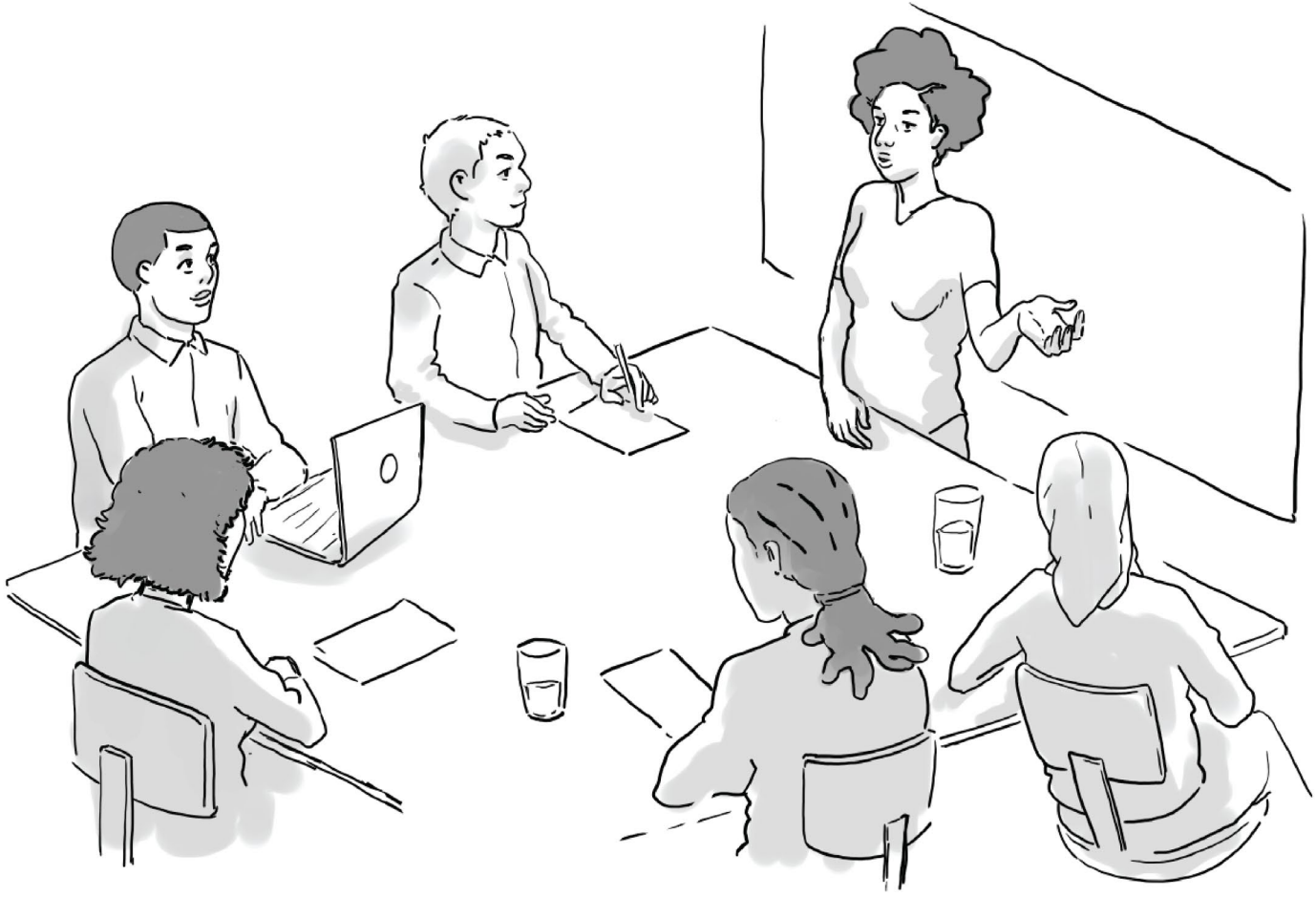
LONG-ACTING REVERSIBLE CONTRACEPTIVES IN CRISIS SETTINGS

PARTICIPANT WORKBOOK

Clinical Outreach Refresher Training Module for Health Care Providers Implementing the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health

Inter-Agency Working Group (IAWG) on Reproductive Health in Crises Training Partnership Initiative with CARE and Jhpiego



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CARE led on the development of this module. Dr. Shabana Zaeem, Technical Consultant, was the primary author. Dr. Kamlesh Giri, Kamille Gardner, and Anushka Kalyanpur provided clinical and programmatic expertise and oversaw the development of this publication and would like to thank CARE USA global team members Sylvie Kambou, Eric Mumbere, and Elizabeth Noznesky for their contributions. The IAWG Training Partnership Initiative Steering Committee, in particular Nadia Ahmed, Alison Greer, and Chelsea Ricker, and Voluntary Contraception Sub-Working Group members also provided inputs and edits to its contents.

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LIST OF ABBREVIATIONS

AMTSL	Active management of the third stage of labor
ART	Antiretroviral treatment
ARV	Antiretroviral drugs
BCS+	Balanced Counseling Strategy Plus
BP	Blood pressure
CIC	Combined injectable contraceptive
COC	Combined oral contraceptive
CVD	Cardiovascular disease
DMPA	Depot medroxyprogesterone acetate
EC	Emergency contraception
ECP	Emergency contraceptive pill
EE	Ethinyl estradiol
EFV	Efavirenz
FP	Family planning
GT	Genital tract
HAZMAT	Hazardous materials
HLD	High-level disinfection
HTSP	Healthy timing and spacing of pregnancy
IEC	Information, education, and communication
IARH	Inter-Agency Emergency Reproductive Health (Kit)
IPC	Infection prevention and control
IUD	Intrauterine device
LAM	Lactational amenorrhea method
LARC	Long-acting reversible contraceptive
LNG-IUD*	Levonorgestrel-releasing intrauterine device
MEC	Medical eligibility criteria
MISP	Minimum Initial Service Package (for Sexual and Reproductive Health)
MoH	Ministry of Health
NET-EN	Norethisterone enanthate
NSAIDs	Nonsteroidal anti-inflammatory drugs
PID	Pelvic inflammatory disease
PPE	Personal protective equipment
S-CORT	Sexual and reproductive health clinical outreach refresher training
STI	Sexually transmitted infection
TB	Tuberculosis
TOT	Training of trainers
UPA	Ulipristal acetate
WHO	World Health Organization

*This resource uses both the 2021 WHO preferred nomenclature of hormonal IUD World Health Organization. "WHO Statement on Levonorgestrel-Releasing Intrauterine Device Nomenclature." Accessed August 11, 2021. www.who.int/publications-detail-redirect/9789240021730 as well as LNG-IUD.

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INTRODUCTION

THE MISP FOR SEXUAL AND REPRODUCTIVE HEALTH AND S-CORTS

The Minimum Initial Service Package (MISP) for Sexual and Reproductive Health is a priority set of lifesaving activities to be implemented at the onset of every emergency. The 2018 MISP has six objectives and another priority activity:

1. Ensure the health sector/cluster identifies an organization and a sexual and reproductive health coordinator to lead and coordinate the implementation for the MISP.
2. Prevent sexual violence and respond to the needs of survivors.
3. Prevent the transmission of and reduce morbidity and mortality due to HIV and other sexually transmitted infections.
4. Prevent excess maternal and newborn morbidity and mortality.
5. Prevent unintended pregnancies.
6. Plan for comprehensive sexual and reproductive health services, integrated into primary health care as soon as possible.

Other priority: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

Neglecting the MISP for Sexual and Reproductive Health in crisis settings has serious consequences: preventable maternal and newborn deaths; sexual violence and subsequent trauma; sexually transmitted infections; unwanted pregnancies and unsafe abortions; and the possible spread of HIV.

Nurses, midwives, and physicians working in emergencies provide the sexual and reproductive health services needed to achieve the objectives of the MISP. IAWG has designed a series of short clinical outreach refresher trainings (S-CORTs) in order to reinforce previously acquired knowledge and skills of health care staff tasked with providing these priority services. *LARC Refresher Training for Service Providers in Crisis Settings* is one of these modules. Please visit www.iawg.net/scorts to access all training materials in the series and more information on their use.

UNIVERSAL ACCESS: ENSURING SERVICES THAT ARE FREE OF STIGMA AND DISCRIMINATION

Words matter when describing and caring for individuals who need access to health care information and services and, in particular, the services presented in the S-CORT series. Language can have a significant impact on sexual and reproductive health and wellbeing as well as access to related information and services. At times, the terminology used in guidance, programs, and policies can be discriminating, stigmatizing, and dehumanizing. Conscious of the tensions that can arise when trying to use inclusive and appropriate language and, at the same time, be concise and efficient, especially in publications, the language used in the S-CORT series was guided by the following considerations:

- **On gender**. Throughout the S-CORT series, the terms "women," "girls," and, at times, the gender-neutral "person," "people," "client," "patient," or "individual" refer to those who use the services presented in the S-CORT. However, the authors recognize and emphasize that:
  - Not only cis-gendered women (women who identify as women and were assigned the female sex at birth) can get pregnant and have rights to quality health care, to be treated with dignity and respect, and to be protected from stigma, discrimination, and violence in all settings. Persons who are trans men/transmasculine, intersex, non-binary, and gender non-conforming can experience pregnancy and face unique barriers to accessing sexual and reproductive health information and services. The S-CORT language strives to reflect this diversity whenever possible but for ease of reference and use, "women" or "women and girls" may be often applied.
  - Sexual violence "survivors" can be women, men, trans, intersex, non-binary, gender non-conforming individuals, and individuals of all ages.
- **On age**.[1] Adolescents—girls, boys, trans, intersex, non-binary, and gender non-conforming—have unique sexual and reproductive health needs and should not be discriminated against in terms of access to information, services, care, and support. Equally important are the sexual and reproductive health needs of older persons. The S-CORT language strives to reflect this age diversity whenever possible, but for ease of reference and use, it often does not use age-specific terminology.
- **On disability.** The sexual and reproductive health needs of persons living with disabilities have been widely neglected. They should not be discriminated against regarding access to sexual and reproductive health information, services, care, and support. While for ease of reference and use disability-specific terminology is not

1. For updated resources and support for organizations supporting adolescents, see the updated IAWG Adolescent *Sexual and Reproductive Health (ASRH) Toolkit for Humanitarian Settings*: 2020 Edition, available at: iawg.net/resources/adolescent-sexual-and-reproductive-health-asrhtoolkit-for-humanitarian-settings-2020-edition.

always applied, the S-CORTs were developed using universal design principles to ensure accessibility of these materials. Facilitators and organizations are encouraged to take into consideration the accessibility needs of participants in these trainings and persons living with disabilities in the communities they serve.

- **On diversity**. All individuals, no matter how diverse their personal, social, cultural, and economic background, have a right to access sexual and reproductive health information, services, care, and support free from stigma, discrimination, and violence. Images and language in this guide have been designed with diversity in mind, however, the S-CORT language is not always able to reflect the rich diversity of individuals who access sexual and reproductive health information, services, care, and support.

S-CORT participants should keep these inclusive considerations of gender, age, disability, and diversity in mind when attending these trainings to further universal access to sexual and reproductive health information, services, care, and support.

WHAT CAN HEALTH STAFF DO?

The use of inclusive, appropriate, and respectful language is a cornerstone of reducing harm and suffering. All terminology requires contextualization to the local language and socio-cultural environment as well as a pragmatic approach, but one that should not sacrifice the promotion and use of stigma-free and all-gender-age-disability-diversity inclusive language. To help mainstream such language, health staff should consider the following principles to guide the way they speak, write, and communicate among themselves and with and about the persons accessing sexual and reproductive health information and services. These principles can help health staff prioritize the use of terminology that adheres to their professional mandate: caring for all people.

- **Engage and ask people and respect their preferences**. As terminology requires adaptation in local languages and cultures, each linguistic and professional community should be engaged in discussing and contextualizing diversity-inclusive terms so that they are acceptable in the circumstances they are to be used. For example, avoid assuming the person's gender ("Miss" or "Mister") and ask instead: "Hello and welcome. My name is B and I am your provider today. Could you please tell me how I should address you?".
- **Use stigma-free, respectful, and accurate language**. Avoid using judgmental terms that are not person-centered. Favor the use of humane and constructive language that promotes respect, dignity, understanding, and positive outlooks (for example, prefer "survivor of sexual violence" to "victim").
- **Prioritize the individual**. It is recommended to place individuals at the center, and their characteristics or medical conditions second in the description (i.e. persons living with disability or persons living with HIV). Therefore, the use of person-centered language should be preferred to describe what people have, their characteristics, or the circumstances in which they live, which should not define who they are and how health staff treat them.
- **Cultivate self-awareness**. Professionals working with persons from diverse backgrounds should be conscious of the language they use as it can convey powerful images and meanings. They should develop cultural humility and self-reflection, be mindful, and refrain from repeating negative terms that discriminate, devalue, and perpetuate harmful stereotypes and power imbalances. They should also encourage colleagues, friends, and their community to do so. Values clarification workshops for health (and non-health) staff working with people with diverse backgrounds and characteristics could be transformative in clarifying values and changing attitudes to improve interactions.

