

HANDOUT 10B Praise and Encouragement

Essential Ideas—Session 10 (Section I: Praise and Encouragement)

- Praise and encouragement are more effective than scolding or arguing in helping clients to acknowledge and solve their problems.
- Clients need praise and encouragement, but above all they need respect. Giving genuine praise and encouragement to clients will show them that you respect their efforts deal with health problems, no matter how misguided or uninformed those efforts may be.
- You can help build clients' self-confidence by treating them like responsible adults. That too can be reflected in praise and encouragement.

Praise

Praise is the expression of approval or admiration. Praising reinforces good behavior by identifying and supporting the good things a client has done. For example, praising clients:

- Shows that you respect their concern for their health
- Acknowledges difficulties they might have overcome to come to the health care facility
- Expresses approval for positive choices and actions

Encouragement

Encouragement means giving support, courage, confidence, and hope. In the health care setting, giving encouragement means letting clients or patients know that you believe they can overcome their problems and helping them find ways to do so. For example, encouraging clients:

- Points out hopeful possibilities
- Focuses on what is good about what they have done and urges them to continue
- Tells them that they are already helping themselves by coming to the health facility

See Handout 10-C for more examples.

Adapted from: Tabbutt, J. 1995. *Strengthening communication skills for women's health: A training guide*. New York: Family Care International.

HANDOUT 10C

Examples of Using Praise and Encouragement

Client's Situation and Statement	Provider's response
Woman who comes late for an injection of Depo-Provera: "I wanted to come for my injection before now, but I couldn't find anyone to look after my children."	"I know that can be difficult. It is good that you made the effort to come now."
Woman who comes to the health care facility with a side effect: "I hope you can help me—my mother-in-law did not think it was necessary for me to come."	"It must have been difficult for you to decide to come to the clinic. It is good that you came now. Let's see what we can do to help you."
Parent of adolescent: "My teenage daughter has been sleeping with her boyfriend because of pills she got from this health center!"	"I can understand your concern, and I'm glad you came to discuss this."
Adolescent: "I've been using the pill, but I forgot a couple and now my period is late."	"You might be worried and it's good that you came to the clinic. I'll help you to determine whether you are at risk for pregnancy and whether you might be pregnant."

Session 10

HANDOUT 10D Nonverbal Communication

Essential Ideas—Session 10 (Section II: Nonverbal Communication)

- When we talk, the three key aspects of that communication—actual words, body language (i.e., the movements of our body and our gestures), and tone of voice—have varying effects on the person(s) with whom we are interacting. U.S. research conducted in the 1970s showed that 55% of the impact of verbal communication was in one's body language, 38% was in one's tone of voice, and just 7% was in the actual words used.[1] Such nonverbal signals or cues can communicate to clients our interest, attention, warmth, and understanding. Nonverbal communication has the greatest impact on what clients hear and perceive during counseling and on other client-provider interaction.
- A good relationship with a client is based not only on what the client hears but also on what she or he observes and senses about the counselor.
- Nonverbal cues vary from culture to culture and sometimes among different groups within a culture (e.g., men and women and adolescents and adults might show different nonverbal patterns). The same nonverbal cue (e.g., a smile) might have different meanings in different cultures and even within different population groups in the same culture.

Positive Nonverbal Cues

- Leaning towards the client
- Smiling (in a way that is culturally appropriate); not showing tension
- Avoiding nervous or inappropriate mannerisms
- Presenting facial expressions that inspire trust
- Maintaining eye contact with the client
- Making encouraging gestures, such as nodding one's head

Negative Nonverbal Cues

- Reading from a chart
- Glancing at one's watch
- Yawning or looking at papers or out of the window
- Frowning
- Fidgeting
- Not maintaining eye contact

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[1] This information is taken from work by Albert Mehrabian that was published in 1971 (Mehrabian, A. 1971. *Silent messages*. Wadsworth, CA: Belmont). Of course, these percentages relate to interpersonal communication; they cannot be generalized to all types of communication (e.g., e-mail, communication in a different language, etc.). However, they do help to provide a more general understanding about the nonverbal aspects of communication. (See http://changingminds.org/explanations/behaviors/body_language/mehrabian.htm for more information.)

HANDOUT 10E Asking Questions during Counseling

Essential Ideas—Session 10 (Section III: Asking Questions)

- Asking questions enables providers to accurately assess a client's FP and SRH needs and knowledge early in the counseling session and to involve the client actively throughout the session. Questions should be used not only for eliciting information or facts about the client's life but also for exploring the client's feelings and opinions. Asking about the client's feelings helps the provider assess and address the client's needs for emotional support as well as other needs.
- Two categories of questions can be used to elicit different kinds of answers: *Closed-ended* questions usually elicit only a very short response, often just one word, which is not as helpful to the provider. *Open-ended* questions encourage longer, more detailed responses that might include the client's opinion or feelings.
- **Closed-ended questions** usually will be answered by a very short response, often just one word. A closed question calls for a brief, exact reply, such as yes or no or a number. Closed questions are valuable for quickly getting basic information about the client's background, condition, and medical history.
- **Open-ended questions** are useful for exploring the opinions and feelings of the client, and they usually call for longer responses. These questions are effective in determining what the client needs (in terms of information or concerns to be addressed) and what he or she already knows.
- Closed-ended questions can be used to ask about feelings, but they usually provide limited insight. For example, the closed question might be "Do you feel okay?", and the answer might be "No." You have to keep asking questions to find out what's going on.
- Similarly, some open-ended questions might get very short answers. For example, the question "What do you know about sexually transmitted infections?" might elicit the response "Nothing." But in general, open-ended questions are more likely than closed-ended questions to encourage the client to talk.
- Both types of questions have an important role to play in FP counseling. However, providers historically have relied much too heavily on closed-ended questions and have missed a lot of information that clients wanted to share but were never asked. Although we do not want to eliminate closed-ended questions, we do want to increase the use of open-ended questions, which can more effectively elicit feelings or opinions, in order to better assess the client's informational and emotional needs and concerns. In addition, encouraging clients to ask questions can often lead to additional information that will help the provider tailor the counseling session.

Adapted from: Tabbutt, J. 1995. *Strengthening communication skills for women's health: A training guide*. New York: Family Care International.

Why Do We Ask Questions during FP Counseling?

- To assess the client's FP needs and knowledge
- To learn about the client's medical status, previous contraceptive use, personal circumstances, preferences, and concerns
- To actively engage the client and elicit information about his or her needs, concerns, and preferences
- To establish a good relationship by showing concern and interest
- To prioritize the key issues to target during the time available for counseling
- To determine the educational or language level that will be best understood by the client
- To avoid repeating information that the client already knows
- To identify areas of misinformation that need to be corrected

Types of Questions

Closed-ended questions usually will be answered by a very short response, often just one word. A closed-ended question calls for a brief, exact reply, such as "yes," "no," or a number. These are good questions for quickly gathering important medical and background information. For example:

- How old are you?
- How many children do you have?
- Do you have a method in mind?
- Are you confident that you can remember to take a pill every day?
- Is your house far from this clinic?
- When was your last menstrual period?
- Are you currently using an FP method?

Open-ended questions are useful for exploring more in-depth information as well as the client's opinions and feelings. They usually require longer responses and so are more effective in determining what the client needs (in terms of information and emotional support) and what he or she already knows. Such questions often start with the words "How," "What," or "Why." However, one has to be very careful, especially when using a "why" question, which might sound confrontational and intimidating, as though you are questioning or doubting client. "Why" questions can be softened by using phrases like "What are your reasons for . . .", "What made you . . . ", "Can you tell me why . . . ", and "Can you tell me the reasons why . . . ".

Examples of open-ended question include:

- How can we help you today?
- What do you like about the method you want to use?
- What have you heard about the method?
- How would you feel if you experienced changes in your monthly bleeding?
- What do you think could have caused this problem?

- What did you do when you had this problem before?
- What have you heard about this FP method?
- What questions or concerns does your husband/partner have about using FP?
- What do you plan to do to protect yourself from getting a sexually transmitted infection again?
- What made you decide to use the same method as your sister?
- Why do you want to change methods? *(Better: Can you tell me why you want to change methods?)*
- Why did you stop using your last method? *(Better: What made you stop using your last method?)*
- How do you remember to take your pill every day?
- What do you do if you forget a pill? What if you forget to take more than one pill?

HANDOUT 10F Listening and Paraphrasing

Essential Ideas—Session 10 (Section IV: Listening and Paraphrasing)

- *Active listening* is a primary tool for showing respect and establishing rapport with clients. If a provider does not listen well, a client might assume that his or her situation is not important to the provider, or that he or she as an individual is not important to the provider. Developing the trust needed for good counseling will be more difficult if the provider is not listening effectively.
- Active listening is also a key communication skill for counseling. It is important for most efficiently determining what the client needs, what the client's real concerns are, and what the client already knows about his or her situation and options.
- *Paraphrasing*, *reflecting*, and *clarification* are techniques used to enhance active listening. ***Paraphrasing*** means restating the client's message simply and in your own words. ***Reflecting*** is recognizing and interpreting the client's feelings and integrating what has been said into further discussion. ***Clarification*** is asking questions to better understand what the client has said. These techniques convey to the client that the provider is listening to what she or he is saying, help the provider understand what the client has said, and encourage the client to continue talking.
- Clients should be encouraged to ask questions during counseling. The questions a client asks can provide additional information about his or her needs, knowledge, and concerns.

Tips for Active Listening

- Establish and maintain eye contact.
- Demonstrate interest by nodding, leaning toward the client, and smiling.
- Sit comfortably and avoid distracting movements.
- Pay attention to the client (e.g., do not engage in other tasks while you are meeting with the client, do not talk to other people, do not interrupt the client, and do not allow others to interrupt).
- Listen to the client carefully. Do not become distracted and think about other things or about what you are going to say next.
- Listen both to *what* your clients say and to *how* they say it, and make note of tone of voice, choice of words, facial expressions, and gestures.
- Imagine yourself in your client's situation as you listen.
- Allow for pauses of silence at times during your interaction so that the client has time to think, ask questions, and talk.
- Encourage the client to ask questions.
- Encourage the client to continue talking by using expressions like "yes," "hmm," and "and then what?"
- Repeat what the client has said. (Note, however, that exact repetition of what the client has said should be used sparingly. Instead, counselors should use paraphrasing or reflecting, as discussed below.)

- Paraphrase (state in your own words) what the client has said.
- Note and reflect the client's feelings—that is, try to understand the feelings and emotions behind what the client is saying, and integrate this information into further discussions.

Paraphrasing is restating what the speaker has said in your own words in order to demonstrate attention and understanding, and to encourage the speaker to continue.

Paraphrasing Guidelines

❏ Listen to the speaker's basic message.

❏ Give the speaker a simple summary of what you believe is the message. Do not add any new ideas.

❏ Observe the client's response and use it as a cue that confirms or denies the accuracy of your paraphrasing, or ask that the client to let you know whether you have correctly understood what he or she has said.

❏ Do not restate negative statements that people might have made about themselves in a way that confirms this perception. If someone says, "I really acted foolishly in this situation," it is not appropriate to say, "So, you feel foolish." Instead, you can try to understand the situation better by asking questions.

❏ Do not overuse paraphrasing. Paraphrasing is best used when the speaker hesitates or stops speaking.

❏ Your objective is to encourage the person to continue speaking, so interrupting him or her will be counterproductive.

Reflecting means identifying and interpreting the feelings and emotions behind what is being said, and integrating this information into further discussion: It is similar to paraphrasing, but it also includes recognition and interpretation of what the client feels or thinks (see examples below).

Clarification is asking questions in order to better understand what the speaker has said. Clarification is similar to paraphrasing, but the purpose is to ensure understanding rather than to motivate the speaker to continue speaking.

Examples of Paraphrasing and Reflecting Statements

("C" stands for client's statement; "P" stands for the provider's possible response)

C: "They say that the IUD causes pain in the abdomen."

P (*paraphrasing*): "You heard that IUD causes pain in the abdomen?"

P (*reflecting*): "You mean, you are concerned about the IUD because of possible side effects?"

C: "Yes doctor, the pill worked very well for me."

P (*paraphrasing*): "So it worked well for you?"

P (*reflecting*): "So you are satisfied with the pill?"

C: "My husband will get angry if he hears that I've come to the clinic."

P (*paraphrasing*): "Will he get angry if he hears that you are here now?"

P (*reflecting*): "Do you mean that you are afraid your husband will disapprove of your coming here?"

C: "People say an injection makes cancer."

P (*paraphrasing*): "People told you that it causes cancer?"

P (*reflecting*): "Are you concerned about the injection?"

C: "I want a method that lasts for two to three years."

P (*paraphrasing*): "You want a method that lasts for two to three years?"

P (*reflecting*): "Do you mean you want to get pregnant afterwards?"

C: "My husband doesn't like the IUD."

P (*paraphrasing*): "He doesn't like it?"

P (*reflecting*): "Are you saying he has concerns about how it will affect you or your relations with him?"

C: "This method is not good for me."

P (*paraphrasing*): "Do you mean that it doesn't work for you?"

P (*reflecting*): "Are you having problems with it?"

Session 10

HANDOUT 10G

Challenging Moments in Counseling

Challenges	Appropriate Provider Attitudes
1. Client becomes silent	• Empathize with the client, telling him or her that you understand that he or she might feel shy, and that many clients feel the same way • Remind the client that everything discussed will remain confidential • Reassure the client that nobody will overhear your discussion • Stress the need to hear more about the client's needs and situation to be better able to help him or her • Find out if there is a language barrier • Check that the client is hearing properly • Review your own communication skills
2. Client cries	• Show the client that you care in the way that is ***culturally most appropriate*** (e.g., holding the client's hand, touching him or her on the shoulder, or giving a tissue) • Show your understanding by reflecting the feelings of the client (e.g., "you must be very sad," or "this must be worrisome") • Reassure the client that you will help him or her • Explain that many clients in the same situation were able to overcome this problem • Switch to another topic; then continue with counseling
3. Client refuses help	• Find out the cause and address it accordingly • Tell client that he or she is free to decide what to do • Explain that you are talking as a friend; you are not dictating anything • Reassure the client that you are there to help any time
4. Client feels unimportant	• Tell the client that you care about him or her • Praise the client for having come to the facility • Try to understand why the client is feeling that way • Reassure the client that she or he is very important to his or her children and family
5. Client is uncomfortable with the provider (because of gender difference, age difference, or similar difference)	• Remind the client that anything discussed will remain confidential • Praise the client for coming to the facility • Explain that you see many male and female clients from different age groups, backgrounds, and so on • Ask if the client would be comfortable more with another service provider • Empathize with the client, explaining that you understand how he or she feels • Stress that you are equals, like friends

Challenging Moments in Counseling *(cont.)*

Challenges	Appropriate Provider Attitudes

6. Client accuses a provider	• Find out if the client's allegation is true
	  ○ If yes, explore and address the issue with the responsible service provider
	  ○ If no, find the cause of the accusation and manage it
	• Show empathy by saying that the client might feel angry and that you understand his or her feelings

7. Provider believes that there is no solution to the problem the client has come for	• Seek assistance from peers, supervisors, or other health facilities
8. Provider makes mistake(s)	• Apologize and correct the mistake (if you have contradicted yourself, admit that you have made a mistake and give the correct information)
9. Provider doesn't know the answer to the client's question.	• Seek assistance from colleagues or supervisors • Check reference materials • Refer the client • Convince the client that you will help him or her resolve the issue
10. Provider is short of time	• Make sure you use the best questioning techniques to elicit the information as quickly and efficiently as possible • Prioritize the client's problems (if he or she has more than one problem to be addressed) and address the most urgent problem first; make an appointment to resolve the other problem • Refer the client to another service provider who is not busy

HANDOUT 11 Addressing Misconceptions

By the end of this session, you should be able to:
- Describe how to address misconceptions about FP methods
- Demonstrate how to correct misconceptions

Essential Ideas—Session 11

- If clients understand why misconceptions are untrue, they are more likely to believe the correct information.
- Misconceptions can lead to discontinuation of FP methods. Thus, correcting misconceptions is an important step in ensuring continued use.

Handling a Client's Misconception

- Ask clients what they have heard about FP methods and what concerns they have about the methods.
- Take the client's concern or misconception seriously.
- Try to find out where the client heard the misconception or rumor.
- Explain tactfully why the misconception or rumor is not true.
- Find out what the client needs to know to have confidence in the FP method. Find out who the client will believe.
- Give the correct information. Be aware of traditional beliefs about health because they can help you both understand rumors and explain health matters in ways that clients can more easily understand and accept.
- Encourage clients to check with a service provider if they are not sure about what they hear about their method of choice or other methods after they leave the health care facility.

Dealing with Rumors in the Community

- Find a credible, respected person (such as a community leaders or satisfied user) who can tell people the truth and counter the rumor. Meet with that person, explain the situation/rumors, provide correct information, and seek their help in ensuring that community members receive the correct information.

Adapted from: Rinehart, W., Rudy, S., and Drennan, M. 1998. GATHER guide to counseling. *Population Reports*, series J, no. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

- Try to figure out why the rumor started. If there was an FP-related complication that led to serious illness or death, it might be necessary to provide accurate and understandable information to the public to counter the rumors and fears that resulted.
- If rumors appear in the media, your facility director might wish to act at the institutional level.
- Encourage people to check first with service providers before they repeat rumors.
- Make use of outreach workers, if they are available locally, to detect and correct rumors.

HANDOUT 12A Filling Clients' Knowledge Gaps

By the end of this session, you should be able to:

- Explain how to assess clients' information needs—what topics to cover and in how much depth
- List basic principles of information giving
- Describe a strategy for talking to clients about side effects
- Describe a strategy for telling clients about health risks and complications
- Demonstrate information giving for different FP methods
- List the side effects of four or five of the most commonly used FP methods (in your country)

Essential Ideas—Session 12

- Clients need to know that they have options in their choice of an FP method and what those options are. However, not all clients need comprehensive information about all FP methods. The counselor should ***tailor*** the information for each client. ***Tailoring*** means adjusting the amount and scope of information to the client's interests and needs. Identifying these needs requires exploring the reason for the client's visit (new clients with a method in mind or no method in mind, or clients returning with problems or returning for resupply or routine follow-up), whether the client wishes to space or limit subsequent births, and what he or she already knows. See Handout 12-B for guidance on how to tailor information for different client categories.
- There are limits to the amount of information people can understand and retain–a major reason why counseling should not cover all details related to every method offered by an FP program. If a client does not have a specific method in mind, the provider should first help the client eliminate methods that do not meet his or her needs and then provide sufficient information to help the client choose among those that are appropriate. The information imparted to clients during this process should be fairly brief, nontechnical, and unambiguous. This approach enhances understanding of the key information on the method (e.g., how to use it, and its side effects) and also leaves time for questions, clarification and checking for comprehension.
- The counselor should also ***personalize*** the information. ***Personalizing*** information means giving the tailored information in terms of what it means for the client. This is done by giving concrete examples that demonstrate how that piece of information relates to the client's circumstances and daily life. This can serve as a reality check that helps the client understand what the information means and its implications for him or her. See Handout 12-B for examples.

(continued)

Essential Ideas—Session 12 (cont.)

- All new clients should be told about the side effects of the method they are choosing and should be prepared through counseling for how to manage them. Information about side effects should be personalized so that clients can understand the implications for their lives and can make informed decisions. Research has shown that clients who are informed about side effects in advance are more likely to continue using the method if they experience side effects. (Management of clients returning with side effects or other problems is covered in Session 24.)
- Although complications are rare, clients should also be told about **health risks and possible complications** associated with their chosen method. Health risks and complications should be explained separately so that the clients do not mistake them for side effects that are more likely to occur. The provider should explain that complications are rare events, describe the warning signs of health risks and complications and explain when to seek medical care. (Management of clients returning with side effects, health risks, complications, or other problems is covered in Session 24.)

Adapted from: U.S. Agency for International Development. Technical Guidance/Competence Working Group (TG/CWG). *Recommendations for updating selected practices in contraceptive use*. Accessed at: www.reproline.jhu.edu/english/6read/6multi/tgwg/Tgrh03e.htm.

HANDOUT 12B How to Give Information

Principles of Giving Information

Principles at a Glance

- Tailor information to the client's needs
  - Find out the client's need or problem (method in mind? return client?)
  - Find out what the client already knows
  - Identify information gaps that need to be filled or misconceptions that need to be corrected
- Personalize information for the client
  - Put information in terms of the client's situation
  - Help the client understand what the new information means to her or him personally (e.g., what would it take or mean to start a new method, to cope with side effects, to discontinue or to switch to another method?)
- Make information understandable (use understandable language, speak clearly, use analogies)
- Put risks into perspective (e.g., the risks associated with carrying a pregnancy to term are much higher that risks associated with using a contraceptive method)

To confirm or make informed choices, clients need objective, accurate, useful, and understandable information. The information should include options that are suitable for the client and an explanation of possible results. It should be **tailored** and **personalized** for the client.

Tailored information is information that is adjusted in amount and scope in response to the client's individual needs and circumstances. In the **exploration** step of REDI counseling, counselors ask questions to learn what decisions the client has already made or is facing. Similarly, to tailor information to the client's needs, the counselor must explore what the client already knows, determine knowledge gaps that need to be filled, and find out what the client is interested in. As a counselor, you must also determine what methods are suitable for the client, ruling out those that are medically contraindicated or that will not meet the client's expressed needs or circumstances. Then you can give specific information that helps the client make or confirm decisions. To avoid overloading and confusing the client, skip information the client already has or that is not relevant.

How to Tailor Information

A *new client with no method in mind* will need a review or overview of all available FP methods. Methods that are irrelevant to the client's needs may be mentioned by name without going into details (e.g., if the client has stated that she is considering having children in the future, methods like female sterilization and vasectomy should only be mentioned by name because they are permanent). The counselor should also tell the client why he or she is not

going into detail about those methods (because the client is still considering having children in the future). For *new clients with a method in mind*, information should start with and focus on the preferred method. Other methods should be briefly mentioned for the purpose of ensuring that the client is aware of them and that the client is making an informed and voluntary decision (i.e., the client is choosing the method in a fully informed manner). In such cases, if the counselor sees an information gap related to other methods and detects that the client has that method in mind but is not fully informed about all other options, the counselor should give information about all other methods as appropriate. "As appropriate" means tailoring.

Returning clients do not need to receive a review of contraceptive methods unless they are considering switching to another method. Information should be limited to the problem or need for which the client has come to the facility (e.g., resupply or routine follow-up).

Personalized information is information placed within the context of the client's situation. Personalizing the information helps the client understand what the information means to her or him in particular. For clients who are considering a method, this means providing concrete examples of what using that method would mean with regard to their circumstances and daily life. For example: "This means that each month you have to take that two-hour bus ride to the town from your village to come to the clinic for your injections." This is what "coming back to the clinic each month" means for that client. In a way, personalizing the information is a reality check that helps the client understand what the information means and implies for him or her.

Example: Information for a woman deciding on whether to use oral contraceptive pills

Good: "Pills have to be taken regularly."

Better (tailored): "You will need to take a pill at the same time every day."

Best (tailored & personalized): "You mentioned that your schedule is different every day. To ensure that the pill is effective, you need to take it at the same time every day. You might take your pill every morning when you get up or every night with your evening meal. How will this work for you?"

Helping Clients Remember Information

1. **Choose appropriate language.** Determine what language and terms to use based on the clients knowledge and comfort.
2. **Start with what is best known.** Start with information or facts that the client already knows. Then move on to areas or topics that are new to the client, always making the link between the topics.
3. **Keep it short.** Choose the most important points that the client must remember.
4. **Keep it simple.** Use short sentences and common words that clients understand.
5. **Put information in perspective.** Say, for example, the risk associated with using the pill is less than the risks associated with pregnancy.
6. **Use examples from everyday life.** In rural communities, you can use crops as an example to convey the benefits of spacing and providing adequate care and nutrition. Children, like crops, do better when they are spaced and given proper attention and nutrition.
7. **Point out what to remember.** For example, say "These three points are important to remember." Then list the three points. The most important points to remember are *what* to do and *when*.
8. **Put first things first.** Give the most important information first. It will be remembered best. Follow a logical sequence.
9. **Organize.** Put information in categories. For example, say "There are four medical reasons to come back to the clinic."
10. **Repeat.** The last thing you say should remind the client of the most important instruction.
11. **Show as well as speak.** Sample contraceptives, flipcharts, wall charts, and other pictures reinforce the spoken word.
12. **Be specific.** For example, "Take the pill regularly every day" is not clear or easy to follow. Instead, say "You should take pills at the same time every day. Otherwise they are less effective. To make remembering this easier, you can take them along with doing another activity that you do every day at the same time, like brushing your teeth. So, if you place your pill packet near your toothbrush, you can remember to take the pill at the same time every day."
13. **Make links.** Help clients find a routine event that reminds them to act. For example, "When you first eat something each day, think about taking your pill at that time." Or, "Please come back for your next injection in the week after the summer festival."
14. **Check understanding.** Ask clients to repeat important instructions. This ensures that they understand the information they have been given and helps them remember it. You can use the opportunity to gently correct any errors.
15. **Send it home.** Give the client simple print materials to take home. Review the materials with the client first.

Session 12

HANDOUT 12C Using REDI to Give Key Information on Contraceptive Methods

Information about FP methods is given to clients at various times and in varying degrees of detail during counseling. During the **exploration** phase of REDI, new clients receive the essential information that will help them compare and eliminate FP methods in order to choose the method that best meets their needs. This information includes what the method is, its effectiveness, expected side effects, possible health risks and complications, health benefits, how it is used and obtained, when the client should return for follow-up, and whether it offers protection from HIV and other STIs.

Clients might not need all of this information before making a decision. For example, just knowing the effectiveness of methods might be sufficient to help some clients eliminate a number of methods. A client desiring permanent contraception can easily eliminate temporary methods, and some clients might eliminate hormonal methods right away, just because they cannot tolerate their side effects. Presenting the methods in a structured way—that is, classifying them as temporary or permanent; hormonal or nonhormonal; male or female; short acting or long acting—helps both the provider and the client eliminate methods that are not relevant to the client's needs.

Before the **decision-making** phase of REDI, clients will have narrowed their choices to one or two methods. Then, before they make their decision, they will need more detailed information on those one or two methods in order to compare them to each other and consider their suitability for their personal circumstances. At this point, the provider should help the client consider the consequences of his or her options (see Session 17).

During the last phase of REDI, **implementing the decision**, the information given to clients should focus on how to use the method, the problems or barriers that might arise during use (e.g., side effects), and what the client should do if they occur (see Session 19).

Key Information for Clients Choosing a Contraceptive Method[1]

Effectiveness. Effectiveness should be explained in easily understood terms. Providers must emphasize that client-controlled methods (e.g., oral contraceptives, barrier methods, natural family planning, and the lactational amenorrhea method) can effectively prevent pregnancy but only if correctly and consistently used. On the other hand, long-term and permanent methods (e.g., sterilization, implants, and IUDs) are nearly 100% effective once properly administered by the provider.

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[1] Adapted from U.S. Agency for International Development. Technical Guidance/Competence Working Group (TG/CWG). *Recommendations for updating selected practices in contraceptive use*. http://www.reproline.jhu.edu/english/6read/6multi/tgwg/Tgrh03e.htm.

Counseling can help clients weigh the tradeoffs between effectiveness and other features of various methods and consider the use of short-term methods in the context of their (and their partners') daily lives. For clients choosing short-term methods, counseling should include plans for correct, consistent use. Issues to consider include whether the client is able and willing to delay intercourse in order to insert a spermicide, take a pill every day at the same time, or return for the next injection at the required time. It is also useful for clients to receive information on how to use oral contraceptives as emergency contraception and where prepackaged emergency contraceptives can be obtained.[1]

Side effects, health benefits, health risks, and complications. Clients need information about common side effects and how to manage them. Information on the health benefits of methods helps clients make their decisions. Clients should also be advised about signs of possible health risks and complications and urged to seek immediate help should they occur. Providers should invite clients to return for advice if they have problems and reassure them that they can change methods if they are dissatisfied.

The Demographic and Health Surveys and other research studies have identified side effects and perceived health problems as the major reasons clients give for stopping FP use; and fear of these effects is major reason for not adopting modern methods in the first place.[2] One African study found that women who receive inadequate counseling about side effects are more likely to become FP dropouts when they experience side effects, while those who are fully counseled on side effects are likely to continue using contraception—either with the same method or a different, more acceptable method.[3] In China, women who received pretreatment counseling about the side effects of depot medroxyprogesterone acetate (DMPA) and ongoing support while they used the method were almost four times more likely than women not counseled to continue with that method.[4]

Women who experience side effects for which they are not adequately prepared might worry that their health is endangered or that the side effect, even if not dangerous, might be permanent and debilitating.[5] They might even blame the method for unrelated ailments. Such worry, followed by discontinuation, is likely to discourage others from using the method, because concerns spread by word of mouth.[6] In addition, if clients have misperceptions— such as about the health and/or libido effects of male and female sterilization, the health consequences of menstrual disruption, the possibility of an IUD traveling outside the uterus, or the accumulation of pills in the body—respectful clarification is called for.

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[2] Ali, M.M., and Cleland, J. 1996. Determinants of contraceptive discontinuation in six developing countries. Paper presented at the annual meeting of the Population Association of America, New Orleans, USA, May 8–11.

[3] Cotton, N., Stanback, J., Maidouka, H., Taylor-Thomas, J., and Turk, T. 1992. Early discontinuation of contraceptive use in Niger and the Gambia. *International Family Planning Perspectives* 18(4):145–149.

[4] Lei, Z., Wu, S.C., Garceau, R.J., Jiang, S., Yang, Q.Z., Wang, W.L., et al. 1996. Effect of pretreatment counseling on discontinuation rates in Chinese women given depo-medroxyprogesterone acetate for contraception. *Contraception* 53(6):357–361.

[5] Mtawali, G., Curtis, K., Angle, M., and Pina, M. 1994. Contraceptive side effects: Responding to clients' concerns. *Outlook* 12(3):X-X.

[6] Bongaarts, J., and Watkins, S.C. 1996. Social interactions and contemporary fertility transitions. *Population and Development Review* 22(4):639–682.

Possible ***health risks or complications and their warning signs*** should be explained separately. The client should not get the false impression that rare complications are as common as side effects. See Handout 12-D for guidance on how to cover side effects and health risks and complications during counseling.

Providers and clients should discuss other important features—the advantages and disadvantages—of the method. However, providers should keep in mind that perceptions of advantage or disadvantage vary widely among individuals and couples. For example, some women might want the highly effective, continual protection offered by the IUD or implant, while others might feel uncomfortable about a "foreign object" in their body or might want control over when to stop using a method. Some want methods with the fewest side effects and others want a method that does not require application at the time of having intercourse. Clients also assess the mode of application differently: Some favor injections, while others shun them; some reject implants because they might be seen and recognized by others, while others cannot remember to take pills; some want condoms because they offer dual protection, while others find them unpleasant.

How to use and how to obtain method or what to expect during the procedure. Clients need brief, specific, and practical information on how to use their selected method and an explanation of how the method works. This is particularly important if the client has misconceptions (e.g., that the oral contraceptives need be taken only when intercourse occurs). Clients also need information on how and where to obtain their selected method and—for injectables, IUDs, implants and sterilization—what to expect during the procedure they will undergo. Clear, specific instructions are associated with better client adherence and outcomes, and instructions are essential for counseling on user-dependent methods such as oral contraceptives and barrier methods. Clients might need to develop strategies for how to use these methods consistently and correctly, and they might need the counselor's advice on what to do if the method fails (e.g., a condom breaks) or is used incorrectly (e.g., skipping pills). Programs that offer or refer women for reproductive health education support the correct use of FP methods by increasing clients' knowledge of the reproductive system, how pregnancy occurs, and how contraception works. In cases where the client's method of choice cannot be provided immediately (e.g., booking at a later date for female sterilization, or referring to another site for IUD or implant insertion), the provider should counsel the client and provide the client with a method to be used in the interim (condoms, etc.).

When to return. Clients need advice on when to return for follow-up or resupply. The follow-up visit is a good time to reinforce the importance of correct and consistent use of client-controlled methods and to ask whether the client is experiencing any unpleasant side effects that need management. If a client has developed medical contraindications to the method or has experienced a change in life stage, circumstances (e.g., a desire to get pregnant in six months), or lifestyle (e.g., the client now has multiple partners), the client should return to the facility and might wish to change or discontinue FP methods. In addition to scheduling return visits, providers should tell clients that they are welcome to return to the facility any time they have questions or concerns. Clients choosing implants might need help remembering when to have the implants removed—follow-up visits can help—and should be told that they can have the implants removed at any time before that date as well. In addition, the provider should give the client a piece of paper that shows the date of the return appointment.

Prevention of HIV and other STIs. As the prevalence of HIV and other STIs has increased, risk assessment and prevention messages are increasingly being integrated into FP counseling. Programs are also increasingly finding ways to approach treatment and referrals for STIs. Clients should know whether their FP method protects them against STIs and that abstinence and the consistent use of condoms are the most effective means of protection available.[7] Those who use long-term and permanent methods might be less likely to use condoms for protection, possibly because contraception is a lower priority or because they no longer associate having intercourse with the need for protection. Some—especially young adults or teens—might incorrectly believe that all contraceptives protect against HIV and other STIs. A study of adolescents in Jamaica found that only about 25% of them knew that oral contraceptives did not provide such protection.[8] Providers should help clients assess their level of STI risk, stressing that the behavior of one's partner can also put a client at risk.[9] This information should be conveyed in a way that is sensitive to the client (e.g., by saying "Many women may not be aware . . . "). Clients at high risk need special encouragement, skills, and support to use condoms in addition to any other method they select; counseling the couple might be the most effective approach. If this is not possible, helping clients build skills for negotiating condom use and communicating with partners about intercourse would be effective ways of the supporting clients.

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[7] Pachauri, S. 1994. Relationship between AIDS and family planning programmes: A rationale for integrated reproductive health services. *Health Transition Review* 4 Suppl:321–348.

[8] Eggleston, E., et al. 1996. Sexual activity and family planning: Behavior, attitudes and knowledge among young adolescents in Jamaica. Paper presented at the annual meeting of the Population Association of America, New Orleans, USA, May 8–11.

[9] Caraël, M., et al. 1994. Extramarital sex: Implications of survey results for STI/HIV transmission. *Health Transition Review* 4 Suppl:153.

HANDOUT 12D Talking about Side Effects, Health Risks, and Complications

Side effects can result from medication, medical treatment, or a FP method. While bothersome, most side effects are tolerable. Many side effects are not harmful and many go away without treatment after a period of time

Health risks and complications are much rarer than side effects. They can result from medication, medical treatment, using an FP method, or a medical or surgical procedure, but they can be serious and usually require medical attention. ***Complication*** is the term used to describe conditions that are specifically related to a clinical procedure, such as the puncturing of the wall of the uterus during IUD insertion, infection at the insertion site of an implant, or bleeding after a vasectomy.

Many service providers believe that explaining side effects and possible health risks and complications associated with FP methods scares away clients. Research shows the contrary. Clients use their method longer when counselors have explained side effects in advance. In addition to explaining side effects, the counselor should ask the client how he or she would feel if the side effects occurred. Some side effects, such prolonged bleeding, might have social or cultural implications (e.g., not being able to have sex, not being able to enter a house of worship, being isolated). Service providers should tell clients that health risks and complications are possible but rare and briefly explain what they are. Once the client has chosen the method (in the **implementing the decision** phase of REDI), service providers should explain the warning signs of any possible health risks and complications.

PREPARING THE CLIENT FOR COMMON SIDE EFFECTS

- New clients:
  - Always explain possible side effects
  - Explain that most people do not experience them but that many do (they are common but are not a cause for concern)
  - Ask how the client would feel and cope if faced with the side effects
- Explain and reassure:
  - Why and how side effects occur
  - Many side effects are harmless and not signs of danger
  - Many side effects go away without treatment and many others can be treated
  - The client is always welcome to come back with any concerns or questions
  - Clients are always welcome to change methods
  - Always address the social and cultural implications of side effects, such as taboos during bleeding
  - Help the client anticipate possible side effects and develop a strategy to cope if a side effect occurs

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Adapted from: Rinehart, W., Rudy, S., and Drennan, M. 1998. GATHER guide to counseling. *Population Reports*, series J, no. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

TELLING THE CLIENT ABOUT HEALTH RISKS AND COMPLICATIONS

- Always tell clients about possible health risks and complications
- Put information on health risks and complications into perspective (help the client compare the risk to other risks, such as risks related to pregnancy, delivery, or a surgical operation)
- Explain health risks and complications separately (not together with side effects)
- Explain signs of health risks and complications clearly, and urge the client to seek immediate help should they occur
- Have clients repeat in their own words the signs of health risks and complications
- Explain and reassure:
  - Health risks and /complications are very rare
  - Clients are always welcome to come back with any concerns or questions

For a list of side effects, health risks, and complications of contraceptive methods, see the method-specific cue cards (Appendix A).

For management of clients returning with side effects, health risks, and complications, see Handout 23: Managing Side Effects and Other Problems.

HANDOUT 13A Using Simple Language and Visual Aids during Counseling

By the end of this session, you should be able to:

- Identify the colloquial terms that clients use to describe reproductive anatomy and physiology as well as sexual practices
- Explain how visual aids should be used during counseling
- Demonstrate the use of nontechnical language to explain reproductive physiology and medical terms to clients

Essential Ideas—Session 13

- For effective communication to occur, counselors must explain SRH issues in ways that clients understand. Even when we feel that we know something very well, it can be hard to find simple ways to explain it. This gets easier with practice.
- Choosing the correct words to use when discussing FP and SRH issues can be a challenge for providers. Sometimes the words that come to mind are too clinical or might be considered offensive. Providers must become familiar with the words that clients will understand and are comfortable using.
- Providers should not feel obliged to use words they consider offensive. However, they should be able to identify the words a client uses for particular body parts or activities and then explain to the client that when a particular term is used, it refers to this.
- If a provider is comfortable enough to use local/colloquial terms as a bridge for understanding, using them will help the client to overcome his or her embarrassment about discussing these subjects. Helping providers feel more comfortable using colloquial terms and hearing them from clients is an important aspect of this training.
- Asking what the client already knows is essential. The client's lets the provider know what type of terminology—i.e., slang, common words, or medical terms—the client will understand and will give the provider a way to reinforce the client's current knowledge and to correct inaccuracies.
- Not finding out first what the client already knows can lead to two common errors: explaining at a level beyond the client's comprehension, or wasting time explaining what he or she already knows (perhaps insulting or frustrating the client in the process).
- The provider will rarely have enough time in counseling to explain everything that the client needs to know. The information-giving process is much more efficient if basic information about anatomy and physiology and key medical terms are explained in group-education before counseling. Then, during counseling, you can quickly review the information to see what the client did or did not understand and what questions he or she might still have.

(continued)

Essential Ideas—Session 13 (cont.)