Additional resources for implementing sexual and reproductive health services in crisis settings are available on the IAWG site at iawg.net/resources. In particular, facilitators and participants in this training may also want to explore:

- *The Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*
- *IAWG Programmatic Guidance for Sexual and Reproductive Health in Humanitarian and Fragile Settings During COVID-19 Pandemic*
- *Adolescent Sexual and Reproductive Health Toolkit for Humanitarian Settings: 2020 Edition*
- *Inter-Agency Emergency Reproductive Health Kits for Use in Humanitarian Settings Manual*. 6th Edition

FURTHER READING/RESOURCES

- Pathfinder International. *Technical Guidance: Family Planning During COVID-19*, 2020. www.pathfinder.org/publications/technical-guidance-family-planning-during-covid-19
- Population Council. *The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings, Trainer's Guide. Third Edition*. Washington, D.C., 2015. www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service
- World Health Organization. App for WHO's Medical Eligibility Criteria for Contraceptive Use. World Health Organization, 2019. https://www.who.int/news/item/29-08-2019-new-app-for-who-s-medical-eligibility-criteria-for-contraceptive-use
- World Health Organization. *Clinical Management of Rape and Intimate Partner Violence Survivors: Developing Protocols for use in Humanitarian Settings*. 2020. https://apps.who.int/iris/handle/10665/331535

- World Health Organization. *Contraceptive Eligibility for Women at High Risk of HIV*. World Health Organization, 2019. https://www.who.int/publications/i/item/9789241550574
- World Health Organization, Reproductive Health and Research, and K4Health. *Family Planning: A Global Handbook for Providers*. Geneva; Baltimore: World Health Organization, Department of Reproductive Health and Research; John Hopkins Bloomberg School of Public Health, Center for Communication programs, Knowledge for Health Project, 2018. https://www.who.int/publications/i/item/9780999203705
- World Health Organization. *Quality of Care in Contraceptive Information and Services, Based on Human Rights Standards: A Checklist for Health Care Providers*, 2017. https://www.who.int/publications/i/item/9789241512091

OBJECTIVE

This refresher training module on long-acting reversible contraception (LARC) is designed for physicians, nurses, midwives, and other service providers to refresh their knowledge and skills for providing LARC services and family planning counseling, particularly in crisis settings or with limited resources. The participant's knowledge will be assessed using pre and post-tests at the start and end of the training. A practical skills assessment will be done during and after completing practice on anatomic models by using skills specific to the checklists for IUD and implant insertion and removal.

TRAINING OVERVIEW

Long-Acting Reversible Contraceptives in Crisis Settings builds upon IAWG's S-CORT series on lifesaving sexual and reproductive health services in acute and prolonged crisis contexts. It contains high-quality user-friendly materials and resources for designing, conducting, and evaluating a training for family planning service providers. The materials are designed for clinical trainers leading a refresher course for service providers who are already familiar with LARCs, including insertion and removal of intrauterine devices (IUDs) and implants. To ensure the provision of high-quality services that emphasize informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination, this module provides an overview of long-acting contraceptives usually available in crisis settings, which is to be combined with *The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings* developed by Population Council.[2]

HOW TO USE THIS WORKBOOK

This workbook is designed to serve as a learning tool during the training session and as a reference guide and job aid for your clinical work post-training. In addition to offering you a centralized location to keep your notes and plans for providing LARC services and family planning counseling in crisis settings, it also provides contextual information, skills checklists, and recommendations for additional resources. You can access this participant workbook in addition to the presentations, facilitator's guidance, and links to supplemental resources on the IAWG website at www.iawg.net/scorts.

SUPPLEMENTARY MATERIALS FOR THIS TRAINING

In addition to the materials included in this workbook, you may receive the following job-aids and materials from your workshop facilitator, or you can download them at any time from the IAWG website at www.iawg.net/scorts.

→ *BCS+ Counseling Cards and Method Brochures* (Population Council, 2015) Available: www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service

→ *Contraceptive Delivery Tool for Humanitarian Settings and App* (WHO, 2018) Available: https://www.who.int/news/item/07-12-2018-delivering-contraceptive-services-in-humanitarian-settings

→ *WHO Medical Eligibility Criteria (MEC) Wheel for Contraceptive Use* (WHO, 2015) Available: https://www.who.int/publications/i/item/9789241549257

→ *WHOMECApp* (WHO, 2019) Available: https://www.who.int/news/item/29-08-2019-new-app-for-who-s-medical-eligibility-criteria-for-contraceptive-use

FEEDBACK ON THE TRAINING MATERIALS

The IAWG Training Partnership Initiative is interested in hearing from you. Please send any questions or feedback to info.iawg@wrcommission.org regarding the training materials and their use in your context.

2. For additional resources, please see *Quality of care in contraceptive information and services, based on human rights standards: A checklist for health care providers*. Geneva: World Health Organization; 2017. Licence: CC BY-NC-SA 3.0 IGO and the Inter-Agency Working Group on Reproductive Health in Crises. *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. iawgfieldmanual.com

UNIT 1

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

- Introduce each other and the training objectives and contents.
- Discuss the complexity of crisis settings and why global standards and principles for humanitarian intervention, including the MISP for Sexual and Reproductive Health, are important and have evolved over the years.
- Describe the basic attributes of long-acting reversible contraceptive (LARC) methods and their use in crisis settings.
- Provide family planning counseling using the Balanced Counseling Strategy Plus (BCS+) tools and the World Health Organization (WHO) Medical Eligibility Criteria (MEC) Wheel and MEC Quick Reference Chart for safe and effective contraception.

DAY 1 SESSIONS

SESSON 1
WELCOME AND INTRODUCTION

↓

SESSION 2
OVERVIEW OF HUMANITARIAN PRINCIPLES AND ACCOUNTABILITY FRAMEWORK

↓

SESSION 3
OVERVIEW TO LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS)

↓

SESSION 4
FAMILY PLANNING COUNSELING (BCS+)

NOTES

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

- Become familiar with each other.
- Discuss the training's contents.
- Set group norms and expectations for the training.
- Complete the knowledge assessment.

COURSE OBJECTIVES

By the end of the three-day training course, participants will be able to:

- Discuss the complexities of crisis settings and why global standards and principles for humanitarian intervention, including the MISP for Sexual and Reproductive Health, are important and have evolved over the years.
- Describe the basic attributes of long-acting reversible contraceptive (LARC) methods and their use in crisis settings.
- Provide family planning counseling using the Balanced Counseling Strategy Plus (BCS+) tools and the World Health Organization (WHO) Medical Eligibility Criteria (MEC) Wheel and MEC Quick Reference Chart for safe and effective contraception.
- Describe the steps of counseling a client using the Balanced Counseling Strategy Plus (BCS+) tools and screening checklist.
- Describe and provide rights-based sexual and reproductive health care in crisis-affected settings.
- Describe and demonstrate infection prevention practices for the provision of LARC services.
- Self-assess and understand how providers' opinions, values, and attitudes can affect, positively or negatively, their relationships with their clients.
- Manage common side effects and potential complications with LARC methods.
- Address rumors and common misconceptions about IUDs and implants.
- Describe and demonstrate the steps of copper IUD insertion and removal on anatomical models using the skills checklist.
- Describe and demonstrate the steps of one/two-rod implant insertion and removal on the arm model using the skills checklist.
- Develop an action plan for post-training follow-up and LARC service provision.

NOTES

MY EXPECTATIONS FOR THIS TRAINING

TOPICS I WANT TO REVISIT

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

- Discuss the complexities of crisis settings and why global standards and principles for humanitarian intervention are important and have evolved over the years.
- Describe the MISP for Sexual and Reproductive Health and how it relates to health in emergencies.

If the training is taking place in the context of the COVID-19 pandemic or other major infectious disease outbreak or pandemic, it is important to keep in mind and emphasize the following during this session:

COVID-19 and Family Planning[9]

- It is crucial to ensure that people have access to rights-based services and information to initiate and/or continue to use contraception. Contraception and family planning information and services are lifesaving and important at all times. All methods of contraceptives should be available, including long-acting reversible contraceptives (LARCs).
- In case of limited access to family planning services or shortage of supplies, clients should opt for a method that is available without a prescription (such as condoms, spermicides, pills, or emergency contraceptive pills) from a nearby pharmacy or drug shop.
- All modern methods of contraception reduce the risk for unintended pregnancy and are safe to use during the COVID-19 pandemic. The best method of contraception is the one that works well for a client and their partner.
- Share updated information on the availability of contraceptive services regularly.
- For change of a contraceptive method, clients should seek advice and information from their health provider and consider using methods that do not have medical restrictions.
- Forecast for and pre-position supplies to meet contraception demand for 6-12 months, including emergency contraception (EC), short-acting methods, and LARCs.
- Develop a plan for periodically updating a facility mapping that indicates which facilities will continue to offer a full range of services (recognizing that some may become dedicated to COVID-19 patient care).
- Removal of long-acting methods such as implants or IUDs after the recommended period of use (and routine follow up appointments) may be deprioritized during the COVID-19 health emergency with the informed consent of the client. As a result, it is possible to delay routine removals of long-acting methods where allowed by the client.
- If, due to restrictions on movement due to the COVID-19 pandemic, a client cannot have their long-acting method removed straight away, it is important to advise use of another method of contraception to avoid pregnancy during this time.
- Addressing misinformation and myths around family planning is crucial in the context of COVID-19. Adopting risk communication and community engagement approaches not only to share adequate information but also to listen to and address misinformation is critical.
- There are no medical problems caused by delaying removal of long-acting methods such as implants or IUDs. Advise clients not to try to remove the contraception method themselves; they should wait until they are able to access health care from a trained provider.

NOTES

3. Refer to the following resources for more information: World Health Organization. "Coronavirus Disease (COVID-19): Contraception and Family Planning," April 2020. www.who.int/news-room/q-a-detail/coronavirus-disease-covid-19-contraception-and-family-planning and Inter-Agency Working Group on Reproductive Health in Crises MISP Sub-Working Group. "MISP Considerations Checklist for Implementation During COVID-19," August 2020. iawg.net/resources/misp-considerations-checklist-for-implementation-during-covid-19.

MINIMUM INITIAL SERVICE PACKAGE FOR SEXUAL AND REPRODUCTIVE HEALTH

Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings

iawg.net/IAFM

OBJECTIVE 1: ENSURE THE HEALTH SECTOR/ CLUSTER IDENTIFIES AN ORGANIZATION TO LEAD IMPLEMENTATION OF THE MISP. THE LEAD SRH ORGANIZATION:

- Nominates an SRH Coordinator to provide technical and operational support to all agencies providing health services
- Hosts regular meetings with all relevant stakeholders to facilitate coordinated action to ensure implementation of the MISP
- Reports back to the health cluster, GBV sub-cluster, and/or HIV national coordination meetings on any issues related to MISP implementation
- In tandem with health/GBV/HIV coordination mechanisms ensures mapping and analysis of existing SRH services
- Shares information about the availability of SRH services and commodities
- Ensures the community is aware of the availability and location of reproductive health services

OBJECTIVE 2: PREVENT SEXUAL VIOLENCE AND RESPOND TO THE NEEDS OF SURVIVORS:

- Work with other clusters especially the protection or gender based violence sub-cluster to put in place preventative measures at community, local, and district levels including health facilities to protect affected populations, particularly women and girls, from sexual violence
- Make clinical care and referral to other supportive services available for survivors of sexual violence
- Put in place confidential and safe spaces within the health facilities to receive and provide survivors of sexual violence with appropriate clinical care and referral

IARH Kit 3 IARH Kit 5 IARH Kit 8 IARH Kit 9

OBJECTIVE 6: PLAN FOR COMPREHENSIVE SRH SERVICES, INTEGRATED INTO PRIMARY HEALTH CARE AS SOON AS POSSIBLE. WORK WITH THE HEALTH SECTOR/CLUSTER PARTNERS TO ADDRESS THE SIX HEALTH SYSTEM BUILDING BLOCKS:

- Service Delivery
- Health Workforce
- Health Information System
- Medical Commodities
- Financing
- Governance and Leadership

GOAL

PREVENT MORTALITY, MORBIDITY, AND DISABILITY IN CRISIS-AFFECTED POPULATIONS

OBJECTIVE 3: PREVENT THE TRANSMISSION OF AND REDUCE MORBIDITY AND MORTALITY DUE TO HIV AND OTHER STIS:

- Establish safe and rational use of blood transfusion
- Ensure application of standard precautions
- Guarantee the availability of free lubricated male condoms and, where applicable (e.g., already used by the population), ensure provision of female condoms
- Support the provision of antiretrovirals (ARVs) to continue treatment for people who were enrolled in an anti-retroviral therapy (ART) program prior to the emergency, including women who were enrolled in PMTCT programs
- Provide PEP to survivors of sexual violence as appropriate and for occupational exposure
- Support the provision of co-trimoxazole prophylaxis for opportunistic infections for patients found to have HIV or already diagnosed with HIV
- Ensure the availability in health facilities of syndromic diagnosis and treatment of STIs

IARH Kit 1 IARH Kit 3 IARH Kit 5 IARH Kit 12 Additional Standard Precautions in kits 2, 4, 6, 8, 9, 11

OBJECTIVE 5: PREVENT UNINTENDED PREGNANCIES:

- Ensure availability of a range of long-acting reversible and short-acting contraceptive methods [including male and female (where already used) condoms and emergency contraception] at primary health care facilities to meet demand
- Provide information, including existing information, education, and communications (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination
- Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

IARH Kit 1 IARH Kit 3 IARH Kit 4

OBJECTIVE 4: PREVENT EXCESS MATERNAL AND NEWBORN MORBIDITY AND MORTALITY:

- Ensure availability and accessibility of clean and safe delivery, essential newborn care, and lifesaving emergency obstetric and newborn care (EmONC) services including:
  - At referral hospital level: Skilled medical staff and supplies for provision of comprehensive emergency obstetric and newborn care (CEmONC) to manage
  - At health facility level: Skilled birth attendants and supplies for vaginal births and provision of basic obstetric and newborn care (BEmONC)
  - At community level: Provision of information to the community about the availability of safe delivery and EmONC services and the importance of seeking care from health facilities. Clean delivery kits should be provided to visibly pregnant women and birth attendants to promote clean home deliveries when access to a health facility is not possible
- Establish a 24 hours per day, 7 days per week referral system to facilitate transport and communication from the community to the health center and hospital
- Ensure the availability of life-saving, post-abortion care in health centers and hospitals
- Ensure availability of supplies and commodities for clean delivery and immediate newborn care where access to a health facility is not possible or unreliable

IARH Kit 2 IARH Kit 6 IARH Kit 8 IARH Kit 9 IARH Kit 10 IARH Kit 11 IARH Kit 12

IARH Kit 8 **Other Priority**: It is also important to ensure that safe abortion care is available, to the full extent of the law, in health centers and hospital facilities.

4. Inter-Agency Working Group on Reproductive Health in Crises. "Quick Reference for the Minimum Initial Service Package (MISP) for Sexual and Reproductive Health (SRH)," 2018. iawg.net/resources/misp-reference

The Minimum Initial Services Package (MISP) for sexual and reproductive health (SRH) is a set of priority life-saving SRH services and activities to be implemented at the onset of every humanitarian emergency to prevent excess sexual and reproductive health-related morbidity and mortality. All service delivery activities of the MISP need to be implemented simultaneously through coordinated actions with all relevant partners.

The MISP forms the starting point for SRH programming and respectful quality of care must be ensured from the start. It is important to note that the components of the MISP form a minimum requirement and should be implemented in all circumstances. These services should be sustained and built upon as soon as possible (ideally 3-6 months) with comprehensive SRH services and supplies throughout protracted crises and recovery.

Fundamental principles for SRH programming in humanitarian settings

- Work in respectful partnership with people receiving care, providers, and local and international partners
- Ensure equality by meeting people's varied sexual and reproductive health needs and ensuring that services and supplies are affordable or free, accessible to all, and of high quality
- Provide comprehensive, evidence-based, and accessible information and choice about the supplies and services available
- Ensure effective and meaningful participation of concerned persons and person-centered care that recognizes patients' autonomous decision-making power and choice for services and commodities
- Ensure privacy and confidentiality for everyone and treat people with dignity and respect
- Promote equity, with respect to age, sex, gender and gender identity, marital status, sexual orientation, location (e.g. rural/urban), disability, race, color, language, religion, political or other opinion, national, ethnic or social origin, property, birth, or other characteristics
- Recognize and address gender and power dynamics in healthcare facilities to ensure that people do not experience coercion, discrimination, or violence/mistreatment/disrespect/abuse in receiving or providing health services
- Engage and mobilize the community, including often marginalized populations such as adolescents, in community outreach to inform the community about the availability and location of MISP services and commodities
- Monitor services and supplies, and share information and results with the aim of improving quality of care

Community Level/Health Post: Community Level/Health Post kits are intended for use by service providers delivering SRH care at the community health care level. Each kit is designed to provide for the needs of 10,000 people over a 3-month period. The kits contain mainly medicines and disposable items.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 1A	Male Condoms	Red
Kit 2	Clean Delivery (A and B)	Dark blue
Kit 3	Post-Rape Treatment	Pink
Kit 4	Oral and Injectable Contraception	White
Kit 5	Treatment of Sexually Transmitted Infections	Turquoise

Primary Health Care Facility Level (BEmONC): Primary Health Care Facility Level (BEmONC) kits contain both disposable and reusable material, for use by trained healthcare providers with additional midwifery and selected obstetric and neonatal skills at the health center or hospital level. These kits are designed to be used for a population of 30,000 people over a 3-month period. It is possible to order theses kits for a population of less than 30,000 persons, this just means that the supplies will last longer.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 6	Clinical Delivery Assistance – Midwifery Supplies (A and B)	Brown
Kit 8	Management of Complications of Miscarriage or Abortion	Yellow
Kit 9	Repair of Cervical and Vaginal Tears	Purple
Kit 10	Assisted Delivery with Vacuum Extraction	Grey

Referral Hospital Level (CEmONC): Referral Hospital Level (CEmONC) kits contain both disposable and reusable supplies to provide comprehensive emergency obstetric and newborn care at the referral (surgical obstetrics) level. In acute humanitarian settings patients from the affected populations are referred to the nearest hospital, which may require support in terms of equipment and supplies to be able to provide the necessary services for this additional case load. It is estimated that a hospital at this level covers a population of approximately 150,000 persons. The supplies provided in these kits would serve this population over a 3-month period.

IARH KIT NUMBERS	IARH KIT NAME	COLOR CODE
Kit 11	Obstetric Surgery and Severe Obstetric Complications Kit (A and B)	Fluorescent Green
Kit 12	Blood Transfusion	Dark Green

NOTE: The Inter-agency Emergency Reproductive Health (IARH) Kits are categorized into three levels targeting the three health service delivery levels. The kits are designed for use for a 3-month period for a specific target population size. Complementary commodities can be ordered according to the enabling environment and capacities of health care providers. As these kits are not context-specific or comprehensive, organizations should not depend solely on the IARH Kits and should plan to integrate procurement of SRH supplies in their routine health procurement systems as soon as possible. This will not only ensure the sustainability of supplies, but enable the expansion of services from the MISP to comprehensive SRH.

**** The new kit structure will only be available late 2019***

LEVEL	COMPLEMENTS	ITEM
Coordination	All Kits	Kit 0 - Administration and Training
Community and Primary Health Care - BEmONC	Kit 1	Kit 1B - Female Condoms
	Kit 2A	Chlorhexidine gel
	Kit 2B	Misoprostol (also complements Kits 6B and 8)
	Kit 4	Depot-medroxyprogesterone acetate - sub-cutaneous (DMPA-SC)
Health Center or Hospital Level - CEmONC	Kit 4	Kit 7A - Intrauterine Device (IUD)
	Kit 4	Kit 7B - Contraceptive Implant
	Kit 6A	Non-Pneumatic Anti-Shock Garment
	Kit 6B	Oxytocin
	Kit 8	Mifepristone
	Kit 10	Hand-held Vacuum Assisted Delivery system

Complementary commodities are a set of disposable and consumable items and/or kits that can be ordered in specific circumstances to complement existing IARH Kits:

- where providers are trained to use the special supply;
- where the supplies were accepted and used prior to the emergency;
- after the rapid first order of SRH supplies in protracted crises or post-emergency settings, while all efforts are made to strengthen or build local sustainable medical commodity supply lines (including local and regional procurement channels); and,
- where the use of the supplies is allowed to the fullest extent of the national law.

Information on the IARH kits and assistance with ordering can be provided by UNFPA country offices, or the UNFPA Humanitarian Office in Geneva. The IARH Kits can be ordered from UNFPA PSB in Copenhagen through either a UNFPA country office or the UNFPA Humanitarian Office; you can also reach out to the SRH working group/sub-sector coordinator to facilitate coordinated procurement of the IARH Kits.

UNFPA Humanitarian Office

UNFPA
Attn: Humanitarian Office
Palais des Nations
Avenue de la paix 8-14
1211, Geneva 10, Switzerland
Email: Humanitarian-SRHsupplies@unfpa.org

UNFPA Procurement Services Branch

UNFPA Procurement Service Branch
Marmovej 51
2100 Copenhagen, Denmark
Email: procurement@unfpa.org
Website: unfpaprocurement.org

Before placing an order, discuss with the SRH coordination group and/or the UNFPA country office to determine what is already being ordered and if orders can be combined.

MISP FOR SEXUAL AND REPRODUCTIVE HEALTH: OBJECTIVE 5

The MISP for Sexual and Reproductive Health is part of the *Inter-Agency Field Manual for Reproductive Health in Humanitarian Settings*, which was revised in 2018.

The 2018 MISP includes the following activities under Objective 5: Prevent Unintended Pregnancies

ENSURING AVAILABILITY → Ensure availability of a range of long-acting reversible and short-acting contraceptive methods (including condoms and emergency contraception) at primary health care facilities to meet demand

ACCESS TO INFORMATION → Provide information, including existing information, education, and communication (IEC) materials, and contraceptive counseling that emphasizes informed choice and consent, effectiveness, client privacy and confidentiality, equity, and non-discrimination

RAISING AWARENESS → Ensure the community is aware of the availability of contraceptives for women, adolescents, and men

HUMANITARIAN PRINCIPLES AND ACCOUNTABILITY FRAMEWORK

NOTES

NOTES

CORE HUMANITARIAN STANDARD[5]

NOTES

WHY IS IT CRITICAL TO ADDRESS SEXUAL AND REPRODUCTIVE HEALTH NEEDS FROM THE START OF A CRISIS?

CHALLENGES:

STRATEGIES:

5. Source: CHS Alliance, Group URD, and Sphere Project. *Core Humanitarian Standard on Quality and Accountability*, 2014. corehumanitarianstandard.org/language-versions

SESSION 3: OVERVIEW OF LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS)

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

- Define the terms family planning, contraception, and healthy timing and spacing of pregnancies.
- Describe basic attributes of LARC methods.
- Demonstrate and practice the use of the WHO Medical Eligibility Criteria (MEC) for Contraceptive Use Wheel / App and Quick Reference Chart in recommending safe and effective contraception methods for clients with medical conditions.

NOTES

LONG-ACTING REVERSIBLE CONTRACEPTIVES (LARCS)

1. _____

2. _____

3. _____

WORLD HEALTH ORGANIZATION (WHO) DEFINITIONS OF FAMILY PLANNING, CONTRACEPTION, AND HEALTHY TIMING AND SPACING OF PREGNANCY[6]

What is family planning?

According to WHO, "family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility."

What is contraception?

Contraception is the intentional prevention of pregnancy by artificial or natural means.

What is healthy timing and spacing of pregnancy (HTSP)?

Healthy timing and spacing of pregnancy is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.

- Women should delay their first pregnancy until at least age 18;
- After a live birth, women should wait at least 24 months before attempting another pregnancy to reduce the risk of adverse maternal, perinatal and infant outcomes; and
- After a miscarriage or induced abortion, women should wait at least six months before attempting another pregnancy to reduce risks of adverse maternal and perinatal outcomes.

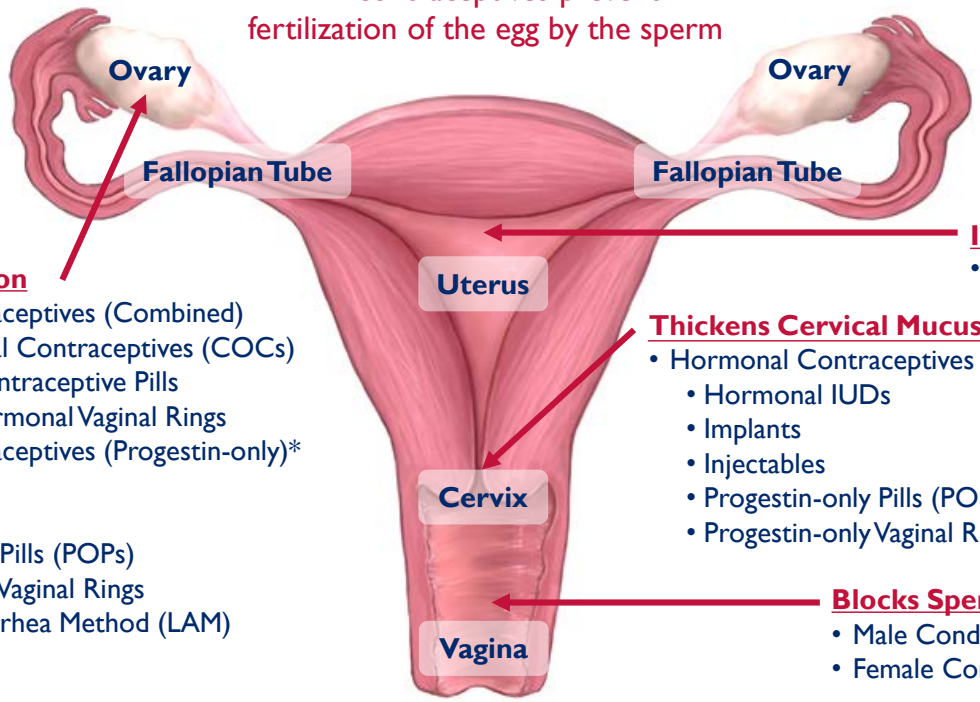
6. World Health Organization, Department of Reproductive Health and Research; Extending Service Delivery Project (ESD). *Healthy Timing and Spacing of Pregnancy Toolkit*. K4Health Toolkits. Available: toolkits.knowledgesuccess.org/toolkits/HTSP?utm_source=Knowledge-SUCCESS&utm_medium=Toolkits-Resource-Page&__hstc=175320440.b73fc762610f3bc1b5d2d4bd94f518e2.1606946504995.1606946504995.1606946504995.1&__hssc=175320440.3.1606946504995&__hsfp=3629513924

USAID FROM THE AMERICAN PEOPLE

Maternal and Child Survival Program

How Contraception Works: Mechanisms of Action

All contraceptives prevent fertilization of the egg by the sperm



Prevents Ovulation
- Hormonal Contraceptives (Combined)
  - Combined Oral Contraceptives (COCs)
  - Emergency Contraceptive Pills
  - Combined Hormonal Vaginal Rings
- Hormonal Contraceptives (Progestin-only)*
  - Implants
  - Injectables
  - Progestin-only Pills (POPs)
  - Progestin-only Vaginal Rings
- Lactation Amenorrhea Method (LAM)