- Talking about sexual body parts and processes makes a lot of people very nervous. Many people show nervousness by laughing. This is normal and good for relieving some of the tension. However, training and counseling must be conducted in a respectful manner. Just as making sexual jokes is not appropriate in the training setting, likewise it should not be allowed between clients and providers.
- Having visual aids around the facility is helpful but not sufficient for providing the necessary education. Clients might be embarrassed by drawings of reproductive anatomy or confused by the representation of internal systems.
- To be effective, visual aids must be explained to clients, not just given to them.

HANDOUT 13B Using Visual Aids for Counseling

Using Information, Education, and Communication Materials

Information, education, and communication (IEC) materials are visual aids that can help clients understand and remember what has been discussed during counseling or at the facility. They might include sample contraceptives, wall charts, take-home pamphlets, wallet cards, brochures, booklets, posters, pictures, models, audiotapes, videotapes, drawings, and diagrams. IEC materials can be used to:

1. Get clients' attention
2. Start a discussion and help clients ask questions and make decisions
3. Provide illustratations of anatomy and contraceptives that might not be familiar to clients
4. Make comparisons between different contraceptive methods
5. Demonstrate what is involved in medical procedures (e.g., IUD insertion)
6. Demonstrate physiological processes (e.g., development of a fetus)
7. Demonstrate physiological or contraceptive features that one cannot see (e.g., the position of an IUD in the uterus) or point out objects such as sexual organs
8. Assist with explaining sensitive and/or complicated subjects like FP and risk related to STIs

Some features of particular IEC materials include the following:

- Clients can take printed materials home.
- Clients can share printed materials with partners and friends.
- Giving brochures to clients helps them remember essential information and instructions about family planning methods or procedures.
- Posters can be used to introduce a new SRH service.
- Flipcharts (illustrated flipbooks) can be used to present step-by-step instructions.

Tips on Using IEC Materials*

- Make sure clients can clearly see the visual materials as you explain them.
- Start by asking the client what the picture looks like to him or her. The next step is to identify parts of the picture that the client knows and then go on to those that he or she is not familiar with.
- Explain pictures and point to them as you talk.
- Look mostly at the client, not at the flipchart or poster.

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* *Adapted from:* Rinehart, W., Rudy, S., and Drennan, M. 1998. GATHER guide to counseling. *Population Reports*, series J, no. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

- Change the wall charts and posters in the waiting room from time to time. This will draw attention to them so that clients can learn something new each time they come to the facility.
- Use sample contraceptives when explaining how to use them. Invite clients to touch them. Clients can practice putting a condom on a model penis, a stick, or a banana. Clients might want privacy when they practice.
- If possible, give clients pamphlets or instruction sheets to take home. They can be helpful reminders of correct method use. Be sure to go over the materials with the client.
- Suggest that the client show take-home materials to other people.
- Small flipcharts are not appropriate for use with large groups.
- Order more materials before they run out.
- Make your own materials if you cannot order them when they run out.

Challenges in Developing and Using IEC materials

1. IEC materials should be carefully developed to focus on and highlight key information. If they contain too much information, the intended message might not be easily understood and clients may have difficulty in remembering key concepts.
2. Unless the health care provider reviews materials with clients, there is no chance for the client to discuss them.
3. Using pictures is essential when working with clients who are illiterate or who speak a different language than the counselor.
4. Print materials are easy to lose and often are thrown away without being read. In addition, they can be expensive to produce

HANDOUT 13C Female and Male Reproductive Systems

Female Anatomy and Physiology

Women have two **ovaries**, which produce eggs and female hormones. Female hormones give women their female characteristics (e.g., breasts and the way their voices sound) and their sex drive. One of the ovaries releases one egg once a month (as the release of the egg is called **ovulation**).

Each ovary is connected by a **fallopian tube** to the **uterus** (or **womb**). When an egg is released from the ovary during ovulation, it travels through one of the fallopian tubes to the uterus.

The **cervix** is the narrow neck of the uterus that connects the uterus with the vagina. The **vagina** is the passage that connects the uterus with the outside of the body.

To start a pregnancy, a man and a woman have sexual intercourse, and the man ejaculates in the woman's vagina. The ejaculated **sperm** from the man then travels from the vagina through the cervix and the uterus until it reaches the fallopian tubes. **Fertilization (conception)** occurs when the man's sperm ("seed") enters the egg; this usually happens in the fallopian tube. **Pregnancy** occurs when a fertilized egg travels down the fallopian tube and attaches itself to the inside wall of the uterus. This is where the fertilized egg grows into a baby over the course of nine months.

When a woman of reproductive age is not pregnant, her uterus sheds its lining, which includes a lot of blood, every month. This is called **menstruation**. Menstrual blood is expelled from the woman's body through the cervix and then through the vagina. The vagina is also the passage (the birth canal) through which a baby passes during delivery. The cervix has to widen to let the baby out. This occurs when a pregnant woman goes into labor.

The **clitoris** is a small bud of tissue and nerve endings covered with a soft fold of skin. It is located above the urinary opening, which is just above the opening to the vagina. It is very sensitive to touch. During sexual arousal, the clitoris swells and becomes erect. It plays an important role in a woman's sexual pleasure and climax **(orgasm)**. The **vulva** is the area around the opening of the vagina, including the folds of skin **(labia)**, the clitoris, the urinary opening, and the opening to the vagina itself. Many areas of the vulva are also sensitive to touch and play a role in female orgasm.

Adapted from: AVSC International, 1995. *Family planning counseling: A curriculum prototype*. New York.

Male Anatomy and Physiology

The **testicles** produce sperm and male hormones. Male hormones give men their masculine characteristics (e.g., facial hair and muscles) and their sex drive (desire for sexual intercourse).

The **scrotum** is the sack of skin that holds the two testicles.

Sperm are "seeds," the cells that enter a woman's egg during fertilization. After being produced in the testicles, the sperm are stored in the **epididymis**, a long, curled-up tube above each testicle.

When the man's body is ready to release sperm, the sperm leave the epididymis and travel through the **vas deferens**. The vas deferens loop over the bladder and joins the **seminal vesicles**, two pouches located on either side of the prostate gland. (One vas deferens leads from each testicle to a seminal vesicle.) The seminal vesicles add fluid that energizes the sperm.

The **prostate gland** is located at the base of the bladder. It produces the majority of the fluid that makes up semen. The prostate fluid is alkaline (basic), which protects the sperm from the acid environment in the woman's vagina.

Semen is the liquid that comes out of the penis when a man climaxes and ejaculates. It contains sperm and fluids from the seminal vesicles and the prostate gland. Sperm make up only a tiny amount of the semen. After a man has a **vasectomy**, semen is still produced, but it no longer contains sperm.

Semen passes from the prostate gland, through the **urethra**, and out through the **penis**. During **sexual intercourse**, the man puts his penis into the woman's vagina and semen is released during **ejaculation**. The urethra is also the tube that carries urine from the bladder when a man urinates. However, when a man ejaculates, a valve at the base of the bladder closes so that no urine can come out with the semen.

Cowper's glands are two small glands that release clear fluid into the penis just before ejaculation. Their purpose is probably to help clean out the acid in the urethra (from urine) before the sperm pass through. This fluid can also contain some sperm or infectious microorganisms. Because the man cannot feel or control this fluid when it comes out, it is important for him to use a condom for all contact between his partner and his penis, if there is any concern about pregnancy or disease.

Other Reproductive Health Terms

When a couple has sex but the man or woman (or both) do something to stop the man's sperm (seed) from joining the egg, this is known as **contraception**.

The **genitals** are the external sexual organs, usually considered to include the penis, scrotum, vagina, labia, and clitoris.

A **miscarriage** occurs when a woman is pregnant but the lining of the womb comes out of the womb, along with the developing baby, before the developing baby is old enough to survive outside the womb. This ends the pregnancy.

An **abortion** is when a pregnancy is ended prematurely (before survival outside the uterus is possible). Abortions may be spontaneous (i.e., a miscarriage) or induced (when the woman does something or a medical procedure is performed to end the pregnancy).

In countries where **female genital cutting** (also referred to as female genital mutilation or female circumcision) is practiced, either the clitoris alone or the clitoris and the labia are removed. Some types of cutting also involve sewing the labia together.[1] Female genital cutting is a harmful practice that can lead to serious complications, including difficulty during childbirth.

Sexually transmitted infections (STIs) are infections that are passed from person to person, primarily by sexual contact. They are also known as sexually transmitted diseases (STDs) or venereal disease (VD). Some STIs can be passed to a baby during pregnancy, delivery, or breastfeeding. Others can be passed through unclean surgical instruments, injection needles, and skin-cutting tools, as well as through blood transfusions.

Discharge is anything moist that comes from the vagina or penis, not including urine. There is normal discharge, such as blood during a woman's menstruation and a clear, slippery or sticky wetness around the time of ovulation. So, different types of discharge throughout the month are normal for women. When there is a change in the character of the discharge, such as a change in the way the discharge looks or smells, it might be a sign of an infection. This applies to both men and women. The discharge might become white, yellow, or slightly greenish; it might smell like yeast or cheese. When men or women experience abnormal discharge, they should be told to see a service provider, and treatment might be necessary.

[1] Arkutu, A. A. 1995. *Healthy women, healthy mothers: An information guide, 2nd edition.* New York: Family Care International, p. 17.

Female Reproductive System

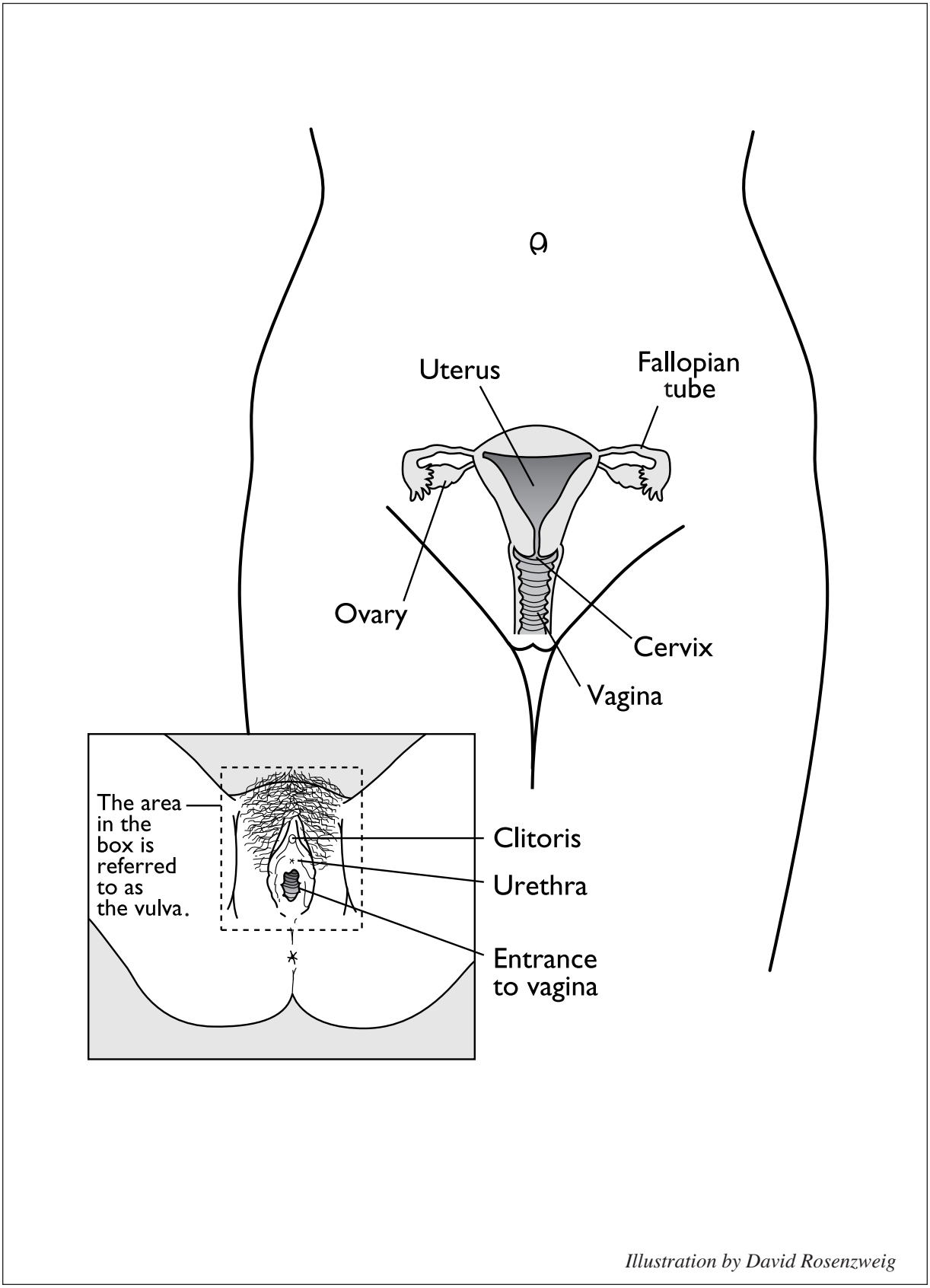

Illustration by David Rosenzweig

Male Reproductive System

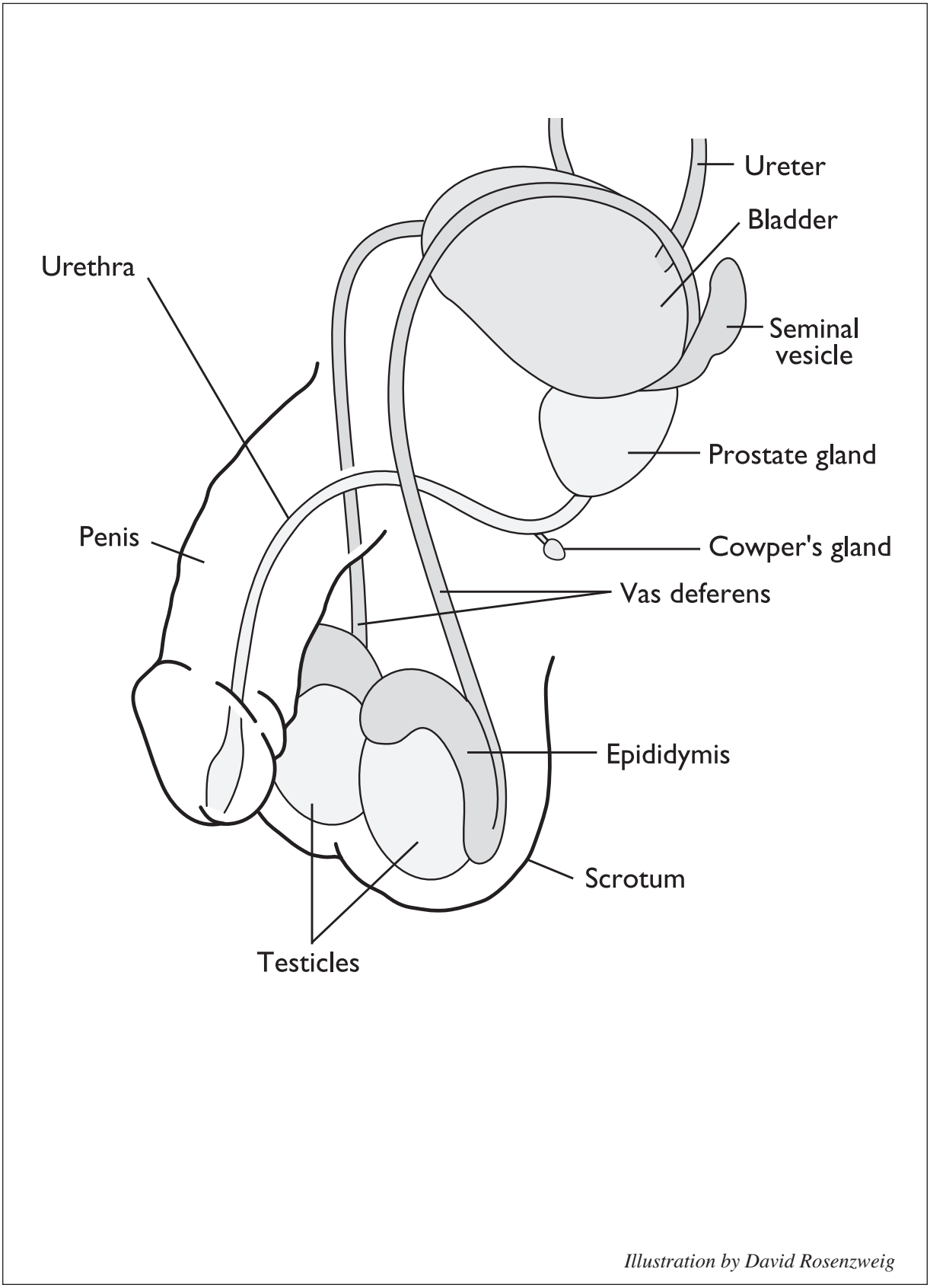

Illustration by David Rosenzweig

HANDOUT 14 Exploring Clients' Sexual Relationships

By the end of this session, you should be able to:

- Explain to clients that sensitive and personal issues and sexual relationships and behaviors will be discussed in counseling
- Identify a strategy to introduce sexuality during counseling
- Demonstrate comfort when introducing the topic of sexuality with clients
- List at least three questions that providers can use to help clients explore their sexual lives, including the social context of their sexual relationships

Essential Ideas—Session 14

- It is the provider's responsibility to be comfortable with introducing the subject of sexuality and to help clients feel comfortable about responding to questions concerning their sexual behavior. Providers should not question different sexual behaviors or practices or judge whether they are right or wrong; rather, they should recognize that these behaviors exist and that they should be considered when helping clients make decisions.
- Sexuality should never be the first thing that a provider talks about with a client.
- There are several ways to help clients understand why providers need to ask **personal and sensitive** questions and to help them feel more at ease in answering them. When initiating a discussion about sexuality, the provider should:
  - ➤ Explain the reasons for asking questions about sexuality (see Handout 9 for the list of reasons)
  - ➤ Explain the importance of discussing sexuality, and assure the client that providers discuss this topic with all clients
  - ➤ Note that what is shared in counseling is confidential, and ensure the client that providers will safeguard their privacy
  - ➤ Explain that the client does not have to answer questions he or she does not want to answer
- *How* a counselor or provider asks and answers questions is just as important as *what* he or she asks. If a provider appears to be nervous or uncomfortable, the client is more likely to feel the same way. Providers should be aware that nonverbal communication (body language, facial expressions, and tone of voice) can convey messages as easily as language can. (Smiling should be considered inappropriate when discussing sexuality with a client because it might be interpreted as judgment.)
- Exploration of the context of a client's sexual relationships is part of ensuring that the client considers all relevant aspects of his or her life when making a decision about FP. This is what is meant by a fully informed and well-considered decision. The kind, number, and history of relationships the client is engaged in have implications for the decisions the client will make. Similarly, sexual behaviors and practices affect the risk of pregnancy and of contracting STIs, including HIV, and therefore the FP method the client will choose. Power imbalances within the client's relationship(s) with partner(s) might also have an effect on decision making.

(continued)

Essential Ideas—Session 14 *(cont.)*

- To help clients accurately perceive where they are on the risk continuum for HIV and other STIs, providers should ask questions to identify the sexual relationships and behaviors they are engaged in.
- For most providers, asking questions about a client's sexual relationships is one of the most difficult parts of counseling. It helps to think in advance about what questions to ask and how to feel comfortable and make the client feel comfortable, while still gathering the personal and sensitive information needed to help clients accurately assess their own risk. These questions might change from client to client and over time, as providers become more comfortable with this process or as the community becomes more aware of the need to discuss such issues with providers.
- In fact, many providers are already familiar with exploring the context of clients' sexual relationships. For example, most providers screen clients (especially gynecology clients, particularly those using an IUD) about pain or discomfort during intercourse to eliminate potential underlying medical problems. Some providers discuss the frequency of intercourse to estimate the client's need for condoms.

Introducing the Subject of Sexuality

When counseling FP clients, providers often need to ask very personal, sensitive questions. This can be challenging for the client, who may not be accustomed to discussing such personal things with someone who is not a family member, or with anyone at all. It can also be challenging for providers, because they too are probably not accustomed to discussing such issues and may fear embarrassing themselves and the client.

Sexuality should never be the first thing a provider addresses with the client. It is always best to start with general, open-ended questions to establish rapport and get the conversation rolling. Specifically, the provider should ask open-ended questions to determine the client's reason for the visit, his or her general health, and his or her particular concerns. This will help pave the way for the sensitive questions that will be asked later.

It is important to explain to clients why providers need to ask personal and sensitive questions and to help them feel more at ease when answering. The provider and the client might never be totally comfortable with these discussions, but it is important to get key information about behaviors and relationships that might put the client at risk for unintended pregnancy, STIs, and other SRH problems or that might affect the client's choice of FP method. The provider's own comfort and confidence in asking such questions will help the client feel comfortable.

The sample statements on the next page are provided merely as a guide for providers. ***Providers should introduce the discussion in their own way,*** depending on what is appropriate for the local culture, the service-delivery setting, the client, and the type of service that the client is seeking or the health complaint the client has.

Sample Statements for Introducing Sexuality

Points to explain	Sample statements
To put the client at ease, explain why you are asking sensitive questions. Explain that this discussion might require asking personal questions about the client's sexual behavior and relationships. Assure the client that the questions have a direct bearing on his or her health care and the decisions made during the visit.	"I will need to ask you some personal, sensitive questions about your life. These will be about your sexual life because sexual behaviors and relationships have relevance to your health concerns or contraceptive choices. It is important for me to ask you these questions so that I can help you make decisions that are right for you."
Explain that, given the serious nature of HIV and other STIs, **it is the policy of this health facility to discuss STIs and their relevance to choices about FP methods with everyone**. Reassure the client that the questions are routine and that everyone is asked the same questions.	"As you may know, HIV and other sexually transmitted infections are occurring more and more frequently these days. We discuss this with all of our clients, so we can make sure that everyone gets the information and services that best meet their needs and can make appropriate FP choices. If it is not relevant to you personally, you might be able to share this information with someone else who needs it."
What is shared in counseling is confidential. Explain your facility's confidentiality policy (if applicable) to the client. If your facility does not have a confidentiality policy, the general standard in counseling is that you share the client's information only with other health care staff and only when necessary (e.g., for a second opinion from a colleague). Note that confidentiality is meaningless if other people can hear what you are discussing with the client and that ensuring privacy is the first step in maintaining confidentiality.	"I want you to know that what you share with me will stay with me only. Nobody will overhear us. If I need to ask another staff member about your problem, I will first ask you whether it is okay. This is our policy."
The client does not have to answer all questions. If the client is not comfortable answering a particular question, he or she has the right not to answer.	"If there are any particular questions you do not feel comfortable answering, feel free to let me know and be aware that you do not have to answer all questions."

Note: This material was adapted from EngenderHealth. 2003. *Comprehensive counseling for reproductive health*. New York.

Participant Worksheet #1 (Session 14)

Note: *This worksheet can be used for writing down some of the questions that were developed in small-group work for this session. You can, of course, add your own questions that you would be more comfortable asking your clients.*

Sample Questions to Explore the Context of a Client's Sexual Relationships

Questions from the REDI framework	Questions you could ask your clients
• What sexual relationships are you in? • What is the nature of your relationship? Does it include violence or abuse? • How do you feel about it (or them)?	
• How do you communicate with your partner about sexuality, family planning, and HIV and other STIs?	
• What do you know about your partner's sexual behavior outside of your relationship?	

HANDOUT 15A The Risk Continuum

By the end of this session, you should be able to:

- Identify the risk of pregnancy and transmission of HIV and other STIs associated with various sexual and nonsexual behaviors
- Explain how particular behaviors can be high-risk in one situation and low-risk in another
- Identify ways of lowering the risk associated with some behaviors
- Explain in simple terms which behaviors put people at risk for pregnancy, HIV, and other STIs

Essential Ideas—Session 15

- The risk of pregnancy and transmission of HIV and other STIs depends not only on the client's own sexual behaviors but also on factors such as the client's partner's sexual history, current behaviors with other people, and infection status.
- Behaviors that may be low-risk in one relationship could be high-risk in another. For example, a typically high-risk behavior such as anal sex would carry no risk at all for STI transmission if neither partner were infected; it also carries no risk for pregnancy. This makes the concept of risk confusing.
- Because the concept of risk is confusing, it is especially important in counseling to use simple and clear explanations to help clients better understand the distinct risks associated with pregnancy and infection with HIV and other STIs. Here are some examples:
  - Risk for pregnancy: any behavior that allows the man's semen to enter the woman's vagina
  - Risk for STI: any behavior (not just sexual) that allows contact with the infected area
  - Risk for HIV: any behavior (such as sexual contact, blood contact, and mother-child contact) that exposes one person to the body fluids (blood, semen, vaginal fluid, or breast milk) of an infected person
- It might not be possible to completely eliminate risk, but *risk reduction* can have a significant positive impact on the client's health. This is why we think of risk on a *continuum* and encourage clients to consider practicing behaviors that are in a lower-risk category or that are entirely without risk.
- Each client should consider his or her risk for STI infection and the need for protection against infection when choosing an FP method.

HANDOUT 15B Behaviors by Type of Risk

	No risk	Low risk	Medium risk	High risk
Pregnancy	• Abstinence • Masturbation • Oral sex on a man • Oral sex on a woman • Deep (tongue) kissing • Anal sex using a condom • Anal sex without using a condom	• Vaginal sex with one partner, using a condom • Rubbing genitals together without penetration, unclothed • Vaginal sex with multiple partners, always using a condom		• Unprotected vaginal sex with your spouse • Unprotected vaginal sex with a monogamous, uninfected partner
HIV	• Abstinence • Masturbation • Sitting on a public toilet seat (provided there is no exchange of body fluids) • Unprotected vaginal sex with a monogamous, uninfected partner	• Vaginal sex with one partner, using a condom • Anal sex using a condom (still more risky than vaginal sex with a condom) • Deep (tongue) kissing • Rubbing genitals together without penetration, unclothed • Vaginal sex with multiple partners, always using a condom	• Oral sex on a man • Oral sex on a woman	• Anal sex without using a condom • Unprotected vaginal sex with your spouse
Other STIs	• Abstinence • Masturbation • Sitting on a public toilet seat (provided there is no exchange of body fluids) • Unprotected vaginal sex with a monogamous, uninfected partner	• Deep (tongue) kissing • Vaginal sex with multiple partners, always using a condom • Vaginal sex with one partner, using a condom	• Anal sex using a condom	• Oral sex on a man (less risky than vaginal or anal sex) • Oral sex on a woman (less risky than vaginal or anal sex) • Anal sex without using a condom • Unprotected vaginal sex with your spouse • Rubbing genitals together without penetration, unclothed

Note: This continuum can change based on social and individual factors, such as involvement with other partners (HIV and sexually transmitted infection risk) or whether the woman is in her fertile time (for pregnancy risk).

HANDOUT 15C Risk Factors for HIV and Other STIs

Relationship Factors and Risk of HIV and Other STIs

How do an individual's role in a sexual relationship and the context of that relationship affect risk? (In other words, how is risk affected if one partner has more power than the other, if one person has other partners, or if one person engages in some specific behavior with the other?)

- If one or both partners in a relationship have other sexual partners, their risk for STIs increases.
- If one person in a relationship has less power, he or she might not be able to negotiate risk reduction with the partner, whether for pregnancy or STIs.
- The "receiver" in vaginal and anal sex is usually at higher risk for STIs than the "giver," and the partner who performs oral sex is at higher risk than the partner who receives it.

Biological Factors and Risk of HIV and Other STIs

What are some biological factors that might increase the risk for STI transmission, either through sexual acts or through mother-to-child transmission?

- Persons with open sores, lesions, or abrasions on the vagina, mouth, anus, or penis are at higher risk for STI infection if they are exposed during unprotected sex. (***Note:*** "Exposed" means having had sexual intercourse—vaginal, oral, or anal—with someone who has an STI; "unprotected sex" means having had vaginal, oral, or anal sex without using either a male or female condom.)
- The tissue lining the rectum is very susceptible to microlesions and tears during anal sex, thus creating entry points for STIs to enter the bloodstream if sex is unprotected.
- Adolescent girls whose vaginal tissue is not fully matured can develop microlesions during intercourse and are thus at higher risk for infection with STIs when exposed during unprotected sex. The same applies to older women with thinning vaginal tissues.
- Someone with an STI, particularly an ulcerative STI such as syphilis or chancroid, is more likely to become infected with HIV if exposed.
- Men who are uncircumcised are more likely to become infected with HIV if exposed during unprotected vaginal sex than are men who are circumcised.
- A person with advanced HIV disease or AIDS has a higher viral load and is thus more likely to pass the infection on during unprotected sex than an HIV-positive person who is healthy. Similarly, a person newly infected with HIV has a high viral load.
- An HIV-infected pregnant woman who is healthy and well nourished and who thus has a lower viral load is less likely to transmit the virus to her baby during pregnancy, labor, or breastfeeding. See also "Preventing Mother-to-Child Transmission of HIV" on the next page.
- An HIV-infected breastfeeding mother is more likely to transmit the virus to her baby while breastfeeding if she has cracked and bleeding nipples (as a result of mastitis, breast abscess, or nipple fissure). See also "Preventing Mother-to-Child Transmission of HIV" on page 101.

Family Planning Methods and Risk of HIV and Other STIs[1]

How do FP methods affect the risk of STI and HIV transmission, either through sexual behaviors or through mother-to-child transmission?

- ***Abstinence from all sex*** provides effective protection only when continuous.
- ***Abstinence from penetrative penile/vaginal, penile/anal intercourse*** alone is not 100% effective, because there is a small risk of transmission of HIV and other STIs, such as human papillomavirus, through oral sex.
- ***Coitus interruptus*** does not protect against HIV or other STIs but reduces the risk somewhat. Pre-ejaculatory fluid can contain HIV.
- ***Fertility awareness*** offers no protection against HIV or other STI transmission.
- ***Lactational amenorrhea method (LAM)*** offers no protection against HIV or other STIs.
- ***Male condoms*** offer the best protection against HIV and other STIs, but they are not 100% effective.
- ***Female condoms*** offer the best protection against HIV and other STIs, but they are not 100% effective.
- ***Spermicides*** do not protect against HIV. Although nonoxynol-9 has been shown to kill HIV in a laboratory, this has not been proven in actual use. Frequent use can cause irritation, which may facilitate HIV transmission. Spermicides offer some protection against STIs.
- ***Diaphragms*** can help protect against some STIs, pelvic inflammatory disease, and cervical dysplasia/cancer. They do not protect against HIV.
- ***IUDs*** offer no protection against HIV or other STIs.
- ***Combined orals/injectables*** offer no protection against STIs. Some evidence indicates that oral contraceptives might increase the risk of transmission from an infected woman to her partner.
- ***Emergency contraception*** offers no protection against HIV or other STIs.
- ***Progestin-only orals/injectables/implants*** offer no protection against HIV or other STIs.
- ***Tubal occlusion*** offers no protection against HIV or other STIs. Since sterilization clients often do not return to FP clinics, it is particularly important to discuss STI prevention before the procedure.
- ***Vasectomy*** offers no protection against STIs. Although semen does not contain sperm after vasectomy, it can contain HIV.
- ***Dual-method use (DMU)*** offers protection against HIV and other STIs.

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[1] *Source:* EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York: EngenderHealth.

Preventing Mother-to-Child Transmission of HIV[2]

A woman infected with HIV can pass HIV to her child during pregnancy, delivery, or breastfeeding. Antiretroviral preventive measures (prophylaxis) given to the mother during pregnancy and labor can reduce the chances that the baby will be infected while developing in the uterus or during delivery. Antiretroviral therapy for the mother, if she needs it for her own health, might also help reduce the chances of HIV transmission through breast milk.

How Can Family Planning Providers Help Prevent Mother-to-Child Transmission of HIV?

1. *Help women avoid HIV infection*.
2. *Prevent unintended pregnancies:* Help women who do not want a child to choose a contraceptive method that they can use effectively.
3. *Offer HIV counseling and testing:* Offer counseling and testing to all pregnant women, if possible, or offer to refer them to an HIV testing service, so they can learn their HIV status.
4. *Refer:* Refer women with HIV who are pregnant or who want to become pregnant to services for the prevention of mother-to-child transmission, if available.
5. *Encourage appropriate infant feeding:* Counsel women with HIV about safer infant feeding practices to reduce the risk of transmission, and help them develop a feeding plan. If possible, refer them to someone trained to counsel women about infant feeding.
   - A woman with HIV should be counseled to choose the feeding option that best suits her situation. If replacement feeding is acceptable, feasible, affordable, sustainable, and safe, the woman should avoid breastfeeding.
   - If replacement feeding does not meet these conditions, a woman with HIV should breastfeed exclusively for the first 6 months. Mixed feeding—that is, giving the baby both breast milk and other liquids or foods—is riskier than exclusive breastfeeding.
   - To further reduce the risk of transmission, when mothers with HIV switch to replacement foods, they should avoid a prolonged period of mixed feeding. Stopping breastfeeding over a period of about two days to three weeks poses the least risk of HIV transmission.
   - To destroy HIV in breast milk, express and heat-treat milk before feeding it to the infant: Heat milk to the boiling point in a small pot, and then cool the milk by letting it stand or by placing the pot in a container of cool water, which cools the milk more quickly.
   - Women with HIV who are breastfeeding need advice on keeping their nutrition adequate and their breasts healthy. Infection of the milk ducts in the breast (mastitis), a pocket of pus under the skin (breast abscess), and cracked nipples increase the risk of HIV transmission. If a problem does occur, prompt and appropriate care is important.

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[2] *Source:* INFO Project. 2007. *Family planning: A global handbook for providers*. Baltimore: INFO Project.

HANDOUT 16 Risk Assessment: Improving Clients' Perception of Risk

By the end of this session, you should be able to:

- Define *risk assessment*
- Explain why and how risk assessment is used in counseling
- Identify at least three reasons why it is difficult for people to perceive their own risks
- Describe at least two ways in which you can help clients perceive and understand their own risks for unintended pregnancy and for transmission of HIV and other STIs
- Describe how *self risk assessment* is done

Essential Ideas—Session 16

- Risk assessment is a counseling process to help clients understand the risk of getting pregnant or becoming infected that is associated with sexual practices in which they or their partners are engaged, and how the level of risk may change depending on changes in their behaviors and circumstances.
- We help clients to assess their own risk so they can use this information to reduce their risk by changing their risky behaviors. This is an ongoing process that begins with the **exploration** phase of REDI and continues through the **decision making** and **implementing the decision** phases. Risk assessment helps providers gain a better understanding of clients' circumstances and behaviors so that they can better tailor counseling.
- When counseling, we must respect peoples' different understandings about what risk means in their lives. For a variety of reasons, people tend to underestimate their risk and perceive themselves to be at lower risk than they actually are. Given this reality, providers need to develop skills to help clients perceive and understand their risks.
- Understanding and accepting one's own risk is essential for behavior change. People who perceive themselves to be at risk will be more motivated to make changes to protect themselves from unintended pregnancy or from the transmission of STIs and HIV than people who do not see themselves as being at risk.
- Providers can help clients better perceive and acknowledge their risks by relating risk to the client's individual circumstances and by using examples of how the client may protect his or her health by reducing risk in other areas.
- Self risk assessment is done when the clients are not willing to acknowledge risk or unwilling to reveal their situation to the provider and are too shy or embarrassed to participate in risk assessment. Self risk assessment complements but does not replace risk assessment done jointly by the provider and client. Self-assessment involves the provider giving the client general information about risky behaviors and relationships, assuring the client that such discussion is standard practice, that it is intended to help him or her, and that providers will not judge him or her. It is hoped that this will give the client sufficient information to accurately identify his or her own risks and take the steps necessary to reduce them.

Portions of this handout were adapted from: STD/HIV Prevention Training Center. 1998. *Bridging theory and practice: Participant manual*. Berkeley.

Risk Assessment

What Is It?

Risk assessment is a counseling process to help clients understand the risk that is associated with sexual practices in which they or their partners engage (i.e., the chance of getting pregnant or becoming infected with an STI) and how the level of risk might increase or decrease depending on changes in circumstances. For example, your risk could increase for any of the following reasons:

- Your uninfected partner becomes infected
- You had one partner and now you have more than one
- You have a new partner and you do not know his or her sexual history
- Your partner changes his or her mind and decides that he or she does not want to use condoms
- You develop side effects with a contraceptive method and discontinue its use
- You have gotten married and you and your partner would like to have a baby soon

Why Do We Do It?

We help clients assess their own risk so that they can use this information to reduce their risk by changing their behavior. Through this process providers gain a better understanding of clients' behaviors and circumstances and are better able to tailor counseling accordingly.

How Do We Use REDI in Risk Assessment?

Exploration

We use exploration to learn about clients' relationships, sexual behaviors, and other factors that might put them at risk and to provide information that clients need to make decisions about reducing their risks.

Decision Making

We use decision making to help clients choose behaviors, FP methods, and medical treatments that will reduce their risks.

Implementing the Decision

We use implementation to help clients make a plan for how they will change behaviors, how they will communicate with their partners, how they will cope with the problems or challenges they might encounter, and how they will deal with changes in their life circumstances.

Barriers to Clients' Perception of Risk

The client's *perception* of whether he or she is actually at risk for unintended pregnancy or STI infection is a crucial place to in helping the client become willing to take some steps toward reducing risk. In many cases, people perceive themselves to be at less risk than they actually are. People have many reasons for underestimating their own risk. **Lack of information and lack of understanding of the *relative risk* or *individual risk* underlie most of the reasons listed below.**

People underestimate their risk for many reasons, including:

- **Stereotyped beliefs about who is at risk.** Many people mistakenly believe that truck drivers, migrant workers, homosexuals, sex workers, and intravenous drug users are the only people who are at risk for HIV. They think that just because they are in a heterosexual relationship they are safe from risk—or that because they are in a marriage or monogamous relationship they can trust that their partner will not have any other partners. For many women, in particular, messages about "being faithful" as a way of avoiding infection might give a false sense of safety, because they are often at risk because of their partners' behavior rather than their own.
- **The illusion of invulnerability.** Some people have a personal belief that they are immune to risk regardless of their behaviors. People generally tend to underestimate their own personal risk in comparison to the risk faced by others who are engaging in the very same behaviors. An example would be an adolescent girl who thinks she will not get pregnant even if she has sex without using an FP method: "It will not happen to me." Adolescents, in particular, as part of their emotional development, often think of themselves as invulnerable to many risks.
- **Fatalism.** Fatalism is a belief that circumstances are beyond one's control: Nothing a person does will change what is going to happen anyway. An example of this would be a person who believes that spiritual forces determine how many children one has and that therefore it is not necessary to use FP.
- **Bigger or more urgent problems.** A person might have other concerns that need immediate attention and that put the threat of STIs or unintended pregnancy into the background. People who live in communities where hunger, violence, or poverty is widespread, for example, are more likely to prioritize other issues, such as feeding and protecting their children from harm.
- **Misconceptions about risk.** Mistaken beliefs can interfere with a person's understanding of what is risky. For example, a person might not have a clear understanding of how HIV is spread (i.e., they might believe that HIV can be transmitted through contact with toilet seats or through the sharing of eating utensils). A young woman might mistakenly believe that she cannot get pregnant the first time she has sex. Clients are often afraid to use the IUD or hormonal FP methods but do not understand that the relative risks of pregnancy-related morbidity and mortality are greater for most clients than risks from using these methods.
- **Traditional gender roles and societal expectations.** Different societal expectations and social norms often influence clients' behaviors. For example, a woman might suspect that her husband is having extramarital relationships, but it might not be acceptable within her social or cultural role to bring this to his attention. If she feels there is little or nothing she can do about it, it is easier for her to not acknowledge or to minimize her perception of the potential risk.

Importance of Client's Perception of Risk

Why is a client's perception of his or her own risk so important?

- Most people will not be able to make a behavior change unless they perceive that they are at risk. If a client does not accurately perceive his or her risk, then he or she will not be motivated to make health-related behavior changes.

- In most cases people need to feel ownership of a plan to change their behavior if they are to carry it out. If the provider simply tells the client what to do, without working with the client to develop a plan that is both meaningful and realistic, it is unlikely that the client will follow it.

What are some of the ways in which providers can help clients perceive and understand their risks?

- Help the client assign risks to the specifics of his or her circumstances. For example, if a client acknowledges that her husband has other partners and does not use condoms, highlight the risk to her. To make it less threatening, one might say that "many women find themselves in similar situations."
- Try to personalize clients' risks by providing personalized information (i.e., information that is specific to the client). For example, if an adolescent girl does not wish to get pregnant but is not using contraception, one could provide her with brochures or comic-style booklets specifically designed for adolescents that discuss the risks and realities of adolescent pregnancy.
- Try to look for ways that clients have protected their health in the past and draw their attention to these successes. For example, if a client has used the pill to prevent unintended pregnancy, acknowledge that she perceived a risk of getting pregnant and took positive action to prevent the risk. Gently suggest that there might be other health risks that she could address as well. For example, if her partner recently was treated for an STI, point out that any sex partner of a person with an STI is at risk.
- Use *self risk assessment* (see below).

Self Risk Assessment

What can be done when clients are not willing to acknowledge risk or are not willing to reveal their situation to the provider?

- Using a self risk assessment approach, the provider gives general information about risky behaviors and relationships to the client, assuring the client that the discussion is standard practice and is intended to help the client, and that the provider will not judge them. The provider can also say that the purpose of the discussion is to help the client pass vital information along to friends and family. This aspect of counseling will enable the client to leave the facility with enough specifics to accurately identify his or her own risks and take the steps necessary to reduce them.
- The provider should stay neutral and avoid reactions that might prompt the client to hide the truth. Assure the client of confidentiality and privacy.
- The definition of self risk assessment:
  - ➤ Self risk assessment complements but does not replace risk assessment conducted jointly by the client and provider.
  - ➤ It is used either in lieu of joint risk assessment (if the client is too shy or embarrassed to participate in joint risk assessment) or in combination with joint risk assessment.

- ➤ The provider uses the information gathered during counseling to estimate possible risks in the client's life.
- ➤ The provider gives the client information and explanations to address those risks.
- ➤ The provider conveys the information in a manner that implies that it is relevant to most people in the client's community.

- Example: Steps in self risk assessment applied to a client who wishes to use the IUD (see box below).

RISK ASSESSMENT and SELF RISK ASSESSMENT FOR A CLIENT WISHING TO USE THE IUD

Steps to take:

1. **Tell the client who should not use the IUD.** Explain that women who have gonorrhea or chlamydia now or who have a very high likelihood of exposure usually should not use the IUD.
2. **Explain the factors that place a woman at very high risk.**
   Explain the indicators of very high risk for STIs and the behaviors that place a woman at very high risk. Common indicators and behaviors include the following:
   - Diagnosed with an STI in the last three months
   - Partner diagnosed with an STI within the last 3 months
   - Partner with STI symptoms such as pain or burning during urination, an open sore in the genital area, or pus coming from his penis
   - More than one sexual partner in the last 3 months, without always using condoms
   - Unprotected sex with a partner who has had more than one partner in the last three months.
3. **Decide on her risk together or ask her to assess her own risk.** Decide together whether she is at very high individual risk or, if she does not want to reveal personal information, ask her to consider for herself whether she still thinks she is a good candidate for an IUD.

   Certain circumstances can lead to behavior that transmits STIs. Tailor the discussion to address locally relevant situations that would place a woman at very high risk for an STI, based on your experience or on clinic guidelines. For example, if a man works far from home for extended periods, he is more likely to have had other sex partners. Having sex in exchange for money, food, or other payment without using condoms every time is also a high-risk situation.
4. **If a woman has a *very high* likelihood of exposure to gonorrhea or chlamydial infection (i.e., high individual risk) and…**
   - She no longer wants an IUD after learning the risks, help her choose another method.
   - She still wants the IUD, refer her for STI testing and treatment and ask her to return for an IUD if the tests are negative. If tests are positive and she has been treated, she may be given an IUD if she is no longer exposed to gonorrhea or chlamydial infection.
   - She still wants the IUD but testing is not available, the IUD is usually not recommended unless other, more appropriate methods are not available or acceptable to her. A health care provider who can carefully assess the woman's specific situation and whether she has access to follow-up to check for pelvic inflammatory disease might decide that she can use the IUD. The provider needs to weigh the risks of using the method against the risks to the woman's health if she becomes pregnant. (The World Health Organization [WHO] Medical Eligibility Criteria category is 3 for women at very high individual likelihood of exposure to gonorrhea or chlamydial infection).

HANDOUT 17A Helping Clients Make or Confirm Decisions

By the end of this session, you should be able to:

- Identify the types of decisions clients might need to make
- Explain the steps in the decision-making process
- Describe how providers can help clients eliminate FP methods that do not respond to their needs
- Practice use of a quick reference chart for the World Health Organization's (WHO's) medical eligibility criteria
- Demonstrate how to help and support clients in making their own decisions

Essential Ideas—Session 17

- During the decision-making phase of FP counseling, the provider helps the client to:
  - ➤ Focus on the key decisions he or she needs to make
  - ➤ Identify appropriate options
  - ➤ Weigh the benefits, disadvantages, and consequences of each option
  - ➤ Reach his or her own decision
- The decision-making phase of counseling is key to supporting the rights of individuals to make their own FP decisions, without pressure or coercion. During this phase, it is important for the provider to ascertain whether other people are trying to pressure the client into doing something that he or she does not want to do or are denying him or her access to services, and to explore with the client how he or she feels about this and how he or she wants to respond. In addition, the provider should assist the client in reaching his or her own decision.
- Because of common power imbalances in the client-provider relationship, including the provider's superior medical knowledge, providers must be careful not to impose "medically correct" decisions. Rather, they should help the client eliminate medically contraindicated options and encourage the client to make his or her decision based on his or her preferences and situation, taking into consideration up-to-date standards such as the WHO medical eligibility criteria and recommendations about healthy timing and spacing of pregnancy (HTSP).
- Helping a client to make a decision, without exerting inappropriate pressure, has been a major challenge for providers. Providers often either tell the client what to do or give information but do not assist the client in making a decision. The approach taught in this curriculum lies somewhere in between these two extremes. An additional challenge is that every client is different in terms of the amount of guidance they need from the provider. This is why the client-centered approach—treating each client as an individual and basing your input on the client's unique needs and concerns—is the best guidance for this step in the REDI process.

Decision-Making Steps in Counseling*

1. **Identify the decisions that need to be made or confirmed in the counseling session.** Depending on the client's needs, there might be one or more decisions that need to be confirmed or made in this counseling session: ***Questions for new clients*** include whether to use FP, which FP method to choose, whether it is necessary to reduce the risk of contracting HIV and other STIs, and whether to use a method that provides dual protection against pregnancy and STIs. For some new clients this might be the first time that they have been faced with making a decision about having another child. Other new clients might already have a method in mind; these clients need information, guidance, and support to confirm whether their decision is appropriate. ***Questions for returning clients*** include whether or not to continue using their current FP method, whether to switch to another FP method, and whether to come back for follow-up. Naming these decisions in the **decision-making** phase of REDI helps the client focus his or her thoughts on the issue and implies that the client is expected to make his or her own decisions.
2. **Explore relevant options for each decision.** This task should be done in an organized and logical way that responds to the expressed needs of the client. Provider should list (although not necessarily explain) all available options and then help the client eliminate those that are not relevant to his or her situation. Options for ***new clients*** include all available FP methods that are appropriate for the particular client, dual-protection options, and other STI risk reduction options. ***New clients with a method in mind*** will need to confirm their decision. In these situations, the provider must give balanced information tailored to the particular method the client has in mind and make sure the client is making a well-considered decision by giving essential information on other methods that would be appropriate given the client's expressed need (the provider does not necessary need to provide all information about each method, just enough detail that the client could rule out the method). ***Returning clients*** need to be told about options such as taking action to alleviate a side effect, discontinuing the method, or switching to another method.
3. **Help the client weigh the benefits, disadvantages, and consequences of each option.** The options need to be presented in a personalized way—that is, by relating them to the unique situation of the client and explaining what choosing that particular option would mean or imply for the client. For ***new clients with no particular method in mind,*** this might mean reviewing the detailed information about FP methods, their side effects, health benefits, health risks, what it would mean or take to obtain those methods, and how each option may contribute to reducing the risk of HIV and other STIs risk reduction. These same areas need to be covered also ***with new clients with a method in mind,*** but in this case the provider should put more emphasis on the preferred method of the client while giving sufficient information about the benefits, disadvantages, and consequences of other options to enable the client to eliminate options. After receiving this information, clients might opt for a method different than the one they originally had in mind. ***Returning clients*** come with an idea about the benefits and disadvantages of the method they have been using (or have used in the past). They need help understanding

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* *Adapted from:* Rinehart, W., Rudy, S., and Drennan, M. 1998. GATHER guide to counseling. *Population Reports,* series J, no. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

what other options would mean or require. Providers should personalize information on the benefits, disadvantages, and consequences of each option. What would discontinuation mean? When would the client need protection again? What are the family and social implications? Clients facing problems with their current FP method need to consider whether to discontinue the method, switch to another method, or cope with the side effects they have been experiencing.

This step also serves as a reality check for the client regarding the possible consequences of her or his choice. The counselor can help by asking questions about how the client would feel or what he or she might do in certain situations. Examples of such questions include "How would you feel about taking the pill everyday?", "What will your husband think of using a condom?", "What might make it difficult for you to come back to the clinic every three months for the injection? What would you do about that?"

4. **Encourage the client to make his or her own decision.**
   The counselor's primary role is to help the client make and finalize his or her decision and to plan how to carry it out. The counselor should ensure that the client's decision is a well-informed and appropriate choice. The counselor can reflect back the decision by saying, "So, you have decided to . . . " or "What is your decision?"

HANDOUT 17B

FHI's Quick Reference Chart for the WHO Medical Eligibility Criteria

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use – to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), norethisterone enantate (NET-EN), copper intrauterine device (Cu-IUD)

CONDITION		COC	DMPA/ NET-EN	CU-IUD
Age	Menarche to 39 years			
	40 years or more			
	Menarche to 17 years			
	18 years to 45 years			
	More than 45 years			
	Menarche to 19 years			
	20 years or more			
Nulliparous				
Breastfeeding	Less than 6 weeks postpartum			*
	6 weeks to 6 months postpartum			
	6 months postpartum or more			
Smoking	Age < 35 years			
	Age ≥ 35 years, < 15 cigarettes/day			
	Age ≥ 35 years, ≥ 15 cigarettes/day			
Hypertension	History of hypertension where blood pressure:			
	CANNOT be evaluated			
	Is controlled and CAN be evaluated			
	Systolic 140 - 159 or diastolic 90 - 99			
	Systolic ≥ 160 or diastolic ≥ 100			
Headaches	Non-migrainous (mild or severe)	I C		
	Migraine without aura (age < 35 years)	I C	I C	
	Migraine without aura (age ≥ 35 years)	I C	I C	
	Migraines with aura		I C	
History of deep venous thrombosis				
Superficial thrombophlebitis				
Complicated valvular heart disease				
Ischemic heart disease/stroke				
Diabetes	Non-vascular disease			
	Vascular disease or diabetes of > 20 years			
Malaria				
Non-pelvic tuberculosis				
Thyroid disease				
Iron deficiency anemia				
Sickle cell anemia				

CONDITION		COC	DMPA/ NET-EN	CU-IUD
Known hyperlipidemias				
Cancers	Cervical			I C
	Endometrial			I C
	Ovarian			I C
Cervical ectropion				
Breast disease	Undiagnosed mass	**	**	
	Family history of cancer			
	Current cancer			
Uterine fibroids without cavity distortion				
Endometriosis				
Trophoblast disease (malignant gestational)				
Vaginal bleeding patterns	Irregular without heavy bleeding			
	Heavy or prolonged, regular and irregular			
	Unexplained bleeding			I C
Cirrhosis	Mild			
	Severe			
Current symptomatic gall bladder disease				
Cholestasis	Related to the pregnancy			
	Related to oral contraceptives			
Hepatitis	Active			
	Client is a carrier			
Liver tumors				
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea			I C
	Vaginitis			
	Current pelvic inflammatory disease (PID)			I C
	Other STIs (excluding HIV/hepatitis)			
	Increased risk of STIs			
	Very high individual risk of exposure to STIs			I C
HIV	High risk of HIV or HIV-infected			
AIDS	No antiretroviral therapy (ARV)			I C
	Not clinically well on ARV therapy			I C
	Clinically well on ARV therapy			
Use of:	Griseofulvin			
	Rifampicin			
	Other antibiotics			

Source: Adapted from *Medical Eligibility Criteria for Contraceptive Use*. Geneva: World Health Organization. Third edition, 2004. Available: http://www.who.int/reproductive-health/publications/MEC/

Category 1 There are no restrictions for use.

Category 2 Generally use; some follow-up may be needed.

Category 3 Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

Category 4 The method should not be used.

I/C (Initiation/Continuation): A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the category indicated – whether or not she is initiating or continuing use of the method.

* Breastfeeding does not affect initiation and use of the IUD. Regardless of breastfeeding status, postpartum insertion of the IUD is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

** Evaluation should be pursued as soon as possible.

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HANDOUT 18 Decision Making for Permanent Methods

By the end of this session, you should be able to:

- Explain how permanent methods differ from temporary methods and why they warrant special attention during counseling
- List the factors contributing to sound decision making and possible regret
- List the topics that should be covered when counseling for permanent methods
- List the seven information elements of informed consent for permanent methods

Essential Ideas—Session 18

- Because of the permanent nature of sterilization and the associated need for a surgical procedure, counseling for sterilization services deserves special attention.
- The counselor's role is to ensure that the client's decision is voluntary, informed, and well considered. Ultimately, the decision to undergo sterilization is the client's alone.
- To ensure that clients make well-considered decisions, counseling must cover all of the seven information elements of informed consent (see "Informed and Voluntary Decision Making and Informed Consent"). This helps to secure the client's rights to *information, comfort,* and *safety.*
- Before making the decision to undergo sterilization, the client should also be given detailed information about the surgical procedure itself.
- The counselor must ensure that all of the client's questions are answered and that he or she understands all of the information provided during the counseling session.
- During counseling, clients should be screened for factors that might contribute to his or her future regret of the decision. Since reversal of the procedure is not a realistic option for many clients and does not always ensure pregnancy, the decision must be very well considered. Clients who might later regret their decision should be counseled carefully and given more time to think.
- The client's informed consent should be documented before the procedure in accordance with the governing laws of each country.

Discussion Summary

The counselor's role is to ensure that the client's decision is voluntary, informed, and well considered. Ultimately, the decision to use sterilization is the client's.

- Counseling clients who are interested in permanent methods requires particular care because female sterilization and vasectomy are **surgical** and have **associated risks** such as infection, bleeding, anesthesia-related problems, and method failure. The client should be informed that the procedure should be considered **permanent**.
- Clients should be informed about **risks** associated with any method. It is important that this information is provided carefully, making every effort not to unduly frighten the client. Although there are risks associated with these operations and complications are possible,

they rarely occur. One way of helping clients understand the risks associated with sterilization and vasectomy is by putting them in context, comparing them to the risks associated with other reproductive health–related risks, such as those associated with pregnancy and childbirth (see the cue card on HTSP in Appendix A of the Participant Handbook. The risk of death from using any method of contraception, including sterilization, is much lower than the risk of death from pregnancy.[1]

- Female sterilization and vasectomy are **intended to be permanent**. Although reversal is possible, it is not a realistic possibility for most clients. Similarly, in vitro fertilization might not be available to many clients. Many factors make reversal of female sterilization and vasectomy difficult or impossible. For example, reversal procedures:
  - Might not be available
  - Are usually costly
  - Often fail
  - Require that the doctor have special skills
  - Might not be appropriate for some individuals due to medical factors
- Providers must understand the policies, laws, and regulations related to sterilization and vasectomy in their country. Some countries have legal restrictions, including age or parity requirements. In all cases, because of the permanent nature of female sterilization and vasectomy, **informed and voluntary decision making** must be documented on an **informed consent** form signed by the client. Similarly, some countries have listed certain medical indications that make the client eligible for sterilization. These indications mostly consist of conditions putting the mother's life or the baby's life in danger and emergency situations in which the client will lose his or her fertility. In all such cases informed consent has to be ensured through counseling and documented on an informed consent form.
- The following conditions are required for a well-considered decision:
  - The client must be aware of all other options, including appropriate temporary methods.
  - The client must understand the permanent nature of the surgical procedure and that he or she will not be able to have children after the procedure.
  - The client should feel free to change his or her mind at any time before the procedure and be aware that he or she will not be denied any services because of having done so.
- Research tells us that clients want to know about the procedure itself (e.g., about anesthesia and pain) and about what to expect after surgery. Before making the decision to undergo sterilization, the client should be given **detailed information about the surgical procedure** itself, including the following:
  - Where and when it will be done
  - How long it will take
  - The type of anesthesia that will be used
  - What to expect in terms of pain
  - How long he or she will be in the hospital

[1] EngenderHealth. 2002. *Contraceptive sterilization: Global issues and trends*. New York: EngenderHealth.

- How long he or she will not be able to work
- Possible risks and complications
- How the procedure might affect her or his sexual relationships

  The counselor must also ensure that all of the client's questions are answered and that he or she understands all of the information given during the counseling session.

- The client's decision to undergo a sterilization procedure must be verified again immediately before the procedure.

Preventing Regret

Factors contributing to sound decision making	Factors contributing to possible regret
• Mature age • Desired family size achieved • Partner in agreement • Marital stability • Well-considered decision	• Young age • Few or no children • Partner's doubt • Pressure from partner, relatives, or service provider • Marital instability • Unrealistic expectations • Unresolved conflict or doubt • Excessive interest in reversal • Decision made under stress (during labor or immediately before or after an abortion)

Clients who undergo female sterilization or vasectomy when they are very young or who have few or no children are more likely to regret their decision later. As their circumstances change, they may wish to have children. The definitions of "young age" and "few children" vary from country to country, depending on the typical age at marriage, the ages at which women normally bear children, and typical family size.

Pressure from family members to undergo female sterilization or vasectomy can lead to a decision that does not reflect the client's wishes. Health providers can also exert pressure on clients, especially because they often have a higher social status and influence and are perceived as being more knowledgeable. This is likely when there are medical indications to prevent pregnancy. When the decision has been forced on the client, regret is likely.
Decisions made under stress might be regretted if and when the situation causing the stress is resolved. For example, if a marriage or other long-term relationship ends, partners might remarry (or form new relationships) and then wish to have children.

Unresolved doubts are an indication that clients are not entirely sure of their decisions and therefore might regret their decision in the future. Examples of issues that might lead to regret include religious or cultural norms that do not support limiting childbearing; unresolved personal feelings about ending fertility; unresolved concerns about possibly wanting more children if a child dies or if the client remarries.

Reversal is not always realistic. It is a difficult procedure to perform; it often is unavailable; and it is too expensive for most clients to afford. In addition, some clients might not be medically eligible for the procedure. Clients who think that female sterilization and vasectomy are reversible are likely to be disappointed and regret their choice. Therefore, the counselor must review the decision carefully, stressing the intended permanence of these procedures.

Delivery and abortion usually are not good times to make a decision about ending fertility. Stress, pain, sedatives, and pressure from others might lead a woman to make a choice she otherwise would not make. Sometimes, however, clients have already carefully considered their decision about female sterilization. For example, in many countries, women who are counseled during antenatal care (when they are pregnant) decide to have female sterilization at the time of delivery. Performing the procedure at the time of delivery or after an abortion might be appropriate in these cases. Providers should weigh each individual's circumstances carefully before deciding to offer and perform the surgery.

- If a client makes the decision to have a sterilization procedure shortly before or shortly after delivery or an abortion, it might be best to provide the client with a temporary method until after the postpartum period or until fully informed consent can be ensured. The health of the newborn should be taken into consideration before the decision is made.
- Fully informed and voluntary consent cannot be obtained if a woman is sedated, in labor, or experiencing stress before, during, or after a pregnancy-related event or procedure.
- In most cases, women with postabortion complications (e.g., infection, hemorrhage, and anemia) should not undergo a sterilization procedure until these conditions are resolved.

Informed and Voluntary Decision Making and Informed Consent

Informed and voluntary decision making is a process through which a client makes a well-considered, voluntary decision based on knowledge of all appropriate and available options, information about these options, and an understanding of the relevant medical facts and potential risks associated with the methods. **Informed consent** is the client's acceptance, agreement, or permission given under his or her own free will after making an informed decision.

Informed consent consists of seven information elements:

1. **Temporary methods of contraception are available** to me and my partner.
2. **The procedure to be performed on me is a surgical procedure,** the details of which have been explained to me.
3. **This surgical procedure involves risks, in addition to benefits,** which have been explained to me, and I understand the information that has been given to me. Among the risks is the possibility that the procedure might fail.
4. If the procedure is successful, **I will be unable to have any more children.**
5. **The effect of the procedure should be considered permanent.**
6. **The procedure does not protect me or my partner against infection** with sexually transmitted infections, including HIV/AIDS.
7. **I can decide not to have the operation at any time before the procedure is performed, even on the operating table** (without losing the right to medical, health, or other services or benefits).

Informed and voluntary decision making and informed consent are clients' rights. Ensuring that they are fulfilled:

- Increases the client's satisfaction
- Lessens the possibility of the client's later regret
- Protects the facility and its staff against charges of involuntary female sterilization or vasectomy and against possible legal action

Informed consent should be documented after the client requests the procedure and after the counselor verifies that the client's decision is voluntary, informed, and well considered. If someone other than the surgeon obtains the client's informed consent, it should be confirmed immediately before the procedure.

HANDOUT 19 Helping Clients Implement Their Decisions

By the end of this session, you should be able to:

- Identify the components of an implementation plan
- Demonstrate how to help clients develop a plan to implement their decisions (such as FP decisions, decisions about risk reduction to prevent HIV and other STIs, and so on)
- Demonstrate how to explain the FP method chosen by the client and how to use it
- Demonstrate how to help clients identify challenges in using their choice of method and strategies for overcoming the challenges

Essential Ideas—Session 19

- When a provider and a client work on a plan for carrying out a decision, the plan must be guided by the client's circumstances and choices. The provider's role is to help the client address key considerations—to be sure that the plan fits into the realities of the client's life and is one that he or she feels confident using.
- Another important role for the provider is to help the client anticipate the consequences of his or her decision(s) and implementation plan and to help strategize about how he or she will deal with them.
- Any plans involving behavior change must be specific. This means that when a client says that he or she will take a particular step to change a behavior, you need to ask questions that will enable the client to say out loud the specific steps that he or she will take and to think through the sequence—for example, talking to the partner about using the pill, taking a pill at the same time every day, placing the pill package near the tooth brush in order to remember to take it, coming back to the facility for resupply every three months, and so on.
- Skills and strategies that clients might need to develop if they are to implement their decisions include skills in communicating and negotiating with their partner(s), skills in using condoms, and knowledge and skills in using other FP methods correctly.

(continued)

The client's decision about which method to use and how he or she will address any problems or concerns about their method of choice (be it a new method or one she or he is. currently using) should guide the counseling session. This means that the counselor should not only **give information** about how to use the method but also help the client **identify possible barriers** to implementing their decision, assist the client **to strategize how to overcome** these barriers, and help the client **build the skills necessary for** overcoming those barriers.

Implementing the Decision—Steps in Detail

REDI Phase 4: Implementing the Decision

1. **Assist the client in making a concrete and specific plan for carrying out the decision (including correct method use).**
   - *Be specific.* The plan should include where and when to obtain the method; economic, family and social implications, and how to use the method. Asking a client the question "What will you do next?" is important in helping him or her develop a plan.

     For example, if the client has decided to start using ***condoms***, the provider should ask the following questions: "How often?" "Where will you get the condoms?" "How will you pay for them?" "How will you tell your partner that you want to use them?" and "Where will you keep them so you will have them with you when you need them?" For the ***pill***, the provider should ask how the client will remember to take it every day. For ***injectables***, the provider's questions should include how the client will remember to return for repeat injections at the appropriate time.

     If the client has chosen a method that is not immediately available or that requires booking at a later date or referral to another facility, the provider should counsel the client and provide the client with another temporary method that the client can use in the interim.

2. **Identify barriers that the client might face in implementing the plan.**
   - Ask about possible consequences of the plan (like the partner's reaction to the decision) and what social supports are available to the client. Who in the client's life can help the client carry out the plan? Who might create obstacles? The questions to ask the client might include the following:
     - "How will your partner(s) (or any other person from the family or community) react?"
     - "Do you fear any negative consequences?"
     - "How will the plan affect relationships with your partner(s)?"
     - "Can you communicate *directly* about the plan with your partner(s)?"
     - "Will indirect communication be more effective at first?"
   - What problems does the client think he or she might have? Examples include returning to the facility for follow-up or resupply/reinjection, taking an oral contraceptive pill at the same time every day, and purchasing supplies at the pharmacy.
   - Does the client think that he or she might experience difficulties (such as transportation, cost or availability) in accessing needed services or a skilled provider?

3. **Develop strategies to overcome the barriers identified.**
   - Make sure that the client understands
     - How to use FP methods that he or she has selected (repeat basic information and encourage him or her to ask for clarification)
     - What to do if side effects arise
     - What to do if warning signs of health risks or complications occur
   - Provide the client with written information, if it is available.

(continued)

Implementing the Decision—Steps in Detail *(cont.)*

- Help the client think through what he or she can or wants to do if the partner does not agree with the choice of method.
  - Offer ideas for improving the client's skills in communicating and negotiating with his or her partner about FP, dual protection, condom use, or sexuality. For example, if a client feels that it might be difficult to negotiate condom use for STI prevention purposes, discuss whether it might be easier to introduce condoms as a means of preventing pregnancy.
  - Help the client practice communicating and negotiating by role playing situations that may occur.
- Make a "Plan B"—that is, if the plan does not work, then what can the client do?

4. Identify and practice skills that the client will need.

- Make sure clients learn and practice the skills they need for use of specific FP methods (e.g., male and female condoms, diaphragm, spermicides, and Standard Days Method).
- Provide written information to the client, if it is available.

5. Make a plan for follow-up and provide referrals, as needed.

- Invite clients back for a follow-up visit if they find they need ongoing support with decision making, negotiation, and method use.
- Explain the timing for medical follow-up visits and contraceptive resupply.
- Refer the client as needed for continued supplies, care, discontinuation (e.g., removal of an IUD), switching to another method, or another service (such as STI diagnosis and treatment).
- Ensure that all of the client's concerns are addressed and that the client understands all of the information provided during the counseling session.

Essential Information on Method Use to Impart to Clients

1. When to start using the method (for pills, male or female condoms, Standard Days Method, spermicides, LAM) or when to have the method inserted (for IUDs or implants), given (for injectables), or performed (for tubal ligation, vasectomy); also consider the circumstances of clients who have just given birth or just had a miscarriage or abortion and the guidelines for use specific to these cases (see also cue cards on postpartum FP and postabortion FP)
2. Where to obtain the method or supplies
3. How to use the chosen FP method (pills, male and female condoms, spermicides, Standard Days Method, LAM) or how to obtain it (IUDs, implants, injectables, tubal ligation, vasectomy)
4. Tips for remembering to use the method correctly (e.g., how to remember to take pills daily; when to return for repeat injections)
5. Common side effects and how to deal with them
6. Warning signs of health risks and complications and what to do if they occur
7. How to prevent HIV and other STIs (including how to use condoms and where to obtain them)
8. How to communicate with partner about use of FP and/or condoms
9. When and where to return for resupply or follow-up

Participant Worksheet #2 (Session 19)

Guidance for Small-Group Work

1. What basic information will your client need in order to implement his or her decision to use FP?

2. What are the questions you would ask your client in order to help him or her identify possible barriers to the implementation of his or her decision? List the actual questions.

3. What are some possible strategies to develop and skills to impart to your client so that he or she can overcome those barriers?

HANDOUT 20 Dual Protection and Condoms

By the end of this session, you should be able to:

- Define *dual protection* and *dual method* use
- List ways of achieving dual protection
- Explain how dual protection counseling supports informed and voluntary decision making
- Identify challenges to dual protection
- List the steps for using a male condom in the correct order
- List the steps for using a female condom in the correct order (if the female condom is used in the activity)
- Demonstrate use of a male condom on a penis model

Essential Ideas—Session 20

- Counselors should inform all FP clients about the risk of HIV and other sexually transmitted infections (STIs) and help them assess their individual risk (**exploration** phase of REDI). All clients who have been identified as at risk and who have decided to reduce their risk should be counseled *about dual protection* and *condom use* (**implementing the decision** phase of REDI).
- The dual protection provided by condoms can be an effective means of protection against both unintended pregnancy and STI infection. Sexual activity is a link between FP and the prevention of STIs because pregnancy and STI infection both are possible outcomes of sexual activity.
- In some cases, it might be appropriate or desirable for clients to use dual methods (i.e., condoms plus another FP method). When explaining the benefits of dual-method use, the provider should be careful not to stigmatize condoms as a less effective FP method or as a method used solely for the prevention of STIs.
- Counseling about dual protection supports informed and voluntary decision making by making sure that clients are knowledgeable and aware of the risks of contracting STIs and of unintended pregnancy that are associated with sexual activity. Clients should consider this when deciding which method of FP to use.
- Pregnancy prevention might be a greater motivator for condom use than is STI infection. Therefore, the twin benefits of condom use (i.e., pregnancy prevention and STI prevention) should be communicated.
- The dual benefit of using condoms is important information that might help clients more easily negotiate condom use with their partners.
- Health service providers tend to assume that clients can and will understand how to use a condom just by being told how. Many studies show that service providers do not demonstrate condom use to their clients.
- Helping clients build skills in using condoms deserves special attention. Whether condoms are being used for FP, for protection from STIs, or for dual protection, building these skills during counseling is very important.

Dual Protection[1]

What are dual protection and dual-method use?

Dual protection is a strategy for preventing both STI transmission (including HIV) and unintended pregnancy through the use of condoms alone, the use of condoms combined with other FP methods (dual-method use), or the avoidance of risky sexual behaviors. More specifically, dual protection can include:

1. **The use of condoms alone:**
   - The use of a condom (male or female) alone for both purposes
2. **Dual-method use:**
   - The use of a condom plus another contraceptive method for extra protection against pregnancy
   - The use of a condom plus emergency contraception, should the condom fail
   - Selective condom use plus another FP method (e.g., using the pill with a primary partner but the pill plus condoms with other partners)
3. Several ways of **avoiding risky sexual behaviors:**
   - Mutual monogamy between uninfected partners, combined with a contraceptive method
   - Abstinence
   - Avoiding all types of penetrative sex
   - Delaying sexual debut (for young people)

   Note that the last three ways might not apply to individuals who have already come to seek FP services.

How does counseling about dual protection support informed and voluntary decision making?

- Counseling about dual protection upholds the concept of informed and voluntary decision making by ensuring that clients are knowledgeable and aware of their risks for STI infection and unintended pregnancy when making decisions about FP.
- Clients are not making truly informed decisions about FP unless they are aware of their risks and how effective the various FP methods are for preventing STIs (see also Handout 15: Risk Continuum, in the Participant Handbook). Counseling about dual protection ensures that clients are aware, knowledgeable, and informed.

What are possible challenges that clients face in dual-method use?

- Using two methods can cost twice as much.
- It is much more difficult to remember to use or carry two FP methods.
- The client might have less incentive to use both methods because one might be sufficient for preventing pregnancy or STI transmission.
- It might be hard enough to convince a partner to use one method, let alone two.
- Using two methods might be disruptive to the spontaneity of sex, depending on which methods they are.

[1] *Adapted from:* EngenderHealth. 2002. *Integration of HIV/STI prevention, sexuality, and dual protection in family planning counseling: A training manual*. New York: EngenderHealth.

Condom Excuses and Possible Responses[2]

1. "I can't feel anything when I wear a condom."

Possible response: "I know there's a little less sensation, but there's not a lot less. Why don't we put a drop of lubricant inside the condom? That'll make it feel more sensitive." (***Note:*** Lubricants should be water-based.)

2. "I don't need to use a condom. I haven't had sex in ___ months, so I know I don't have any diseases."

Possible response: "That's good to know. As far as I know, I'm disease-free too. But I'd still like to use a condom because either of us could have an infection and not know it."

3. "If I have to stop and put it on, I won't be in the mood anymore."

Possible response: "I can help you put it on. That way, you'll continue to be aroused, and we'll both be protected."

4. "Condoms are messy, and they smell funny."

Possible response: "It's really not that bad. And sex can be a little messy sometimes. But this way, we'll be able to enjoy it and both be protected from pregnancy and HIV and other STIs."

5. "Let's not use condoms just this once."

Possible response: "No. Once is all it takes to get pregnant or get an infection."

6. "I don't have a condom with me."

Possible response:"That's okay. I do."

7. "You never asked me to use a condom before. Are you having an affair?"

Possible response: "No. I just think we made a mistake by never using condoms before. One of us could have an infection and not know it. It's best to be safe."

8. "If you really loved me, you wouldn't make me wear one."

Possible response: "If you really loved me, you'd want to protect yourself—and me—from infections and pregnancy so that we can be together and healthy for a long time."

9. "Why are you asking me to wear a condom? Do you think I'm dirty or something?"

Possible response: "It's not about being dirty or clean. It's about avoiding pregnancy and the risk of infection."

10. "Only people who have anal sex need to wear condoms, and I'm not like that."

Possible response: "That's not true. A person can get an infection during any kind of sex, including what we do together."

[2] *Adapted from:* EngenderHealth. 2005. *Sexually transmitted infections online minicourse*. New York. Accessed at: www.engenderhealth.org/res/onc/sti/index.html.

11. "Condoms don't fit me."

Possible response: "Condoms can stretch a lot—in fact, they can stretch to fit over a person's head! So we should be able to find one that fits you."

12. "Why should we use condoms? They just break."

Possible response: "Actually, they told me that condoms are tested before they're sent out—so while they have been known to break, it rarely happens, especially if you know how to use one correctly—and I do."

13. "What happens if it comes off? It can get lost inside you, and you'll get sick or could even die. Do you want that?"

Possible response: "It's impossible for the condom to get lost inside me. If it came off, it would be inside my vagina, and I could just reach in and pull it out."

14. "If you don't want to get pregnant, why don't you just take the birth control pill?"

Possible response: "Because the birth control pill only protects against pregnancy. The condom protects against both pregnancy and infections."

15. "My religion says that using condoms is wrong."

Possible response: "It might help to talk with one of your religious leaders. A lot of people from different religions use condoms, even though their religion is against it. They figure that preventing infection or unintended pregnancy is more important than worrying about the morality of condoms."

16. "Well, I'm not going to use a condom, and that's it. So let's have sex."

Possible response: "No. I'm not willing to have sex without a condom."

17. "No one else uses them. Why should we be so different?"

Possible response: "Because a lot of people who didn't use them have ended up with HIV."

18. "You're a woman. How can you possibly ask me to use a condom? How can I respect you after this?"

Possible response: "You should respect me even more because I am acting responsibly. I'm suggesting this because I care about you and respect myself enough to protect myself. That's enough for me."

Steps for Using a Male Condom

- Check the manufacture or expiration date on package. *Hint:* Make sure condoms have been stored properly and obtained from a good source.[3]
- Remove the condom from the package. *Hint:* Do not use teeth, long nails, or a sharp object to open the condom package.

[3] "Stored properly" means that the condoms are stored away from heat and direct sunlight.

- Unroll the condom slightly to make sure it unrolls properly.
- Place the condom on the tip of the erect penis.
- Squeeze the air out of tip of condom.
- Unroll the condom down penis. *Hint:* If the condom is initially placed on the penis backwards and it doesn't unroll, do not turn it around. Throw it away and start with a new one.
- Smooth out the air bubbles.
- With the condom on, insert penis for intercourse.
- After ejaculation, hold on to the condom at base of penis while withdrawing penis.
- Withdraw while still erect.
- Remove the condom from penis.
- Tie the condom to prevent spills or leaks.
- Dispose of the condom.

Steps for Using a Female Condom

- Check the manufacture or expiration date on package. *Hint:* Make sure condoms are stored properly and obtained from a good source.[4]
- Rub the outside of the package to spread the lubrication evenly.
- Remove the condom from package. *Hint:* Do not use teeth, long nails, or a sharp object to open the condom package.
- Squeeze the ring on the closed end with your thumb and middle finger.
- Spread the outer and inner lips of the vagina (labia) with the other hand.
- Insert the squeezed inner ring into the vagina.
- Using your index finger, push the inner ring as far up into the vagina as it will go. *Hint:* Make sure the condom is inserted straight, not twisted.
- Leave the outside ring to rest against the outer lips of the vagina.
- Guide the penis to enter the vagina in the condom. *Hint:* If the penis starts to enter the vagina underneath the sheath, STOP having intercourse and start again with a new condom.
- After ejaculation, hold onto the outer ring and twist to keep the semen inside.
- Gently pull out the condom.
- Tie the condom to prevent spills or leaks.
- Dispose of the condom safely.

[4] "Stored properly" means that the condoms are stored away from heat and direct sunlight.