Incapacitates Sperm
- Copper IUD †

Thickens Cervical Mucus Plug
- Hormonal Contraceptives (Progestin-only)*
  - Hormonal IUDs
  - Implants
  - Injectables
  - Progestin-only Pills (POPs)
  - Progestin-only Vaginal Rings

Blocks Sperm
- Male Condoms
- Female Condoms

* Progestin-only hormonal methods have more than one mechanism of action.
† The Copper IUD works by preventing fertilization but in *very rare* instances, if used as Emergency Contraception, it *may* prevent implantation of a fertilized egg.

www.mcsprogram.org

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7. Reproduced with permission from Maternal and Child Survival Program (MCSP). (2019) How Contraception Works. Available at: www.mcsprogram.org/resource/how-contraception-works-mechanisms-of-action

COPPER INTRAUTERINE DEVICE (IUD) FACT SHEET[8]

What is an IUD and a Copper IUD?	• The intrauterine contraceptive device (IUD) is a small, flexible, plastic frame with copper wire around it that is inserted into a woman's uterus to prevent pregnancy. The most commonly used IUDs are shaped like a T and have copper wires or bands on the plastic stem and arms. • The Copper T 380A, or "Copper T" is the most widely used copper IUD in the world. It is effective for up to 12 years.
Primary Mechanism of Action	• Prevents fertilization • The copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tubes and fertilizing the egg (Rivera et al. 1999)
Timing of Insertion	• At any time, if you are reasonably sure the client is not pregnant • During the menstrual cycle · Within 12 days · If more than 12 days, make sure she is not pregnant · No need for a backup method • When switching from another method · Immediately, if using the method correctly and consistently. Otherwise, make sure she is not pregnant. No need for a backup method. · If the woman is switching from an injectable contraceptive, the Copper T 380A can be inserted prior to the next scheduled injection. No backup method is needed. • Soon after childbirth (breastfeeding or non-breastfeeding) · Within 48 hours of delivery, or during a cesarean section · If more than 48 hours, then delay until four weeks • Post-abortion/miscarriage · Immediately or days after a first or second trimester abortion, if no infection · Delay after medical (nonsurgical) abortion until confirmed that the uterus is completely empty • For emergency contraception · Within five days after unprotected sex · After taking emergency contraceptive pills (ECP) the Copper T 380A can be inserted on the same day. No need for back up method. • No monthly bleeding (amenorrhea that is not related to childbirth or breastfeeding) · At any time, if reasonably sure she is not pregnant. No need for a backup method.
Characteristics of Copper IUDs	• **Contraceptive Effectiveness:** The IUD is effective as soon as it is inserted. The IUD is one of the most effective and long acting contraceptive methods. Its effectiveness is comparable to that of female and male sterilization. The failure (pregnancy) rate associated with IUD is: · Less than 1 percent in the first year of use. This means less than one pregnancy per 100 women in the first year of use (6 to 8 pregnancies per 1000 women). · A very small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUD. • **Effective life span:** The Copper T 380A is effective up to 10-12 years. Follow local guidelines. • **Removal or Replacement:** Copper T 380A should be replaced or removed no later than the full life span of IUD (10-12 years) from the date of insertion. It can also be removed any time the woman wants before completion of the total duration. • **Return to Fertility:** A woman's fertility returns promptly after an IUD is removed (Andersson et al. 1992; Belhadj et al. 1986). The provider must make this message very clear to clients having an IUD removed. Unless she wants to get pregnant, the client should have another IUD inserted immediately after removal of the first (if desired and appropriate) or she should immediately start on another contraceptive method.

8. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. *Long-Acting Reversible Contraception (LARC) Learning Resource Package*, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP. World Health Organization, Reproductive Health and Research, and World Health Organization. *Selected Practice Recommendations for Contraceptive Use*, 2016. USAID, World Health Organization, and United Nations Population Fund. "Fact Sheet: Copper IUDs." In *Training Resource Package for Family Planning. Intrauterine Devices (IUDs) Module*, 2018. www.fptraining.org/resources/iuds-handout-3-fact-sheet-copper-iuds. World Health Organization, Reproductive Health and Research, and K4Health. *Family Planning: A Global Handbook for Providers*. Geneva; Baltimore: World Health Organization, Department of Reproductive Health and Research; John Hopkins Bloomberg School of Public Health, Center for Communication programs, Knowledge for Health Project, 2018. apps.who.int/iris/bitstream/10665/260156/1/9780999203705-eng.pdf?ua=1. Acknowledgments: This fact sheet and its contents were referenced from the LARC Learning Resource Package from USAID Maternal & Child Survival Program (MCSP) implemented by Jhpiego.

Advantages of IUDs	• No constant/daily supplies needed • Effective immediately upon insertion • No user action required • Do not interfere with intercourse • Long-acting and reversible • Have beneficial non-contraceptive effects (protection from endometrial cancer and ectopic pregnancy) • Can be used by postpartum and lactating women • Do not interact with any medicines the client may be taking • Fertility returns promptly on removal • Can be used as an emergency contraceptive if inserted within five days of the first act of unprotected sexual intercourse
Limitations of IUDs	• A trained provider is needed to insert and remove the IUD • Pelvic examination before IUD insertion is mandatory, which is not so for other spacing methods • May cause minor pain or discomfort during insertion and removal procedures • Have side effects of changes in menstrual pattern and cramps • Small risk of expulsion • Provide no protection from sexually transmitted infections (STIs), including HIV
Side Effects *Generally not signs of a health problem; may diminish or change over time*	• Pain or cramping during menses • Prolonged and heavy menstrual bleeding • Bleeding or spotting between monthly periods
Potential Health Risks	• Spontaneous expulsion occurs in about 2-8 % clients (Trieman et al. 1995) and is most likely to occur during the first three months after insertion and during menstrual periods. • If pregnancy occurs with the IUD in situ, there is a risk of spontaneous abortion, sepsis, and ectopic pregnancy; however, IUD is not reported to have any adverse effects on the fetus. • Infection following insertion is less than 1 percent. This minimal risk is highest during the first 20 days after insertion, especially if aseptic precautions have not been taken, rather than because of the device itself (Hatcher et al, 2004). • Uterine perforation during insertion is a rare complication, which occurs in 0.5-1.5 per 1000 insertions and is associated with the level of provider's skill and experience (Trieman et al. 1995).
Who Can Have a Copper IUD Inserted?	• Women of any parity or reproductive age, married or unmarried, including nulliparous women who: · Want to use this method of contraception · Have no known conditions that preclude safety
Who Should Not Have a Copper IUD Inserted?	• Women who have the following known conditions: · Known or suspected pregnancy · Sepsis following childbirth or abortion (if insertion is immediately postpartum or post abortion) · Unexplained vaginal bleeding · Cervical, endometrial or ovarian cancer · Pelvic inflammatory disease · Purulent cervicitis (gonorrhea or chlamydia) · Malignant gestational trophoblastic disease · Known pelvic tuberculosis · Uterine fibroid or other anatomical abnormalities resulting in distortion of the uterine cavity, which is incompatible with IUD insertion
Use of IUDs by Women with HIV and AIDS	• An IUD can be provided to a woman with HIV if she has no symptoms of AIDS. • An IUD generally should not be initiated in a woman with AIDS who is not taking antiretroviral drugs (ARVs). • A woman who develops AIDS while using an IUD can continue to use the device. • A woman with AIDS who is doing clinically well on ARV therapy can both initiate and continue IUD use, but follow-up may be required.

Provide Follow-up and Counseling For	• Any client concerns or questions • Potential side effects and reassure the client: that they are temporary, are not a sign of any disease and can be managed easily • A follow up visit is recommended after her first monthly bleeding or 3-6 weeks after insertion OR • At any time, if having any concerns or side effects related to the IUD • Any signs of complications, although rare, counsel the woman to come back immediately if she sees any of the following warning signs
Warning Signs	Tell the client to return to the clinic if any of the following signs develop: • PAINS: · **P**eriod related problems or pregnancy · **A**cute abdominal cramping during the first three to five days after insertion (perforation) · **I**nfection: Fever and chills, unusual vaginal discharge, low abdominal pain (possible infection) · **N**ot feeling well · **S**tring-related problems

LEVONORGESTREL INTRAUTERINE DEVICES (LNG-IUDS) / HORMONAL IUD FACT SHEET[9]

What is an LNG-IUD?	• The LNG-IUD is a small, flexible, T-shaped plastic frame with a white cylinder-shaped vertical stem with two nylon threads at the end of it for removal. The vertical stem of the system has the reservoir containing the hormone Levonorgestrel. • It is inserted into a woman's uterus through her vagina and cervix by a specifically trained health care provider to prevent pregnancy. • The LNG-IUD is effective for up to 3-7 years, depending on type.
Primary Mechanism of Action	• Prevents fertilization of the egg by: · Thickening of the cervical mucus · Interfering with sperm movement
Characteristics of LNG-IUDs	• Highly effective, Long-acting and reversible • No constant supplies or user action required after insertion. • Does not interfere with intercourse • Can be safely used by breastfeeding women • No delay in return to fertility after removal • Significantly reduces menstrual blood loss as periods become lighter, shorter, or no periods, and less painful. • Has non-contraceptive health benefits (may provide protection from endometrial and cervical cancer; protect against iron-deficiency anemia; reduce menstrual cramps, heavy monthly bleeding, symptoms of endometriosis (pelvic pain, irregular bleeding) and reduces risk of ectopic pregnancy) • Trained provider needed to initiate and discontinue use • May cause minor pain or discomfort during insertion and removal procedures • Has minimal systemic hormonal side effects

9. USAID, World Health Organization, and United Nations Population Fund. "Levonorgestrel Intrauterine Devices (LNG-IUDs) Handout #3: Fact Sheet: LNG-IUDs." In *Training Resource Package for Family Planning*. Hormonal Intrauterine Device Module, 2021. fptraining.org/resources/levonorgestrel-intrauterine-devices-lng-iuds-handout-3-fact-sheet-lng-iuds

Characteristics of LNG-IUDs *Contd.*	• Complications (e.g., pelvic inflammatory disease and uterine perforation) are rare • Small risk of expulsion • Provides no protection from sexually transmitted infections, including HIV
Side Effects *Generally not signs of a health problem; may diminish or change over time*	• Changes in bleeding patterns including: · Lighter bleeding and fewer days of bleeding · Infrequent bleeding · Irregular bleeding · No monthly bleeding · Prolonged bleeding • Systemic hormonal side effects such as, headaches, breast tenderness or pain, nausea, weight gain, acne dizziness, and mood changes. • Ovarian cysts
Who can have an LNG-IUD inserted	• Women of any age, married or unmarried, including women who have or have not had children who: · Want to use this method of contraception · Have no known conditions that preclude safe use (such conditions are rare)
Who should not have an LNG-IUD inserted *For a complete list, see WHO medical eligibility criteria*	• Women who have the following known conditions: · Has current untreated pelvic infection, current STI or is at high individual risk of STI · Gave birth more than 48 hours but less than 4 weeks ago · Was told that she has cancer of the uterus or cervix, or breast cancer · Has unexplained vaginal bleeding · Has serious liver disease, such as severe cirrhosis or liver tumor · Has acute deep venous thrombosis (DVT) · Systemic lupus erythematosus with positive (or unknown) anti-phospholipid antibodies not on immunosuppressive treatment · Has anatomical abnormality of the uterine cavity (e.g. uterine fibroid) that will not allow appropriate LNG-IUD insertion
Use of LNG-IUDs by women with HIV and AIDS	• An LNG-IUD can be provided to a woman with HIV if she has mild or no clinical disease, whether or not she is on antiretroviral therapy. • An LNG-IUD generally should not be initiated in a woman with HIV infection with advanced or severe clinical disease. • A woman who becomes infected with HIV while she has an LNG-IUD in place can continue to use the device. • An LNG-IUD user with HIV who develops advanced or severe clinical disease can keep the IUD but should be closely monitored for pelvic inflammatory disease. • Women at risk of acquiring HIV can have an LNG-IUD inserted.
Provide follow-up and counseling for	• Any client concerns or questions • Side effects and their management • Signs of complications; although rare, counsel woman to come back immediately if she develops: · bleeding or severe abdominal cramping during the first three to five days after insertion (possible perforation) · persistent irregular bleeding or pain (possible dislocation, partial expulsion, or perforation) · fever and chills, unusual vaginal discharge, or low abdominal pain (possible infection) · missing strings (possible expulsion)
Dispelling myths regarding LNG-IUDs. They do not:	• Migrate from the woman's uterus to other parts of her body • Prevent a woman from having children after it is removed • Require a rest period (a new IUD can be inserted the same day the existing IUD is removed) • Prevent pregnancy by causing an abortion

CONTRACEPTIVE IMPLANTS FACT SHEET[10]

What are contraceptive implants?	• Progestin-only implants are small plastic rods that release a hormone in a woman's body to prevent pregnancy. • They are inserted under the skin in a woman's upper non-dominant arm. Current systems consist of one or two rods. • Types of implants include: · **Jadelle**, a two-rod system designed to deliver a steady daily dose of levonorgestrel over a period of five years. · **Sino-implant (II)**, which has the same active ingredient as Jadelle and similar in size but is approved for use over a period of three years. Sino-implant (II) is now being sold under the global brand Levoplant. · **Implanon NXT**, a single-rod system that releases a steady daily dose of the progestin etonogestrel for a period of up to three years. Implanon NXT is sometimes called Nexplanon. Implanon NXT/Nexplanon are newer versions of Implanon, which is no longer available, but some women may still have it and need removal.
Mechanism of action	• Thickens cervical mucus (making it difficult for sperms to reach egg) • Prevents the release of eggs from the ovaries (ovulation)
Timing of insertion	• Implants may be inserted at any time during the menstrual cycle when the provider is reasonably certain that the client is not pregnant. · If insertion is within 7 days of menstrual cycle, no need of any back up method. · If it is more than 7 days after the start of monthly bleeding, she can have implant inserted any time if it is reasonably certain that she is not pregnant. She will need a backup method for the first 7 days after insertion. · If switching from another non-hormonal method use back up method for 7 days. · If she is switching from injectables, she can have implants inserted when the repeat injection would have been given. No need for a backup method. · If switching from IUD/LNG-IUD: starting during the first 7 days of monthly bleeding, insert implant and remove the IUD. No need for a backup method. · If switching from LNG-IUD and amenorrheic, rule out pregnancy first, insert implant and remove the IUD. No need to wait for the next menstrual bleeding. No need for a backup method. · After miscarriage or abortion: Immediately after a surgical evacuation. If implants are inserted within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. If it is more than 7 days after first- or second trimester miscarriage or abortion, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. For women undergoing medical abortion, Implants can be inserted immediately after the first pill of the medical abortion regimen. · After taking emergency contraceptive pills (ECPs): After taking progestin-only or combined ECPs: Implants can be inserted on the same day as she takes the ECPs. She will need to use a backup method for the first 7 days. If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant. · Implants can be inserted on the 6th day after taking UPA-ECPs. No need to wait for her next monthly bleeding. Implants and UPA interact. If an implant is inserted sooner, and thus both are present in the body, one or both may be less effective. · Can be inserted during immediate postpartum period (Category 2).

10. Source: USAID, World Health Organization, and United Nations Population Fund. "Fact Sheet: Contraceptive Implants." In *Contraceptive Implants Training Module. Training Resource Package for Family Planning*, 2018. www.fptraining.org/resources/implants-handout-4-fact-sheet-implants

Characteristics of progestin-only implants	• Benefits: · Highly effective · Easy to use · Long-acting pregnancy protection but easily reversible · Do not interfere with intercourse, private · Have no effect on quality or quantity of breast milk · Have non-contraceptive health benefits (help prevent ectopic pregnancy and iron-deficiency anemia) • Limitations: · Have side effects including changes in menstrual bleeding and non-menstrual effects · Insertion involves minor procedure and some discomfort for a day or two · Cannot be initiated or discontinued without a trained provider · Provide no protection from sexually transmitted infections including HIV • Side effects (generally not signs of a health problem; may diminish or change over time) · Light spotting or bleeding · Irregular bleeding · Prolonged bleeding · Infrequent bleeding · Amenorrhea · Headaches · Weight change · Abdominal pain · Acne (can improve or worsen) dizziness, mood changes, nausea, and breast tenderness (less common than with combined oral contraceptives)
Who can use progestin-only implants?	• Women of any parity or reproductive age (including adolescents), married or unmarried, who: · Want to use this method of contraception · Have no known conditions that preclude safe use (such conditions are rare) · Postpartum women
Who should not initiate progestin-only implants *For a complete list, see WHO eligibility criteria*	• Women who have the following known conditions: · Currently have deep venous thrombosis (unless on established anticoagulant therapy) · Unexplained vaginal bleeding · History of or current breast cancer · Severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells)
Who should be advised to discontinue use of progestin-only implants and switch to a non-hormonal method?	• Women with unexplained vaginal bleeding • Women with migraine headaches with aura
Use of progestin-only implants by women with HIV and AIDS	• Women with HIV can use progestin-only implants without restrictions, whether or not they are on anti-retroviral (ARV) therapy. • Women with AIDS who take ARVs can generally use progestin-only implants because the effectiveness of implants seems not to be significantly affected by ARVs. However, women on Efaverizine (EFVs) should be advised about the possible drug interactions between EFV and implants that may lead to a higher than usual contraceptive failure rate. Women taking efavirenz should also use condoms to enhance protection from pregnancy, or consider other methods that do not interact with efavirenz such as injectables or IUDs

Provide follow-up and counseling for	• Any client concerns or questions • Side-effects, especially irregular bleeding or spotting or amenorrhea • Any signs of complications (although rare); counsel the woman to come back immediately if any of the following symptoms develop: · Infection or pus at the insertion site · Severe headaches that start or become worse after initiation · Unusually heavy or prolonged bleeding · Severe pain in the lower abdomen (symptom of ectopic pregnancy) · Amenorrhea after having regular cycles (signs of pregnancy) · Expulsion of rod · Unusual yellow coloration of eyes and skin • Explain to the client that implants can be removed at any time for any reason
Dispelling myths regarding progestin-only implants	• Progestin-only implants do not: · Break and move around within a woman's body if inserted correctly · Cause birth defects · Cause cancer · Cause abortion if inserted during a pregnancy · Have any contraindication for use by adolescents, despite myths or fears that adolescents should not use them

HOW AND WHEN TO USE THE PREGNANCY CHECKLIST AND PREGNANCY TESTS: JOB AID[11]

Match your client's menstrual status and chosen contraceptive method with one of the options below and follow the instructions.

Client with amenorrhea (postpartum or other type)

Implants, pills, ring, injectables, or patch	IUDs Copper or LNG
Use pregnancy checklist.[1]	
Pregnancy ruled out: provide method.	
Pregnancy not ruled out: use a pregnancy test.	
Pregnancy test is negative (or test is not immediately available): provide the method now.[2] Schedule a follow-up pregnancy test in 3–4 weeks.	Pregnancy test is negative (or test is not immediately available): advise woman to use COCs, DMPA, or condoms or abstain for 3-4 weeks, then repeat the pregnancy test. Second pregnancy test is negative: provide an IUD.

Client between two regular menses (monthly bleeding)*

Implants, pills, ring, injectables, or patch	IUDs Copper or LNG
Use pregnancy checklist.[1]	
Pregnancy ruled out: provide method.	
Do not use a pregnancy test (in most cases, it is too early for it to be effective).	
Pregnancy not ruled out: provide the method now.[2] Return for a pregnancy test if next menses are delayed.	Pregnancy not ruled out: do not provide method. Advise woman to return for LNG IUD insertion within 7 days of onset of her next menses or within 12 days for a copper IUD; but in the meantime, use COCs, DMPA, or condoms or abstain. Return for a pregnancy test if next menses are delayed.

[1] See page 2 (reverse) for pregnancy checklist.

[2] For implants, counsel about the need to remove the implant if pregnancy is confirmed and she wishes to continue the pregnancy.

In cases where pregnancy cannot be ruled out, offer emergency contraception if the woman had unprotected sex within the last 5 days.

Counsel all women to come back any time they have a reason to suspect pregnancy (for example, she misses a period).

* **If the client presents with a late/missed menses, use a pregnancy test to rule out pregnancy.** If using a highly sensitive pregnancy test (for example, 25 mIIU/ml) and it is negative, provide her desired method.

If using a test with lower sensitivity (for example, 50 mIU/ml) and it is negative during the time of her missed period, wait until at least 10 days after expected date of menses and repeat the test. Advise the woman to use condoms or abstain in the meantime. If the test is still negative, provide her desired method.

If test sensitivity is not specified, assume lower sensitivity.

11. Source: Reprinted with permission from FHI 360. "Job Aid: How and When to Use the Pregnancy Checklist and Pregnancy Tests," 2017. www.fhi360.org/resource/job-aid-how-and-when-use-pregnancy-checklist-and-pregnancy-tests

PREGNANCY CHECKLIST

How to be Reasonably Sure a Client is Not Pregnant: Client History

Ask the client questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions.

NO	1.	Did your last menstrual period start within the past 7 days?*	YES
NO	2.	Have you abstained from sexual intercourse since your last menstrual period, delivery, abortion or miscarriage?	YES
NO	3.	Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period, delivery, abortion or miscarriage?	YES
NO	4.	Have you had a baby in the last 4 weeks?	YES
NO	5.	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	6.	Have you had a miscarriage or abortion in the past 7 days?*	YES

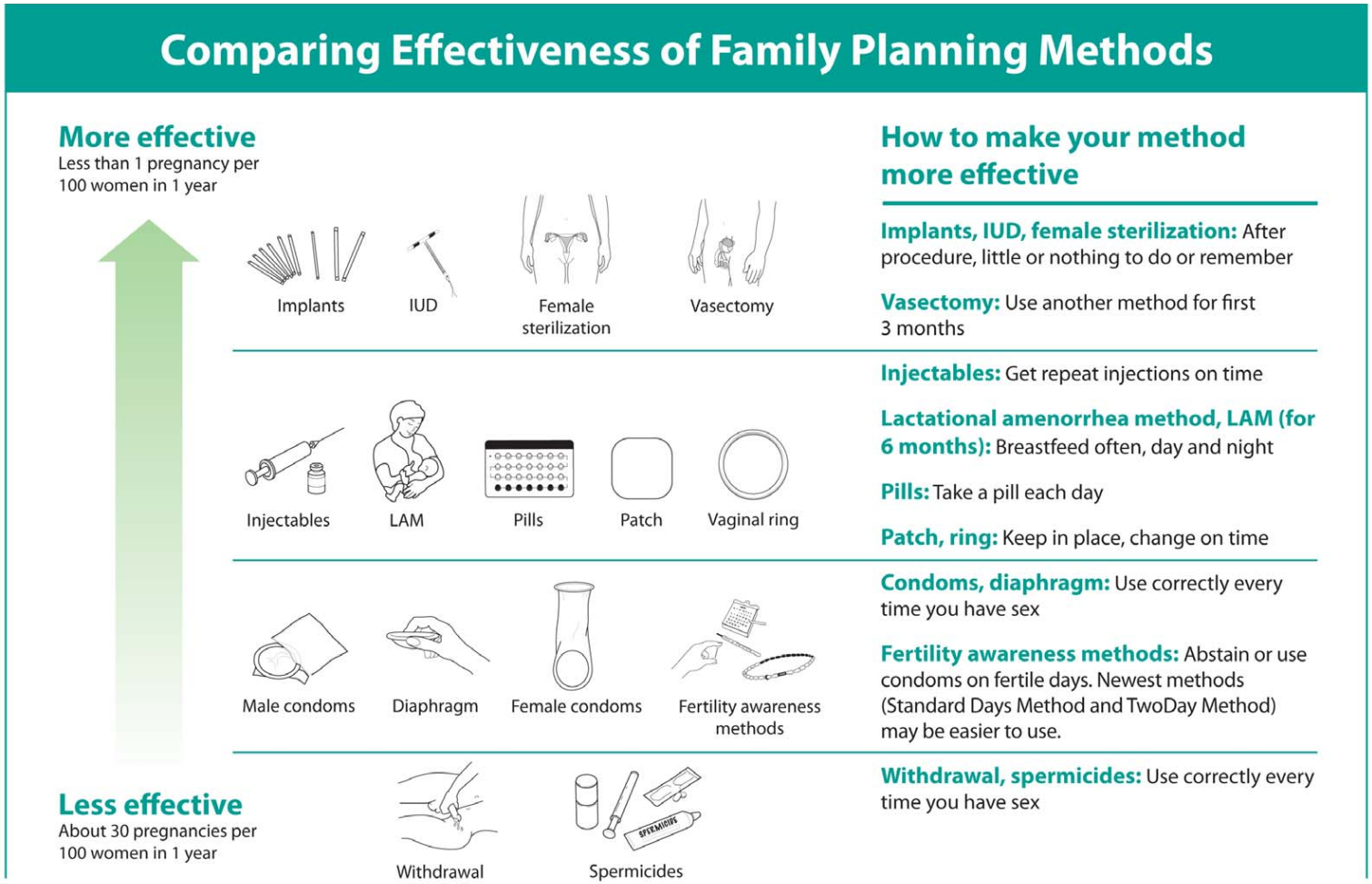
**** If the client is planning to use a copper IUD, the 7-day window is expanded to 12 days.***

If the client answered **NO** to ***all of the questions,*** pregnancy cannot be ruled out using the checklist.

Rule out pregnancy by other means.

If the client answered **YES** to ***at least one of the questions,*** you can be reasonably sure she is not pregnant.

COMPARING EFFECTIVENESS OF FAMILY PLANNING METHODS JOB AID[12]



12. Source: World Health Organization, and Johns Hopkins Center for Communication Programs (CCP). "Comparing Effectiveness of Family Planning Methods," 2007. toolkits.knowledgesuccess.org/toolkits/iud-toolkit/comparing-effectiveness-family-planning-methods

METHOD EFFECTIVENESS CHART[13]

Method	If method is used consistently and correctly (perfect use):	If method is occasionally used incorrectly or not used (typical use):
Implants	less than 1	less than 1
IUD	less than 1	less than 1
Male and Female Sterilization	less than 1	less than 1
Injectables	less than 1	6
Pills	less than 1	9
Male condoms	2	18
Standard Days Method	5	12
Female condoms	5	21
Diaphragm	6	12
Withdrawal	4	22
Spermicides	8	28

If 100 Women Use a Method for One Year, How Many Will Become Pregnant?

Note: The lactational amenorrhea method (LAM) is a highly effective temporary method with 1 to 2 pregnancies per 100 women in the first 6 months after childbirth.