HANDOUT 21

Strengthening Skills in Partner Communication and Negotiation

By the end of this session, you should be able to:

- Identify possible reasons why clients might not talk with their partners about FP and SRH concerns
- List the deeper personal and social factors behind clients' difficulties in discussing FP and SRH issues with their partners
- Help clients discuss FP and SRH issues more effectively with partners (even in relationships marked by violence or a power imbalance between partners)

Essential Ideas—Session 21

- Clients might feel that they cannot discuss FP and SRH issues and concerns with their partners. Identifying the reasons why they feel this ways is an important first step in helping clients determine whether they can move past these blocks and find ways to start these important conversations with their partners.
- Some clients have deeper fears or social factors, such as domestic violence or sexual abuse, behind their reasons for not talking with their partners. Addressing these might require more advanced counseling skills, and in such cases, the client should be referred. All counselors should know where they can refer clients for more help.
- Clients' reasons for feeling that they cannot discuss FP or sexuality openly with their partner(s) can be *real* or *perceived*. Providers should respect the client's reasons, even if the perception does not fit with the provider's view or understanding of the client's situation.
- If a client does not feel able to discuss FP or issues related to sexual activity in his or her relationship, he or she should not be forced to do so. Such clients should be encouraged to come back for further discussion. In the end, however, the client knows his or her relationship best.
- When there is a power imbalance in a relationship, the client should not be pressed to pursue the issue, especially if violence or abuse has occurred or he or she fears that it might occur. Pursuing the issue could result in placing the client's health and life in danger. Instead, the counselor should explore with the client possible strategies for discussing issues related to FP and sexuality.
- Even when there is a power imbalance or violence in a relationship, a person has options for negotiating safer sex and contraception. This often requires the client to be creative and willing to adapt the approach to meet his or her partner's needs. Many of these options can be considered "survival strategies," as they are options of last resort and serve primarily to reduce harm. Although a counselor might find this approach frustrating or even challenging, it is important to recognize and work within the client's perceived needs and the realities of his or her current situation, without being judgmental.
- Do not criticize the partner or spouse, and do not simply suggest to the client that he or she leave the partner. Abusive or controlling relationships are rarely resolved by suggesting that the client leave; nor is leaving always the client's best or most realistic option.

(continued)

Essential Ideas—Session 21 *(cont.)*

- Providers should familiarize themselves with services available in the community for people who are in abusive relationships or who live with gender-based violence, and providers should refer clients, as appropriate.
- It is not the FP counselor's job to help the client with gender-based violence. FP counselors might come across signs or evidence of gender-based violence during FP counseling. If they do, they should encourage the client to consider this while making FP decisions but otherwise should refer clients for services available in the community.

Examples of Barriers to Talking with Partners about SRH Concerns

Clients' reasons	Possible deeper personal and social factors
"I cannot tell him that I want to use family planning because he thinks that it goes against our religion."	Following social norms and values
"My partner does not want to discuss family planning because she wants to have more children."	Following social norms and values
"My partner will think I am cheating if I ask him to use condoms."	Fear of losing the relationship; fear of violence
"We love each other, so why should we use condoms?"	Denial
"We do not talk about things like that."	Following social norms and values; fear of change; power imbalance in the relationship; potential for or past violence
"People like me do not get HIV or other sexually transmitted infections (STIs)."	Misinformation about how HIV and other STIs are transmitted; denial; lack of understanding of personal risk
"My partner will think I have HIV or another STI if I ask him to use condoms, and he will kick me out of the house and tell everyone about it."	Power imbalance; fear of retribution; fear of loss of support; fear of violence
"I do not want my partner to know that I have other sexual partners."	Fear of a negative reaction; fear of violence; fear that the partner will want to end the relationship
"I cannot tell him that I am unhappy with our sex life—he will find someone else."	Fear of abandonment
"I cannot tell him that it hurts because it is a woman's obligation to have sex with her husband any way that he wants."	Following social norms and values; power imbalance; fear of violence
"I cannot tell her that I have an STI because then she will know that I cheat on her."	Fear of a negative reaction
"I cannot ask him about his smelly discharge because he will get embarrassed."	Fear of hurting feelings or embarrassing partner

Adapted from: EngenderHealth. 2003. *Comprehensive counseling for reproductive health: An integrated curriculum*. New York: EngenderHealth.

How Power Imbalances Affect FP Use

Many clients—and in particular, women—face challenges in discussing FP concerns with their partners under the best of circumstances. How are these challenges made more complicated when there is a power imbalance, violence, or abuse in the relationship?

- Fewer options might be feasible for a woman who is controlled or abused by her partner.
- She feels greater pressure to fix what is wrong with the relationship, rather than considering what would best meet her FP needs.
- The woman might be suffering from depression or a sense of hopelessness as result of the power imbalance and therefore might not take care of herself by practicing safer sex or FP.

Strategies for Detecting and Addressing Barriers

What suggestions can providers make to clients for discussing sexuality issues and FP concerns with their partners?

The client could take the following approaches:

- Identify areas of family life or relationships that they *do* talk about. See if there is some way that these issues can serve an entry point for the discussion.
- Start the conversation by saying that this is something that she heard about in a talk at the health care facility and that she wonders if her partner knows anything about it.
- Compliment the partner or use another tactic to make him realize that using condoms, having a vasectomy, and allowing the client to use FP are ways of exercising his power. (*Note:* This could be considered a "survival strategy.")
- Say that he or she has some health issues that the provider wants to discuss with him or her, in light of his or her role in the family, or that there are some decisions that they need to make together (in the context of exploring the possibility and benefit of a joint visit by the client and the partner).
- Identify family members (of either partner) who might be supportive, and ask them to help him or her communicate about these issues with the partner.

Notes to the provider:

- The issue of a power imbalance or violence often comes up naturally when the counselor addresses negotiation. Questions like "Do you discuss FP with your partner/husband?", "How about HIV and other STI prevention?", "If not, what makes it difficult? What would happen if you tried?", "If yes? How did it work for you?" will help elicit information related to power imbalances and potential violence.
- Use role playing with the client to allow him or her to practice these strategies. Sometimes it is helpful at first for the client to practice being the partner and for the provider to play the role of the client to model how these issues can be discussed. Then switch roles to give the client a chance to practice saying these things herself or himself.
- Providers should be nonjudgmental of the partner as well as of the client. Criticizing the partner might threaten the client's sense of well-being and interfere with the counseling relationship.
- Providers should respect the client's willingness and ability to negotiate with the partner. If clients say that they cannot discuss this with their partner, explore the options. If there are truly no other options, schedule a follow-up visit or refer the client to a social worker (if available) with the necessary resources to address the problem.

HANDOUT 22 Counseling Return Clients

By the end of this session, you should be able to:

- Describe how the counseling needs of returning clients differ from those of new clients
- List possible reasons for return visits
- Identify appropriate provider attitudes and approaches for addressing the concerns of return clients

Essential Ideas—Session 22

- Return clients constitute a significant portion of the clients who come to facilities for services. Return visits provide the opportunity for continuous support to the client—that is, the opportunity to ensure that he or she is satisfied with the FP method, that he or she is using it safely, and that his or her other emerging SRH needs are met in a timely manner. Return visits can be considered part of the **implementing the decision** phase of REDI counseling, during which providers continue helping the client to implement his or her initial decision.
- Returning clients should not be served in a cursory manner based on the assumption that they have already been using their chosen method and do not need follow-up. Nor should returning clients be forced to see a counselor or listen to information that they do not need. Providers must assess each individual client's needs and then provide appropriate counseling and services as efficiently as possible, without wasting time. The phases of the REDI framework should be tailored to the assessed need of the returning clients. Clients with problems or concerns should be given careful attention and counseling relevant to the reason for the visit. Returning clients with no problem should be given the service or supplies they came for, without unnecessary delays.
- The provider should ask (using open-ended questions) whether the returning client is having any method- or SRH-related problems or concerns, then confirm that the client is using the method correctly and encourage the client to ask any questions he or she might have.
- If the client has questions or concerns, is experiencing problems, or has had a change of circumstances, these issues should be explored and addressed by the provider.
- Clients' concerns and complaints be taken seriously and should never be dismissed. The counselor should be supportive of the client when addressing his or her concerns. The counselor's approach is examined in greater detail in Session 23.
- Meeting the expressed needs of the client, as well as inquiring about unexpressed SRH needs, is one of the provider's primary tasks. If the client's particular need cannot be met by the provider or cannot be met within the facility, the client should be referred to another service provider or facility.
- If a client is happy with his or her method and is using it correctly, the provider should fulfill the client's request for a resupply and remind him or her of when to return.

Reasons for Return Visits and Appropriate Provider Responses

Reasons for Clients' Return Visits	Appropriate Provider Attitudes and Counseling Responses
Resupply of a method	• Ask whether the client is satisfied and if he or she is experiencing any problems • Inquire about correct use • Provide resupply without delay, if no problems
Follow-up of a method or procedure	• Ask whether the client is satisfied and if he or she is experiencing any problems • Inquire about correct use • Provide appropriate services, such as checking IUD placement
Concerns	• Explore what the concerns are and the underlying reasons for the concerns (e.g., side effects, misconceptions, rumors) • Take the client seriously • Address concerns through counseling, clinical management (if needed), and other service options, such as discontinuing the method and switching to another one
Side effects	• Explore the nature of side effects to see if the side effects are within the expected and acceptable range • If appropriate, counsel the client to assure him or her that the side effects are harmless, experienced by many, and transient (see Handout 23) • Manage side effects as per guidelines (see Handout 23) • Give the client the option to switch to another method if she or he finds the side effects intolerable
Other problems related to method use (economic, social, partner-related)	• Explore the nature of the problem and the underlying reasons for it • Explore with the client options for eliminating the problem, including switching to another method
Wanting to switch methods	• Explore the client's reasons for wanting to switch • Confirm that the client is making an informed and voluntary decision • Provide appropriate services
Wanting to discontinue using the method	• Explore the client's reasons for wanting to discontinue • Counsel about other FP options, if appropriate • Provide appropriate services
Wanting to get pregnant	• Explore when the client wants to get pregnant • Provide the needed service (if provider intervention, such as removal of an IUD, is needed to discontinue) the FP method • Counsel about or refer for preconception and pregnancy care

(continued)

Reasons for Return Visits and Appropriate Provider Responses *(cont.)*

Reasons for Clients' Return Visits	Appropriate Provider Attitudes and Counseling Responses
Change in client's circumstances (change of partner, marital status, risk for HIV and other STIs)	• Explore with the client the change and its implications for the client's need for FP • Help the client identify the decisions to make, if any • Provide the counseling and services needed
Warning signs/symptoms of health risks/complications	• Explore the nature of the symptoms • If the client is experiencing a health risk/complication, manage or refer as appropriate
Other SRH problems (such as an infection)	• Explore the nature of the problem • Manage or refer as appropriate
Other health problems	• Explore the nature of the problem • Manage or refer as appropriate
Complaints that are unrelated to the method	• Explore the nature of the problem • Manage or refer as needed • Assure the client that his or her complaints are not related to the FP method
To have a partner or a relative counseled	• Thank the client • Praise and encourage the partner or the relative for coming • Provide counseling and services as appropriate
To accompany a friend or relative	• Thank the client • Praise and encourage the partner or the relative for coming • Provide counseling and services as appropriate
Express gratitude	• Thank the client • Inquire if he or she has other sexual and reproductive health needs

HANDOUT 23

Managing Side Effects and Other Problems

By the end of this session, you should be able to:

- List the steps of managing side effects and other problems
- Describe the management of side effects and other problems for each FP method
- Demonstrate how to help clients cope with side effects and other problems

Essential Ideas—Session 23

- Fears, concerns, and actual side effects constitute the main reasons for clients' discontinuation of their chosen FP method. Addressing and managing such concerns and complaints helps clients resume and continue using their method.
- Health care workers should take clients' complaints seriously, explore them in depth, and provide information and support to help clients cope with the situation.
- Most health care workers are also responsible for managing side effects and health risks/complications by either treating the problem or referring the client for treatment elsewhere.
- If clients' concerns and complaints cannot be resolved by reassurance and treatment, the client should be given the option of switching to another method.

Steps for Managing Side Effects and Other Problems

- Always acknowledge clients' complaints
- Take clients' complaints seriously
- Gain a full understanding of the complaint: Ask and listen! (Is it a side effect, a sign of a health risk/complication, or another problem?)
- Inform and reassure (for side effects):
  - Explain to the client why and how side effects occur
  - Assure the client that the side effect or complaint is benign and not a sign of a serious health problem
  - Determine whether the side effect will go away without treatment or should be treated
  - Explain what the client can do to cope with the inconvenience caused by the side effect
  - Remind the client of the warning signs of health risks/complications
  - Remind the client that he or she is always welcome to come back with any concerns or questions
  - Remind the client that he or she is always welcome to change methods
- Discuss and/or offer medical management as appropriate (for side effects and health risks/complications)
  - Discuss medical treatment options
  - Treat side effects or complications as per guidelines, or refer the client if treatment is not available at your facility
  - If the client is not satisfied with these options, offer the client the option of switching to another method

Adapted from: Rinehart, W., Rudy, S., and Drennan, M. 1998. GATHER guide to counseling. *Population Reports*, series J, no. 48. Baltimore: Johns Hopkins University School of Public Health, Population Information Program.

Management of Side Effects and Other Problems, by Method

METHOD	COMMON MANAGEMENT
Combined Oral Contraceptives (COCs)	

Nausea or dizziness	• Pills can be taken at bedtime or with food.
	• If symptoms continue:
	  ○ Consider locally available remedies.
	  ○ Consider extended use if her nausea comes after she starts a new pack of pills.

Irregular bleeding (at unexpected times that bothers the client)	• Reassure her that many women using COCs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use.
	• Check to see if she has missed any pills.
	• Inquire about factors that would reduce the effectiveness of the pill (e.g., vomiting, diarrhea, use of other medicines)
	• To reduce irregular bleeding:
	  ○ Urge her to take a pill each day at the same time each day.
	  ○ Teach her to make up for missed pills properly, including after vomiting or diarrhea.
	  ○ Try 800 mg ibuprofen three times daily after meals for five days, or another nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts.
	  ○ If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different COC formulation, if available. Ask her to try the new pills for at least three months.
	• If irregular bleeding continues or starts after several months of having normal or no monthly bleeding, or if you suspect for other reasons that something might be wrong, consider underlying conditions unrelated to method use.

No monthly bleeding	• Ask if she is having any bleeding at all. If she is, reassure her.
	• Reassure her that some women using COCs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up insider her.
	• Ask if she has been taking a pill every day. If she has, reassure her that she is not likely to be pregnant. She can continue taking her COCs as before.
	• Ask her if she skipped the seven-day break between two packs (for 21-day packs) or skipped the seven nonhormonal pills (for 28-day packs)? If she did, reassure her that she is not pregnant. She can continue using COCs.
	• If she has missed hormonal pills or started a new pack late:
	  ○ She can continue using COCs.
	  ○ If she has missed three or more pills or started a new pack three or more days late, she should return to the facility if she develops signs and symptoms of early pregnancy.

(continued)

Source: INFO Project. 2007. *Family planning: A global handbook for providers*. Baltimore: INFO Project.

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Combined Oral Contraceptives (COCs)	
Ordinary headaches (nonmigrainous)	• Try the following (one at a time): ○ Suggest aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (325 to 1000 mg), or another pain reliever. ○ Some women get headaches during the hormone-free week (the seven days when the woman does not take hormonal pills). Consider extended use (i.e., taking hormonal pills for 12 weeks without a break, followed by taking one week of nonhormonal pills or taking no pills for one week). • Any headaches that get worse or occur more often during COC use should be evaluated.
Very bad headaches (migraines)	• Regardless of her age, a woman who develops migraine headaches, with or without aura, or whose migraine headaches become worse while using COCs, should stop using COCs. • Help her choose a method without estrogen.
Unexplained vaginal bleeding or heavy or prolonged bleeding (twice as much as usual or longer than eight days) *Note:* Such bleeding may be suggestive of a medical condition not related to the method.	• Refer or evaluate the woman by history and pelvic examination. Diagnose and treat as appropriate. • The woman can continue using COCs while her condition is being evaluated. • If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using COCs during treatment.
Starting treatment with anticonvulsants or rifampicin	• Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, and rifampicin may make COCs less effective. If the woman expects long-term use of any of these medications, she might want a different method such as monthly injectables, progestin-only injectables, or a copper-bearing or hormonal IUD. • If she will be using these medications on a short-term basis, she can use a backup method along with COCs.
Circumstances that will keep her from walking for one week or more	• If she is having major surgery or her leg is in a cast, or for other reasons she will be unable to move about for several weeks, she should: ○ Tell her doctors that she is using COCs ○ Stop taking COCs and use a backup method during this period ○ Restart COCs two weeks after she can move about again
Certain serious health conditions (suspected heart or liver disease, high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, damage to arteries, or gall bladder disease)	• Tell the woman to stop taking COCs. • Help her choose a backup method to use until the condition is evaluated. • Refer her for diagnosis and care, if she is not already receiving care for her condition.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Combined Oral Contraceptives (COCs)	
Minor side effects during the first three months	• Offer the woman another low-dose pill or a progestin-only pill.
Suspected pregnancy	• Assess for pregnancy. • Tell her to stop taking COCs if pregnancy is confirmed. • There are no known risks to a fetus conceived while a woman is taking COCs.
Progestin-Only Pills (POPs)	

Irregular bleeding (bleeding at unexpected times that bothers the client)	• Reassure the woman that many women using POPs experience irregular bleeding (including women who are breastfeeding). It is not harmful and sometimes becomes less or stops after the first several months of use. However, some women have irregular bleeding the entire time they are taking POPs.
	• Other possible causes of irregular bleeding:
	  ○ Vomiting or diarrhea
	  ○ Taking anticonvulsants or rifampicin
	• To reduce irregular bleeding:
	  ○ Teach the woman to make up for missed pills properly, including after vomiting or diarrhea.
	  ○ For modest short-term relief, she can try 800 mg ibuprofen three times daily after meals for five days or another nonsteroidal anti-inflammatory drug (NSAID), beginning when irregular bleeding starts. NSAIDs provide some relief of irregular bleeding for implants, progestin-only injectables, and IUDs, and they may also help POP users.
	  ○ If she has been taking the pills for more than a few months and NSAIDs do not help, give her a different POP formulation, if available. Ask her to try the new pills for at least three months.
	• If the woman's irregular bleeding continues or starts after several months of normal or no monthly bleeding, or if you suspect for other reasons that something might be wrong, consider underlying conditions unrelated to the method.

Heavy or prolonged bleeding (twice as much as usual or longer than eight days)	• Reassure the woman that some women using POPs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months. • For modest short-term relief, she can try NSAIDs, beginning when heavy bleeding starts. Try the same treatments as for irregular bleeding. • To help prevent anemia, suggest that the woman take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas). • If the heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or if you suspect for other reasons, that something might be wrong, consider underlying conditions unrelated to the method

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Progestin-Only Pills (POPs)	

No monthly bleeding	• Breastfeeding women:
	  ○ Reassure the woman that this is normal during breastfeeding. It is not harmful.
	• Women not breastfeeding:
	  ○ Reassure the woman that some women using POPs stop having monthly bleeding, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her.

Severe pain in lower abdomen (suspected ectopic pregnancy or enlarged ovarian follicles or cysts)	• Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening.
	• In the early stages of ectopic pregnancy, symptoms might be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
	  ○ Unusual abdominal pain or tenderness
	  ○ Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from the woman's usual bleeding pattern
	  ○ Lightheadedness or dizziness
	  ○ Fainting
	• If you suspect ectopic pregnancy or another serious health condition, refer the woman at once for immediate diagnosis and care.
	• Abdominal pain might be the result of other problems such as enlarged ovarian follicles or cysts.
	  ○ There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that these conditions usually disappear on their own. To be sure the problem is resolving, see the client again in six weeks, if possible.

Unexplained vaginal bleeding (suggestive of a medical condition not related to the method)	• Refer the woman or evaluate by history and pelvic examination. Diagnose and treat as appropriate. • The woman can continue using POPs while her condition is being evaluated. • If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using POPs during treatment.
Starting treatment with anticonvulsants or rifampicin	• Barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, and rifampicin might make POPs less effective. If the woman expects long-term use of these medications, she might want a different method, such as monthly injectables, progestin-only injectables, or a copper-bearing or hormonal IUD. • If she will be using these medications on a short-term basis, she can use a backup method along with POPs.
Migraine headaches	• If the woman has migraine headaches without aura, she can continue to use POPs if she wishes. • If she has migraine aura, she must stop using POPs. Help her choose a method without hormones.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Progestin-Only Pills (POPs)	
Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, liver disease, or breast cancer)	• Tell the woman to stop taking POPs. • Help the woman choose a backup method to use until the condition is evaluated. • Refer her for diagnosis and care if she not already receiving care for her condition.
Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke	• A woman who has one of these conditions can safely start POPs. However, if the condition develops after she starts using POPs, she should stop. Help her choose a method without hormones. • Refer her for diagnosis and care if she is not already receiving care for her condition.
Suspected pregnancy	• Assess the woman for pregnancy, including ectopic pregnancy. • Tell her to stop taking POPs if pregnancy is confirmed. • There are no known risks to a fetus conceived while a woman is taking POPs.
Progestin-Only Injectables (DMPA and NET-EN)	
Late injections	• If the client is less than two weeks late for a repeat injection, she can receive her next injection. There is no need for tests, evaluation, or a backup method. • A client who is more than two weeks late can receive her next injection under any of the following circumstances: ○ She has not had sex since two weeks after she should have had her last injection. ○ She has used a backup method or has taken emergency contraceptive pills after any unprotected sex since 2 weeks after she should have had her last injection. ○ She is fully or nearly fully breastfeeding and she gave birth less than six months ago. She will need a backup method for the first seven days after the injection. • Discuss why the client was late and possible solutions. If coming back on time is often a problem for her, discuss using a backup method when she is late for her next injection, taking emergency contraceptive pills, or choosing another method.
No monthly bleeding	• Reassure the woman that most women using progestin-only injectables stop having monthly bleeding over time, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her. • If she is not having monthly bleeding bothers her, she might want to switch to monthly injectables, if they are available.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Progestin-Only Injectables (DMPA and NET-EN)	
Irregular bleeding (bleeding at times that bothers the client)	• Reassure the woman that many women using progestin-only injectables experience irregular bleeding. It is not harmful and usually becomes less or stops after the first few months of use. • For modest short-term relief, she can take 800 mg ibuprofen three times daily or 500 mg mefenamic acid two times daily after meals for five days, beginning when irregular bleeding starts. • If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or if you suspect for other reasons that something might be wrong, consider underlying conditions unrelated to the method. Inquire about possible underlying reasons (e.g., STIs, pelvic inflammatory disease), and treat and/or refer as needed. If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using progestin-only injectables during treatment.

Heavy or prolonged bleeding (twice as much as usual or longer than eight days)	• Reassure the woman that some women using progestin-only injectables experience heavy or prolonged bleeding. It is not harmful and usually becomes less or stops after a few months.
	• For modest short-term relief, she can try (one at a time):
	  ○ COCs, taking one pill daily for 21 days, beginning when heavy bleeding starts
	  ○ 50 micrograms of ethinyl estradiol daily for 21 days, beginning when heavy bleeding starts
	• If bleeding becomes a health threat or if the woman wants to switch methods, help her choose another method. In the meantime, she can take ethinyl estradiol or COCs as above to help reduce bleeding.
	• To help prevent anemia, suggest that the woman take iron tablets and tell her that it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
	• If the heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or if you suspect that something might be wrong for other reasons, consider underlying conditions unrelated to the method.

Ordinary headaches (nonmigrainous)	• Suggest aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (325 to 1000 mg), or another pain reliever. • Any headaches that get worse or occur more often during use of injectables should be evaluated.
Very bad headaches (migraines)	• If the woman has migraine headaches without aura, she can continue to use the method if she wishes to. • If she has migraine aura, do not give the injection. Help her choose a method without hormones.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Progestin-Only Injectables (DMPA and NET-EN)	
Unexplained vaginal bleeding (suggestive of a medical condition no related to the method)	• Refer the woman or evaluate by history and pelvic examination. Diagnose and treat as appropriate. • If no cause of bleeding can be found, consider stopping the progestin-only injectables to make diagnosis easier. Help the woman choose another method (not implants or a copper-bearing or hormonal IUD) to use until the condition is evaluated and treated. • If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using progestin-only injectables during treatment.
Certain serious health conditions (suspected blocked or narrowed arteries, liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes)	• Do not give the woman the next injection. • Give her a backup method to use until her condition is evaluated. • Refer her for diagnosis and care if she is not already receiving care for the condition.
Suspected pregnancy	• Assess the woman for pregnancy. • Stop injections if pregnancy is confirmed. • There are no known risks to a fetus conceived while a woman is using injectables.
Implants	
No monthly bleeding	• Reassure the woman that some women stop having monthly bleeding when using implants, and this is not harmful. There is no need to lose blood every month. It is similar to not having monthly bleeding during pregnancy. She is not infertile. Blood is not building up inside her.

Irregular bleeding (bleeding at unexpected times that bothers the client)	• Reassure the woman that many woman using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use.
	• For modest short-term relief, she can take 800 mg ibuprofen or 500 mg mefenamic acid three times daily after meals for five days, beginning when irregular bleeding starts.
	• If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts:
	  ○ Combined oral contraceptives with the progestin levonorgestrel (one pill daily for 21 days)
	  ○ 50 micrograms ethinyl estradiol daily for 21 days
	• If the irregular bleeding continues or starts after several months of normal or no monthly bleeding, or if you suspect for other reasons that something may be wrong, consider underlying conditions unrelated to the method.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Implants	
Heavy or prolonged bleeding (twice as much as usual or longer than eight days)	• Reassure the woman that some women using implants experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months. • For modest short-term relief, she can try any of the treatments for irregular bleeding listed above, beginning when heavy bleeding starts. Combined oral contraceptives with 50 micrograms of ethinyl estradiol might work better than lower-dose pills. • To help prevent anemia, suggest that she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas). • If the heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or of you suspect for other reasons that something might be wrong, consider underlying conditions unrelated to the method.
Ordinary headaches (nonmigrainous)	• Suggest aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (325 to 1,000 mg), or another pain reliever. • Any headaches that get worse or occur more often during use of implants should be evaluated.
Mild abdominal pain	• Suggest aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (325 to 1,000 mg), or another pain reliever. • Consider locally available remedies.
Severe pain in lower abdomen (suspected ectopic pregnancy or enlarged ovarian follicles or cysts)	• Many conditions can cause severe abdominal pain. Be particularly alert for signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening. • In the early stages of ectopic pregnancy, symptoms might be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy: ○ Unusual abdominal pain or tenderness ○ Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from the woman's usual bleeding pattern ○ Lightheadedness or dizziness ○ Fainting • If you suspect ectopic pregnancy or another serious health condition, refer the woman at once for immediate diagnosis and care. • Abdominal pain might be caused by other problems, such as enlarged ovarian follicles or cysts. ○ A woman can continue to use implants during evaluation. ○ There is no need to treat enlarged ovarian follicles or cysts unless they grow abnormally large, twist, or burst. Reassure the client that these conditions usually disappear on their own. To be sure the problem is resolving, see the client again in six weeks, if possible.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Implants	
Pain after insertion or removal	• For pain after insertion, check that the bandage or gauze on the woman's arm is not too tight. • Put a new bandage on the arm and advise her to avoid pressing on the site for a few days. • Give her aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (325 to 1,000 mg), or another pain reliever.
Infection at the insertion site (redness, heat, pain, pus)	• Do not remove the implants. • Clean the infected area with soap and water or antiseptic. • Give the woman oral antibiotics for seven to 10 days • Ask her to return after taking all of the antibiotics if the infection does not clear. If the infection has not cleared, remove the implants or refer the woman to have them removed. • Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an implant coming out.
Abscess (pocket of pus under the skin due to infection)	• Clean the area with antiseptic. • Cut open (incise) and drain the abscess. • Treat the wound. • Give oral antibiotics for seven to 10 days. • Ask the client to return after taking all of the antibiotics if she has heat, redness, pain, or drainage of the wound. If infection is present when she returns, remove the implants or refer her to have them removed.
Expulsion (when one or more implants begins to come out of the arm)	• This condition is rare and usually occurs within a few months of insertion or with infection. • If no infection is present, replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer the woman to have it replaced.
Migraine headaches	• If the woman has migraine headaches without aura, she can continue to use implants if she wishes • If she has migraine aura, remove the implants. Help her choose a method without hormones.
Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, liver disease, or breast cancer)	• Remove the implants or refer the woman to have them removed. • Help her choose a backup method to use until her condition is evaluated. • Refer her for diagnosis and care if she is not already receiving care for the condition.
Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke	• A woman who has one of these conditions can safely start implants. However, if the condition develops while she is using implants: ○ Remove the implants or refer her to have them removed. ○ Help her choose a method without hormones. ○ Refer her for diagnosis and care if she not already receiving care for the condition.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Implants	
Suspected pregnancy	• Assess the woman for pregnancy, including ectopic pregnancy. • If she plans to carry the pregnancy to term, remove the implants or refer her to have them removed. • There are no known risks to a fetus conceived while a woman has implants in place.
Copper-Bearing Intrauterine Device (IUD)	
Heavy or prolonged bleeding (twice as much as usual or longer than eight days)	• Reassure the woman that many women experience heavy or prolonged bleeding while using an IUD. It is generally not harmful and usually becomes less or stops after the first several months of use. • For modest short-term relief she can try (one at a time): ○ Tranexamic acid (1,500 mg) three times daily for three days, then 1,000 mg daily for two days, beginning when heavy bleeding starts ○ Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) or indomethacin (25 mg) two times daily after meals for five days, beginning when heavy bleeding starts. Other NSAIDs—except aspirin—also might provide some relief. • Provide iron tablets, if possible, and tell her it is important for her to eat foods containing iron. • If heavy or prolonged bleeding continues or starts after several months of having normal bleeding or long after the IUD was inserted, or if you suspect for other reasons that something might be wrong, consider underlying conditions unrelated to the method.
Irregular bleeding (bleeding at unexpected times that bothers the client)	• Reassure the woman that many IUD users experience irregular bleeding. It is not harmful and usually lessens or stops after several months. • For modest short-term relief, she can try NSAIDs such as ibuprofen (400 mg) or indomethacin (25 mg) two times daily after meals for five days, beginning when irregular bleeding starts. • If irregular bleeding continues or starts after several months of normal bleeding, or if you suspect for other reasons that something might be wrong, consider underlying conditions unrelated to the method.
Cramping and pain	• Women can expect some cramping and pain for the first day or two after insertion of an IUD. • Explain to the woman that cramping is common in the first three to six months of IUD use, particularly during monthly bleeding. Generally this is not harmful, and it usually decreases over time. • Suggest aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (32 to 1,000 mg), or another pain reliever. If she also has heavy or prolonged bleeding, aspirin should not be used because it might increase bleeding. If the cramping continues and occurs outside of monthly bleeding: • Evaluate the woman for underlying health conditions and treat or refer her. • If no underlying condition and cramping is severe, discuss removal. ○ If the removed IUD looks distorted, or if difficulties during removal suggest that the IUD was out of proper position, explain to the client that she can have a new IUD that might cause less cramping.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Copper-Bearing Intrauterine Device (IUD)	
Possible anemia	• If a woman already has low iron blood stores before a copper-bearing IUD is inserted and the IUD causes heavier monthly bleeding, the IUD might contribute to anemia.. • Pay special attention to IUD users with any of the following signs and symptoms: ○ Inside of eyelids or underneath fingernails looks pale; pale skin; fatigue or weakness; dizziness; irritability; headache; ringing in the ears; sore tongue; brittle nails ○ If blood testing is available, a test result showing hemoglobin less than 9 g/dl or hematocrit less than 30 • Provide iron tablets, if possible. • Tell the woman that it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
Partner can feel IUD strings during sex	• Explain the woman that this happens sometimes when strings are cut too short. • If her partner finds the strings bothersome, describe the available options: ○ Strings can be cut even shorter so they are not coming out of the cervical canal. Her partner will not feel the strings, but the woman will no longer be able to check the IUD strings. • If the woman wants to be able to check her IUD strings, the IUD can be removed and a new one can be inserted. (To avoid discomfort, the strings should be cut so that three centimeters hang out of the cervix.)
Severe pain in lower abdomen (suspected pelvic inflammatory disease [PID])	• Some common signs and symptoms of PID also occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID. • If possible, perform an abdominal examination and a pelvic examination. • If a pelvic examination is not possible, and the woman has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID: ○ Unusual vaginal discharge ○ Fever or chills ○ Pain during sex or urination ○ Bleeding after sex or between monthly bleeding periods ○ Nausea and vomiting ○ A tender pelvic mass ○ Pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness) • Treat PID or immediately refer the woman for treatment: ○ Because of the serious consequences of PID, health care providers should treat all suspected cases, based on the signs and symptoms above. Treatment should be started as soon as possible. Treatment is more effective at preventing long-term health risks/complications when appropriate antibiotics are given immediately. ○ Treat for gonorrhea, chlamydia, and anaerobic bacterial infections. Counsel the client about condom use and, if possible, give her condoms. ○ There is no need to remove the IUD if she wants to continue using it. If she wants it removed, take it out after starting antibiotic treatment.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Copper-Bearing Intrauterine Device (IUD)	
Severe pain in lower abdomen (suspected ectopic pregnancy)	• Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening. • In the early stages of ectopic pregnancy, symptoms might be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy: ○ Unusual abdominal pain or tenderness ○ Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from the woman's usual bleeding pattern ○ Lightheadedness or dizziness ○ Fainting • If ectopic pregnancy or another serious health condition is suspected, refer the woman at once for immediate diagnosis and care. • If she does not have these additional symptoms or signs, assess for pelvic inflammatory disease.
Suspected uterine puncturing (perforation)	• If puncturing is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately (and remove the IUD if inserted). Carefully observe the woman: ○ For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every five to 10 minutes. ○ If the client remains stable after one hour, check for signs of intra-abdominal bleeding (such as low hematocrit or hemoglobin), if possible, and check her vital signs. Observe her for several more hours. If she has no signs or symptoms, she can be sent home, but she should avoid intercourse for two weeks. Help her choose another method. ○ If she has a rapid pulse and falling blood pressure, or if she has new pain or increasing pain around the uterus, refer her to a higher level of care. ○ If uterine perforation is suspected within six weeks after insertion, or if it is suspected later and is causing symptoms, refer the client to a clinician experienced at removing such IUDs.
IUD partially comes out (partial expulsion)	• If the IUD partially comes out, remove the IUD. Discuss with the client whether she wants another IUD or a different method. If she wants another IUD, she can have one inserted at any time, if she is reasonably certain she is not pregnant. If she does not want to continue using an IUD, help her choose another method.
IUD completely comes out (complete expulsion)	• If the client reports that the IUD came out, discuss with her whether she wants another IUD or a different method. If she wants another IUD, she can have one inserted at any time, if she is reasonably certain she is not pregnant. • If complete expulsion is suspected and the client does not know whether the IUD came out, refer her for an x-ray or ultrasound to assess whether the IUD might have moved to the abdominal cavity. Give her a backup method to use in the meantime.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Copper-Bearing Intrauterine Device (IUD)	

Missing strings (suggesting possible pregnancy, uterine perforation, or expulsion)	• Ask the client:
	  ○ Whether and when she saw the IUD come out
	  ○ When she last felt the strings
	  ○ When she had her last monthly bleeding
	  ○ If she has any symptoms of pregnancy
	  ○ If she has used a backup method since she noticed missing strings
	• Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half the time that IUD strings are missing, they can be found in the cervical canal.
	• If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUD has been expelled unnoticed. Rule out pregnancy before attempting more invasive procedures. Refer the woman for evaluation. Give her a backup method to use in the meantime, in case the IUD came out.

Unexplained vaginal bleeding (that suggests a medical condition not related to the method)	• Refer or evaluate by history or pelvic examination. Diagnose and treat as appropriate. • The client can continue using the IUD while her condition is being evaluated. • If bleeding is caused by a sexually transmitted infection or pelvic inflammatory disease, she can continue using the IUD during treatment.

Suspected pregnancy	• Assess the client for pregnancy, including ectopic pregnancy.
	• Explain that an IUD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or second trimester, which can be life-threatening.
	• If the woman does not want to continue the pregnancy, counsel her according to program guidelines.
	• If she continues the pregnancy:
	  ○ Advise her that it is best to remove the IUD.
	  ○ Explain the risks of pregnancy with an IUD in place. Early removal of the IUD reduces these risks, although the removal procedure itself involves a small risk of miscarriage.
	  ○ If she agrees to removal, gently remove the IUD or refer her to have it removed.
	  ○ Explain that she should return at least once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).
	  ○ If she chooses to keep the IUD, her pregnancy should be followed closely by a nurse or doctor. She should see a nurse or doctor at least once if she develops any signs of septic miscarriage.
	• If the IUD strings cannot be found in the cervical canal and the IUD cannot be safely retrieved, refer the client for ultrasound, if possible, to determine whether the IUD is still in the uterus. If it is, or if ultrasound is not available, her pregnancy should be followed closely. She should seek care at once if she develops any signs of septic miscarriage.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Female Sterilization	
Infection at the incision site (redness, heat, pain, pus)	• Clean the infected area with soap and water or antiseptic. • Give the woman oral antibiotics for seven to 10 days. • Ask the client to return after taking all antibiotics if the infection has not cleared.
Abscess (a pocket of pus under the skin caused by infection)	• Clean the area with antiseptic. • Cut open (incise) and drain the abscess. • Treat the wound. • Give oral antibiotics for seven to 10 days. • Ask the client to return after taking all of the antibiotics if she has heat, redness, pain, or drainage of the wound.
Severe pain in lower abdomen (suspected ectopic pregnancy)	• Ectopic pregnancy is any pregnancy that occurs outside the uterine cavity. Early diagnosis is important. Ectopic pregnancy is rare but can be life-threatening. • In the early stages of ectopic pregnancy, symptoms might be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy: ○ Unusual abdominal pain or tenderness ○ Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from the client's usual bleeding pattern ○ Lightheadedness or dizziness ○ Fainting Symptoms and care for *ruptured ectopic pregnancy:* • *Symptoms:* Sudden sharp or stabbing lower abdominal pain, sometimes on one side and sometimes throughout the body, suggests a ruptured ectopic pregnancy (when the fallopian tube breaks due to the pregnancy). Pain in the right shoulder can develop due to blood from a ruptured ectopic pregnancy pressing on the diaphragm. Within a few hours, the abdomen usually becomes rigid and the woman goes into shock. • *Care:* Ectopic pregnancy is a life-threatening, emergency condition requiring immediate surgery. If ectopic pregnancy is suspected, perform a pelvic examination only if facilities for immediate surgery are available. Otherwise, immediately refer and/or transport the woman to a facility where definitive diagnosis and surgical care can be provided.
Male Sterilization	
Bleeding or blood clots after the procedure	• Reassure the client that minor bleeding and small uninfected blood clots usually go away without treatment within a couple of weeks. • Large blood clots might need to be surgically drained. • Infected blood clots require antibiotics and hospitalization.
Infection at the puncture or incision site (redness, heat, pain, pus)	• Clean the infected area with soap and water or antiseptic. • Give the client oral antibiotics for seven to 10 days. • Ask the client to return after taking all of the antibiotics, if the infection has not cleared.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Male Sterilization	
Abscess (a pocket of pus under the skin caused by infection)	• Clean the area with antiseptic. • Cut open (incise) and drain the abscess. • Treat the wound. • Give the client oral antibiotics for seven to10 days. • Ask the client to return after taking all of the antibiotics, if he notices heat, redness, pain, or drainage of the wound.
Pain lasting for months	• Suggest elevating the scrotum with snug underwear or pants or an athletic supporter. • Suggest soaking in warm water. • Suggest aspirin (325 to 650 mg), ibuprofen (200 to 400 mg), paracetamol (325 to 1,000 mg), or another pain reliever. • Provide antibiotics if you suspect an infection. • If pain persists and cannot be tolerated, refer the client for further care.
Male Condoms	
Condom breaks, slips off the penis, or is not used	• Emergency contraceptive pills can help prevent pregnancy in cases where a condom fails. If a man notices a break or slip, he should tell his partner so that she can use emergency contraceptive pills, if she wants to. • Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer. • If a client reports that a condom breaks or slips: ○ Ask the client to show you how they are opening the condom package and putting the condom on, using a model or other item. Correct any errors. ○ Ask the client if any lubricants are being used. The wrong lubricant or too little lubricant can increase breakage. Too much lubricant can cause the condom to slip off. ○ Ask the client when the man withdraws his penis. Waiting too long to withdraw (i.e., until after the erection begins to subside) can increase the chance of slips.
Difficulty putting on the condom	• Ask clients to show how they put the condom on, using a model or other item. Correct any errors.
Man cannot maintain an erection while putting on or using a condom	• Often this problem is the result of embarrassment. Discuss ways of making condom use more enjoyable and less embarrassing (i.e., the woman may put the condom on for the man). • Suggest a small amount of water or water-based lubricant on the penis and extra lubricant on the outside. This might increase sensation and help maintain the erection.