Training Resource Package for Family Planning, Contraceptive Method Effectiveness , 11/2011

13. Source: USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Job Aid 2-2: Method Effectiveness Chart." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*. Module 2: Family Planning Counseling, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

WHO MEC QUICK REFERENCE CHART[14]

2016 WHO Medical Eligibility Criteria for Contraceptive Use: Quick Reference Chart for Category 3 and 4

to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), progestin-only implants, copper intrauterine device (Cu-IUD), levonorgestral intrauterine system (LNG-IUS)

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Pregnancy		NA	NA	NA		
Breastfeeding	Less than 6 weeks postpartum				See i.	See i.
	≥ 6 weeks to < 6 months postpartum					
	≥ 6 months postpartum					
Postpartum not breastfeeding VTE = venous thromboembolism	< 21days				See i.	See i.
	< 21days with other risk factors for VTE*					
	≥ 21 to 42 days with other risk factors for VTE*					
Postpartum timing of insertion	≥ 48 hours to less than 4 weeks	See i.	See i.	See i.		
	Puerperal sepsis					
Postabortion (immediate post-septic)						
Smoking	Age ≥ 35 years, < 15 cigarettes/day					
	Age ≥ 35 years, ≥ 15 cigarettes/day					
Multiple risk factors for cardiovascular disease						
Hypertension BP = blood pressure	History of (where BP cannot be evaluated)					
	BP is controlled and can be evaluated					
	Elevated BP (systolic 140-159 or diastolic 90-99)					
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)					
	Vascular disease					
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE					
	Acute DVT/PE					
	DVT/PE, established on anticoagulant therapy					
	Major surgery with prolonged immobilization					
Known thrombogenic mutations						
Ischemic heart disease (current or history of)				I C		I C
Stroke (history of)				I C		
Complicated valvular heart disease						
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies					
	Severe thrombocytopenia		I C		I C	

CONDITION	Sub-condition	COC	DMPA	Implants	Cu-IUD	LNG-IUS
Headaches	Migraine without aura (age < 35 years)	I C				
	Migraine without aura (age ≥ 35 years)	I C				
	Migraines with aura (at any age)		I C	I C		I C
Unexplained vaginal bleeding (prior to evaluation)					I C	I C
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels					
	Persistently elevated β-hCG levels or malignant disease					
Cancers	Cervical (awaiting treatment)				I C	I C
	Endometrial				I C	I C
	Ovarian				I C	I C
Breast disease	Current cancer					
	Past w/ no evidence of current disease for 5 yrs					
Uterine distortion (due to fibroids or anatomical abnormalities)						
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I C	I C
	Current pelvic inflammatory disease (PID)				I C	I C
	Very high individual risk of exposure to STIs				I C	I C
Pelvic tuberculosis					I C	I C
Diabetes	Nephropathy/retinopathy/neuropathy					
	Diabetes for > 20 years					
Symptomatic gall bladder disease (current or medically treated)						
Cholestasis (history of related to oral contraceptives)						
Hepatitis (acute or flare)		I C				
Cirrhosis (severe)						
Liver tumors (hepatocellular adenoma and malignant hepatoma)						
AIDS	No antiretroviral (ARV) therapy	See ii.	See ii.	See ii.	I C	I C
	Not improved on ARV therapy				I C	I C
Drug interactions	Rifampicin or rifabutin					
	Anticonvulsant therapy **					

Adapted from: *Medical Eligibility Criteria for Contraceptive Use, 5th Edition.* Geneva: World Health Organization, 2015. Available: http://www.who.int/reproductivehealth/publications/family_planning/en/index.html

This chart shows a complete list of all conditions classified by WHO as Category 3 and 4. Characteristics, conditions, and/or timing that are Category 1 or 2 for all methods are not included in this chart (e.g., menarche to < 18 years, being nulliparous, obesity, high risk of HIV or HIV-infected, < 48 hours and more than 4 weeks postpartum).

- **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. Where I/C is not marked, the category is the same for initiation and continuation.

NA Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.

i The condition, characteristic and/or timing is not applicable for determining eligibility for the method.

ii Women who use methods other than IUDs can use them regardless of HIV/AIDS-related illness or use of ART.

* Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m2, postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

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14. Source: Reprinted with permission by FHI 360. "Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use," 2016. www.fhi360.org/resource/quick-reference-chart-who-medical-eligibility-criteria-contraceptive-use

PRACTICE SCENARIOS AND ANSWERS USING THE MEC WHEEL AND QUICK REFERENCE CHART[15]

1. 30-year-old Julia delivered a baby girl eight hours ago. She is not breastfeeding and wants to have a copper intrauterine device (IUD) inserted.

2. Sophia is 35 years old, has four children, had a mastectomy in her right breast due to cancer two months ago and wants to use combined oral contraceptive pills (COCs).

3. Charlie had their last menstrual cycle five days ago; they have multiple sex partners and do not use condoms. They want to use the copper IUD.

4. Kristina has a 4-week-old, fully breastfed baby. She wants to use the contraceptive implant.

5. Linda is 18 years old. She got married two months ago, is nulliparous, and wants to use injectables.

6. Pamela had unexplained vaginal bleeding twice in the last six months. She wants to use an IUD or the levonorgestrel intrauterine device (LNG-IUD).

7. Sara has been diagnosed as having active liver disease. She wants to have COCs.

15. Used with permission from USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Module 3: Medical Eligibility and Client Assessment, Activity 3-2: Scenarios for Practice Using the MEC Wheel and Quick Reference Chart." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

8. Sherry delivered a baby four weeks ago, is breastfeeding and wants to use the levonorgestrel intrauterine device (LNG-IUD).

9. Linda developed acute thrombophlebitis in her leg after her last delivery one week back; she wants to use the contraceptive implant.

10. Jo has diabetes, which is controlled on insulin. They want to use the implant.

11. Jane has uncontrolled hypertension with blood pressure greater than 160/110. They want to have the progestin-only injectable.

12. Mary developed pelvic inflammatory disease (PID) nine months after she had a copper IUD inserted. She wants to continue using the IUD.

13. Sheela has stage three AIDS and is on antiretroviral drugs (ARVs). She wants to have an implant inserted.

14. Linda is 40 years old. She smokes 20 cigarettes per day and wants to use the contraceptive implant.

15. Sandra has uterine fibroids, located outside the uterine cavity. She wants to use the IUD or the levonorgestrel intrauterine device (LNG-IUD).

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

- Describe family planning counseling, particularly during crisis situations.
- Describe the four stages of the Balanced Counseling Strategy (BCS+) for family planning.
- Practice how to use the BCS+ job aids to assist a client in making an informed decision about whether and which contraceptive method to choose.

Ensuring Contraceptive Use Is Voluntary[16]

All persons have the human right to reproductive self-determination and, thus, to make decisions regarding their reproductive health without being subjected to violence, coercion, or discrimination. Consequently, a human rights–based approach to providing contraception requires that all contraceptive services be offered on a voluntary and informed basis. Providers must ensure that clients are provided with accurate information and are free to choose their preferred method without being subjected to undue influence or coercion.

The key tenets of voluntarism in providing contraception include the following:

- People have the opportunity to choose voluntarily whether to use a specific contraceptive method or not.
- Individuals have access to information on a wide variety of contraceptive choices, including the benefits, side effects and any health risks of particular methods.
- Clients are offered, either directly or through referral, a broad range of contraceptive methods and services.
- The voluntary and informed consent of any clients choosing sterilization is verified by a written consent document signed by the client.

Human Rights Framework and Contraceptive Service Provision[17]

- Coercing people to use a contraceptive method is unacceptable and in violation of international human rights law.
- Under international law, universal access to family planning is a human right as all individuals and couples have the right to decide on the number, spacing, and timing of their children.
- Everyone has a right to privacy and the right to equality and non-discrimination.
- Everyone has a right to impart and receive information on contraception and birth spacing.

NOTES

16. Inter-Agency Working Group on Reproductive Health in Crises. "Unit 6: Prevent Unintended Pregnancies." In *Minimum Initial Service Package for Sexual and Reproductive Health In Crisis Situations: A Distance Learning Module*, 2019. iawg.net/resources/minimum-initial-service-package-distance-learning-module
17. Inter-Agency Working Group on Reproductive Health in Crises. "Contraception Programming." In *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. iawgfieldmanual.com

TIPS FOR SUCCESSFUL COUNSELING[18]

Counseling Guidelines	Tips for Successful Counseling
Provide emotional support and ensure client is safe	Crises can bring about high levels of stress, anxiety, and anger. Seek out and connect with social support. Identify local support groups or available crisis counselors to talk to.
The conversation is confidential	Clients may become embarrassed when discussing contraceptive methods. Try to set the tone of the visit in a low-key, non-pressured manner. Assure the client (or couple) that the conversation is confidential.
Be patient	Never put pressure on the client to finish speaking. Let the client's wishes and needs guide the discussion.
Use open-ended questions	Encourage the client to explain needs, express concerns, and ask questions that require more than "yes" or "no" answers to increase the amount of information the client gives you.
Use simple language	Give just key information and instructions. Use words the client knows.
Be respectful	Show every client respect and help each client feel at ease.
Discuss side effects openly and honestly	Bring up side effects, if any. Take the client's concerns seriously.
Be alert to related needs if any	Be alert to related needs such as protection from sexually transmitted infections including HIV and support for condom use.
Check the client's understanding	Ask the client to repeat back to you the key points to ensure understanding.
Give the client written information	Give the client written information (if available and appropriate) as a reminder of instructions.
Invite the client for a return visit	Invite the client to come back at any time, for any reason, if needed.

Effective counseling helps clients choose and use family planning methods that suit them. Clients differ, their situations differ, and they need different kinds of help. The best counseling is tailored to the individual client.

Client Type	Usual Counseling Tasks
New clients with no method in mind	• Discuss the client's situation, plans, and what is important to her about a method (including the method's length of effectiveness and role of client in administering method [e.g., daily pill versus implant], types of side-effects that she can tolerate, etc.). • Help the client consider methods that might suit her. If needed, help her reach a decision. • Support the client's choice, give instructions on use and discuss how to cope with any side effects.
New clients with a method in mind	• Check that the client's understanding is accurate, including the understanding of the side effects that may be experienced. • Support the client's choice, if the client is medically eligible. • Discuss how to use the method and how to cope with any side effects.
Returning clients with problems	• Acknowledge the problem and help resolve it—whether the problem is side-effects, trouble using the method, an uncooperative partner, or another problem. Reassure the client that you will do your best to support her. If it is an issue that will likely resolve with time, encourage her to be patient and revisit the facility as needed. If the problem is too difficult to tolerate, provide symptomatic treatment or help her choose a different method that meets her needs.
Returning clients with no problems	• Provide more supplies or routine follow-up. • Ask a friendly question about how the client is doing with the method.

18. World Health Organization, Reproductive Health and Research, and K4Health. "Chapter 25: Family Planning Provision: Importance of Providing Family Planning Methods." In *Family Planning: A Global Handbook for Providers*. Geneva; Baltimore: World Health Organization, Department of Reproductive Health and Research; John Hopkins Bloomberg School of Public Health, Center for Communication programs, Knowledge for Health Project, 2018. https://www.who.int/publications/i/item/9780999203705

Give time to clients who need it. Many clients are returning with no problems and need little counseling. Returning clients with problems and new clients with no method in mind need the most time, but usually these types of clients are few.

Counseling has succeeded when clients:

- Feel they received the help they wanted
- Know what to do and feel confident that they can do it
- Feel respected and appreciated
- Come back when they need to

And most importantly,

- when clients use their methods effectively and with satisfaction

NOTES

TIPS FOR COUNSELING DURING A CRISIS

ALGORITHM FOR USING THE BALANCED COUNSELING STRATEGY PLUS[19]

PRE-CHOICE STAGE

1. Establish and maintain a warm, cordial relationship.
2. Inform client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation.
3. Ask client about current family size and current contraceptive practices. Counsel client on Healthy Timing and Spacing of Pregnancy using counseling card.
   a) If client is currently using a family planning method or delaying pregnancy, ask about her/his satisfaction with it and interest in continuing or changing the method.
   b) If partner is present, use the male services and support card.
4. Rule out pregnancy using the Checklist to Make Reasonably Sure a Woman is not Pregnant card to be reasonably sure the woman is not pregnant.
5. Display all of the method cards. Ask client if she/he wants a particular method.
6. Ask all of the following questions. Set aside method cards based on the client's responses.
   a) Do you wish to have children in the future?
      If "Yes," set aside vasectomy and tubal ligation cards. Explain Why.
      If "No," keep all cards and continue.
   b) Have you given birth in the last 48 hours?
      If "Yes," set aside combined oral contraceptives (the Pill) and combined injectables. Explain why.
      If "No," continue with the next question.
   c) Are you breastfeeding an infant less than 6 months old?
      If "Yes," set aside the combined oral contraceptives (the Pill) and combined injectable cards. Explain why.
      If "No," or she has begun her monthly bleeding again, set aside the lactational amenorrhea (LAM) card. Explain why.
   d) Does your partner support you in family planning?
      If "Yes," continue with the next question
      If "No," set aside the following cards: female condom, male condom, Standard Days Method©, Two Days Method©, and withdrawal. Explain why.
   e) Do you have any medical conditions? Are you taking any medications?
      If "Yes," ask further about which conditions or medications. Refer to WHO Medical Eligibility Criteria Wheel or current national guidelines and set aside all contraindicated method cards. Explain why.
      If "No," keep all the cards and continue.
   f) Are there any methods that you do not want to use or have not tolerated in the past?
      If "Yes," set aside the cards the client does not want.
      If "No," keep the rest of the cards.