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Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Male Condoms	
Difficulty persuading partner to use condoms or not able to use a condom every time	• Discuss with clients ways to talk about condoms with partners and also the rationale for dual protection. • Explain that the client can consider combining condoms with: ○ Another effective contraceptive method for better pregnancy protection ○ A fertility awareness method, using condoms only during the fertile time, If the client is not at risk for STI infection • Especially if the client or partner is at risk for STIs, encourage continued condom use while working out problems with the partner. If neither partner has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use, but it does not protect against pregnancy.
Mild irritation in or around the vagina or penis or mild allergic reaction to condom (itching, redness, rash, and/or swelling of genitals, groin, or thighs during or after condom use)	• Suggest trying another brand of condoms. A person may be more sensitive to one brand of condoms than to others. • Suggest putting lubricant or water on the condom to reduce rubbing that might cause irritation. • If symptoms persist, assess or refer, as appropriate, for possible vaginal infection. or STI as appropriate. ○ If there is no infection and irritation continues or recurs, the client might have an allergy to latex. ○ If the client is not at risk for STIs, help the client choose another method. ○ If the client or partner is at risk for STIs, suggest using female condoms or plastic male condoms, if available. If not available, urge continued use of latex condoms. Tell the client to stop using latex condoms if symptoms become severe. ○ If neither partner has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use, but it does not protect against pregnancy.
Female partner is using miconazole or econazole (for treatment of vaginal infections)	• A woman should not rely on latex condoms during vaginal use of miconazole or econazole. They can damage latex. (Oral treatment will not harm condoms.) • She should use female condoms, plastic male condoms, or another contraceptive method, or abstain from sex until treatment is completed.
Severe allergic reaction to condom (hives or rash over much of body, dizziness, difficulty breathing, or loss of consciousness during or after condom use)	• Tell the client to stop using latex condoms. • Refer the client for care, if necessary. A severe allergic reaction to latex could lead to life-threatening anaphylactic shock. Help the client choose another method. • If the client or partner cannot avoid risk of STIs, suggest that they use female condoms or plastic male condoms, if available. If neither partner has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use, but it does not protect against pregnancy.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Female Condoms	
Difficulty inserting the female condom	• Ask the client how she inserts a female condom. If a model is available, ask her to demonstrate and let her practice with the model. If not, ask her to demonstrate using her hands. Correct any errors.
Inner ring uncomfortable or painful	• Suggest that the client reinsert or reposition the condom so that the inner ring is tucked back behind the pubic bone and out of the way.
Condom squeaks or makes noise during sex	• Suggest adding more lubricant to the inside of the condom or onto the penis.
Condom slips, is not used, or is used incorrectly	• Emergency contraceptive pills can help prevent pregnancy. • Little can be done to reduce the risk of STIs if a condom breaks, slips, or is not used. If the client has signs or symptoms of STIs after having unprotected sex, assess or refer. • If the client reports slips, she might be inserting the female condom incorrectly. Ask her to show how she is inserting the condom, using a model or demonstrating with her hands. Correct any errors.
Difficulty persuading partner to use condoms or not able to use a condom every time	• Discuss with the clients ways to talk with her partner about the importance of condom use for protection from pregnancy and STIs.

Mild irritation in or around the vagina or penis (itching, redness, or rash)	• Explain that irritation usually goes away on its own without treatment.
	• Suggest adding lubricant to the inside of the condom or onto the penis to reduce rubbing that might cause irritation.
	• If symptoms persist, assess and treat for possible vaginal infection or STI, as appropriate.
	  ○ If there is no infection, help the client choose another method, unless the client is at risk for HIV or other STIs.
	  ○ For clients at risk of STIs, suggest using male condoms. If using male condoms is not possible, urge continued use of female condoms despite the discomfort.
	  ○ If neither partner has an infection, a mutually faithful sexual relationship provides STI protection without requiring condom use, but it does not protect against pregnancy.

Suspected pregnancy	• Assess the client for pregnancy. • A woman can safely use female condoms during pregnancy for continued STI protection.
Spermicide	
Allergic reaction or sensitivity to spermicide, such as burning or itching	• Check the client for infection, and treat or refer as appropriate • If he or she does not have an infection, suggest using a different type or brand of spermicide.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Diaphragm	
Difficulty inserting or removing diaphragm	• Give the client advice on inserting and removing the diaphragm. Ask her to insert and remove the diaphragm in the clinic. Check its placement after she inserts it. Correct any errors.
Discomfort or pain with diaphragm use	• A diaphragm that is too large can cause discomfort. Check to see if it fits well. ○ If the diaphragm is too large, fit the client with a smaller diaphragm. ○ If it appears to fit properly and different kinds of diaphragms are available, try a different diaphragm. • Ask the client to insert and remove the diaphragm in the clinic. Check the diaphragm's placement after she inserts it. Give further advice as needed. • Check for vaginal lesions: ○ If the client has vaginal lesions or sores, suggest that she use another method (condoms or oral contraceptives) temporarily and give her supplies. ○ Assess for vaginal infection or sexually transmitted infection (STI). Treat or refer for treatment as appropriate. ○ Lesions will go away on their own if the client switches to another method.
Irritation in or around the vagina or penis (she or her partner has itching, rash, or irritation that lasts for a day or more)	• Check for vaginal infection or STI and treat or refer for treatment as appropriate. • If the client does not have an infection, suggest trying a different type or brand of spermicides.
Urinary tract infection (burning or pain with urination, frequent urination in small amounts, blood in the urine, back pain)	• Treat the client with cotrimoxazole 240 mg orally once a day for three days or trimethoprim 100 mg orally once a day for three days or nitrofurantoin 50 mg orally twice a day for three days. • If infection recurs, consider refitting the client with a smaller diaphragm.
Bacterial vaginosis (abnormal white or grey vaginal discharge with unpleasant odor; may also have burning during urination and/or itching around the vagina)	• Treat the client with metronidazole 2 g orally in a single dose or metronidazole 400 to 500 mg orally twice daily for seven days.
Candidiasis (abnormal white vaginal discharge that can be watery or thick and chunky; may also have burning during urination and/or redness and itching around the vagina)	• Treat the client with fluconazole 150 mg orally in a single dose, miconazole 200 mg vaginal suppository once a day for three days or clotrimazole 100 mg vaginal tablets, twice a day for three days. • Miconazole suppositories are oil-based and can weaken a latex diaphragm. Women using miconazole vaginally should not use latex diaphragms or condoms during treatment. They can use a plastic female or male condom or another method until all medication is taken. (Oral treatment will not harm latex.)

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Diaphragm	
Suspected pregnancy	• Assess the client for pregnancy. • There are no known risks to a fetus conceived while using spermicides.
Recurring urinary tract infections or vaginal infections (such as bacterial vaginosis or candidiasis)	• Consider refitting the client with a smaller diaphragm.
Latex allergy (redness, itching, rash, and/or swelling of genitals, groin, or thighs [mild reaction]; or hives or rash over much of the body, dizziness, difficulty breathing, loss of consciousness [severe reaction])	• Tell the client to stop using a latex diaphragm. Give her a plastic diaphragm, if available, or help her choose another method, but not latex condoms.
Toxic shock syndrome (sudden high fever, body rash, vomiting, diarrhea, dizziness, sore throat, and muscle aches)	• Treat the client or refer her for immediate diagnosis and care. Toxic shock syndrome can be life-threatening. • Tell the client to stop using the diaphragm. Help her choose another method, but not the cervical cap.
Fertility Awareness Methods	
Inability to abstain from sex during the fertile time	• Discuss the problem openly with the couple and help them feel at ease, not embarrassed. • Discuss possible use of condoms, diaphragm, withdrawal, spermicides, or sexual contact without vaginal sex during the fertile time. • If they have had unprotected sex in the past five days, the woman can consider emergency contraceptive pills.
Calendar-based methods ***Cycles outside the range of 26 to 32 days*** for Standard Days Method	• If the client has two or more cycles outside the range of 26 to 32 days within any 12 months, suggest that she use the calendar rhythm method or a symptoms-based method instead.
Calendar-based methods ***Very irregular menstrual cycles***	• Suggest that the client use a symptoms-based method instead.
Symptoms-based methods ***Difficulty recognizing different types of secretions*** for the ovulation method	• Counsel the client and help her learn how to interpret cervical secretions. • Suggest that she use the TwoDay Method, which does not require the user to tell the difference between types of secretions.

(continued)

Management of Side Effects and Other Problems, by Method *(cont.)*

METHOD	COMMON MANAGEMENT
Fertility Awareness Methods	
Symptoms-based methods ***Difficulty recognizing the presence of secretions*** for the ovulation method or the TwoDay Method	• Provide additional guidance on how to recognize secretions. • Suggest that the client use a calendar-based method instead.
Lactational Amenorrhea Method (LAM)	
Baby is not getting enough milk	• Reassure the client that most women can produce enough breast milk to feed their babies. • Reassure her that if her newborn is gaining more than 500 grams a month, weighs more than birth weight at two weeks, or urinates at least six times a day, the baby is getting enough breast milk. • Tell her to breastfeed her newborn about every two hours to increase milk supply. • Recommend that she reduce any supplemental foods and/or liquids if the baby is less than six months of age.
Sore or cracked nipples	• If the client's nipples are cracked, she can continue breastfeeding. Assure her that they will heal over time. • To aid healing, advise her to take the following measures: ○ Apply drops of breast milk to the nipples after breastfeeding and allow to air dry. ○ After feeding, use a finger to break suction first before removing the baby from the breast. ○ Do not wait until the breast is full to breastfeed. If the breast is full, she should express some milk before breastfeeding the baby. • Teach her about proper attachment and how to check for signs that the baby is not attaching properly. • Tell her to clean her nipples with only water once a day and to avoid soaps and alcohol-based solutions. • Examine her nipples and the baby's mouth and buttocks for signs of fungal infection (thrush).
Sore breasts	• If the client's breasts are full, tight, and painful, then she might have engorged breasts. If one breast has tender lumps, then she might have blocked ducts. Engorged breasts or blocked ducts can progress to red and tender infected breasts. Treat infected breasts with antibiotics according to clinic guidelines. To aid healing, advise the woman to take the following measures: ○ Continue to breastfeed often ○ Massage her breasts before and during breastfeeding ○ Apply heat or warm compress to breasts ○ Try different breastfeeding positions ○ Ensure that the infant attaches properly to the breast ○ Express some milk before breastfeeding

HANDOUT 24 Helping Clients Continue or Switch Methods

By the end of this session, you should be able to:

- Identify possible reasons for method discontinuation
- Develop strategies to support clients in method continuation
- Describe when and how to support clients in switching methods

Essential Ideas—Session 24

- Many clients decide, for a variety of reason, to discontinue the method that they are using or to switch from one FP method to another.
- Discontinuation and switching should not always be considered as inappropriate. The client's decision might be the result of a change in his or her fertility plans or dissatisfaction with a method. In fact, switching methods can be a way to help clients continue using FP when they are dissatisfied with their current methods or their needs change.
- Some clients however, might decide to discontinue a method or switch to another one because of lack of information (especially on side effects) or because they are being influenced by rumors or misconceptions.
- The provider should identify the underlying reasons for the client's decision to discontinue and should be able to identify signs that a client is dissatisfied.
- For both discontinuation and switching, a provider who is supportive of clients' rights should ensure that the client is making an informed, voluntary, and well-considered decision by determining the reasons and giving information and options to the client—rather than just discouraging a change—and by maintaining a trustful relationship through counseling.
- Supporting method switching as an option prevents negative consequences of discontinuation, such as unintended pregnancy.

Reasons for Method Discontinuation and Switching

Appropriate reasons

- Wanting to become pregnant
- A change in health status (a chronic disease like hypertension or diabetes)
- A change in social status (lifestyle, economics, or relationships)
- Changed risk (either an increase, a decrease, or elimination of risk) for HIV and other sexually transmitted infections (STIs)
- No longer needing protection against pregnancy (not having a partner anymore)
- Pregnancy resulting from the failure of the method

Reasons that warrant further counseling

- Side effects of the method being used and/or lack of information about side effects
- Health risks/complications of the method being used
- Concerns about the method
- Rumors or misconceptions about the method combined with lack of correct information
- Partner's (or other family members') objection to the method being used
- Complaints that are unrelated to the method

Supporting Clients Who Want to Discontinue

1. **Explore the underlying reason for the client's desire to discontinue the method.**
"Why does the client want to discontinue the method?"

A. Because of side effects or other health and social reasons	A. Because of concerns stemming from lack of information	C. Because the client wants to get pregnant (or preserve a pregnancy resulting from method failure) or no longer needs protection (i.e., change of circumstances, no longer at risk of pregnancy)
2. **Explore the reason in depth to see if it can be alleviated by treatment or other precautions** (like treating irregular bleeding during the initial DMPA injections, or counseling and providing correct information to the client's partner, to counter misinformation). 3. If the client decides to continue the method with additional treatment or precaution, **provide appropriate counseling and service.** 4. **Suggest switching to another method** if the client still wants protection against pregnancy, **and provide counseling and services as needed.**	2. **Explore the concerns and misconceptions in depth, correct as needed, and fill in knowledge gaps.** 3. If the client decides to continue using the current method, **continue providing appropriate counseling and services.** 4. If the client still wants to discontinue the method, despite wanting protection against pregnancy, **offer the option of switching to another method** and provide counseling and services as needed.	2. **Counsel the client and provide the service** as needed (e.g., removal of the IUD or implant). 3. **Refer the client for preconception or antenatal care** and encourage her to come back again after pregnancy.
5. If the client still wants protection against pregnancy but cannot yet decide on another method, **remind the client about the pregnancy risk and encourage the client to come back later.**		

Part III:

FP Counseling in Practice

The final sessions in this curriculum will help the you actually practice or apply FP counseling by putting all of the components together. You will have the opportunity to practice a complete counseling session in counseling role plays, using skills and approaches covered in previous sessions and receiving feedback.

Applying new counseling skills acquired in training requires more than training itself: Administrators and supervisors must be supportive of new practices and approaches, to help you and their coworkers adjust to and sustain any changes that are required. You also will need follow-up from trainers and supervisors to help overcome problems, continue to improve your skills, and maintain your commitment to providing FP counseling. This part of the workshop helps you plan what to do after the training.

HANDOUT 25A Counseling Role Plays

By the end of this session, you should be able to:

- Demonstrate how to counsel FP clients, applying all of the counseling skills covered in this workshop and using the REDI model and profiled clients
- Describe *self-assessment* and *peer assessment* after counseling practice

Essential Ideas—Session 25

- This workshop provides all participants with the opportunity to practice counseling and receive feedback. This is a very effective way of acquiring counseling skills.
- Once you are back at your workplaces, you can continue practicing counseling and receiving feedback to further improve your counseling skills. This can be done in two ways: *self-assessment* and *peer assessment*.
- Self-assessment can be performed using the Learning Guides for FP Counseling Skills in Appendix B of the Participant Handbook. After conducting a counseling session, you can go through the learning guides to score your own performance and identify the gaps they should work on.
- Peer assessment can be conducted by using the Counseling Skills Observation Guide (Handout 25-B). As you conduct counseling, a peer or colleague trained in counseling observes you. At the end of the counseling session, the peer fills in the Counseling Skills Observation Guide and gives you constructive oral feedback. **Constructive feedback** should always:
  - Start with strengths and positive points and then continue with ways to improve
  - Be given at a private moment, as soon as the counselor is ready to listen
  - Be specific in describing what exactly was observed and its impact (or consequences)
  - Invite the counselor to respond or react
  - Focus on solutions (the constructive part of feedback)

HANDOUT 25B

Counseling Skills Observation Guide

Instructions: This observation guide was developed for use by trainers/supervisors, to regularly observe family planning (FP) counselors in their program and provide ongoing support. The trainer/supervisor, marks the following scores according to the performance level for each client-provider interaction observed:

2 = Competently performed (step performed correctly)

1 = Needs improvement (step performed partially or incorrectly)

0 = Step omitted (step not done)

NA = Not applicable

Any area that is scored less than 2 needs improvement (except when it is not applicable).

For a more complete description of each task, the trainer/supervisor, can use the "Learning Guides for FP Counseling Skills; *New Clients, Satisfied Return Clients, Dissatisfied Return Clients*" in the Participant Handbook Appendix B. The supervisor completes one form for each provider observed over one or more observations or supervisory visits.

Name: _____ **Service Site:**_____

Supervisor:_____ **Date(s):** _____

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	**Clients/Rating**		
	1	**2**	**3**
Rapport Building (Items 3, 5, 6, 7, and 8 should be observed during all phases of REDI. Please mark scores for them only after observing the entire counseling session.)			
1. Did the provider greet the client politely, according to local custom?			
2. Did the provider offer the client a seat?			
3. Did the provider ensure **privacy** throughout the session, with no interruptions?			
4. Did the provider explain that he or she asks personal and sometimes embarrassing questions of all clients to better help them select and use FP and stress that everything is **confidential** (i.e., that no one outside the counseling room will learn what is discussed)?			
5. Did the provider **ask open-ended questions** to encourage the client to speak?			
6. Did the provider **listen** to the client without interruptions?			
7. Did the provider give correct information to the client, using clear and simple language to ensure **informed choice**?			
8. Did the provider use visual aids (brochures, flipcharts, contraceptive samples, posters, etc.)?			

(continued)

Counseling Skills Observation Guide *(cont.)*

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients Rating		
	1	2	3
Exploration			
9. Did the provider ask the client questions to identify the type of visit? (*Circle type of client and go to the appropriate category of client below*) • New client with a method in mind • New client with no method in mind • Satisfied return client with no problems (routine follow-up visit or resupply) • Dissatisfied return client/client with problem/side effects/concerns			
FOR NEW CLIENTS ONLY: If return client, **skip to** ⇛⇛ ***5***			
10. Did the provider ask about the client's past experience with FP and assess the client's knowledge about FP?			
11. Did the provider ask questions about: • The client's sexual relationship(s) and habits • Communication with partner(s) about sex, FP, and sexually transmitted infections (STIs), including HIV and AIDS • Support from partner and family to use FP • Possible domestic violence • Socioeconomic circumstances			
12. Did the provider explain STI/HIV prevention and help the client perceive his or her risks for STI/HIV transmission?			
13. Did the provider give appropriate information to the client based on the client's needs (i.e., tailored to the need of the client)?			
14. Did the provider screen client for FP use according to standard (medical conditions and history)?			
FOR RETURN CLIENTS ONLY: If new client, **skip to** ⇛⇛ ***18***			
15. Did the provider ask if the client has any problems or concerns with the method?			
16. Did the provider ask about possible **changes in client's life**? • New health-related problems or concerns • New partner(s)/possible exposure to STIs/HIV • Change in fertility plans			
FOR DISSATISFIED RETURN CLIENTS ONLY: If satisfied return client, ***skip to*** ⇛⇛ ***18***			
17. Did the provider appropriately **address the concerns or problems** raised by the client and help the client to develop possible solutions?			

(continued)

Counseling Skills Observation Guide *(cont.)*

REDI: TASKS DURING CLIENT/PROVIDER INTERACTION	Clients Rating		
	1	2	3
Decision Making			
18. Did the provider help the client consider his or her different options or reconfirm his or her choice? • Select an FP method based on correct knowledge about side effects, health benefits, and health risks of suitable methods, considering her/his preferences and needs for FP and STI/HIV prevention (**new client with no method in mind**) • Reconfirm her choice of method based on correct knowledge about its side effects, health benefits, and health risks, including the level of STI/HIV protection it offers (**new client with a method in mind AND satisfied return client**) • Consider options related to discontinuation and method switching (**dissatisfied return client**)			
Implementing the Decision (the provider often does not need to cover all of these tasks with satisfied return clients)			
19. Did the provider help the client make a plan for implementing the decision by asking about next steps and the timeline for implementation?			
20. Did the provider help the client consider ways to overcome potential barriers to implement his or her decision(s)?			
21. Did the provider ensure that the client has adequate knowledge and skills to implement the decision(s) (e.g., how to use the method, condom demonstration/practice, communication and negotiation skills, provision of information about safer sex practices)			
22. Did the provider ensure that the client understands what **follow-up** is required (return visits, referral, and/or resupply)?			
23. Did the provider ensure that the client understands what the possible **side effects** of the method are and what to do about side effects?			
24. Did the provider ensure that the client knows the warning signs of the method and that he or she needs to return to the facility immediately if he or she experiences warning signs?			
25. Did the provider assure the client that he or she is welcome to return to the facility any time that he or she has concerns or problems or thinks he or she might prefer to switch to another method?			
TOTAL			

Additional comments:

HANDOUT 26A Action Plan

- What will I do differently in counseling?
- What can I do to help make counseling more client-centered in my facility?

Specific changes or activities to implement immediately	Possible challenges or barriers	Strategies for overcoming challenges

HANDOUT 26B Action Plans to Apply New Learning

By the end of this session, you should be able to:

- Identify three changes to make in your work as a result of what you learned in the course
- Develop action plans for implementing the changes identified

Essential Ideas—Session 26

- This workshop material might or might not have been completely new to you. Some of it might be reassuring, while some of it might leave you feeling that quality counseling is difficult or impossible within your work settings. As these ideas settle in, we encourage you to try out the different counseling strategies, reject those that are not useful, and maintain those that are useful. You might choose to share some ideas with colleagues, friends, or perhaps even sexual partners; you might also find some of the ideas unacceptable or disturbing.
- All of this is okay. Helping people deal with decisions affecting one of the most important and yet the most private parts of their lives—their sexuality—is not easy.
- No lasting change happens overnight or even over the course of a single workshop. When developing individual action plans, you should focus on a *few key actions and strategies* to apply to their work. Some activities can be implemented immediately; others might take longer to implement. These concrete and probably small changes allow the chance to practice what was learned and to see how it works. Bigger changes will take more time, may be more difficult to implement, and will require a "champion" to promote them within the work setting. You may need to speak with managers, supervisors, and staff in the workplace about the importance of the new ideas and ways of doing things. Participants in this workshop should consider yourselves to be champions of change. As a champion, you will need to help strategize how to introduce the changes and to follow up so that necessary steps are taken for the changes to be successfully introduced and maintained over time.
- During the daily wrap-ups, the workshop participants selected one activity that could be implemented as soon as they return to work. This session is a reminder of those ideas and gives you a framework for strategizing about how to implement them.
- Being clear about why the various activities should be carried out will be very important in deciding on the priorities for action. Having a rationale will also help in explaining the activities to other people who may be curious or concerned about the changes they see or whose work is also affected by the changes. Knowing the reason for making a change also helps clarify the desired outcome—that is, the expected achievement (e.g., making clients feel more comfortable when discussing these issues or being better able to tailor counseling sessions to the individual needs of the particular client).
- These action plans will be reexamined during follow-up visits after the training (see Session 27). You should share your plans with your supervisors when you return to your workplaces, to ensure that supervisors understand, are in agreement, and support the plans. The action plans will also remind you and your colleagues of your commitments and help you to track progress toward the goal of improving the quality of services.

Barriers and Strategies

Listed below are some examples of barriers that providers might identify and some possible strategies for addressing those barriers. (Note: These should not be copied on the action plan framework as ready-made strategies to overcome barriers, nor should you try to adopt all of these barriers and strategies.) This list gives hints to help you identify barriers that are specific to your situation or service site and strategies that could be applied or need to be developed to address the specific barriers at your service sites or programs. There are three main ways in which barriers can be addressed. These include:

F = Facilitative supervision and management

I = Information, training, and development

S = Supplies, equipment, and infrastructure

Barriers to Effective FP Counseling	Strategies for Overcoming Barriers
Lack of time for counseling	**F:** • Reorganize facility flow to use time more efficiently and free up staff time for counseling. • Recognize the importance of counseling and allow staff to spend time on counseling. • Involve frontline staff in intake and in group education, to cover basic informational tasks of counseling. (The strategies depend on the nature of the problem and available resources, but many of them are influenced by administrators and supervisors.)
Lack of space to ensure privacy	**F/S:** • Partition or curtain off large rooms (e.g., waiting areas) to provide visual privacy. • Set aside one area of a large room with chairs arranged far enough away to provide listening privacy. • Use semiprivate spaces (e.g., examining rooms or administrative offices) that are not always in use. • Use space outdoors that is comfortable and private. • Schedule services so that some rooms that won't be used during certain hours of the day can be used as private space for ensuring privacy during counseling.
Lack of support or awareness from co-workers and supervisors for necessary changes (e.g., space and time)	**F/I:** • Orient the entire staff, including supervisors, to the importance of counseling, changes that might be necessary, benefits of making the necessary changes, and contributions they can make. • Explain the benefits that can be expected. • Ask for the supervisor's help in making quality counseling services a priority for the facility and its staff.

Barriers to Effective FP Counseling	Strategies for Overcoming Barriers
Embarrassment about raising issues of sexuality	**F/I:** • Orient and ask for help from supervisors in reinforcing the importance of raising issues of sexuality, acknowledging that it can be embarrassing for providers, and helping with problem solving (e.g., through role playing). • Arrange for trainers or supervisors to provide follow-up to training to address this issue (whether providers mention it or not) and provide reinforcement for overcoming the embarrassment. • Form "peer support groups" of providers who have gone through the training, so they can help each other by acknowledging that embarrassment is normal and by providing tips for getting over it.
Reluctance to identify clients' needs that cannot be met at the facility	**F/I:** • Managers and supervisors should inform providers of offsite facilities where needed services are provided. • Supervisors, managers, and providers should explore whether referral mechanisms exist and how they can be used. • Supervisors should motivate providers to use referral systems.
Pressure from administrators to meet service-delivery targets	**F/I:** • Trained providers should orient supervisors and administrators to quality of care, clients' rights, and the benefits of meeting clients' needs (as opposed to meeting "targets"). • Trained providers stress the importance of having satisfied and continuing clients rather than more but dissatisfied clients who frequently discontinue contraceptive use.

Appendixes

Appendix A
Family Planning Cue Cards

Appendix A

HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP)

For more detailed guidance, refer to: Extending Service Delivery Project. 2007. *A pocket guide for health practitioners, program managers and community leaders.* Washington, DC: Pathfinder International.

Discuss reproductive intentions with your clients whenever there is an opportunity—do they wish to delay or space the births of children, or do they want to limit the number of children they have?

- During antenatal care (checkups before delivery)
- During postpartum care (checkups after delivery)
- During well-baby clinics and services for children under 5 (such as immunizations)
- During family planning (FP) services (especially services for *engaged couples, HIV-positive women who wish to become pregnant, newlyweds, young couples, married couples with children, single mothers, and women who have experienced a miscarriage or abortion)*
- During postabortion care
- During services related to sexually transmitted infections (STIs) and HIV and AIDS
- During youth services
- During men's health services
- During community outreach

The following information is not relevant for those clients who have completed their family size and wish to use a contraceptive method or procedure to limit. Be sure to establish what the client's reproductive intentions are before discussing healthy timing and spacing.

What is healthy timing and spacing of pregnancy?

Healthy timing and spacing of pregnancy (HTSP) is a way of achieving healthier pregnancies and deliveries and reducing pregnancy-related risks to the health of the mother and babies. HTSP has 3 **key messages** that should be discussed with couples and individuals "taking into consideration health risks and benefits and other circumstances such as their age, fecundity, fertility aspirations, access to health care services, child-rearing support, social and economic circumstances, and personal preferences." Those key messages are:

- **After a live birth:**
  To achieve the healthiest pregnancy outcomes, couples can use an effective FP method of choice continuously for at least 2 years, but not more than 5 years after the last birth, before trying to become pregnant again.
- **After a miscarriage or abortion:**
  To achieve the healthiest pregnancy outcomes, couples can use an effective FP method of choice continuously for at least 6 months after a miscarriage or abortion, before trying to become pregnant again.
- **For adolescents:**
  To achieve the healthiest pregnancy outcomes, adolescents need to use an effective FP method of their choice continuously until they are 18 years of age before trying to become pregnant.

HEALTHY TIMING AND SPACING OF PREGNANCY (HTSP) *(cont.)*

What happens when HTSP messages are not taken into consideration?

- **When pregnancies are too close together:**
  Less than 24 months from the last live birth to the next pregnancy:
  - Newborns can be born too soon, too small, or with a low birth weight.
  - Infants and children may not grow well and are more likely to die before the age of 5.

  Less than 6 months from the last live birth to the next pregnancy:
  - Mothers may die in childbirth.
  - Newborns can be born too soon, too small, or with a low birth weight.
  - Infants and children may not grow well and are more likely to die before the age of 5.
- **When pregnancies are too far apart (more than 5 years):**
  - Mothers are at a higher risk of developing preeclampsia, a potentially life-threatening complication of pregnancy.
  - Newborns can be born too soon, too small, or with a low birth weight.
- **When pregnancies occur too soon (less than 6 months) after a miscarriage or abortion:**
  - Mothers are at a higher risk of developing anemia or premature rupture of membranes.
  - Newborns can be born too soon, too small, or with a low birth weight.
- **When first pregnancies occur to adolescents less than 18 years old:**
  - Adolescents are at a higher risk of developing pregnancy-induced hypertension, anemia, and prolonged or obstructed labor.
  - Newborns may die, be born too soon, too small, or with a low birth weight.
  - Additionally, the potential health risks associated with short pregnancy spacing intervals and/or having a pregnancy too early in life are exacerbated for women who already have pre-existing health problems, such as HIV, anemia, malnutrition, malaria, tuberculosis, heart disease, and diabetes.

Counseling clients for HTSP

1. Explain the HTSP messages to clients clearly, in language that they understand
2. Explain that to time and space pregnancies, the couple can use an effective FP method of their choice
3. Mention the wide range of FP methods available to the couple, including fertility awareness-based methods
4. Explain how to obtain and use FP methods
5. Emphasize the health, social, and economic benefits of practicing HTSP
6. Remind the clients that HTSP benefits the whole family and the community
7. Encourage clients to ask questions and share the information with partners, family members, and friends

PREGNANCY CHECKLIST

How to be Reasonably Sure a Client is Not Pregnant

Ask the client questions 1–6. As soon as the client answers **YES** to ***any question***, stop, and follow the instructions.

NO	1. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3. Have you had a baby in the last 4 weeks?	YES
NO	4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	5. Have you had a miscarriage or abortion in the past 7 days?	YES
NO	6. Have you been using a reliable contraceptive method consistently and correctly?	YES

If the client answered **NO** to ***all of the questions***, pregnancy cannot be ruled out. Client should await menses or use a pregnancy test.

If the client answered **YES** to ***at least one of questions*** and she is free of signs or symptoms of pregnancy, provide client with desired method.

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Appendix A

COMBINED ORAL CONTRACEPTIVES (COCs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Combined Oral Contraceptives?

- Combined oral contraceptives (COCs) are pills that are taken once a day to prevent pregnancy. They contain the hormones estrogen and progestin.
- COCs are also called "the Pill," low-dose combined pills, oral contraceptive pills (OCPs), and oral contraceptives (OCs).
- COCs work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective Are COCs?

The effectiveness of COCs depends on the user:

- As commonly used, in the first year, about 8 pregnancies occur per 100 women using COCs.
- When no pill-taking mistakes are made, in the first year, less than 1 pregnancy occurs per 100 women using COCs (3 per 1,000 women).
- *Return of fertility after COCs are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns, including:
  - Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, no monthly bleeding
- Headaches
- Dizziness
- Nausea
- Breast tenderness
- Weight change
- Mood changes
- Acne (can improve or worsen, but usually improves)
- Increase in blood pressure (by a mm Hg)

Health Benefits

Help protect against:

- Pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Cancer of the ovary
- Symptomatic pelvic inflammatory disease

May help protect against:

- Ovarian cysts
- Iron deficiency anemia

Reduce incidence of:

- Menstrual cramps
- Menstrual bleeding problems
- Painful ovulation
- Excess hair on face or body
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

Health Risks and Their Warning Signs

Very rare:

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism). Warning signs include a sharp pain in the leg or abdomen.

Extremely rare:

- Stroke—Warning signs include severe headache with vision problems.
- Heart attack—Warning signs include severe chest pain or shortness of breath.

COCs and cancer:

- Research findings about COCs and breast cancer are difficult to interpret. Current users of COCs and those who have used COCs within the past 10 years are more likely to be diagnosed with breast cancer, but the cancers are less advanced than cancers diagnosed in other women.
- Use of COCs for 5 years or more appears to speed development of persistent HPV infection into cervical cancer. Only a very small number of such can-cers are thought to be associated with COC use.

Why Some Women Say They Like COCs

- They are controlled by the woman.
- They can be stopped at any time, without a provider's help.
- They do not interfere with sex.

Correcting Misunderstandings

- COCs do not build up in a woman's body.
- COCs do not collect in the stomach; instead, they dissolve each day.
- Women do not need a "rest" from taking COCs.
- COCs must be taken every day, whether or not a woman has sex that day.
- COCs do not make women infertile.
- COCs do not cause birth defects or multiple births.
- COCs do not change women's sexual behavior.
- COCs do not disrupt an existing pregnancy.

COMBINED ORAL CONTRACEPTIVES (COCs) *(cont.)*

Who Can Use COCs?

Women of any reproductive age or parity can use COCs, including women who:

- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes—if under 35 years old
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not taking antiretroviral medications

Women can begin using COCs without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant –see Pregnancy Checklist cue card)

Who Cannot Use COCs?

Women who have the following conditions (contraindications) cannot use COCs:

- Breastfeeding fully (or nearly fully) a baby less than 6 months old
- Having had a baby in the last 3 weeks
- Having a current or history of breast cancer
- Having a liver tumor, liver infection, or cirrhosis, or having developed jaundice while using COCs
- Being age 35 or older and smoking
- Having blood pressure 140/90 mmHg or higher
- Having current gallbladder disease
- Having diabetes for more than 20 years, or damage to arteries, vision, kidneys or nervous system caused by diabetes
- Having current or history of stroke, blood clot in legs or lungs, heart attack or serious heart problems
- Migraines with aura or migraines without aura at age 35 or older
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin)
- Planning major surgery that will keep her from walking for 1 week

When to Start Using COCs?

- Any time (during the menstrual cycle) it is reasonably certain that the client is not pregnant (see cue card titled Pregnancy Checklist)
- Within 5 days after the start of her monthly bleeding
- Immediately when stopping IUD or another hormonal method. No need to wait for her next monthly bleeding.
- Postpartum:
  - 6 months after giving birth if using LAM
  - At 6 weeks if partially breastfeeding
  - At least after 3 weeks if not breastfeeding (on days 21–28)
  - Beyond those dates, pregnancy has to be ruled out.
- Postabortion (after induced abortion or miscarriage), immediately or within 7 days

How Are COCs Used?

- The client should always take 1 pill each day.
- *For 28-pill packets* (21 hormonal pills and 7 reminder pills containing iron)—When the client finishes 1 packet, she should take the first pill from the next packet on the **very next day.**
- *For 21-pill packets*—After the client takes the last pill from 1 packet, she should wait **7 days** and then take the first pill from the next packet.
- If the client forgets to take a pill or pills (all instructions for pills containing 30–35 µg estrogen):
  - Missed 1 or 2 hormonal pills or started a new pack 1 or 2 days late—Take a hormonal pill as soon as possible and then continue taking pills daily, 1 each day.
  - Missed 3 or more hormonal pills in the first 2 weeks or started a pack 3 or more days late—Take a hormonal pill as soon as possible and continue taking pills daily, 1 each day. Use a back-up method (condoms or abstain from sex) until you have taken hormonal pills for 7 days in a row. If missed 3 or more pills in the third week, finish the hormonal pills in your current pack and start a new pack the next day. You should not take the 7 nonhormonal pills. Use a back-up method for 7 days. You may miss a period. This is okay.
  - Missed 1 or more of any nonhormonal pills—Throw the missed pills away. Take the rest of the pills as usual, 1 each day. Start a new packet as usual on the next day.

  *For pills with **20 _g of estrogen or less,** women missing 1 pill should follow the same guidance as missing 1 or 2 30–35 _g pills. Women missing 2 or more pills should follow the same guidance as missing 3 or more 30–35 _g pills.*
- The client should also be told about the **warning signs for health risks** (see on first page).

PROGESTIN-ONLY PILLS (POPs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers. Baltimore and Geneva; and WHO. 2004. Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Progestin-Only Contraceptive Pills?

Progestin-only pills (POPs) are pills that are taken once a day to prevent pregnancy.

- Unlike COCs, POPs, do not contain any estrogen, and therefore they can be used throughout breastfeeding and by women who cannot use methods with estrogen.
- POPs are also called "minipills" and progestin-only oral contraceptives.
- POPs work primarily by:
  - Thickening cervical mucus (this blocks sperm from meeting an egg)
  - Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation)

How Effective Are POPs?

Effectiveness depends on the user. For breastfeeding women:

- As commonly used, about 1 pregnancy per 100 women using POPs over the first year.
- When taken everyday, less than 1 pregnancy per 100 women using POPs over the first year (3 per 1,000).
- They are less effective for women not breastfeeding: as commonly used, 3–10 pregnancies per 100 women and when pills are taken every day, less than 1 pregnancy per 100 women (9 per 1,000 women). Women not breastfeeding should take pills at the same time every day (no later than 3 hours) for pills to be effective.
- *Return of fertility after POPs are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side effects (which are temporary and not dangerous)

- Changes in bleeding patterns including:
  - Frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding, and, for breastfeeding women, lengthened postpartum amenorrhea
- Headaches
- Dizziness
- Mood changes
- Breast tenderness
- Abdominal pain
- Nausea
- For women not breastfeeding, enlarged ovarian follicles).