METHOD CHOICE STAGE

7. Briefly review the methods that have not been set aside and indicate their effectiveness.
   a) Arrange the remaining cards in order of effectiveness (see back of each card).
   b) In order of effectiveness (highly effective to not effective), briefly review the attributes on each method card.
8. Ask the client to choose the method that is most convenient for her/him.
   a) If client is adolescent use the counseling card to inform her that she can get any method
9. Using the method-specific brochure, check whether the client has any condition for which the method is not advised.
   a) Review "Method not advised if you…" section in the brochure
   b) If the method is not advisable, ask the client to select another method from the cards that remain. Repeat the process from **Step 8.**

19. Reprinted with permission from Population Council. "Algorithm." In *The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings*, Third. Washington, D.C., 2015. www.popcouncil.org/uploads/pdfs/2015RH_BCS-Plus_Algorithm_en.pdf

POST-CHOICE STAGE

10. Discuss the method chosen with the client, using the method-specific brochure as a counseling tool. Determine the client's comprehension and reinforce key information.
11. Make sure the client has made a definite decision. Give her/him the method chosen, a referral, and a back-up method depending on the method selected.
12. Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.

SYSTEMATIC SCREENING FOR OTHER SERVICES STAGE

13. Using information collected previously, determine client's need for postpartum, newborn, infant care, well-child services or post abortion care.
    a) If client reported giving birth recently, review the Promoting Healthy Postpartum Period and Promoting Newborn and Infant Health card with client. Provide or refer for services, if needed.
    b) For clients with children less than 5 years of age, ask if children have been taken to well-child services. Provide or refer for immunizations and growth monitoring services, if needed.
    c) If client reported a recent abortion, review the Post Abortion Care card with the client. Provide or refer post abortion care services, if needed.
14. Ask client when she had her last screening for cervical cancer (VIA/VILI or pap smear) or breast cancer.
    a) If her last Cervical Cancer screening was more than 3 years ago (*6-12 months if she is HIV positive) or she doesn't know, ask if she would like to have a screening today. Review the Screening for Cervical Cancer card. Provide or refer for services.
    b) If her last Cervical Cancer screening was less than 3 years ago continue with next question.
    c) Review Breast Cancer Information and Awareness counseling card with client.
15. Discuss STI/HIV Transmission & Prevention and dual protection with client using counseling cards. Offer condoms and instructions on correct and consistent use.
16. Conduct STI and HIV risk assessment using the counseling card. If symptoms are identified, treat her/him syndromically.
17. Ask client whether s/he knows her/his HIV status.
    a) If client knows s/he is living with HIV,
       - Review Positive Health, Dignity, & Prevention counseling card with client.
       - Refer client to center for wellness care and treatment.
    b) If client knows s/he is HIV negative,
       - Discuss a time frame for repeat testing.
    c) If client does not know her/his status,
       - Discuss HIV Counseling and Testing (HCT) with client, using counseling card.
       - Offer or initiate testing with client, according to national protocols.
       - Counsel client on test results. If client is living with HIV, review Positive Health, Dignity, & Prevention counseling card and refer client to center for wellness care and treatment.
    d) Counsel client using Women's Support & Safety Card.
       - If client shows any major Intimate Partner Violence (IPV) triggers, refer her for specialized services.
18. Give follow-up instructions, a condom brochure, and the brochure for the method chosen. Set a date for next visit.
19. Thank her/him for the visit. Complete the counseling session.

POPULATION COUNCIL
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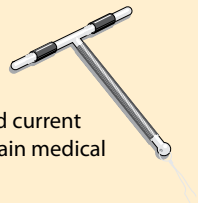
Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD



Research findings over the past 30 years have established that intrauterine devices (IUDs) are safe and effective for use by most women, including those who have not given birth, who want to space births, and those living with or at risk of HIV infection. For some women, IUDs are not recommended because of the presence of certain medical conditions, such as genital cancer and current cervical infection. For these reasons, women who desire to use an IUD must be screened for certain medical conditions to determine if they are appropriate candidates for the IUD.

FHI 360 (formerly Family Health International), with support from the U.S. Agency for International Development (USAID), has developed a simple checklist (see center spread) to help health care providers screen clients who were counseled about contraceptive options and made an informed decision to use an IUD. This checklist is a revised version of the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD* produced by FHI 360 in 2008. This version complies with the recommendations of the *Medical Eligibility Criteria for Contraceptive Use* (WHO, updated 2015). This revision also includes guidance for providers whose clients may be eligible to use the IUD for emergency contraception. The checklist consists of 21 questions designed to identify medical conditions and high-risk behaviors that would prevent safe IUD use or require further evaluation. Clients who are ruled out because of their response to some of the medical eligibility questions may still be good candidates for an IUD if the suspected condition can be excluded through appropriate evaluation.

A health care provider should complete the checklist before inserting an IUD. In some settings the responsibility for completing the checklist may be shared — by a counselor who completes questions 1–14, and an appropriately trained health care provider who determines the answers to the remaining questions during the pelvic exam. Providers trained to perform insertions may include nurses, nurse-midwives, nurse-practitioners, midwives, physicians, and, depending on the educational and professional standards in a country, physician's assistants and associates.

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives,* the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN),* the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants,* and the *Checklist on How to be Reasonably Sure a Client is Not Pregnant.* For more information about the provider checklists, please visit www.fhi360.org.

Determining Current Pregnancy

Questions 1–6 are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers "yes" to any of these questions and there are no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. An IUD should never be inserted in a woman who is pregnant, as it may result in a septic miscarriage. Note, if a client answers "yes" to question 4, IUD insertion should be delayed until four weeks postpartum. There is an increased risk of perforating the uterus when IUDs are inserted after 48 hours and up to four weeks postpartum. However, IUDs can be inserted by a trained professional within the first 48 hours after the client has given birth.

Assessing Medical Eligibility for the IUD

7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?

Unexplained vaginal bleeding may be a sign of an underlying pathological condition, such as genital malignancy (cancer) or infection. These conditions must be ruled out before an IUD can be inserted. If necessary, refer the client to a higher-level provider or specialist for evaluation and diagnosis. Counsel the client about other contraceptive options available, and provide condoms to use in the meantime.

8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?

Clients with genital cancer or trophoblastic disease are at higher risk of perforation and bleeding at the time of insertion. IUD insertion in clients with current pelvic tuberculosis may lead to a higher risk of secondary infection and bleeding. If a woman has any one of these three conditions, she should not have an IUD inserted. Counsel her about other appropriate contraceptive options and provide condoms to use in the meantime.

9. Have you ever been told that you have a rheumatic disease, such as lupus?

This question is intended to identify women who have been diagnosed with systemic lupus disease with severe thrombocytopenia. Women with severe thrombocytopenia have an increased risk of bleeding and should usually not initiate use of an IUD.

Note: Questions 10–13 are intended to identify clients at high individual risk of sexually transmitted infections (STIs), because there is a possibility that they may currently have chlamydia and/or gonorrhea infection. Unless these STIs can be reliably ruled out, clients at high risk are not good candidates for IUD insertion. IUD insertion may increase risk of pelvic inflammatory disease (PID) in these clients. They should be

20. Reprinted with permission from FHI 360. "Checklists for Screening Clients Who Want to Initiate Use of the Copper IUD," 2015. www.fhi360.org/resource/checklists-screening-clients-who-want-initiate-use-copper-iud

counseled about other contraceptive options and provided with condoms for STI protection. However, if other contraceptive methods are not available or acceptable, and there are no signs of STI, an IUD still can be inserted. Careful follow-up is required in such cases.

10. Within the last 3 months, have you had more than one sexual partner?

Clients who have multiple sexual partners are at high risk of contracting STIs. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. *(See note regarding questions 10–13).*

11. Within the last 3 months, do you think your partner has had another sexual partner?

Clients whose partners have more than one sexual partner are at high risk of contracting STIs. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. In situations where polygamy is common, the provider should ask about sexual partners outside of the union. *(See note regarding questions 10–13).*

12. Within the last 3 months, have you been told you have an STI?

There is a possibility that these clients currently have chlamydia and/or gonorrhea infection. Unless these STIs can be reliably ruled out, these clients are not good candidates for IUD insertion. *(See note regarding questions 10–13).*

13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?

(Note: There are two parts to this question. Answering "yes" to either part or both parts of the question restricts IUD insertion).

Clients whose partners have STIs may have these infections as well. Unless chlamydia and/or gonorrhea infection can be reliably ruled out, these clients are not good candidates for IUD insertion. *(See note regarding questions 10–13.)*

14. Are you HIV-positive, and have you developed AIDS?

If the woman is HIV-positive but has not developed AIDS, the IUD may generally be used. However, if the woman has developed AIDS, ask whether she is taking ARVs and make sure she is doing clinically well. If she is doing clinically well, she may be a candidate for the IUD. If she is not, an IUD usually is not recommended unless other more appropriate methods are not available or not acceptable. There is concern that HIV-positive clients who have developed AIDS and are not taking ARVs may be at increased risk of STIs and PID because of a suppressed immune system. IUD use may further increase that risk.

Pelvic Examination

15. Is there any type of ulcer on the vulva, vagina, or cervix?

Genital ulcers or lesions may indicate a current STI. While an ulcerative STI is not a contraindication for IUD insertion, it indicates that the woman is at high individual risk of STIs, in which case IUDs are not generally recommended. Diagnosis should be established and treatment provided as needed. An IUD can still be inserted if co-infection with gonorrhea and chlamydia are reliably ruled out.

16. Does the client feel pain in her lower abdomen when you move the cervix?

Cervical motion tenderness is a sign of PID. Clients with current PID should not use an IUD. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. Counsel the client about condom use and other contraceptives.

17. Is there adnexa tenderness?

Adnexa tenderness and/or adnexa mass is a sign of a malignancy or PID. Clients with genital cancer or PID should not use an IUD. Diagnosis and treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist.

18. Is there purulent cervical discharge?

Purulent cervical discharge is a sign of cervicitis and possibly PID. Clients with current cervicitis or PID should not use an IUD. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. Counsel the client about condom use.

19. Does the cervix bleed easily when touched?

If the cervix bleeds easily at contact, it may indicate that the client has cervicitis or cervical cancer. Clients with current cervicitis or cervical cancer should not have an IUD inserted. Treatment should be provided as appropriate. If necessary, referral should be made to a higher-level provider or specialist. If, through appropriate additional evaluation beyond the checklist, these conditions may be excluded, then the woman can receive the IUD.

20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?

If there is an anatomical abnormality that distorts the uterine cavity, proper IUD placement may not be possible. Cervical stenosis also may preclude an IUD insertion.

21. Were you unable to determine the size and/or position of the uterus?

Determining size and position of the uterus is essential before IUD insertion to ensure high fundal placement of the IUD and to minimize the risk of perforation.

Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD

First, be reasonably sure that the client is not pregnant. If she is not menstruating at the time of her visit, ask the client questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 6.

YES	1. Did your last menstrual period start within the past 12 days?	NO
YES	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	3. Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period or delivery?	NO
YES	4. Have you had a baby in the last 4 weeks?	NO
YES	5. 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?	NO
YES	6. Have you had a miscarriage or abortion in the last 12 days?	NO

If the client answered **YES** to ***any one of questions 1–6*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–14.
However, if she answers **YES** to ***question 4,*** the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

If the client answered **NO** to ***all of questions 1–6,*** ask if every unprotected sex act since last menses occurred within the last 5 days. If yes, she can be considered for IUD insertion as emergency contraception;* if no, pregnancy cannot be ruled out using the checklist. Rule out pregnancy by other means.
Give her condoms to use until pregnancy can be ruled out.

To determine if the client is medically eligible to use an IUD, ask questions 7–14. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 14.

NO	7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	YES
NO	8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	9. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	10. Within the last 3 months, have you had more than one sexual partner?	YES
NO	11. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	12. Within the last 3 months, have you been told you have an STI?	YES
NO	13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	14. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to ***all of questions 7–14,*** proceed with the **PELVIC EXAM**.

During the pelvic exam, the provider should determine the answers to questions 15–21.

If the client answered **YES** to ***any of questions 7–9,*** an IUD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to ***any of questions 10–13,*** she is not a good candidate for an IUD unless chlamydia and/or gonorrhea infection can be reliably ruled out.

If she answered **YES** to the ***second part of question 14*** and is not currently taking ARV drugs, IUD insertion is not usually recommended. If she is doing clinically well on ARVs, the IUD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUD use.

NO	15. Is there any type of ulcer on the vulva, vagina, or cervix?	YES
NO	16. Does the client feel pain in her lower abdomen when you move the cervix?	YES
NO	17. Is there adnexa tenderness?	YES
NO	18. Is there purulent cervical discharge?	YES
NO	19. Does the cervix bleed easily when touched?	YES
NO	20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUD insertion?	YES
NO	21. Were you unable to determine the size and/or position of the uterus?	YES

If the answer to ***all of questions 15–21*** is **NO**, you may insert the IUD.

If the answer to ***any of questions 15–21*** is **YES**, the IUD cannot be inserted without further evaluation. See explanations for more instructions.

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** Women who are medically ineligible for an IUD as emergency contraception should be offered EC pills.*

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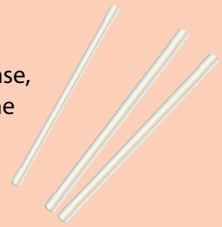
Checklist for Screening Clients Who Want to Initiate Contraceptive Implants



Contraceptive implants, such as Jadelle, Sino-implant (II), and Implanon, are safe and effective for use by most women, including those who are at risk of cardiovascular disease, sexually transmitted infections (STIs) and HIV infection, or those living with HIV. For some women, implants are generally not recommended because of the presence of certain medical conditions, such as breast cancer or most types of liver tumors. Women who desire to use implants must therefore be screened for certain medical conditions to determine if they are appropriate candidates.