Health Benefits and Health Risks

Help protect against risks of pregnancy.

Why Some Women Say They Like POPs

- Can be used while breastfeeding
- Can be stopped any time without a provider's help
- Do not interfere with sex
- Controlled by the woman

Correcting Misunderstandings

Progestin-only pills:

- Do not cause a breastfeeding woman's milk to dry up.
- Must be taken every day, whether or not a woman has sex that day. They don't require a "rest" period between packs.
- Do not make women infertile.
- Do not cause diarrhea in breastfeeding babies.
- Reduce the risk of ectopic pregnancy.
- Do not build up in a woman's body. That's why they have to be taken everyday to maintain their effectiveness.
- Do not cause birth defects.

Who Can Use POPs?

Women of any reproductive age or parity can use POPs, including women who:

- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have or have not had children
- Are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, regardless of whether they are taking antiretroviral medications

Women can begin using POPs without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see cue card titled Pregnancy Checklist).

PROGESTIN-ONLY PILLS (POPs) *(cont.)*

Who Cannot Use POPs?

Women who have the following conditions cannot use POPs:

- Breastfeeding a baby less than 6 weeks old
- Liver tumor, liver infection, or cirrhosis
- Current serious problem with blood clots in legs or lungs
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

When to Start Using POPs?

- **Any time** it is reasonably certain that the client is not pregnant. See Pregnancy Checklist cue card.
- **No monthly bleeding**—Any time it is reasonably certain that the client is not pregnant. A back-up method needed for the first 2 days of taking pills.
- Immediately when **switching from copper-bearing IUD or another hormonal method,** if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding.
- The day after the client finishes taking emergency contraceptive pills.
- **Having menstrual cycles or switching from a nonhormonal method**—within 5 days after the start of her monthly bleeding and no back-up method; or more than 5 days after the start of monthly bleeding—any time it is certain that the client is not pregnant, and a back-up method Is used for the first 2 days of taking pills.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding*—Six weeks after giving birth, and any time between 6 weeks and 6 months, if her monthly bleeding has not returned
  - *Partially breastfeeding*—At 6 weeks after giving birth; if less than 6 weeks and monthly bleeding has returned, a back-up method should be used until 6 weeks have passed since giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant, and a back-up method should be used for the first 2 days.
  - *Breastfeeding and monthly bleeding has returned*—As advised for women having menstrual cycles.
  - *Not breastfeeding*—Any time within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned, then any time it is reasonably certain that client is not pregnant, plus a back-up method should be used for the first 2 days of taking pills; if monthly bleeding has returned, then as advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage)—Immediately or within 7 days, no back-up method is needed; more than 7 days after, any time it is reasonably certain that client is not pregnant, and a back-up method should be used for the first 2 days of taking pills.

How Are POPs Used?

- The client should always take 1 pill each day. When she finishes 1 packet, she should take the first pill from the next packet on the **very next day**. There is no wait between packets.
- **IMPORTANT:** It is best to take the pill at the same time each day, if possible. This helps remembering and ensures effectiveness. Taking a pill more than 3 hours late increases the risk of pregnancy.
- If the client **forgets to take a pill or pills** or **is 3 or more hours late taking a pill:**
  - **Having monthly bleeding (including those who are breastfeeding):** She should take 1 pill as soon as possible, continue taking the pills as usual, 1 each day and use a back-up method for the next 2 days. If she had sex in the past 5 days, she can also consider taking emergency contraceptive pills (ECP).
  - **Breastfeeding AND no monthly bleeding:** She should take 1 pill as soon as possible and continue taking the pills as usual, 1 each day. This may mean that she takes 2 pills at the same time or on the same day.
- The client should also be told about the **warning signs for complications,** such as severe abdominal pain (a warning sign for ectopic pregnancy).

EMERGENCY CONTRACEPTIVE PILLS (ECPs)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Emergency Contraceptive Pills (ECPs)?

- Emergency contraceptive pills (ECPs) are pills that contain a progestin alone, or a progestin and an estrogen together—hormones like the natural hormones progesterone and estrogen in a woman's body. ECPs help to prevent pregnancy when taken up to 5 days after unprotected sex. The sooner they are taken, the better.
- ECPs are sometimes called "morning after" pills or postcoital contraceptives.
- They provide an opportunity for women to start using an ongoing family planning method.
- ECPs work primarily by preventing or delaying the release of eggs from the ovaries (ovulation). They do not work if a woman is already pregnant.
- Use of copper-bearing IUDs for ***emergency contraception*** is described on the Copper-Bearing Intrauterine Device cue card.

What Pills Can Be Used as Emergency Contraceptive Pills?

- A special ECP product with the progestin levonorgestrel
  - 1.5 mg of levonorgestrel in a single dose
- A special ECP product with estrogen and levonorgestrel
  - 0.5 mg levonorgestrel + 0.1 mg ethinyl estradiol, followed with same dose 12 hours later.
- Progestin-only pills with levonorgestrel or norgestrel
  - 1.5 mg levonorgestrel in a single dose or 3 mg norgestrel in a single dose
- Combined oral contraceptives with estrogen and a progestin (levonorgestrel, norgestrel, or norethindrone)
  - 0.5 mg levonorgestrel + 0.1 mg ethinyl estradiol followed with same dose 12 hours later
  - 1 mg norgestrel + 0.1 mg ethinyl estradiol followed with same dose 12 hours later
  - 2 mg norethindrone + 0.1 mg ethinyl estradiol followed with same dose 12 hours later

When Should ECPs Be Taken?

- *As soon as possible* after unprotected sex. The sooner ECPs are taken after unprotected sex, the better they prevent pregnancy.
- ECPs can prevent pregnancy when taken any time up to 5 days after unprotected sex.

How Effective Are ECPs?

- If 100 women each had sex once in the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
- If all 100 women used progestin-only ECPs, 1 would likely become pregnant.
- If all 100 women used estrogen and progestin ECPs, 2 would likely become pregnant.
- *Return of fertility after taking ECPs:* No delay (A woman can become pregnant immediately after taking ECPs. Taking ECPs will not protect a woman from pregnancy from acts of sex after she takes ECPs—not even on the next day. To stay protected from pregnancy, women must begin to use another contraceptive method at once.)
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous) • Changes in bleeding patterns, including: ◦ Light vaginal bleeding for 1–2 days after taking ECPs ◦ Monthly bleeding that starts earlier or later than expected	In the week after taking ECPs: • Nausea • Abdominal pain • Fatigue • Headache • Breast tenderness • Dizziness • Vomiting (less frequent with progestin-only formulations)
Health Benefits Help protect against risks of pregnancy.	***Health Risks*** None

EMERGENCY CONTRACEPTIVE PILLS (ECPs) *(cont.)*

Why Some Women Say They Like ECPs

- Offer a second chance at preventing pregnancy
- Are controlled by the woman
- Reduce seeking out abortion in the case of contraceptive errors or if contraception is not used
- Can have on hand in case an emergency arises

Correcting Misunderstandings

Emergency contraceptive pills:

- Do not cause abortion.
- Do not cause birth defects if pregnancy occurs.
- Are not dangerous to a women's health.
- Do not promote sexual risk-taking.
- Do not make women infertile.

Who Can Use ECPs?

All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Tests and examinations are not necessary for using ECPs. They may be appropriate for other reasons—especially if sex was forced.

Who Cannot Use ECPs?

Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman.

When Can ECPs Be Used?

ECPs can be used at any time within 5 days after unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are. ECPs can be used any time a woman is worried that she might become pregnant. For example, after:

- Sex was forced (rape) or coerced
- Any unprotected sex
- Contraceptive mistakes, such as:
  - Condom was used incorrectly, slipped, or broke.
  - Fertility awareness method was used incorrectly (e.g., couple failed to abstain or to use another method during the fertile days).
  - Man failed to withdraw, as intended, before he ejaculated.
  - Woman missed 3 or more combined oral contraceptive pills, or starts a new pack 3 or more days late, or is too late for a repeat injection.
  - IUD has come out of place.

How Are ECPs Used?

- The client takes the pills at once, or if she is using the 2-dose regimen, she takes the next dose in 12 hours.
- Women who have had nausea with previous ECP use or with the first dose of a 2-dose regimen can take antinausea medication.
- If the woman vomits within 2 hours after taking ECPs, she should take another dose. (She can use anti-nausea medication with this repeat dose.) If vomiting continues, she can take the repeat dose by placing the pills high in her vagina. If vomiting occurs more than 2 hours after taking ECPs, she does not need to take any extra pills.
- No routine return visit is required

Counseling Clients:

- **Explain:**
  - How to take the pills
  - Most common side effects and what to do if they occur (especially nausea and vomiting)
  - That ECPs will not protect the client from pregnancy for any future sex acts—even the next day.
- **Discuss** ongoing contraception options and, if the client is at risk, protection from STIs and HIV
  - If the client does not want to start a contraceptive method now, give her condoms or oral contraceptives in case she changes her mind and invite her to come back any time if she wants another method.
- **Invite the client** to come back for any questions or problems or if she wants to switch to another method, if she experiences any major change in her health status, or if she thinks she might be pregnant.

PROGESTIN-ONLY INJECTABLES

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Progestin-Only Injectables?

- To prevent pregnancy, a shot is given into the muscle (intramuscular injection) every 2 or 3 months, depending on the type of injectable. The 2-monthly injectable contains norethisterone enantate (NET-EN—Noristerat®, Syngestal®), and the 3-monthly injectables contain depot medroxyprogesterone acetate (DMPA—Depo-Provera®, Megestron®, Petogen®).
- Progestin-only injectable contraceptives contain no estrogen. Therefore, they can be used throughout breast-feeding and by women who cannot use methods with estrogen.
- Progestin-only injectables work primarily by preventing the release of eggs from the ovaries (ovulation).
- A new subcutaneous formulation of DMPA has been developed specifically for injection into the tissue just under the skin (subcutaneously). Called DMPA-SC, this new formulation will be available in prefilled syringes and will contain 30% less hormone than typical DMPA (104 mg instead of 150 mg). Thus, it may cause fewer side effects, with an injection every 3 months which clients can deliver themselves. It has been approved in the United States under the name "Depo-subQ provera 104."

How Effective Are Progestin-Only Injectables?

- As commonly used, injectables have a failure rate of 3 pregnancies per 100 women over the first year of use.
- When women have injections on time, the failure rate is less than 1 pregnancy per 100 women over the first year (3 per 1,000 women).
- *Return of fertility after progestin-only injectables are stopped:* An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods.
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns including:
  - With DMPA first 3 months: irregular bleeding, prolonged bleeding
  - With DMPA at 1 year: no monthly bleeding, infrequent bleeding, irregular bleeding
  - NET-EN affects bleeding patterns less than DMPA. Fewer days of bleeding in the first 6 months and less likely to cause no bleeding after 1 year
- Weight gain (about 1–2 kg per year)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive
- Loss of bone density

Health Risks

None

Health Benefits

DMPA:

- Helps protect against
  - Risks of pregnancy
  - Cancer of the lining of uterus (endometrial cancer)
  - Uterine fibroids
- May help protect against
  - Symptomatic pelvic inflammatory disease
  - Iron deficiency anemia
- Reduces:
  - Sickle cell crisis among women with sickle cell anemia
  - Symptoms of endometriosis (pelvic pain, irregular bleeding)

NET-EN

- Helps protect against iron deficiency anemia
- May also offer many of the health benefits as DMPA

Correcting Misunderstandings

Progestin-only injectables:

- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Do not disrupt an existing pregnancy.
- Do not make women infertile.
- Do not cause birth defects.

Why Some Women Say They Like Progestin-Only Injectables

- Do not require daily action
- Do not interfere with sex
- Private: No one else can tell that a woman is using contraception
- No monthly bleeding (for many women)
- May help women to gain weight

PROGESTIN-ONLY INJECTABLES *(cont.)*

Who Can Use Progestin-Only Injectables?

Women of any reproductive age or parity, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have just had abortion or miscarriage
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Are infected with HIV, whether or not they are taking antiretroviral medications

Women can begin using progestin-only injectables without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when the woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see Pregnancy Checklist cue card).

Who Cannot Use Progestin-Only Injectables?

Women who have the following conditions:

- Breastfeeding a baby less than 6 weeks old
- Active liver disease (severe cirrhosis of the liver, a liver infection, or liver tumor)
- Systolic blood pressure 160 or higher or diastolic blood pressure 100 or higher
- Diabetes for more than 20 years or with damage to the arteries, vision, kidneys, or nervous system
- History of heart attack, heart disease due to blocked or narrowed arteries, or stroke or current blood clot in the deep veins of the leg or in the lung
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition.
- Current or history of breast cancer

When to Start Using Progestin-Only Injectables?

- At **any time** that it is reasonably certain that the client is not pregnant (If it has been more than 7 days since the last monthly bleeding started, a back-up method [such as abstinence, male or female condoms, spermicides, or withdrawal] is needed for the next 7 days.)
- **Having menstrual cycles or switching from a nonhormonal method:** If within 7 days after the start of monthly bleeding, there is no need for a back-up method. If more than 7 days after the start of monthly bleeding, a back-up method is needed for the first 7 days after the injection.
- **Switching from another hormonal method:** Immediately, if the client has been using the previous method consis-tently and correctly. There is no need to wait for a first period and no need for a back-up method. The day after, when the client finishes taking emergency contraceptive pills; a back-up method is needed for the first 7 days after the injection.
- **No monthly bleeding** (not related to childbirth or breastfeeding): Any time it is reasonably certain that the client is not pregnant. A back-up method is needed for the first 7 days after the injection.
- **Postabortion** (after abortion or miscarriage): Immediately or within 7 days. No back-up method needed. Beyond 7 days, any time it is reasonably certain the client is not pregnant; a back-up method is needed for the first 7 days after injection.
- **Postpartum:**
  - Fully or nearly fully breastfeeding: Six weeks after giving birth, and any time between 6 weeks and 6 months if her monthly bleeding has not returned. If more than 6 months, need to be certain that she is not pregnant, and a back-up method is needed for the first 7 days after the injection.
  - Partially breastfeeding: At 6 weeks after giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after injection.
  - Breastfeeding and monthly bleeding has returned: As advised for women having menstrual cycles.
  - Not breastfeeding: Any time, within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned, any time it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after the injection. If monthly bleeding has returned, as advised for women having menstrual cycles.

How Are Progestin-Only Injectables Used?

- The client should not massage the injection site, should be told the name of the injection, and should return in **3 months (13 weeks) for her next DMPA injection** and in **2 months (8 weeks) for NET-EN** on the day agreed upon.
- The repeat injection for DMPA and NET-EN can be given up to **2 weeks early,** or up to **2 weeks late** without the need for additional contraceptive protection, but it is best to return on time.
- If the client is **more than 2 weeks late** for the DMPA or NET-EN repeat injection, she can have the injection, if it is reasonably certain that she is not pregnant. She will need to use a back-up method for the first 7 days after the injection. She may consider emergency contraception if she has had unprotected sex in the past 5 days.

MONTHLY INJECTABLES

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use. 3rd ed.* Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Monthly Injectables?

- Monthly injectables contain 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body. (Combined oral contraceptives also contain these 2 types of hormones.) They are administered by intramuscular injection once a month.
- Monthly injectables also are called combined injectable contraceptives (CICs). Information in this cue card applies to medroxyprogesterone acetate + estradiol cypionate (MPA/E2C, which is marketed under the trade names Cyclofem®, Ciclofem®, Ciclofemina®, Cyclo-Provera®, Feminena®, Lunelle®, Lunella®, and Novafem®) and to norethisterone enanthate + estradiol valerate (NET-EN/E2V, which is marketed under the trade names Mesigyna® and Norigynon®). It may also apply to older formulations, about which less is known. The most widely available CICs are Cyclofem® (25 mg depot-medroxyprogesterone acetate and 5 mg estradiol cypionate) and Mesigyna® (50 mg norethindrone enanthate and 5 mg estradiol valerate).
- Monthly injectables work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective Are Monthly Injectables?

- As commonly used, the failure rate is about 3 pregnancies per 100 women over the first year.
- When women have injections on time, the failure rate is less than 1 pregnancy per 100 women over the first year (5 per 10,000 women).
- Return of fertility after injections are stopped: An average of about 1 month longer than with most other methods.
- Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns, including:
- Lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding
- Weight gain
- Headaches
- Dizziness
- Breast tenderness

Health Benefits and Health Risks

Long-term studies of monthly injectables are limited, but researchers expect that their health benefits and health risks are similar to those of combined oral contraceptives (see the cue card Combined Oral Contraceptives, Health Benefits and Health Risks).

Why Some Women Say They Like Monthly Injectables

- Private; no one else can tell that a woman is using contraception
- Do not require daily action
- Injections can be stopped at any time
- Good for spacing births

Correcting Misunderstandings

Monthly injectables:

- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman's body.
- Are not in experimental phases of study. Government agencies have approved them.
- Do not make women infertile.
- Do not cause early menopause.
- Do not cause birth defects or multiple births.
- Do not cause itching.
- Do not change women's sexual behavior.

Who Can Use Monthly Injectables?

Women of any reproductive age and parity, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion or miscarriage
- Smoke any number of cigarettes and are younger than 35
- Smoke fewer than 15 cigarettes daily and are older than 35
- Have anemia now or had anemia in the past
- Have varicose veins
- Are infected with HIV, whether or not they are taking antiretroviral medications

Women can begin using monthly injectables without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see Pregnancy Checklist cue card).

MONTHLY INJECTABLES *(cont.)*

Who Cannot Use Monthly Injectables?

Women who have the following conditions (contraindications):

- Fully or nearly fully breastfeeding a baby less than 6 months old
- Partially breastfeeding a baby less than 6 weeks old
- Have had a baby in the last 3 weeks
- Smoking 15 or more cigarettes a day and being age 35 or older
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor); women with mild cirrhosis or gall bladder disease can use monthly injectables.
- Systolic blood pressure 140 mm Hg or higher or diastolic blood pressure 90 or higher
- Diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes
- Current or history of stroke, blood clot in legs or lungs, heart attack, or serious heart problems
- Current or history of breast cancer
- Migraines with aura or migraines without aura at age 35 or older
- Planning major surgery that will keep her from walking for 1 week or more

When to Start Using Monthly Injectables?

- **Any time** it is reasonably certain that the client is not pregnant. If it has been more than 7 days since menstrual bleeding stared, a back-up method (such as abstinence, male or female condoms, spermicides, or withdrawal) is needed for the next 7 days.
- **Having menstrual cycles or switching from a nonhormonal method:** If within 7 days after the start of monthly bleeding, there is no need for a back-up method. If more than 7 days after the start of monthly bleeding, a back-up method is needed for the first 7 days after the injection.
- **Switching from another hormonal method,** immediately if the client has been using the previous method consistently and correctly. No need to wait for a first period. No need for a back-up method. **After using emergency contraceptive pills** (ECPs), the same day as the client finishes taking pills; a back-up method is needed for the first 7 days after the injection.
- **No monthly bleeding:** Any time when it is reasonably certain that the client is not pregnant; a back-up method is needed for the first 7 days after the injection.
- **Postabortion** (after abortion or miscarriage): Immediately or within 7 days. No back-up method is needed. Beyond 7 days after abortion or miscarriage, any time it is reasonably certain as the client is not pregnant; a back-up method is needed for the first 7 days after the injection.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding*—6 months after giving birth or when breast milk is no longer the baby's main food, whichever comes first. After 6 months and if her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more than 6 months and monthly bleeding has returned, as advised for women having menstrual cycles.
  - *Partially breastfeeding*—At 6 weeks after giving birth, at the earliest. After 6 weeks and if her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more 6 weeks and her monthly bleeding has returned, as advised for women having menstrual cycles.
  - *Not breastfeeding*—On days 21–28 after giving birth (within fourth week). If more than 4 weeks after giving birth and her monthly bleeding has not returned, any time it is reasonably certain that the she is not pregnant, along with using a back-up method for the first 7 days after the injection. If more than 4 weeks and her monthly bleeding has returned, as advised for women having menstrual cycles.

How Are Monthly Injectables Used?

- The injection should be given every 4 weeks.
- The client should not massage the injection site, and she should be told the name of the injection.
- Subsequent injections can be given up to 7 days earlier and 7 days later than the scheduled injection day.
- For ease of use, the injections can be scheduled for the same day of each month.
- If the client comes more than 7 days late, she should abstain from sex or use condoms, spermicides, or withdrawal until she can get an injection. She can also consider emergency contraceptive pills if she has had unprotected sex in the past 5 days.
- The client should also be told about the **warning signs for health risks** (see the cue card on Combined Oral Contraceptives).

IMPLANTS

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Implants?

- Implants are small plastic rods or capsules, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body. A specifically trained provider performs a minor surgical procedure to place the implants under the skin on the inside of a woman's upper arm.
- Implants do not contain estrogen, and so they can be used throughout breastfeeding and by women who cannot use methods containing estrogen.
- There are many types of implants: *Jadelle* consists of 2 rods and lasts 5 years; *Implanon* consists of 1 rod and lasts 3 years. (Studies are underway to see if it lasts f4our years); *Norplant* consists of 6 capsules and is labeled for 5 years of use (large studies found it effective for 7 years); *Sinoplant* consists of 2 rods and lasts 5 years.
- Implants work primarily by thickening cervical mucus (which blocks the sperm from meeting an egg) and by disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation).

How Effective Are Implants?

- Pregnancy rates are less than 1 pregnancy per 100 women using implants over the first year (5 per 10,000 women).
- Pregnancy risk continues beyond first year of use. Over 5 years of Jadelle use, the rate is about 1 pregnancy per 100 women; over 3 years of Implanon use, the rate is less than 1 pregnancy per 100 women (1 per 1,000 women); over 7 years of Norplant use, the rate is about 2 pregnancies per 100 women.
- Jadelle and Norplant implants begin to lose effectiveness sooner in heavier women.
- *Return of fertility after implants are removed:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side effects (which are temporary and not dangerous)

- Changes in bleeding patterns including:
  - In first several months, lighter bleeding and fewer days of bleeding, Irregular bleeding that lasts more than 8 days, irregular bleeding, no monthly bleeding
  - After about 1 year, lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding
- Headaches
- Abdominal pain
- Acne (can improve or worsen)
- Weight change
- Breast tenderness
- Dizziness
- Mood changes
- Nausea
- Enlarged ovarian follicles

Health Benefits

- Help protect against
  - Risks of pregnancy
  - Symptomatic pelvic inflammatory disease
  - Uterine fibroids
- May help protect against
  - Iron deficiency anemia

Health Risks

None

Complications and Their Warning Signs

Uncommon:

- Infection at insertion site (mostly within the first 2 months)—Warning signs include arm pain and pus or bleeding at the insertion site.
- Difficult removal (rare if properly inserted and the provider is skilled at removal)

Rare:

- Expulsion of implant (mostly within the first 4 months)

Correcting Misunderstandings

Implants:

- Stop working once they are removed. Their hormones do not remain in a woman's body.
- Can stop monthly bleeding, but this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not building up inside the woman.
- Substantially reduce the risk of ectopic pregnancy.
- Do not make women infertile.
- Do not move to other parts of the body.

Why Some Women Say They Like Implants

- Do not require the user to do anything once they are inserted
- Prevent pregnancy very effectively for many years
- Convenient
- Do not interfere with sex

IMPLANTS *(cont.)*

Who Can Use Implants?

Women of any reproductive age or parity, including women who:

- Have or have not had children, or are not married.
- Are of any age, including adolescents and women older than 40.
- Have just had an abortion, a miscarriage, or an ectopic pregnancy.
- Smoke cigarettes, regardless of age or number of cigarettes smoked.
- Are breastfeeding (starting as soon as 6 weeks after childbirth).
- Have anemia, now or in the past.
- Have varicose veins.
- Have HIV infection, whether or not they are taking antiretroviral medications.

Women can begin using implants without a pelvic examination, without any blood tests or other routine laboratory tests, without cervical cancer screening, without a breast examination, and even when a woman is not having monthly bleeding at the time (as long as it is reasonably certain that she is not pregnant—see the Pregnancy Checklist cue card).

Who Cannot Use Implants?

Women cannot use implants if they have the following conditions:

- Breastfeeding a baby less than 6 weeks old
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor)
- Current problem with a blood clot in legs or lungs
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

How Are Implants Used?

- Implants are inserted and removed by trained health care providers. Insertion takes a few minutes.
- The woman receives an injection of local anesthetic under the skin to prevent pain in her arm.
- The implant(s) are inserted through an incision made on the inside of the upper arm. Implanon does not require an incision. It is inserted through its applicator. The woman stays fully awake throughout the procedure.
- The incision is closed with an adhesive bandage. Stitches are not needed.
- For removal, the same steps of injection and incision are completed, and the provider pulls out the implants with the help of an instrument. The client may feel slight pain ore soreness for a few days after removal. Stitches are not needed. An adhesive bandage is used to close the incision.
- The client should also be told about the **warning signs for complications** (see the first page).

When to Start Using Implants?

- **Any time** it is reasonably certain that the client is not pregnant. (See Pregnancy Checklist cue card.)
- **No monthly bleeding**—Any time it is reasonably certain that the client is not pregnant. A back-up method is needed for the first 7 days after insertion.
- Immediately when **switching from another hormonal method,** if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding. No need for a back-up method.
- **After taking emergency contraceptive pills (ECPs),** within the first 7 days (5 days for Implanon) after next monthly bleeding, or any time it is reasonably certain the client is not pregnant. Will need to use a back-up method or the pill the day after taking ECPs, until implant insertion.
- **Menstruating or switching from nonhormonal method,** within 7 days (5 for Implanon) after start of monthly bleeding and no back-up method, or more than 7 days after start of monthly bleeding—any time it is certain client is not pregnant; use back-up method for first 7 days after insertion.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding*—Six weeks after giving birth, and any time between 6 weeks and 6 months, if her monthly bleeding has not returned. If more than 6 months after giving birth and her monthly bleeding has returned, any time it is reasonably certain that she is not pregnant; a back-up method should be used for the first 7 days after insertion.
  - *Partially breastfeeding*—At 6 weeks after giving birth; if more than 6 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant; a back-up method should be used for the first 7 days.
  - *Breastfeeding, monthly bleeding has returned*—As advised for women with menstrual cycles.
  - *Not breastfeeding*—Any time within 4 weeks after giving birth; If beyond 4 weeks and monthly bleeding has not returned, any time it is reasonably certain that she is not pregnant; a back-up method is needed for the first 7 days of taking pills. If monthly bleeding has returned, as advised for women having menstrual cycles
- **Postabortion** (after abortion or miscarriage)—If immediately after or within 7 days, no back-up method is needed. If more than 7 days after, any time it is reasonably certain that she is not pregnant; a back-up method is needed for the first 7 days after insertion.

COPPER-BEARING INTRAUTERINE DEVICE (IUD)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is the Intrauterine Device (IUD)?

- The IUD is a small, flexible plastic device with copper sleeves or wire around it. A specially trained health care provider inserts it into a woman's uterus through her vagina and cervix. Almost all types of IUDs have 1 or 2 strings, or threads, tied to them. The strings hang through the cervix into the vagina.
- The most commonly used IUD in family planning programs is the copper-bearing TCu-380A IUD, which is effective for up to 12 years of use. Other copper-bearing IUDs are the MLCu-375 (Multiload) and Nova T, which are effective for 5 years.
- The IUD works primarily by causing a chemical change that damages sperm and egg before they can meet.

How Effective Are IUDs?

- IUDs are highly effective in providing long-term, reversible contraception. For the TCu-380A, the pregnancy (failure) rate during the first year of use is less than 1 pregnancy for 100 women (6–8 per 1,000 women). Over 10 years of IUD use, the failure rate is about 2 pregnancies per 100 women.
- *Return to fertility after IUD is removed:* No delay
- *Protection against sexually transmitted diseases (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

Changes in bleeding patterns (especially in the first 3–6 months), including:

- Prolonged and heavy monthly bleeding
- Irregular bleeding
- More cramps and pain during monthly bleeding

Health Benefits

- Helps protect against risks of pregnancy.
- May help protect against cancer of the lining of the uterus (endometrial cancer).

Health Risks and Warning Signs

- **Uncommon:** May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
- **Rare:** Pelvic inflammatory disease (PID) may occur if the woman has chlamydia or gonorrhea at the time of IUD insertion. Warning signs include increasing or severe pain in the lower abdomen, pain during intercourse, unusual vaginal discharge, fever, chills, nausea, and/or vomiting.

Complications

- **Rare:** Puncturing (perforation) of the wall of the uterus by the IUD or an instrument used for insertion may occur. This usually heals without treatment.

Why Some Women Say They Like the IUD

- Highly effective protection from pregnancy
- Long-lasting
- Relatively inexpensive at the start, and no further costs
- Does not require the user to do anything once the IUD is inserted

Correcting Misunderstandings

Intrauterine devices:

- Rarely lead to PID after insertion.
- Do not increase the risk of contracting STIs, including HIV.
- Do not increase the risk of miscarriage when a woman becomes pregnant after IUD removal.
- Do not make women infertile.
- Do not cause birth defects.
- Do not cause cancer.
- Do not move to the heart or brain.
- Do not cause discomfort or pain for the woman during sex.
- Do not require a "rest period" after several years of use.
- Substantially reduce the risk of ectopic pregnancy.

Who Can Use an IUD?

Most women can use IUDs safely and effectively, including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women older than 40
- Have just had an abortion or miscarriage (if there is no evidence of infection)
- Are breastfeeding
- Do hard physical work
- Have had an ectopic pregnancy
- Have had PID
- Have vaginal infections
- Are infected with HIV or are taking antiretroviral medications and doing well

Women can begin using an IUD without STI testing, without an HIV test, without any blood tests or other routine laboratory tests, without cervical cancer screening, and without a breast examination.

COPPER-BEARING INTRAUTERINE DEVICE (IUD) *(cont.)*

Who Cannot Use an IUD?

The IUD should not be used by women who have the following conditions:

- Gave birth more than 48 hours ago but less than 4 weeks ago
- Had an infection following childbirth or abortion
- Experienced unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition
- Have female conditions or problems (gynecologic or obstetric conditions or problems), such as genital cancer or pelvic tuberculosis
- Have current cervical, endometrial, or ovarian cancer
- Have AIDS and are clinically not well or are not using antiretroviral therapy (If the woman is at risk of HIV or is infected with HIV but does not have AIDS, she can use an IUD; if a woman who has an IUD in place develops AIDS, she can keep the IUD.)
- Are at very high individual risk for chlamydial infection or gonorrhea *(see below)*
- Might be pregnant

Assessing a client's risk of STIs; Women who are at ***high individual risk*** of infection should not have an IUD inserted. Steps to take:

1. Tell the client that a woman who faces a very high individual risk of some STIs usually should not use an IUD.
2. Ask the woman to consider her own risk and to think about whether she might have an STI. Risky situations include: a sexual partner with STI symptoms (pus coming from penis, pain or burning during urination, open sore in the genital area); she or a sexual partner diagnosed with an STI recently; and she or her sexual partner having had more than 1 sexual partner recently. The provider also can mention other high-risk situations that exist locally.
3. Ask if she thinks she is a good candidate for an IUD or would like to consider other methods.

When Can the IUD Be Inserted?

- **Having menstrual cycles:** If starting within 12 days after start of monthly bleeding, there is no need for a back-up method. If it is more than 12 days after the start of monthly bleeding, client can have IUD inserted whenever it is reasonably certain she is not pregnant; there is no need for a back-up method.
- **Switching from another method:** Immediately, if client has been using previous method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. There is no need to wait for next monthly bleeding. There is no need for a back-up method.
- For **emergency contraception:** Within 5 days after unprotected intercourse. After taking **emergency contraceptive pills** (ECPs), the same day that she finishes taking ECPs. There is no need for a back-up method.
- **No monthly bleeding:** Any time, if it can be determined she is not pregnant. There is no need for a back-up method.
- **Postpartum:**
  - Any time within 48 hours of giving birth (requires a provider with specific training in postpartum insertion), or 4 weeks after giving birth (in all other cases)
  - *Fully or nearly fully breastfeeding:* If monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth; if more than 6 months after giving birth, any time it is reasonably certain she is not pregnant. There is no need for a back-up method.
  - *Partially breastfeeding or not breastfeeding:* If more than 4 weeks since giving birth and monthly bleeding has not returned, if it can be determined she is not pregnant. There is no need for a back-up method.
  - *Breastfeeding and monthly bleeding has returned:* As advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage): Immediately or within 12 days, if no infection is present. No back-up method is needed. Beyond 12 days after abortion or miscarriage, any time it is reasonably certain she is not pregnant. No back-up method is needed. If infection is present, after infection has completely cleared. IUD insertion ***after a second-trimester abortion or miscarriage*** requires specific training. If specifically trained health care provider is not available, insertion should be delayed until 4 weeks after abortion or miscarriage.

How Are IUDs Used?

- IUDs are inserted and removed by trained health service providers. The client should be told the type of the IUD, the date to return, for how long it protects from pregnancy, and when it will need to be removed or replaced.
- For **insertion**, to assess the client's eligibility for the IUD, the provider first conducts a bimanual exam, followed by the speculum exam to inspect the vagina and the cervix). The provider cleans the cervix and then holds the cervix by closing the tenaculum. Then the provider passes the uterine sound through the cervix to measure the depth and position of the uterus. Finally, the provider inserts the IUD slowly through the cervix and cuts its strings at 3 cm.
- The client can expect some cramping and pain for a few days after insertion. She can use ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever, as needed. Also, she can expect some bleeding or spotting immediately after insertion. This may continue for 3–6 months.
- A follow-up visit after her first monthly bleeding or 3–6 weeks following insertion is recommended.
- (If she wants) the client can check the IUD strings to confirm that her IUD is in place.
- The client should also be told about the **warning signs for health risks and complications** (see the first page) and to return to the clinic if she feels the strings are missing or feels the hard plastic of an IUD that has come out.
- For **removal**, the provider inserts a speculum to see the IUD and its strings, cleans the cervix and the vagina with an antiseptic, asks the woman to take slow, deep breaths to relax, and using a narrow forceps pulls the IUD strings slowly.

LEVONORGESTREL INTRAUTERINE DEVICE (LNG-IUD)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is the Levonorgestrel Intrauterine Device (LNG-IUD)?

- The LNG-IUD is a T-shaped plastic device that steadily releases small amounts of levonorgestrel each day. (Levonorgestrel is a progestin widely used in implants and oral contraceptive pills.) It is effective for 5 years.
- A specifically trained health care provider inserts it into a woman's uterus through her vagina and cervix.
- The LNG-IUD is also called the levonorgestrel-releasing intrauterine system (LNG-IUS) or the hormonal IUD. It is marketed under the brand names *Mirena* and *LevoNova*. Other IUDs are available with progesterone (*Progestasert*) and other progestins, such as etonogestrel. Information provided in this cue card pertains to the LNG-IUD, but it may be applicable to other hormonal IUDs.
- The LNG-IUD works primarily by suppressing the growth of the lining of uterus (endometrium).

How Effective Is the LNG-IUD?

- The LNG-IUD's failure rate is less than 1 pregnancy per 100 women over the first year (2 per 1,000 women). Over 5 years of LNG-IUD use, the failure rate is less than 1 pregnancy per 100 women (5 to 8 per 1,000).
- *Return to fertility after LNG-IUD is removed:* No delay
- *Protection against sexually transmitted diseases (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Changes in bleeding patterns (especially in the first 3–6 months), including:
  - Lighter bleeding and fewer days of bleeding
  - Infrequent bleeding, Irregular bleeding
  - No monthly bleeding
  - Prolonged bleeding
- Acne
- Headaches
- Breast pain or tenderness
- Nausea
- Weight gain
- Dizziness
- Mood changes
- Ovarian cysts

Health Benefits

- Helps protect against risks of pregnancy and iron deficiency anemia.
- May help protect against pelvic inflammatory disease (PID).

Health Risks:

None

Complications:

Rare: Puncturing (perforation) of the wall of the uterus by the LNG-IUD or an instrument used for insertion may occur. This usually heals without treatment.

Who Can Use the LNG-IUD?

Nearly all women can use the LNG-IUD safely and effectively.

Who Should Not Use the IUD?

The LNG-IUD should not be used by women who have the following conditions:

- Gave birth less than 4 weeks ago
- Infection following childbirth or abortion
- Unexplained vaginal bleeding suggesting pregnancy or an underlying medical condition
- Female conditions or problems (gynecologic or obstetric conditions or problems) such as genital cancer or pelvic tuberculosis
- Known current cervical, endometrial or ovarian cancer
- AIDS and clinically not well or are not on antiretroviral therapy (If she is at risk of HIV or infected by HIV but does not have AIDS, she can use an LNG-IUD. If a woman who has an LNG-IUD in place develops AIDS, she can keep the LNG-IUD.)
- Very high individual risk for chlamydial infection or gonorrhea *(see Assessment of Individual Risk on the Copper-Bearing IUD cue card)*
- Might be pregnant
- Current blood clot in the deep veins of legs or lungs
- Serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumor)
- Current or history of breast cancer

LEVONORGESTREL INTRAUTERINE DEVICE (LNG-IUD) *(cont.)*

When Can the LNG-IUD Be Inserted?

- **Having menstrual cycles or switching from a nonhormonal method:** If starting within 7 days after the start of her monthly bleeding, no back-up method is needed. If it is more than 7 days after the start of her monthly bleeding, she can have the LNG-IUD inserted any time it is reasonably certain she is not pregnant. A back-up method is needed for the first 7 days after insertion.
- **Switching from a hormonal method:** Immediately, if she has been using the previous method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for next monthly bleeding. No back-up method is needed.
- After taking **emergency contraceptive pills** (ECPs): The LNG-IUD can be inserted within 7 days after the start of the client's next monthly bleeding or any other time it is reasonably certain that the client is not pregnant. A back-up method is needed until the LNG-IUD is inserted.
- **No monthly bleeding:** Any time it can be determined she is not pregnant; a back-up method is needed for the first 7 days after insertion.
- **Postpartum:**
  - *Fully or nearly fully breastfeeding:* If monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth. No back-up method is needed. If more than 6 months after giving birth and her monthly bleeding has not returned, any time it is reasonably certain she is not pregnant; a back-up method is needed for the first 7 days after insertion.
  - *Partially breastfeeding or not breastfeeding:* If more than 4 weeks since giving birth and her monthly bleeding has not returned, LNG-IUD can be inserted anytime it can be determined she is not pregnant. A back-up method is needed for the first 7 days after insertion.
  - *Breastfeeding and monthly bleeding has returned:* As is advised for women having menstrual cycles.
- **Postabortion** (after abortion or miscarriage): Insert immediately, or within 7 days if no infection is present; no back-up method is needed. Beyond 7 days after abortion or miscarriage, insert any time it is reasonably certain she is not pregnant; no back-up method is needed. If infection is present, insert after infection has completely cleared. LNG-IUD insertion ***after second-trimester abortion or miscarriage*** requires specific training. If specifically trained health care provider is not available, insertion should be delayed until after 4 weeks following the abortion or miscarriage.

How Is LNG-IUD Used?

- LNG-IUDs are inserted and removed by trained health service providers. The client should be told the type of the LNG-IUD, the date to return, for how long it protects from pregnancy, and when it will need to be removed or replaced.
- For **insertion**, to assess the client's eligibility for the IUD, the provider first conducts a pelvic exam (a bimanual exam, followed by the speculum exam to inspect the vagina and the cervix). The provider cleans the cervix and then holds the cervix by closing the tenaculum. Then the provider passes the uterine sound through the cervix to measure the depth and position of the uterus. Finally the provider inserts the LNG-IUD slowly through the cervix and cuts its strings at 3 centimeters. After the insertion the client can rest on the examination table until she feels ready to get dressed.
- The client should return within the first 3 months to make sure that the LNG-IUD is in the right place.
- (If she wants) the client can check the LNG-IUD strings to confirm that her LNG-IUD is in place.
- The client should also be told about the **warning signs for complications** (see the first page) and to return to the clinic if she feels the strings are missing or feels the hard plastic of an LNG-IUD that has come out.
- For **removal**, the provider inserts a speculum to see the LNG-IUD and its strings. After cleaning the cervix and the vagina with an antiseptic solution, the provider asks the woman to take slow, deep breaths to relax, and using a narrow forceps pulls the LNG-IUD strings slowly.

FEMALE STERILIZATION

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is Female Sterilization?

- Permanent contraception for women who will not want more children.
- The 2 surgical approaches most often used:

Minilaparotomy involves making a small incision in the abdomen, and the fallopian tubes are brought to the incision to be cut or blocked.

Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen.

- Also called tubal sterilization, tubal ligation, voluntary surgical contraception, tubectomy, bi-tubal ligation, tying the tubes, minilap, and "the operation."
- Works because the fallopian tubes are blocked or cut. Eggs released from the ovaries cannot move down the tubes, and so they do not meet sperm. It is immediately effective.

How Effective Is Sterilization?

- Less than 1 pregnancy per 100 women over the first year after having the sterilization procedure (5 per 1,000).
- Over 10 years of use: About 2 pregnancies per 100 women (18 to 19 per 1,000).
- *Fertility does not return because sterilization generally cannot be stopped or reversed.* The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy.
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects None

Health Benefits

- Helps protect against risks of pregnancy and pelvic inflammatory disease (PID).
- May help protect against ovarian cancer

Health Risks

- **Uncommon to extremely rare:** Complications of surgery and anesthesia

Complications of Surgery

- **Uncommon to extremely rare:** Serious complications are uncommon and death due to procedure or anesthesia is extremely rare. The risk of complications with local anesthesia is significantly lower than with general anesthesia. Complications can be kept to a minimum if appropriate techniques are used and if procedure is performed in an appropriate setting.

Why Some Women Say They Like Female Sterilization

- No side effects
- No need to worry about contraception again
- Easy to use, nothing to do or remember

Correcting Misunderstandings

Female sterilization:

- Does not make women weak
- Does not cause lasting pain in back, uterus, or abdomen.
- Does not remove a woman's uterus or lead to a need to have it removed.
- Does not cause hormonal imbalances.
- Does not cause heavier bleeding or irregular bleeding or otherwise change women's menstrual cycles.
- Does not cause any changes in weight, appetite, or appearance.
- Does not change women's sexual behavior or sex drive.
- Substantially reduces the risk of ectopic pregnancy.

Who Can Have Female Sterilization?

With proper counseling and informed consent, any woman can have female sterilization safely, including women who:

- Have no children or few children or are not married
- Do not have husband's permission
- Are young
- Just gave birth (within the last 7 days)
- Are breastfeeding
- Are infected with HIV, whether or not on antiretroviral medications

Women can have female sterilization without any blood tests or routine laboratory tests, without cervical cancer screening and even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant (see cue card titled **Pregnancy Checklist**).

Who Cannot Have Female Sterilization? *No medical condition prevents a woman from using female sterilization.* Some medical conditions may limit when, where, or how the female sterilization procedure should be performed. In such situations one should use ***caution***, ***delay*** the procedure or make ***special*** arrangements.

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition (e.g., past PID, previous abdominal or pelvic surgery, hypothyroidism, moderate iron deficiency anemia).

continued

FEMALE STERILIZATION *(cont.)*

- *Delay* means postpone female sterilization. These conditions must be treated and resolved before female sterilization can be performed. The client should be given a back-up method* to use until the procedure can be performed (e.g., current pregnancy, pelvic inflammatory disease, malignant trophoblast disease, active viral hepatitis).
- *Special* means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other back-up medical support (e.g., AIDS, endometriosis, severe cirrhosis of the liver).

For a complete list of medical conditions that necessitate caution, delaying of the procedure, and making special arrangements, see the *Family Planning: A Global Handbook for Providers* or see WHO Medical Eligibility Criteria, 2004.

When Can Female Sterilization Be Performed?

- **Having menstrual cycles or switching from another method**—If procedure is performed within 7 days after the start of her monthly bleeding, no need to use another method before the procedure. If it is more than 7 days after the start of her monthly bleeding, she can have the procedure any time it is reasonably certain she is not pregnant.
- **No monthly bleeding**—Any time it is reasonably certain she is not pregnant.
- After using **emergency contraceptive pills** (ECPs), woman can have sterilization procedure done within 7 days after the start of her next monthly bleeding or, any other time it is reasonably certain she is not pregnant. She should be given a back-up method or oral contraceptives to start the day after she finishes taking the ECPs, to use until she can have the procedure.
- **After childbirth (Postpartum):**
  - Immediately or within 7 days after giving birth, if she has made a voluntary, informed choice in advance.
  - Any time 6 weeks or more after childbirth, if it is reasonably certain she is not pregnant.
- **After abortion or miscarriage (postabortion)** Within 48 hours after uncomplicated abortion, if she has made a voluntary, informed choice in advance.

How Is Female Sterilization Performed?

- The client should be counseled and have decided after having fully understood the 7 points of informed consent (see Participant Handbook, p. 109).
- **Before the procedure** the client should not eat anything for 8 hours and should not take any medication for 24 hours.
- The most common approaches used are minilaparotomy and laparoscopy. It can also be done during caesarean section. Based on the surgical approach and type of anesthesia, the client should be told about what to expect during the procedure.
- The procedure can be performed under local or **general anesthesia**. If the procedure will be done under local anesthesia, the woman receives light sedation (with pills or into a vein) to relax her. Local anesthetic is injected at the incision site.
- **Minilaparotomy** involves a 2–5 centimeter incision just above the pubic hairline (for interval female sterilization) or a 1.5–3 cm incision at the lower edge of the navel (for postpartum female sterilization). Inserting a special instrument (uterine elevator) into the vagina, through the cervix, and into the uterus, the provider raises each of the 2 fallopian tubes so they are closer to the incision. This may cause discomfort. Through the incision, the provider grasps the tubes and occludes them, by tying and cutting them or by closing them with a clip or ring. The incision is then closed with stitches and covered with an adhesive bandage.
- **Laparoscopy** starts with the insertion of a special needle into the women's abdomen. Through the needle, the provider inflates (insuflates) the abdomen with gas or air. The provider makes a small incision (about 1 cm) and inserts a long, thin tube (laparoscope) with which to visualize the tubes. Then another instrument is inserted through the laparoscope to close the fallopian tubes by applying a clip or ring or by using electric current (electrocoagulation) to block the tube. The provider then removes the instrument and the laparoscope, the gas or air is let out, and the provider closes the incision with stitches and covers it with an adhesive bandage. A laparoscope is not used in the immediate postpartum period because of the risk of injury to the large vascular uterus.
- Local anesthesia is safer than spinal, epidural, or general anesthesia, lets the client leave the clinic or hospital sooner (in a few hours), allows faster recovery, and makes it possible to perform female sterilization in more facilities.
- **After the procedure,** the client is observed for 2–6 hours at the clinic or hospital. She receives instructions on what to do after she leaves. She should:
  - Rest for 2 days and avoid vigorous work and heavy lifting for a week.
  - Keep the incision clean and dry for 1–2 days.
  - Not have sex for at least 1 week.
- The client should be told about the warning signs of complications of surgery, such as:
  - Bleeding, pain, pus, heat, swelling, or redness of the wound that becomes worse or does not go away
  - High fever (greater than 38°C/101°F)
  - Fainting, persistent light-headedness, or extreme dizziness in the first 4 weeks
- The client should return within 7 days to have the incision site checked and any stitches removed, and any time soon after the procedure if signs of infection are present.

VASECTOMY

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is Vasectomy?

- Vasectomy is permanent contraception for men who will not want more children.
- Through a puncture or small incision in the scrotum, the provider locates each of the 2 tubes that carry sperm to the penis (vas deferens) and cuts or blocks it by cutting and tying it closed or by applying heat or electricity (cautery).
- Vasectomy is also called male sterilization and male surgical contraception.
- Vasectomy works by closing off each vas deferens, keeping sperm out of semen. Semen is ejaculated, but it cannot cause pregnancy.
- There is a 3-month delay in vasectomy's taking effect. Therefore, the man or couple must use condoms or another contraceptive method for 3 months after vasectomy.

How Effective Is Vasectomy?

- Where men cannot routinely have their semen examined to see if it still contains sperm, pregnancy rates are about 2 or 3 per 100 women over the first year after their partners have had a vasectomy. Where men can have their semen examined after vasectomy, pregnancy rates are less than 1 per 100 women over the first year after their partners have had vasectomies (2 per 1,000).
- Some pregnancies occur within the first year because the couple does not use condoms or another effective method correctly and consistently in the first 3 months, before the vasectomy is fully effective.
- Over 3 years of use: About 4 pregnancies per 100 women
- *Fertility does not return because vasectomy generally cannot be stopped or reversed.* The procedure is intended to be permanent. Reversal surgery is difficult, expensive, and not available in most areas. When performed, reversal surgery often does not lead to pregnancy
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side effects, Health Benefits and Health Risks

- None

Complications of Surgery

- ***Uncommon to rare:*** Severe scrotal or testicular pain that lasts for months or years
- ***Uncommon to very rare:*** Infection at the incision site or inside the incision (uncommon with conventional incision technique; very rare with no-scalpel technique)
- ***Rare:*** Bleeding under the skin that might cause swelling or bruising (hematoma)

Correcting Misunderstandings

Vasectomy:

- Does not remove the testicles. In vasectomy, the tubes carrying sperm from the testicles are blocked. The testicles remain in place.
- Does not decrease sex drive.
- Does not affect sexual function. A man's erection is as hard, it lasts as long, and he ejaculates the same as before.
- Does not cause a man to grow fat or become weak, less masculine, or less productive.
- Does not cause any diseases later in life.
- Does not prevent transmission of STIs, including HIV.

Why Some Women Say They Like Vasectomy

- Safe, permanent, and convenient
- Fewer side effects and complications than many methods for women
- Man takes responsibility for contraception—takes burden off woman
- Increases enjoyment and frequency of sex

VASECTOMY *(cont.)*

Who Can Have a Vasectomy?

With proper counseling and informed consent, any man can have a vasectomy safely, including men who:

- Have no children or few children
- Are not married
- Do not have wife's permission
- Are young
- Have sickle cell disease
- Are at high risk of HIV or other STI infection
- Are infected with HIV, whether or not on antiretroviral medications

In some of these situations, especially careful counseling is important to make sure the man will not regret his decision.

Men can have a vasectomy without any blood tests or routine laboratory tests, without having their blood pressure checked, without a hemoglobin test, without having their cholesterol or liver function checked, and even if they cannot have their semen examined by microscope later to see if there are still sperm in it.

Who Cannot Have a Vasectomy?

No medical condition prevents a man from using vasectomy. Some medical conditions may limit when, where, or how the vasectomy procedure should be performed. In such situations, one should use ***caution***, ***delay*** the procedure, or make ***special*** arrangements.

- *Caution* means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition (e.g., previous scrotal injury, large varicocele or hydrocele, undescended testicle [one side only], diabetes, depression).
- *Delay* means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. The client should be given a back-up method* to use until the procedure can be performed (e.g., active STI, scrotal skin infection, a mass in the scrotum, systemic infection).
- *Special* means that special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anesthesia, and other back-up medical support (e.g., hernia in the groin, undescended testicles [both sides], AIDS, coagulation disorders [blood fails to clot]).

For a complete list of medical conditions that necessitate caution, delaying of the procedure, and making special arrangements, see the sources cited on the front of this cue card.

When Can Vasectomy Be Performed?

Vasectomy can be performed any time a man requests it (if there is no medical reason to delay).

How Is Vasectomy Performed?

- The client should be counseled and have decided after having fully understood the 7 points of informed consent (see Participant Handbook, p. 109).
- Male sterilization is performed through either **no-scalpel vasectomy (NSV)** or **conventional vasectomy**. NSV is the preferred method, because it uses a smaller puncture instead of incisions, it causes less pain and bruising, recovery time is shorter, and it reduces the operating time. Based on the approach used, the client should be told about what to expect during the procedure and how to prepare for the procedure.
- The man receives an injection of local anesthetic in his scrotum to prevent pain. He stays awake throughout the procedure.
- In **NSV**, the skin is punctured with a special instrument and each vas deferens is reached and occluded through the puncture. As the puncture is so small, it can be covered with adhesive bandage.
- In **conventional vasectomy**, the clinician makes 1–2 cm incision(s) in the scrotal skin. Through the incision(s), each vas deferens is reached and occluded. The skin is then closed with stitches.

Both conventional vasectomy and NSV are performed almost exclusively under **local anesthesia** only.

- **After the procedure**, the client receives clear instructions about postoperative care. Following the procedure, the client can leave within a few hours, often in less than 1 hour. He should:
  - Rest for 2 days, if possible
  - Apply cold compresses on the scrotum for the first 4 hours, if possible
  - Wear snug underwear or pants for 2–3 days
  - Not have sex for at least 2–3 days
  - (If his wife is not using an effective contraceptive,) use condoms to use for 3 months, until sperm are cleared from his system.
  - Return in 3 months for semen analysis, if available
- The client should be told about the warning signs of complications of surgery, such as:
  - Bleeding, pain, pus, heat, swelling, or redness in the genital area that becomes worse or does not go away

MALE CONDOM

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Male Condoms?

- A male condom is a thin sheath usually made of rubber (latex) that is placed on an erect penis before intercourse. It is the only method of contraception that also provides protection from sexually transmitted infections (STIs), including HIV.
- Male condoms are also called rubbers, "raincoats," "umbrellas," skins, and prophylactics, and are known by many different brand names.
- Male condoms form a barrier that keeps sperm out of the vagina, preventing pregnancy; they also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

How Effective Are Condoms?

Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used with every act of intercourse.

- As commonly used, the failure rate is about 15 pregnancies per 100 women whose partners use male condoms over the first year.
- When used correctly with every sex act, the male condom has a failure rate of about 2 pregnancies per 100 women whose partners use male condoms over the first year.
- *Return of fertility after use of condoms is stopped:* No delay
- *Protection against HIV and other STIs:*
  - When used consistently and correctly, the male condom prevents 80–95% of HIV transmission that would have occurred without condoms.
  - Condoms reduce the risk of becoming infected with many STIs when used consistently and correctly.
    - ⇒ They are most effective for preventing STIs spread by discharge, such as HIV, gonorrhea, and chlamydia.
    - ⇒ They reduce the risk of becoming infected with STIs spread by skin-to-skin contact, such as herpes and human papillomavirus.

Side Effects, Health Benefits, and Health Risks

Side Effects None

Health Benefits

Condoms help protect against:

- Risk of pregnancy
- STIs, including HIV
- They may help protect against conditions caused by STIs:
- Recurring pelvic inflammatory disease and chronic pelvic pain
- Cervical cancer
- Infertility (male and female)

Health Risks

Extremely rare: Severe allergic reaction (among people with latex allergy)

Why Some Men and Women Say They Like Male Condoms

- No hormonal side effects
- Can be used as a temporary back-up method
- Can be used without seeing a health care provider
- Are sold in many places and are generally easy to obtain
- Help protect against both pregnancy and STIs, including HIV

Correcting Misunderstandings

Male condoms:

- Do not make men sterile, impotent, or weak, or decrease their sex drive.
- Cannot get lost in the woman's body.
- Do not have holes that HIV can pass through.
- Are not laced with HIV.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.
- Do not cause illness in men because sperm "backs up."
- Are used by many married couples. They are not only for use outside of marriage.

Who Can Use Male Condoms?

All men and women can safely use male condoms, except for those with severe allergy to latex rubber. Also, condoms can be used by:

- Men and women needing a **temporary** method while waiting for a regular one
- Couples needing a **back-up** method
- Men and women who have intercourse infrequently
- Couples who need contraception **immediately**
- Couples in which either partner has **more than 1 sexual partner**, even if using another method

MALE CONDOM *(cont.)*

When to Start Using Male Condoms?
Use of male condoms can start any time the client wants.

How Are Male Condoms Used?
IMPORTANT: Whenever possible, show the client how to put on a condom. Use a model of a penis, if available, or some other item, like a banana, to demonstrate.

1. **Use a new condom for each sex act.**
   - Check the condom package. Do not use if torn or damaged.
   - Tear open the package carefully. Do not use finger nails, teeth or anything that could damage the condom.

2. **Before any physical contact, place the condom on the tip of the erect penis with the rolled side out.**
   - For the most protection, put the condom before the penis makes any genital, oral or anal contact.

3. **Unroll the condom all the way to the base of the erect penis.**
   - The condom should unroll easily. Forcing it on could cause it break during use.
   - If the condom does not unroll easily, it may be on backwards, damaged, or too old. Throw it away and use a new condom.
   - If the condom is on backwards and a new one is not available, turn it over and unroll it onto penis.

4. **Immediately after ejaculation, hold the rim of the condom in place and withdraw the penis while it is still erect.**
   - Withdraw the penis.
   - Slide the condom off, avoiding spilling semen.
   - If having sex again or switching from one sex act to another, use a new condom.

5. **Dispose of the used condom safely.**
   - Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.

Also:
- Explain about use of emergency contraceptive pills (ECPs), in case there are errors in condom use.
- Discuss skills and techniques for negotiating condom use with partners.

FEMALE CONDOM

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What Are Female Condoms?

- Female condoms are sheaths, or linings, made of thin, transparent, soft plastic film that fit loosely inside a woman's vagina.
  - They have flexible rings at both ends. One ring, at the closed end, helps the woman to insert the condom, and the ring at the open end holds part of the condom outside the vagina
  - They are lubricated inside and out with a silicone-based lubricant.
- Different brand names of female condoms include FC Female Condom, Reality, Femidom, Dominique, Femy, Myfemy, Protectiv', and Care. In some countries, latex female condoms may be available.
- They work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy; they also keep infections in the semen, on the penis, or in the vagina from infecting the other partner.

How Effective Are Female Condoms?

Effectiveness depends on the user. The risk of pregnancy is greatest when condoms are not used with every act of intercourse.

- As commonly used, the failure rate for the female condom is 21 pregnancies per 100 women over the first year of use.
- When used correctly with every sex act, female condoms have a failure rate of about 5 pregnancies per 100 women over the first year.
- *Return of fertility after use of female condom is stopped:* No delay
- *Protection against HIV and other sexually transmitted infections (STIs):* Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every sex act.

Side Effects, Health Benefits, and Health Risks

Side Effects

None

Health Benefits

Female condoms help protect against

- Risk of pregnancy
- STI, including HIV

Health Risks

None

Correcting Misunderstandings

Female condoms:

- Cannot get lost in the woman's body.
- Are not difficult to use, but correct use needs to be learned.
- Do not have holes that HIV can pass through.
- Are used by many married couples; they are not only for use outside marriage.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.

Why Some Women Say They Like Female Condoms

- Women can initiate their use.
- Female condoms have a soft, moist texture that feels more natural during sex.
- Female condoms protect against pregnancy and STIs, including HIV.
- The outer ring provides added sexual stimulation for some women.
- Female condoms can be used without the need to see a health care provider.

Why Some Men Say They Like Female Condoms

- Female condoms can be inserted ahead of time so that use does not interrupt sex.
- They are not tight or constricting like male condoms.
- They do not dull the sensation of sex, like male condoms do.
- Female condoms do not have to be removed immediately after ejaculation.

Who Can Use Female Condoms?

Any women can use female condoms. No medical conditions prevent the use of this method.

When to Start Female Condoms?

Female condom use can begin anytime the client wants.

FEMALE CONDOM *(cont.)*

How Are Female Condoms Used?

IMPORTANT: Whenever possible, show the client how to insert the female condom. Use a model or picture, if available, or your hands to demonstrate. You can create an opening similar to a vagina with one hand and show how to insert the female condom with the other hand. Basic steps and important details are of using a female condom are as follows.

1. **Use a new female condom for each act of intercourse.**
   - Check the condom package. Do not use the product if the packaging is torn or damaged.
   - If possible, wash your hands with mild soap and clean water before inserting the condom.

2. **Before any physical contact, insert the condom into the vagina.**
   - The female condom can be inserted up to 8 hours before sex. For the most protection, insert the condom before the penis comes into contact with the vagina.
   - Choose a position that is comfortable for insertion—squat, raise one leg, sit, or lie down.
   - Rub the sides of the female condom together to spread the lubricant evenly.
   - Grasp the ring at the closed end, and squeeze it so that it becomes long and narrow.
   - With the other hand, separate the outer lips (labia) and locate the opening of the vagina.
   - Gently push the inner ring into the vagina as far up as it will go. Insert a finger into the condom to push it into place. About 2–3 cm of the condom and the outer ring should remain outside the vagina.

3. **Ensure that the penis enters the condom and stays inside the condom.**
   - The man or woman should carefully guide the tip of his penis inside the condom—not between the condom and the wall of the vagina. If his penis goes outside the condom, withdraw and try again.
   - If the condom is accidentally pulled out of the vagina or pushed into it during sex, put the condom back in place.

4. **After the man withdraws his penis, he should hold the outer ring of the condom, twist it to seal in fluids, and gently pull it out of the vagina.**
   - The female condom does not need to be removed immediately.
   - Remove the condom before standing up, to avoid spilling semen.
   - If the couple has sex again, they should use a new condom.
   - Reuse of female condoms is not recommended.

5. **Dispose of the used condom safely.**
   - Wrap the condom in its package and put it in the rubbish or latrine. Do not put the condom into a flush toilet, as it can cause problems with plumbing.

Also:

- Explain about use of emergency contraceptive pills (ECPs), in case there are errors in condom use.
- Discuss skills and techniques for negotiating condom use with partners.

SPERMICIDES

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What Are Spermicides?

- Spermicides are sperm-killing substances inserted deep in the vagina, near the cervix, shortly before sex.
  - Nonoxynol-9 is most widely used spermicide.
  - Others include benzalkonium chloride, chlorhexidine, menfegol, octoxynol-9, and sodium docusate.
- Spermicides are available in foaming tablets, melting or foaming suppositories, cans of pressurized foam, melting film, jelly, and cream. Jellies, creams, and foam from cans can be used alone, with a diaphragm, or with condoms. Films, suppositories, and foaming tablets or suppositories can be used alone or with condoms.
- Spermicides work by causing the membrane of sperm cells to break, killing them or slowing their movement. This keeps sperm from meeting an egg.

How Effective Are Spermicides?

The effectiveness of spermicides depends on the user. The risk of pregnancy is greatest when spermicides are not used with every act of intercourse.

- Spermicides are one of the least effective family planning methods.
- As commonly used, spermicides have a failure rate of about 29 pregnancies per 100 women over the first year.
- When used correctly with every act of intercourse, spermicides have a failure rate of about 18 pregnancies per 100 women over the first year.
- *Return of fertility after spermicides are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None. Frequent use may increase risk of HIV infection.

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Irritation in or around the vagina or penis
- Vaginal lesions

Health Benefits

Help protect against risk of pregnancy.

Health Risks

- ***Uncommon:*** Urinary tract infection, especially when spermicides are used 2 or more times a day
- ***Rare:*** Frequent use of nonoxynol-9 may increase risk of HIV infection.

Why Some Women Say They Like Spermicides

- Controlled by the woman
- No hormonal side effects
- Increase vaginal lubrication
- Can be used without seeing a health care provider
- Can be inserted ahead of time, so they do not interrupt sex

Correcting Misunderstandings

Spermicides:

- Do not reduce vaginal secretions or make women bleed during sex.
- Do not cause cervical cancer or birth defects.
- Do not protect against STIs.
- Do not change men's or women's sex drive or reduce sexual pleasure for most men.
- Do not stop women's monthly bleeding.

SPERMICIDES *(cont.)*

Who Can Use Spermicides?
Spermicides are safe and suitable for nearly all women.

Who Cannot Use Spermicides?
All women can safely use spermicides, except for those who:
- Are at high risk for HIV infection
- Have HIV infection
- Have AIDS

When to Start Using Spermicides?
Spermicides can be started at any time the client wants.

How Are Spermicides Used?
- Spermicides should be inserted before sex.
  - Foam or cream: Any time less than 1 hour before sex.
  - Tablets, suppositories, jellies, film: Between 10 minutes and 1 hour before sex.
- The client checks the expiration date and washes her hands with mild soap and clean water, if possible.
- The client applies the spermicide by:
  - ***Foam or cream:*** Shaking can of foam hard, squeezing spermicide from the can or tube into a plastic applicator, inserting the applicator deep into the vagina, near the cervix, and pushing the plunger.
  - ***Tablets, suppositories, jellies:*** Inserting the spermicide deep into the vagina, near the cervix, with an applicator or with fingers.
  - ***Film:*** Folding film in half and inserting with dry fingers (or else the film will stick to the fingers and not the cervix).
- The client should insert additional spermicide before each act of vaginal sex.
- Douching is not recommended, because it will wash away the spermicide and will also increase the risk of STIs. If the client must douche, she should wait for at least 6 hours after sex before doing so.
- Explain about emergency contraceptive pills (ECPs), in case the spermicide is not used at all or is not used properly.

DIAPHRAGM

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is the Diaphragm?

- The diaphragm is a soft latex cup that covers the cervix. It is placed deep in the vagina before sex. The rim contains a firm, flexible spring that keeps the diaphragm in place.
- The diaphragm comes in different sizes and requires fitting by a specifically trained provider.
- This method requires correct use with every act of intercourse for greatest effectiveness.
- The diaphragm is used with spermicidal cream, jelly, or foam to improve its effectiveness.
- The diaphragm blocks sperm from entering the cervix; spermicides kill or disable sperm. Both keep sperm from meeting an egg.

How Effective Is the Diaphragm?

The effectiveness of the diaphragm depends on the user. The risk of pregnancy is greatest when the diaphragm with spermicides is not used with every act of intercourse.

- As commonly used, the diaphragm has a failure rate of about 16 pregnancies per 100 women over the first year.
- When used correctly with every act of intercourse, the diaphragm has a failure rate of about 6 pregnancies per 100 women over the first year.
- *Return of fertility after use of the diaphragm is stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* The diaphragm may provide some protection against certain STIs, but clients should not rely on it for STI prevention.

Side Effects, Health Benefits, and Health Risks

Side Effects (which are temporary and not dangerous)

- Irritation in or around the vagina or penis
- Vaginal lesions

Health Benefits

- Helps protect against risks of pregnancy
- May help protect against
  - Certain STIs (chlamydia, gonorrhea, pelvic inflammatory disease, trichomoniasis)
  - Cervical precancer and cancer

Health Risks

- ***Common to uncommon:*** Urinary tract infection
- ***Uncommon:*** Bacterial vaginosis, candidiasis
- ***Rare:*** Increased risk of HIV infection, from frequent use of nonoxynol-9
- ***Extremely rare:*** Toxic shock syndrome

Why Some Women Say They Like the Diaphragm

- Controlled by the woman
- No hormonal side effects
- Can be inserted ahead of time, so does not interrupt sex

Correcting Misunderstandings

Diaphragms:

- Do not affect the feeling of sex. (A few men report feeling the diaphragm during sex, but most do not.)
- Cannot pass through the cervix, and cannot go into the uterus or otherwise get lost in the woman's body.
- Do not cause cervical cancer.

Who Can Use the Diaphragm?

Nearly all women can use the diaphragm safely and effectively.

Who Cannot Use the Diaphragm?

Women cannot use the diaphragm if they:

- Have had a baby or a second-trimester abortion in the past 6 weeks.
- Are allergic to latex rubber.
- Are at high risk for HIV infection.
- Have an HIV infection.
- Have AIDS.

When to Start Using the Diaphragm?

A client can begin using the diaphragm any time she wants, except within 6 weeks of a full-term delivery or a second-trimester spontaneous or induced abortion.

DIAPHRAGM *(cont.)*

How Is the Diaphragm Used?
A pelvic examination is needed before starting use. The provider determines the correct diaphragm size and checks that it fits properly and does not come out easily. With a properly fitted diaphragm, the client should not be able to feel anything inside her vagina, even when she walks or when she has intercourse.
IMPORTANT: Whenever possible, show the woman the location of the pubic bone and cervix with a model or picture. Explain that the diaphragm is inserted behind the pubic bone and covers cervix.

1. **Squeeze a spoonful of spermicidal cream, jelly, or foam into the diaphragm and around the rim.**
   - Wash hands with mild soap and clean water if possible.
   - Check the diaphragm for holes, cracks, or tears by holding it up to the light.
   - Check the expiration date of the spermicide and avoid using any beyond its expiration date.
   - Insert the diaphragm less than 6 hours before having sex.

1

2. **Press the rim together; push the diaphragm into the vagina as far as it goes.**
   - Choose a position that is comfortable for insertion—squatting, raising one leg, sitting, or lying down.

2

3. **Feel the diaphragm to make sure that it covers the cervix.**
   - Through the dome of the diaphragm, the cervix feels like the tip of the nose.
   - If the diaphragm feels uncomfortable, take it out and insert it again.

4. **Keep the diaphragm in place for at least 6 hours after sex.**
   - Keep the diaphragm in place at least 6 hours after having sex, but no longer than 24 hours.
   - *Leaving the diaphragm in place for more than 1 day may increase the risk of toxic shock syndrome.* It can also cause a bad odor and vaginal discharge.
   - For multiple sex acts, make sure that the diaphragm is in the correct position, and insert additional spermicides in front of the diaphragm before each act.

3

5. **To remove the diaphragm, slide a finger under the rim to pull it down and out.**
   - Wash hands with mild soap and clean water, if possible.
   - Insert a finger into the vagina until the rim of the diaphragm is felt.
   - Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail.
   - Wash the diaphragm with mild soap and clean water, and dry it after each use.

Also:
- Explain emergency contraceptive pill (ECP) use, in case the diaphragm moves out of place or is not used properly.
- Explain when to replace the diaphragm (when it gets thin, develops holes, or becomes stiff, or about every 2 years).

FERTILITY AWARENESS METHODS

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Are Fertility Awareness Methods?

- "Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant.)
- This approach is also called periodic abstinence or natural family planning. These methods can be used alone or in combination and can be grouped into:
  - ***Calendar-based methods.*** These methods involve keeping track of days of the menstrual cycle to identify the start and end of the fertile time. Examples: *Standard days method and calendar rhythm method.*
  - ***Symptoms-based methods.*** These methods depend on observing signs of fertility.
    - ⇒ Cervical secretions: When a woman sees or feels cervical secretions, she may be fertile.
    - ⇒ Basal body temperature (BBT): A woman's resting body temperature goes up slightly near the time of ovulation (release of an egg), when she could become pregnant.
    - ⇒ Examples: Two-Day Method, BBT method, ovulation method, and the symptothermal method
- Fertility awareness methods require partner's cooperation for abstaining or using another method on fertile days.
- Fertility awareness methods work primarily by helping a woman know when she could become pregnant. The couple prevents pregnancy by avoiding unprotected vaginal sex during these fertile days—usually by abstaining or by using condoms or a diaphragm. Some couples use spermicides or withdrawal, but these are among the least-effective methods.
- Clients should be told about emergency contraceptive pills (ECPs), in case there are errors in identifying fertile days.

How Effective Are Fertility Awareness Methods?

Effectiveness depends on the user. Pregnancy risk is greatest when couples have unprotected sex on the fertile days.

- As commonly used, periodic abstinence has a failure rate in the first year of about 25 pregnancies per 100 women.
- Pregnancy rates with correct and consistent use vary for different types of fertility awareness methods—5 pregnancies per 100 women over the first year of use of the standard days method, 9 per 100 women over the first year of use of the calendar rhythm method, 4 per 100 women over the first year of use of the Two-Day method, 1 per 100 women over the first year of use of the basal body temperature (BBT) method, 3 per 100 women over the first year of use of the ovulation method, and 2 per 100 women over the first year of use of the symptothermal method.
- *Return of fertility after fertility awareness methods are stopped:* No delay
- *Protection against sexually transmitted infections (STIs):* None

Side Effects and Health Risks

None

Correcting Misunderstandings

Fertility awareness methods:

- Can be very effective if used consistently and correctly.
- Do not require literacy or advanced education.
- Do not harm men who abstain from sex.
- Do not work when a couple is mistaken about when the fertile time occurs, such as thinking it occurs during monthly bleeding.

Why Some Women Say They Like Fertility Awareness Methods

- Have no side effects.
- Do not require procedures and usually do not require supplies.
- Help women learn about their bodies and fertility.
- Allow some women to adhere to their religious or cultural norms about contraception.
- Can be used to identify fertile days by both women who want to become pregnant and women who want to avoid pregnancy.

Who Can Use Calendar-Based Methods and Symptoms-Based Methods?

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them harder to use effectively and necessitate using caution or delaying their use. Caution means that additional or special counseling may be needed to ensure correct use of the method. Delay means that use of a particular fertility awareness method should be delayed until a condition is evaluated or corrected.

Calendar-Based Methods

- *Caution*—Menstrual cycles have just started or have become less frequent or stopped due to older age.
- *Delay*—The woman recently gave birth or is breastfeeding, recently had an abortion or miscarriage, is having irregular vaginal bleeding, is using drugs that may delay ovulation)

Symptoms-Based Methods

- *Caution*—Woman may have recently had an abortion or miscarriage, menstrual cycles may have just started or may have become less frequent or stopped due to older age, or woman may have a chronic condition that raises her body temperature (for BBT and symptothermal methods)
- *Delay*—The woman recently gave birth or is breastfeeding, has an acute condition that raises her body temperature [for BBT and symptothermal methods], is having irregular vaginal bleeding, is experiencing abnormal vaginal discharge, or is using drugs that may affect cervical secretions, raise body temperature, or delay ovulation).

FERTILITY AWARENESS METHODS *(cont.)*

When to Start Using Fertility Awareness Methods?
Once trained, a woman or couple usually can begin using fertility awareness methods at any time.

- **Having regular menstrual cycles**—Any time of the month. No need to wait for the next monthly bleeding.
- **No monthly bleeding**—Calendar-based methods cannot be used. Delay symptoms-based methods until monthly bleeding returns.
- **After childbirth** (whether or not breastfeeding)—Delay standard days method until woman has had 3 menstrual cycles; she can start symptothermal methods once normal secretions have returned.
- **After miscarriage or abortion**—Delay standard days method until the start of woman's next monthly bleeding. Start symptothermal methods immediately, with special counseling and support.
- **When switching from a hormonal method**—Delay standard days method until the start of her next monthly bleeding. Start symptothermal methods in the next menstrual cycle after stopping a hormonal method.
- **After taking emergency contraceptive pills** – Delay standard days method until the start of her next monthly bleeding. Start symptothermal methods once normal secretions have returned.

How Are Symptoms-Based Methods Used?

Two-Day Method
(If the woman has a vaginal infection or another condition that changes cervical mucus, the Two-Day method will be difficult to use.) The woman checks for cervical secretions every afternoon and/or evening, on fingers, underwear, or tissue paper or by sensation in or around the vagina. As soon as she notices any secretions of any type, color, or consistency, she considers herself fertile that day and the following day. The couple avoids unprotected sex or uses condoms or a diaphragm on each day that she considers herself fertile and the following day. The couple can have unprotected sex again after the woman has had 2 dry days (days without secretions of any type) in a row.

Basal Body Temperature (BBT) Method
(If a woman has fever or other changes in body temperature, the BBT method will be difficult to use.) The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph. She watches for her temperature to rise slightly—0.2° to 0.5°C (0.4° to 1.0°F)—around the time of ovulation (usually about midway through the menstrual cycle). The couple avoids vaginal sex, or uses condoms or a diaphragm from the first day of monthly bleeding until 3 days after the woman's temperature has risen above her regular temperature. The couple can have unprotected sex on the 4th day and until her next monthly bleeding.

Symptothermal Method
Users identify fertile and nonfertile days by combining BBT and ovulation method instructions. Women may also identify the fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around the time of ovulation). The couple avoids unprotected sex between the first day of monthly bleeding and either the fourth day after peak cervical secretions or the third full day after the rise in temperature (BBT), whichever happens later. Some women who use this method have unprotected sex between the end of monthly bleeding and the beginning of secretions, but not on 2 days in a row.

***Ovulation Method** (also known as the Billings method or cervical mucus method):*
(If a woman has a vaginal infection or another condition that changes cervical mucus, this method may be difficult to use.) The woman checks every day for any cervical secretions on her finger, underwear, or tissue paper or by sensation in the vagina. The couple avoids unprotected sex on days of heavy bleeding that makes mucus difficult to observe. Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding intercourse on the second day allows time for semen to disappear and for cervical mucus to be observed.) As soon as she notices any secretions, the woman considers herself fertile and avoids unprotected sex. She continues to check her cervical secretions each day. The secretions have a "peak day"—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex. The couple can have unprotected sex on the 4th day after her peak day and until her next monthly bleeding begins.

Standard Days Method (SDM)
Can be used if most of the cycles in a year are between 26 to 32 days long. A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1. Avoids unprotected sex or uses condoms or a diaphragm on days 8–19 that are considered fertile days for all users of the SDM. The couple can have unprotected sex on all other days of the cycle. They can use color-coded beads or calendar as memory aid.

Calendar Rhythm Method
Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1. The woman estimates the fertile time by subtracting 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time. The couple avoids unprotected sex or uses condoms or a diaphragm during the fertile time. She updates these calculations each month, always using the 6 most recent cycles.

LACTATIONAL AMENORRHEA METHOD (LAM)

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes.

What Is LAM?

- The lactational amenorrhea method (LAM) is a temporary family planning method based on the natural effect of breastfeeding on fertility. ("Lactational" means related to breastfeeding. "Amenorrhea" means not having monthly bleeding.) LAM provides contraception for the mother and the best approach for feeding for the baby.
- LAM is effective as long as all 3 of the following conditions are met:
  - The mother's monthly bleeding has not returned.
  - The baby is fully or nearly fully breastfed, and is fed often, day and night.
  - The baby is less than 6 months old.
- "Fully breastfeeding" includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).
- "Nearly fully breastfeeding" means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.
- LAM works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

How Effective Is LAM?

Effectiveness depends on the user: With LAM, the risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant.

- As commonly used, LAM has a failure rate of about 2 pregnancies per 100 women in the first 6 months after childbirth.
- When used correctly, LAM has a failure rate of less than 1 pregnancy per 100 women in the first 6 months after childbirth.
- *Return of fertility after LAM is stopped:* This depends on how much the woman continues to breastfeed.
- *Protection against sexually transmitted infections (STIs):* None

Side Effects, Health Benefits, and Health Risks

Side Effects
None

Health Benefits
- LAM helps protect against the risk of pregnancy.
- LAM encourages the best breastfeeding patterns, with health benefits for both mother and baby.

Health Risks
None

Why Some Women Say They Like LAM
- It is a natural family planning method.
- LAM supports optimal breastfeeding, providing health benefits for the baby and the mother.
- There is no direct cost for family planning or for feeding the baby.

Correcting Misunderstandings
LAM:
- Is highly effective when a woman meets all 3 criteria.
- Can be used by a woman with viral hepatitis.

LACTATIONAL AMENORRHEA METHOD (LAM) *(cont.)*

Who Can and Cannot Use LAM?

All women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Has HIV infection, including AIDS (Important: Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding—5–20 of every 100 infants breastfed by mothers with HIV will become infected. Women taking antiretroviral medications [ARVs] can use LAM. In fact, ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk. Rapid weaning also decreases the risk of HIV transmission. She should stop breastfeeding over 2 days to 3 weeks. Replacement feeding poses no risk of HIV transmission. Replacement feeding is recommended for the first 6 months after childbirth if—*and only if*—replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.)
- Is using certain medications during breastfeeding (including mood altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants)
- The newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, being unable to digest food normally, or having deformities of the mouth, jaw, or palate)

When to Start Using LAM?

The woman should start breastfeeding immediately (within 1 hour) or as soon as possible after the baby is born. LAM can be initiated at any time within 6 months after childbirth if the woman has been fully or nearly fully breastfeeding her baby since birth and her monthly bleeding has not returned.

How Is LAM Used?

- ***Ask the mother these 3 questions:***
  - Has your monthly bleeding returned?
  - Are you regularly giving the baby other food besides breast milk or allowing long periods without breastfeeding, either day or night?
  - Is your baby more than 6 months old?

  If the answer to all of these 3 questions is no, she can use LAM.
- An ideal pattern is feeding on demand (that is, whenever the baby wants to be fed) and at least 10–12 times a day in the first few weeks after childbirth and 8–10 times a day thereafter, including at least once at night in the first months. Daytime feedings should be no more than 4 hours apart, and nighttime feedings should be no more than 6 hours apart.
- She should start giving other foods in addition to breast milk when the baby is 6 months old. At this age breast milk can no longer fully nourish a growing baby.

POSTPARTUM FAMILY PLANNING

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and Republic of Turkey Ministry of Health General Directorate of MCHFP and EngenderHealth. 1999. *Postpartum family planning counseling.* Ankara.

What Is Postpartum Family Planning?

Postpartum family planning is the initiation of family planning method use within the 6 weeks following childbirth. There are important considerations in helping pregnant women and new mothers decide how they will avoid pregnancy after childbirth. These are:

- **Timing of counseling:** Ideally, family planning counseling should start ***during antenatal care***. This allows sufficient time for clients to be counseled and to make their decisions free of the stress associated with the delivery. It also helps to ensure that clients can receive their method of choice immediately after giving birth or just following (*immediate postpartum*)—e.g., the postpartum IUD or female sterilization. Usually, it is not appropriate to counsel the client ***just before delivery***. In this case, the stress that she is experiencing may impair sound decision making. The provider has the responsibility to confirm that such clients are making an informed, voluntary, and sound decision. If there are signs of stress, counseling and the client's decision making should be postponed. The next appropriate opportunity for counseling the client is ***after delivery*** but before the client leaves the facility. At this point, it may be too late to provide the client's method of choice during or at the end of the delivery or procedure, but this may help to ensure that the client gets his or her method of choice *before discharge* or returns later to get it at *follow-up*.
- **Healthy timing and spacing of pregnancy (HTSP) messages:** To achieve healthiest pregnancy outcomes for the baby and the mother, a woman should wait until her baby is at least 2 years old before trying to become pregnant again. See the HTSP cue card for details.
- **Breastfeeding status:** Since about 99% of women breastfeed their infants for some period of time, providers need to consider the impact of contraceptive methods on breast milk, breastfeeding, and infant health when helping clients choose a method. Within this context, the following 3 points should be taken into consideration when discussing use of contraceptive methods after childbirth:
  - All women should be encouraged to breastfeed.¨
  - Breastfeeding should continue when use of a family planning method is initiated.
  - The family planning method should not have any adverse effects on breastfeeding or infant health.
- **Return of fertility:** To make an informed decision, a woman needs to know when she will become fertile again following childbirth.
  - If not fully or nearly fully breastfeeding, she is able to become pregnant as soon as 6 weeks after childbirth.
  - If fully or nearly fully breastfeeding, she is able to become pregnant as soon as 6 months postpartum (see the LAM cue card).

For maximum protection, a woman should not wait until the return of monthly bleeding to start a contraceptive method, but should instead start as soon as guidance allows (see table below).

* Detailed breastfeeding guidance for HIV-positive women is provided in Handout 15-C of the Participant Handbook, p. XX.

Earliest Time That a Woman Can Start a Family Planning Method after Childbirth

Family Planning Method	Fully/Nearly Fully Breastfeeding	Partially/Not Breastfeeding
Lactational amenorrhea method (LAM)	Immediately	Not applicable
Vasectomy	Immediately or during partner's pregnancy†	
Male or female condoms	Immediately	
Spermicide		
Copper-bearing IUD	Within 48 hours, otherwise wait 4 weeks	
Female sterilization	Within 7 days, otherwise wait 6 weeks	
LNG-IUD	4 weeks after childbirth	
Diaphragm	6 weeks after childbirth	
Fertility awareness methods	Start when normal secretions have returned (symptoms-based methods) or when she has had 3 regular menstrual cycles (calendar-based methods). This is later for breastfeeding women than for those are not breastfeeding.	
Progestin-only pills	6 weeks after childbirth‡	Immediately if not breastfeeding; 6 weeks after childbirth if partially breastfeeding
Progestin-only injectables		
Implants		

† If a man has a vasectomy during the first 6 months of his partner's pregnancy, it will be effective by the time she delivers her baby.

‡ Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.

POSTPARTUM FAMILY PLANNING *(cont.)*

Counseling Clients for Postpartum Family Planning

During Antenatal Care (Check-Ups before Delivery)	*During Postpartum Care (Check-Ups after Delivery)*
• Emphasize the importance of breastfeeding, which benefits both mothers and newborns. • Explain the benefits for future births of healthy timing and spacing of pregnancy (HTSP) • Discuss family planning methods, including: ◦ LAM ◦ Methods that can be started during or immediately after delivery (IUD, female sterilization) ◦ Methods that can be used while breastfeeding and afterwards ◦ Discuss ways of reducing transmission risk of HIV and other sexually transmitted infections (STIs)	• Provide counseling about the benefits of delaying the next pregnancy for 2 years (HTSP) • Emphasize the benefits of breastfeeding, which can delay the next birth if the infant is exclusively breastfed • Explain that using exclusive breastfeeding as a temporary family planning method (LAM) protects women from pregnancy for up to 6 months • Discuss when to start using family planning methods (including when to switch from LAM to another method) • Discuss ways of reducing risk of HIV and STI transmission

Invite the client to come back for any questions or problems, when she thinks she is ready to start using a method, to switch from LAM to another family planning method, or if she has any problems with the method she has just started using.

POSTABORTION FAMILY PLANNING

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers*. Baltimore and Geneva; and WHO. 2004. *Medical eligibility criteria for contraceptive use.* 3rd ed. Geneva. For more detailed guidance, please refer directly to these volumes and to the method-specific cue cards.

What Is Postabortion Family Planning?

Access to family planning counseling and methods is an important aspect of postabortion care, to ensure that women are able to avoid a future unplanned pregnancy or successfully achieve a planned pregnancy following a miscarriage. Important considerations in helping women avoid pregnancy in this period include:

- **Timing of counseling:** Postabortion clients have particular needs related to their personal circumstances—their recent pregnancy, in this case—(e.g., worries, stress, pain they may be experiencing, hurry to return home). The provider needs to assess the best timing for family planning counseling for these clients. For postabortion clients, counseling ***before the procedure*** can only be an option if the client is not under stress. Usually, counseling the client just before a procedure to address abortion complications is not appropriate. In this case, sound decision making may be impaired by the stress the client is experiencing. If there are signs of stress, the counseling and decision making of the client should be postponed. The next appropriate opportunity to counsel the client is ***after the procedure*** to address abortion complications, but before the client leaves the facility. At this point, it may be too late to provide the client's method of choice immediately at the end of the procedure (e.g., an IUD), but this may help ensure that the clients get their method of choice *predischarge* or return later to get it at *follow-up*.
- **Timing of pregnancy:** To achieve the healthiest pregnancy outcomes for the baby and the mother, the woman should wait at least 6 months after a miscarriage or abortion before trying to become pregnant again. See the cue card on **Healthy Timing and Spacing of Pregnancy (HTSP)** for details.
- **Return of fertility:** Fertility returns very quickly postabortion. A woman can become pregnant as early as within the first 2 weeks following a first-trimester miscarriage or abortion, and within 4 weeks after a second-trimester abortion. Therefore, she needs protection from pregnancy almost immediately.

For maximum protection, a woman should not wait until her next monthly bleeding to start a contraceptive method, but instead she should start as soon as guidance allows (see table on page F-42).

Counseling Clients for Postabortion Family Planning

Before Abortion Procedure

- Explain the benefits of healthy timing and spacing of pregnancy for expected newborns (HTSP)
- Discuss family planning methods, including:
  - Methods that can be started immediately after the procedure (see table above)
  - IUD (which can be inserted after a procedure to address abortion complications, providing there is no infection present)
  - Back-up method options for methods that can be provided later
- Discuss ways of reducing risk of HIV and sexually transmitted infection (STI) transmission

After Abortion Procedure

- Provide counseling about the benefits of delaying the next pregnancy for 2 years (HTSP)
- Discuss family planning methods (see table above):
  - When to start using them
  - Back-up method options for methods that can be provided later
- Discuss ways of reducing risk of HIV and STI transmission

Invite the client to come back for any questions or problems, when she thinks she is ready to start using a method, or if she has any problems with the method she has just started using.

POSTABORTION FAMILY PLANNING *(cont.)*

Earliest Time That a Woman Can Start a Family Planning Method after Abortion/Miscarriage		
Family Planning Method	**When to Start**	**Special Considerations**
Oral contraceptives (combined or progestin-only)	Immediately	
Injectables (combined or progestin-only)		
Implants		
Combined patch		
Male or female condom		
Withdrawal		
Combined vaginal ring	Immediately	Once any injury to the genital tract is healed.
Spermicide		
Cervical cap		
Diaphragm	Immediately	Once any injury to the genital tract is healed. Must be refitted after uncomplicated first-trimester miscarriage. After uncomplicated second-trimester miscarriage, use should be delayed 6 weeks.
IUDs	Immediately	Provided there is no infection and any injury to the genital tract is healed. IUD insertion after a second-trimester abortion requires a specially trained provider.
Female sterilization	Immediately	Provided there is no infection any injury to the genital tract is healed. Must be decided upon in advance, not while the woman is sedated, under stress, or in pain.
Vasectomy	Any time, regardless of the timing of miscarriage or abortion	
Fertility awareness methods	Delay until there are no noticeable secretions or bleeding related to injury or infection.	Provided there is no infection any injury to the genital tract is healed. For calendar-based methods, delay until the woman has had at least one monthly bleed after all such secretions and bleeding has stopped.

FAMILY PLANNING FOR PEOPLE LIVING WITH HIV

Note: The content in this cue card is adapted from two primary sources: World Health Organization (WHO) and Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). 2007. *Family planning: A global handbook for providers.* Baltimore and Geneva; and WHO. 2006. *Reproductive choices and family planning for people living with HIV: Counseling tool.* Geneva.

People living with HIV:

- **Can enjoy a healthy sexual life** (see "Ways of lowering risk")
- **Have options for preventing unwanted pregnancy and further transmission of HIV** (See "Contraceptives for clients with STIs, HIV, and AIDS" as well as **Dual Protection** in Handout 20 in the Participant Handbook.)
- **Can have a healthy baby** (See "Thinking about pregnancy," next page)

Ways of Lowering Risk

- **Mutual faithfulness**—Two partners faithful to each other
- **Limited number of sexual partners**
- **Safer sex**—For example, using condoms or avoiding penetrative sex
  - **Examples of acts with no risk:** Pleasuring self, massage, hugging, kissing on lips
  - **Examples of low-risk acts:** vaginal or anal intercourse using condom, oral sex (safer with condoms or other barrier)
  - **Examples of high-risk acts:** anal intercourse without a condom, vaginal intercourse without a condom
  - These apply whether client's partner(s) is/are same or opposite sex.

- **Early treatment of sexually transmitted infections (STIs) and avoidance of sex if client or partner has an STI**
- **Not having sex**—Need to be prepared to use condoms if client returns to sexual activity

Contraceptives for Clients with STIs, HIV, and AIDS

People with STIs, with HIV and AIDS, or on ARV therapy can start and continue to use most contraceptive methods safely. There are a few limitations, however. See the table below and each cue card on contraceptive methods for more information and for considerations for clients with HIV, including those taking ARV medications.

- **Male and female condoms** are the only methods that prevent both pregnancy and infection. It is important to use them correctly with every act of vaginal or anal intercourse.
- All **hormonal methods** (combined and progestin-only pills, injectables, implants) can be safely used. Rifampicin taken for tuberculosis usually reduces the effectiveness of contraceptive pills and implants. Some antiretrovirals (protease inhibitors and nonnucleoside reverse transcriptase inhibitors [NNRTIs]) may lower the effectiveness of hormonal methods. This is not known for sure. (Nucleoside reverse transcriptase inhibitors [NRTIs] are not a concern.)
- **Fertility awareness-based methods** can be safely used. In case of infection that causes vaginal discharge or fever, fertility awareness–based methods may be difficult to use.
- The **lactational amenorrhea method** (LAM) risks passing HIV to the baby. Women with HIV should be counseled to choose the feeding option that best suits their situation. (Important: Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding—5–20 of every 100 infants breastfed by mothers with HIV will become infected. Women taking antiretroviral medications [ARVs] can use LAM. In fact, ARV treatment during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk. Rapid weaning also decreases the risk of HIV transmission. She should stop breastfeeding over 2 days to 3 weeks. Replacement feeding poses no risk of HIV transmission. Replacement feeding is recommended for the first 6 months after childbirth if—*and only if*—replacement feeding is acceptable, feasible, affordable, sustainable, and safe. If replacement feeding cannot meet these 5 criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.)
- For **IUDs, female sterilization, vasectomy,** and **spermicides,** there are special considerations (see table, page F-44).

In general, contraceptives and ARV medications do not interfere with each other. It is not certain whether some antiretroviral medications make low-dose hormonal contraceptives less effective. Even if they do, condom use can make up for that.

FAMILY PLANNING FOR PEOPLE LIVING WITH HIV *(cont.)*

Special Family Planning Considerations for Clients Who Have STIs, Who Have HIV, or Who Are Receiving Antiretroviral Therapy (ART)

METHOD	HAS STI	HAS HIV OR AIDS	RECEIVES ART
Intrauterine Device (copper-bearing or hormonal)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or pelvin inflammatory disease (PID). (A current IUD user who becomes infected with gonorrhea or chlamydia or who develops PID can safely continue using an IUD during and after treatment.)	• A woman with HIV but not AIDS can have an IUD inserted. • A woman with AIDS should not have an IUD inserted unless she is clinically well on ARV therapy. (A woman who develops AIDS while using an IUD can safely continue using the method.)	Do not insert an IUD if the client is not clinically well.
Female Sterilization	If the client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Delay sterilization if the client is currently ill with an AIDS-related illness.	
Vasectomy	If the client has a scrotal skin infection, an active STI, balanitis, epididymitis, or orchitis, delay sterilization until the condition is treated and cured.	Delay sterilization if the client is currently ill with an AIDS-related illness.	
Spermicides	Can be safely used, including when used with diaphragm or cervical cap	Should not be used if the client is at high risk of HIV, is infected with HIV, or has AIDS.	

Thinking about Pregnancy: What the Client Needs to Know

It's your decision about getting pregnant.
Pregnancy risks and risks of infecting the baby are not as high as many people think.

Risks to baby:
- If the mother is living with HIV, the baby may get HIV during pregnancy, childbirth, or breastfeeding (3 out of 10 babies). Most babies do not get infected. Treatment lowers this risk to 1 of 10 babies who will get infected.
- If the mother is living with HIV, there is greater chance of stillbirth, premature birth, or low birth weight.

Risks to mother:
- HIV infection raises the risk of childbirth complications such as fever and anemia, particularly with delivery by caesarean section.
- Pregnancy will not speed up the course of HIV infection, but it is best to avoid pregnancy in some health situations (see under "What the client needs to consider before getting pregnant").

Risks to partner:
- If the woman is uninfected and her partner is infected, she may have to risk getting HIV to become pregnant.
- If the man is uninfected and the woman is infected, he can avoid HIV risk by using artificial insemination.

What the Client Needs to Consider before Getting Pregnant

Her health now:
- *Pregnancy is possible,* if her health is good, if her CD4 count is greater than 200 (consider starting women with CD4 counts of 200–350 on antiretrovirals before pregnancy), if she is at clinical Stage 1 or 2 (where CD4 count is not available), if she is on prophylaxis to prevent opportunistic infections or is on antiretrovirals (if eligible), and if she has no sign or symptoms of tuberculosis.
- *If pregnancy may cause problems* now, delay pregnancy and reevaluate later (e.g., if her health is worsening, if her CD4 count is less than 200, if her tuberculosis status is unknown, if she is taking no prophylaxis to prevent opportunistic infections, or if she is in her first 6 weeks of antiretrovirals).
- *Pregnancy* is not a good idea now if her health is poor (e.g., if she is in clinical Stage 3 or 4, if she is on tuberculosis treatment, if her CD4 count is less than 100, or if she is waiting to start antiretrovirals).

Medical care for her and her baby: Are services available? Where?

Her partner's support:
- Has she got a steady partner? Does her partner know her HIV status?
- Is her partner supportive, and will her partner help with the baby? Does her partner know his own status or is he willing to be tested? What is her partner's health status?

Family support:
- Is her family supportive? Or would they reject a child with HIV? Are family members close by, and can they help?

Telling others her HIV status:
- Has she told others? Is she planning to? Who cannot be told?

Feeding her baby: Is she able to feed her infant in the recommended way to lower the chances of transmitting HIV?

Appendix B
Learning Guides for FP Counseling Skills

Appendix B

LEARNING GUIDE FOR FP COUNSELING SKILLS: *NEW* CLIENT

TASKS *(Check the box for tasks successfully accomplished)*	Subtasks
RAPPORT BUILDING	
1. Greet client with respect ❑	• Welcome the client • Offer a seat; help the client to feel comfortable and relaxed
2. Make introductions ❑	• Introduce yourself • Ask general questions such as name, age, number of children, contact information; record as needed • Ask the purpose of visit (new or return client) ***If return client, use other learning guides***
3. Assure confidentiality and privacy ❑	• Make the client feel comfortable by assuring him or her that all information discussed during your conversation will remain confidential. • Create an atmosphere of privacy throughout the counseling session by ensuring the client that no one can interrupt or overhear your conversation, even if you are not able to use a separate room.
4. Explain the need to discuss sensitive and personal issues ❑	• Explain the reasons for asking questions about sexual relationships and behavior • Make clear the relevance of these issues to the client's potential risk for becoming pregnant and/or contracting HIV and other sexually transmitted infections (STIs). • Explain that these issues are discussed with all clients and that they do not have to answer any questions they are not comfortable answering.
5. Use communication skills effectively *(initially in rapport building* ***and*** *throughout the counseling session)* ❑	• Show friendliness by smiling; maintain eye contact with the client • Use simple and clear language; ask open-ended questions • Encourage the client to ask questions and to express his or her concerns • Actively listen to the client; answer all of the client's questions • Paraphrase the client to ensure correct understanding • Do not interrupt the client unless absolutely necessary; remain nonjudgmental
EXPLORATION	
6. Explore in-depth the client's reason for the visit ❑	• Explore in-depth the needs, problems, concerns, thoughts, and feelings that led the client to seek services. • Explore what the client needs to know. • Ask the client if he or she has a method in mind.
7. Explore client's reproductive history and goals ❑	• Pregnancy history and outcome, number and ages of children • Whether he or she wants more children and, if yes, when, to determine nature of contraceptive protection desired (duration, effectiveness, etc.) • Inform the client about healthy timing and spacing of pregnancy (HTSP) • Current and past FP use • What he or she knows about FP methods
8. Explore client's social context, circumstances, and relationships ❑	• Partner/spouse/family involvement and support for contraceptive use with particular emphasis on method(s) of interest • Ability to communicate with the partner(s) about FP/RH decisions • Past and current history of violence and/or rape • Other factors (socioeconomic, cultural, religious, fear of violence, tensions within an extended family) that might influence choice and use of FP method(s) of interest

(continued)

Appendix B

LEARNING GUIDE FOR FP COUNSELING SKILLS: *NEW* CLIENT *(cont.)*

TASKS *(Check the box for tasks successfully accomplished)*	**Subtasks**
9. Explore issues related to sexuality ❑	• Questions/concerns/problems client has about sexual relations/practices • What are the sexual relationships the client is in? • Nature of sexual relationships (frequency, regularity, possible partner absence, and whether the partner has other partners) that might affect contraceptive choice and use • Ability to communicate with the partner about sexuality
10. Explore client's history of HIV and other STIs ❑	• Any current unusual vaginal or penile discharge, pain with sex, or lower abdominal pain • History of STIs within the last three months • More than one sexual partner within the last three months (either partner) • Partner's STI history or presence of current vaginal or penile discharge in partner • HIV status of client and partner, if known (for referral, possible treatment, or special counseling for serodiscordant couples)
11. Explain STI risk and dual protection, and help the client determine his or her risk for contracting and/or transmitting STIs ❑	• ***Explore what the client knows*** about HIV and other STIs, their prevention, dual protection, and condom use • Ask the client about knowledge and practice of condom use or other safe sex practices • Fill in knowledge gaps by ***tailoring*** your information to the needs of the client (such as transmission of STIs, importance of condoms as the only method that protects against pregnancy and STI transmission, other options for dual protection, etc.) • Remind the client that STI risk is related to clients' and partners' individual sexual practices (making sure to discuss the risks of a variety of sexual practices) • Ask the client if he or she feels at risk for contracting HIV or another STI, or thinks that his or her partner might be at risk
12. Focus your discussion on the method(s) of interest to client ❑	• Starting with the client's preferred method (if any), ***explore what the client already knows***; correct misperceptions; fill in knowledge gaps in areas below, by ***tailoring*** the information to the client's needs: a. **Effectiveness** (including how the method(s) works) b. **Side effects**, health benefits, health risks, and complications c. **How to use and where to obtain** the method(s) or what to expect during the procedure (for IUD, injectables, implants and sterilization) d. **When to return** e. Whether the method provides **protection against HIV and other STIs** • Show sample(s) of method(s) and encourage the client to touch them • Provide brochures or other printed information and ask what questions client has
13. Rule out pregnancy and explore factors related to monthly bleeding and any recent pregnancy ❑	• Date of last monthly bleeding • Whether client has had unprotected intercourse since last monthly bleeding (see Pregnancy Checklist cue card) • Nature of her monthly bleeding (how long; how much bleeding; how much pain/cramping, particularly for clients interested in IUD, pills, injectables, and implants) • Whether client has had a recent abortion/miscarriage • Date of last birth and current breastfeeding status

(continued)

LEARNING GUIDE FOR FP COUNSELING SKILLS: *NEW* CLIENT *(cont.)*

TASKS *(Check the box for tasks successfully accomplished)*	Subtasks
14. Screen client for possible medical conditions ❑	• Ask the client if he or she has any health concerns or health problems, including but not limited to the following: ◦ Cardiovascular disease, including high blood pressure ◦ Bleeding/spotting between periods or after sex ◦ Reproductive tract cancers, including trophoblastic disease ◦ Liver disease or hepatitis ◦ Severe anemia ◦ Possible allergies
DECISION MAKING (based on information exchange above)	
15. Identify the decisions client needs to confirm or make ❑	• Explain the importance of the client making his or her own decisions • Help client prioritize the decisions that need to be made on the day of the visit, Including: ◦ Which FP method to use ◦ Whether to take action to reduce risk of contracting HIV and other STIs (based on risk assessment in **exploration** phase) ◦ Seeking health care for a problem or complying with a treatment, etc.
16. Explore relevant options for each decision ❑	• Encourage the client to ask questions • Discuss FP, dual protection, and STI prevention options in more detail, making sure the discussion centers on options that are appropriate to clients' individual needs
17. Help client weigh the benefits, disadvantages, and consequences of each option ❑	• Help the client anticipate the potential outcomes (positive or negative) of and barriers to each option a. How he or she and the partner would react or feel if they were to experience common **side effects**, b. Possible impact of the method on sexual relations, religious practice, or family life c. Recurrent cost, need for resupply, and so on d. The protection the method provides or lacks against HIV and other STIs • Ask the client what else he or she needs to be able to make a decision, and provide information and emotional support accordingly
18. Encourage the client to make his or her own decision ❑	• Reconfirm the selection of the method of interest by asking the client what his or her decision is • Confirm that the decision(s) is (are) well considered, informed, voluntary, and free of pressure from spouse, partner, family members, friends, or service providers • Confirm that the decision(s) can actually be carried out (given the relationship with spouse/partner, family situation, economic situation, anticipated problems, and barriers)

(continued)

Appendix B

LEARNING GUIDE FOR FP COUNSELING SKILLS: *NEW* CLIENT *(cont.)*

TASKS *(Check the box for tasks successfully accomplished)*	**Subtasks**
IMPLEMENTATION (after client has confirmed his or her desire for the method selected)	
19. Assist the client in making a concrete and specific plan for carrying out the decision(s) (obtaining and using the FP method chosen, risk reduction for STIs, dual protection, etc.) ❑	Review and have the client repeat information as appropriate to ensure understanding: • **When to start** using the method • **Where to obtain** the method and supplies • **How to use** the chosen FP method *(pills, male and female condoms, spermicides, Standard Days Method, lactational amenorrhea method [LAM])* and/or **how to obtain** it *(IUDs, implants, injectables, female sterilization, vasectomy)*, including tips for remembering to use the method correctly • Common **side effects** and how to deal with them • **Warning signs** of health risks/complications and what to do if the experiences them • **How to prevent HIV and other STIs** (see the following two points) • **How to communicate with partner** about use of FP and/or condoms
20. Have the client develop skills to use his or her chosen method and condoms* ❑	• Demonstrate use of the method (for clients who have chosen male or female condoms or the diaphragm) on a model (penis or pelvic) • Have the client practice on the model • Provide written information, if available
21. Identify barriers the client may face in implementing his or her decision ❑	Review potential barriers, such as: • Side effects • Partner reaction • Cost and availability of the method, lack of skills or difficulty using the method (especially with the condom), need to return to the clinic for resupply or reinjection revisit (transportation issues)
22. Develop strategies to overcome the barriers ❑	• Review what to do when faced with side effects or difficulties • Provide the client with written information, if appropriate and available • Talk about the availability and use of emergency contraception (if needed) • Talk about the option to switch to another method if the client is dissatisfied or has different needs • Discuss and practice communication and negotiation with partner for FP and/or condom use • Help client develop a "plan B" in case the decision cannot be implemented
23. Make a plan for follow-up and/or provide referrals as needed ❑	• Agree on the timing of medical follow-up visit or resupply (make appointment, if needed) • Refer the client for supplies, care, discontinuation, switching, or another service • Ensure and check that the client understands all the information • Remind the client to return or call whenever he or she has questions, concerns, or problems, or needs help with negotiation and ongoing method use

* For clients who have decided to use condoms for dual protection or as a backup method.

LEARNING GUIDE FOR FP COUNSELING SKILLS: *SATISFIED* RETURN CLIENT

TASKS *(Check the box for tasks successfully accomplished)*	Subtasks
RAPPORT BUILDING	
1. Greet client with respect ❑	• Welcome the client • Offer a seat; help the client to feel comfortable and relaxed
2. Make introductions ❑	• Introduce yourself • *If you do not already know the client:* Ask general questions such as name, age, number of children, and contact information; record as needed • Ask the purpose of visit (new or return client) ***If new client or dissatisfied return client, use other learning guides***
3. Assure confidentiality and privacy ❑	• Make the client feel comfortable by assuring him or her that all information discussed during your conversation will remain confidential. • Create an atmosphere of privacy throughout the counseling session by ensuring that no one can interrupt or overhear your conversation, even if you are not able to use a separate room.
4. Explain the need to discuss sensitive and personal issues ❑	• Explain the reasons for asking questions about sexual relationships and behavior. • Make clear the relevance of these issues to the client's potential risk for becoming pregnant and/or contracting HIV and other sexually transmitted infections (STIs). • Remind the client that these issues are discussed with all clients and that they do not have to answer any questions they are not comfortable answering.
5. Use communication skills effectively *(initially in rapport building* ***and*** *throughout the counseling session)* ❑	• Show friendliness by smiling; maintain eye contact with the client • Use simple and clear language; ask open-ended questions • Encourage the client to ask questions and to express his or her concerns • Actively listen to the client; answer all of the client's questions • Paraphrase the client to ensure correct understanding • Do not interrupt the client unless absolutely necessary; remain nonjudgmental
EXPLORATION	
6. Explore client's satisfaction with the current method ❑	• Ask how satisfied the client is with the his or her current method (probe for any misconceptions the client might have) • Check if the client has any questions or concerns or problems, especially regarding side effects
7. Confirm correct method use ❑	• Ask the client to describe how he or she is using the method
8. Ask client about changes in his or her life ❑	• Changes in medical history or circumstances since last visit and questions or concerns he or she might have about her health • Changes in partners (or any new partners) since last visit • Any concerns that he or she might be exposed to HIV or another STI through his or her partner(s); ask about dual-method use • If any changes necessitate the review of the client's decisions about FP or STI prevention, go to the DECISION MAKING section of the Learning Guide for FP Counseling Skills: New Clients.

(continued)

LEARNING GUIDE FOR FP COUNSELING SKILLS: *SATISFIED* RETURN CLIENT *(cont.)*

TASKS *(Check the box for tasks successfully accomplished)*	**Subtasks**
DECISION MAKING (based on information exchange above)	
9. Help client identify what services he or she needs during this return visit ❑	• Regular well-woman visit • Other reproductive health services or referral
IMPLEMENTATION	
10. Make a plan for follow-up and/or provide referrals as needed ❑	• Agree on the timing of medical follow-up visit or resupply (make appointment, if needed) • Refer for supplies, care, discontinuation, switching, or another service • Ensure and check that the client understands all the information • Remind the client to return or call whenever he or she has questions, concerns, or problems or needs help with negotiation and ongoing method use

LEARNING GUIDE FOR FP COUNSELING SKILLS: *DISSATISFIED* RETURN CLIENT

TASKS *(Check the box for tasks successfully accomplished)*	Subtasks
RAPPORT BUILDING	
1. Greet client with respect ❑	• Welcome the client • Offer a seat; help the client to feel comfortable and relaxed
2. Make introductions ❑	• Introduce yourself; • *If you do not already know the client:* Ask general questions such as name, age, number of children, and contact information; record as needed • Ask the purpose of visit (new or return client) ***If new client or satisfied return client, use other learning guides***
3. Assure confidentiality and privacy ❑	• Make the client feel comfortable by assuring him or her that all information that will be discussed during your conversation will remain confidential. • Create an atmosphere of privacy throughout the counseling session by ensuring that no one can interrupt or overhear your conversation, even if you are not able to use a separate room.
4. Explain the need to discuss sensitive and personal issues ❑	• Explain the reasons for asking questions about sexual relationships and behavior • Make clear the relevance of these issues to the client's potential risk for becoming pregnant and/or contracting HIV and other sexually transmitted infections (STIs). • Remind the client that these issues are discussed with all clients and that they do not have to answer any questions they are not comfortable answering.
5. Use communication skills effectively *(initially in rapport building* ***and*** *throughout the counseling session)* ❑	• Show friendliness by smiling; maintain eye contact with the client • Use simple and clear language; ask open-ended questions • Encourage the client to ask questions and to express his or her concerns • Actively listen to the client; answer all of the client's questions • Paraphrase the client to ensure correct understanding • Do not interrupt the client unless absolutely necessary; remain nonjudgmental
EXPLORATION	
6. Explore the client's satisfaction with the current method ❑	• Ask how satisfied the client is with the his or her current method (probe for any misconceptions the client might have) • Check if the client has any questions or concerns or problems, especially regarding side effects
7. Confirm correct method use ❑	• Ask the client to describe how he or she is using the method • Changes in medical history or circumstances since the last visit and questions or concerns he or she might have about her health
8. Ask the client about changes in his or her life ❑	• Changes in partners (or any new partners) since last visit • Any concerns that he or she might be exposed to HIV or other STIs through his or her partner(s); ask about dual-method use • If any changes necessitate review of the client's decisions about FP or STI prevention, go to the DECISION MAKING section of the Learning Guide for Counseling Skills: New Clients.

(continued)

Appendix B

LEARNING GUIDE FOR FP COUNSELING SKILLS: *DISSATISFIED* RETURN CLIENT *(cont.)*

TASKS *(Check the box for tasks successfully accomplished)*	**Subtasks**
9. Explore in-depth the reasons for the client's dissatisfaction or the problems ❑	• Explore the problems and the reasons for dissatisfaction, discuss possible solutions, and encourage the client to ask questions. ***Tailor*** the discussion to the problem. Problems may include the following: ◦ **Side effects** and what client has done or what can be done to manage side effects (including treatment and switching to another method) ◦ **Rumors** about the method that bother the client ◦ **Difficulty in accessing services** for routine revisits or resupply ◦ **Lack of partner or family support** for using the method: discuss and practice possible communication and other strategies that the client can try ◦ **Incorrect method use:** discuss how to use the method and a backup method correctly, and discuss use of emergency contraception pills ◦ **Suspected pregnancy:** ask client about her and her partner's reaction to possible pregnancy and explain screening testing to be done: (1) if screening and pregnancy test are negative, discuss client's contraceptive options; (2) if pregnancy test is positive, discuss client's options (e.g., emergency contraception, if appropriate) ◦ **Change in reproductive goals/desire for pregnancy:** congratulate and counsel client on what to do for a healthy pregnancy ◦ **Warning signs of health risks/complications:** explain screening/other exams, tests, and treatment to be done during visit, or refer as needed/indicated ◦ **Change in individual STI risk:** help client perceive his or her risk; explain risk reduction and dual-method use
DECISION MAKING (based on information exchange above)	
10. Identify what decisions the client needs to confirm or make ❑	• Explain the importance of the client making his or her own decisions • Help the client prioritize the decisions that need to be made on the day of the visit, including: ◦ Continuing with the current FP method ◦ Switching to another FP method ◦ Discontinuing FP ◦ STI risk reduction and/or dual protection ◦ Complying with treatment
11. Explore relevant options for each decision ❑	• Encourage the client to ask questions, making sure the discussion centers on options that are appropriate to the client's individual needs: ◦ **Side effects:** to tolerate after learning that they are harmless, to wait till they subside, to have them treated, or to switch to another method ◦ **Rumors about the method:** to continue using the method after being relieved by the provider's explanation or to switch to another method ◦ **Difficulty in accessing services:** to find another service site that is easier to access or to switch to another FP method that does not require frequent access to services ◦ **Lack of partner or family support:** to try new strategies to convince partner/family or to switch to another method ◦ **Incorrect method use:** to start using the method correctly or, if correct use is inconvenient, to switch to another method ◦ **Change in reproductive goal/desire for pregnancy:** switch to another method or discontinue FP ◦ **Suspected or confirmed pregnancy:** whether or not to continue pregnancy and discontinue FP ◦ **Warning signs of health risks/complications:** to comply with suggested treatment/referral options ◦ **Change in individual risk for HIV and other STIs:** risk reduction, dual-method use, or condom use

LEARNING GUIDE FOR FP COUNSELING SKILLS: *DISSATISFIED* RETURN CLIENT *(cont.)*

TASKS *(Check the box for tasks successfully accomplished)*	Subtasks
12. Help the client weigh the benefits, disadvantages, and consequences of each option ❑	• Help the client to anticipate the potential outcomes (positive or negative) of and barriers to each option, including: ◦ Partner's reaction to the decision ◦ The risk of unintended pregnancy (for those who decide to discontinue FP) ◦ The risk of contracting HIV and other STIs (for those who decide to discontinue dual protection or condom use) ◦ Cost, side effects, health benefits, and health risks (for those switching to another FP method) ◦ Negotiating condom use with partner • Ask the client what else he or she needs to be able to make a decision, and provide information and emotional support accordingly
13. Encourage the client to make his or her own decision ❑	• Confirm that the decision(s) is (are) well considered, informed, and voluntary • Confirm that the decision(s) can actually be carried out (given the relationship with spouse/partner, family situation, economic situation, anticipated problems, and barriers)
IMPLEMENTATION	
14. Assist the client in making a concrete and specific plan for carrying out the decision(s) ❑	• Help the client plan for and implement his or her decision: ◦ **Clients who continue** with their current method: Help them develop strategies to deal with the side effects and problems they are facing (see IMPLEMENTATION section of Learning Guide for FP Counseling Skills: New Clients) ◦ **Clients who switch** to another method: Help them obtain and use the method correctly; provide the information and skills needed for correct use (especially for condoms) (see IMPLEMENTATION section of the Learning Guide for FP Counseling Skills: New Clients) ◦ **Clients who discontinue FP:** Help them get the services they need or refer (for preconception care and antenatal care); for clients who want to discontinue IUD or implants, explain removal procedure and answer their questions
15. Make a plan for follow-up and/or provide referrals ❑	• Agree on the timing of medical follow-up visit or resupply (make appointment, if needed) • Refer for continued supplies, care, discontinuation, switching or another service • Ensure and check that the client understands all the information • Remind the client to return or call whenever he or she has questions, concerns, or problems or needs help with negotiation and ongoing method use