FHI 360 (formerly Family Health International), with support from the U.S. Agency for International Development (USAID), has developed a simple checklist (see center spread) to help health care providers screen clients who have been counseled about contraceptive options and who have made an informed decision to use implants. This checklist is a revised version of the checklist produced by FHI 360 in 2008. Changes reflected in this version are based on recommendations included in the *Medical Eligibility Criteria for Contraceptive Use* (WHO, updated 2015). This revision also includes guidance for providers whose clients may be eligible for emergency contraception.

The checklist consists of 11 questions and provides guidance based on clients' responses. The first five questions are designed to identify medical conditions that would prevent safe use of implants or require further evaluation. Clients who are ruled out because of their response to some of the medical eligibility questions may still be good candidates for implants if the suspected condition can be excluded through appropriate evaluation. The last six questions enable providers to determine with reasonable certainty that a woman is not pregnant before initiating the method.

A health care provider should complete the checklist before inserting the implant(s). In some settings the responsibility for initiating implants may be shared — by a counselor who completes the checklist and an appropriately trained health care provider who performs the insertion. Providers trained to perform insertions may include nurses, nurse-midwives, nurse-practitioners, midwives, physicians, and, depending on the educational and professional standards in a country, physician's assistants and associates.

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives,* the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN),* the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD,* and the checklist entitled, *How to be Reasonably Sure a Client is Not Pregnant.* For more information about the provider checklists, please visit www.fhi360.org.

Assessing Medical Eligibility for Implants

1. Have you ever been told you have breast cancer?

This question is intended to identify women who know they have had or currently have breast cancer. These women are not good candidates for implants because breast cancer is a hormone-sensitive tumor and implant use may adversely affect the course of the disease.

2. Do you currently have a blood clot in your legs or lungs?

This question is intended to identify women with known blood clots, not to determine whether a woman might have an undiagnosed blood clot. Women with blood clots in their legs or lungs usually experience acute symptoms that prompt them to seek health care. For this reason, they would likely be aware of the condition and would answer "yes." Because implant use may make these conditions worse, answering "yes" to the question means that the woman is usually not a good candidate for contraceptive implants. However, women with blood clots in their legs or lungs who are on established anticoagulant therapy generally can use implants.

21. Source: Reprinted with permission from FHI 360. "Checklists for Screening Clients Who Want to Initiate Contraceptive Implants." www.fhi360.org/resource/checklists-screening-clients-who-want-initiate-contraceptive-implants

3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?

This question is intended to identify women who know that they currently have a serious liver disease such as severe cirrhosis, malignant liver tumors, and most benign liver tumors. Women with these conditions should usually not use implants, because the hormones used in implants are processed by the liver and may further compromise liver function. Women with other liver problems, such as acute or chronic hepatitis and focal nodular hyperplasia (a benign tumor that consists of scar tissue and normal liver cells), can use implants safely.

4. Have you ever been told that you have a rheumatic disease, such as lupus?

This question is intended to identify women who have been diagnosed with systemic lupus disease. Women who have systemic lupus disease and who are not on immunosuppressive treatment should usually not use implants, due to concerns about a possible increased risk of thrombosis.

5. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?

This question is intended to identify women who may have an underlying pathological condition. While these conditions are not directly affected by implants, changes in bleeding patterns which are common among implant users, could make such conditions harder to diagnose. Unusual, unexplained bleeding changes may indicate infection or cancer that should be evaluated without delay or treated by a higher-level health care provider. Implant use should be postponed until the condition can be evaluated. In contrast, women for whom heavy, prolonged, or irregular bleeding constitutes their usual bleeding pattern may initiate and use implants safely.

Determining Current Pregnancy

Questions 6–11 are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers "yes" to any of these questions and has no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. The client can have implants inserted now.

If the client is within 7 days of the start of her menstrual bleeding (5 days for Implanon), she can start the method immediately. No back-up method is needed.

If it has been more than 7 days since her first day of bleeding (more than 5 days for Implanon), she can start the method immediately, but must use a back-up method (i.e., using a condom or abstaining from sex) for 7 days to ensure adequate time for the implants to become effective.

If you cannot determine with reasonable certainty that the woman is not pregnant (using the checklist), you will need to rule out pregnancy using another means (e.g., wait until monthly bleeding resumes, use a pregnancy test if monthly bleeding is delayed). She should be given condoms to use in the meantime.

Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

To determine if the client is medically eligible to use implants, ask questions 1–5. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 5.

NO	1. Have you ever been told you have breast cancer?	YES
NO	2. Do you currently have a blood clot in your legs or lungs?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Have you ever been told that you have a rheumatic disease, such as lupus?	YES
NO	5. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES

If the client answered **NO** to ***all of questions 1–5,*** she can use implants. Proceed to questions 6–11.

If the client answered **YES** to ***question 1,*** she is not a good candidate for implants. Counsel about other available methods or refer.

If the client answered **YES** to ***any of questions 2–5,*** implants cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

Ask questions 6–11 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 11.

YES	6. Did your last menstrual period start within the past 7 days?	NO
YES	7. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	8. Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period or delivery?	NO
YES	9. Have you had a baby in the last 4 weeks?	NO
YES	10. 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?	NO
YES	11. Have you had a miscarriage or abortion in the last 7 days?	NO

If the client answered **YES** to ***at least one of questions 6–11*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can have implants inserted now.

If the client began her last menstrual period ***within the past 7 days (5 days for Implanon),*** she can have implants inserted now. No additional contraceptive protection is needed.

If the client began her last menstrual period ***more than 7 days ago (5 days for Implanon),*** she can ***have implants inserted now,*** but instruct her that she must ***use condoms or abstain from sex for the next 7 days.*** Give her condoms to use for the next 7 days.

If the client answered **NO** to ***all of questions 6–11,*** pregnancy cannot be ruled out using the checklist.

Rule out pregnancy by other means. Give her condoms to use until pregnancy can be ruled out.

Offer emergency contraception if every unprotected sex act since last menses occurred within the last 5 days.

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BCS+ PRACTICE ROLE PLAYS[22]

When practicing, participants should role model the following basic principles of contraceptive counseling:

- Non-judgmental attitudes toward contraceptive users and non-users, respecting their choices, dignity, privacy, and confidentiality.
- Full explanation of advantages and disadvantages of different methods and information on management of side effects.
- Evidence-based and tactful responses to rumors and misconceptions regarding contraceptive methods.
- Sensitivity to the needs of specific groups (e.g., adolescents, persons living with disabilities, people living with HIV, persons engaged in sex work, LGBTQIA+).
- Maintaining confidentiality for services and recognizing that partner permission or notification is not required.
- Communication techniques, such as open interactive dialogue with clients: encouraging clients to express their questions and concerns, active listening, clarifying, asking clients to restate their understanding, acknowledging client feelings, and summarizing the discussion.
- Documenting method choice and storing information in a confidential location.*

BCS+ PRACTICE ROLE PLAYS
You are a 23-year-old married woman who has two young children and are currently living in a refugee settlement. Given the uncertainty of your family's refugee status and ongoing instability in your home country, you want to wait 2-3 years before getting pregnant again. Your husband does not care much about family planning. You have not used modern contraceptive methods before. Your last child is five months old and you are breastfeeding. You are very scared to use the intrauterine device (IUD) and refuse it if offered. You are not sure of your HIV status, but think your husband had many partners before marriage.
You are an 18-year-old girl. You started your menstrual bleeding 10 days ago. You are sexually active and have a boyfriend. You want to avoid getting pregnant and want the pill. Neither you nor your boyfriend want to use condoms. Later during the consult, you reveal that you had unprotected sex two days ago. You have come to the clinic because you heard the pill prevents pregnancy. You have a slight vaginal discharge.
Your family lost their home and farming land after a cyclone. For your family's economic well-being and your own protection, you were forced to marry. A year later, at the age of 20 you gave birth to your first child and are breastfeeding your baby. You now have the opportunity to continue your education and do not want to have the second baby soon. You read about progestin-only implants in a family planning brochure and you have come to the family planning site to learn more.
You are a 30-year-old married woman who does not want to have any more children. You already have four and are tired and fed up with being pregnant. Your partner is interested in more children. Your husband likes having sex frequently and does not like using condoms. You are afraid of injections. You have had mild seizures in the past and sometimes take medicine for them. If offered the minipill, explain that you are afraid you will forget to take the pill every day. Your husband travels occasionally and you are not sure if he is faithful.
You are a 35-year-old married woman who has five children. Your latest child is seven weeks old. You are on the seventh day of your menstruation. After the violence and death of many in your community, your partner believes it is important that you have many more children. However, the crisis has made you nervous and you want to wait until things stabilize to even consider having any more children for a while. Despite the insecurity, your husband likes having sex frequently and does not like using condoms. You are afraid of injections. You are also afraid you will forget to take a pill every day. You have a history of vaginal infections. You do not know what kind of infections—you have just been going to the clinic and they give you medicine.
You are an adolescent boy who has come to the clinic with an STI but not HIV. You are concerned about getting an STI again. You have had several girlfriends. Your current girlfriend wants to get pregnant to show you that she loves you, but you are not so happy about the idea. If the "provider" offers you condoms, agree. Before you leave, ask the provider how your girlfriend can avoid getting pregnant.
You are a 20-year-old woman with a four-month-old child that you are breastfeeding. With ongoing insecurity in your home country, you and your baby are living with relatives across the border. Your husband stayed home to work as seasonal labor. He works 22 days of the month but comes to visit you for the rest of the month. You have never used family planning but want to control your fertility. You are about to start your menstruation. It is Monday and your husband is coming home this weekend. He does not like to use condoms and is not that supportive of family planning.

22. Used with permission from Population Council. *The Balanced Counseling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High STI/HIV Prevalence Settings, Trainer's Guide*. Third Edition. Washington, D.C., 2015. www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service

* Inter-Agency Working Group on Reproductive Health in Crises. "Contraception Programming." In *Inter-Agency Field Manual on Reproductive Health in Humanitarian Settings*, 2018. iawgfieldmanual.com

BCS+ PRACTICE ROLE PLAYS
You are a 35-year-old married woman who has three children. The youngest child is six weeks old. You are not ready to have another child for a while. Your husband does not cooperate with family planning. You live relatively far from the health center. You have heard evil things about the IUD and refuse it if offered. If offered implants, explain that your husband would notice and be very angry with you. You had an extramarital affair several years ago.
You are 18 years old and single. You have a boyfriend and do not want to get pregnant. You and your boyfriend go to school. You are about to begin your menstruation. If offered the IUD or Norplant, reveal that you do not want something foreign in your body. If offered injectables, scream and say you hate needles. If offered the minipill, explain that you have come to the clinic before for the minipill, but they are always out of stock. You have no conditions that prevent you from taking the pill. Besides, there is a pharmacy in your community that carries the most popular pill. You have had several boyfriends in the past.
You are 29 years old and have been fully breastfeeding your child and using the lactational amenorrhea method (LAM) as a birth control method. You are beginning to give your infant food. You had started having your first monthly bleeding five days ago. You want to have a reliable contraceptive method. You have chosen LAM because you want to breast-feed your baby and you are very religious.
You are a 22-year-old woman with a one-year-old child. You are in a stable marriage and your husband supports family planning. You do not like modern contraceptive methods. Sometimes he will use a condom but not consistently because it reduces feeling for him. You do not like the side effects of hormonal methods. You are religious and would not like a modern method. If the provider offers you a fertility awareness method, such as Standard Days Method or TwoDay Method, appear to be interested. Then, reveal that your monthly menstruation cycles are very irregular.
You are 39 years old and have six children. You are tired and do not want any more children. Your husband cooperates with family planning but will not use a condom. You have tried hormonal methods in the past but do not like the side effects. Furthermore, you were not good at remembering to take the pill, which resulted in your fifth pregnancy. You are afraid of the IUD and you have heard that women can get pregnant with it. Since the nearby hospital was targeted in the airstrikes last year, the hospital is no longer functional. It is more challenging to get to the hospital in town, but with planning could go there. You would arrange a ride with your cousin who lives in the next village. Despite your dislike of the side effects of the pill, you would be open to a monthly injectable until you get a tubal ligation at the hospital. You suspect your husband has not been faithful.
You are a 38-year-old man who has come to the clinic with his wife who wants family planning. You cannot afford to have any more children—you have five children now. Your wife has used several methods, which have resulted in her five pregnancies. You both have had enough. If tubal ligation is offered, mention that your wife just discovered she is pregnant. Toward the end of the consult, also reveal that you are HIV positive. You confess that you have been with many women in the past.
You are a 21-year-old married woman with one child and wants to have your next pregnancy at least after three years. Due to the insecurity in and around the refugee camp you live in, you would prefer a method that does not require you to visit the health facility very often. You have heard about family planning methods at the clinic and read a brochure. You think that DMPA is a good method for you.
You are a 32-year-old married woman with four children. You want to start using a reliable family planning method again and your husband is supportive of this desire. You do have history of high blood pressure during pregnancy. You have used condoms but conceived the fourth child.

UNIT 2

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

- Describe and provide rights-based sexual and reproductive health care in crisis-affected settings.
- Describe and demonstrate infection prevention practices for the provision of LARC services.
- Describe and demonstrate the steps of copper IUD insertion and removal on anatomical models using the skills checklist.
- Describe and demonstrate the steps of one/two-rod implant insertion and removal on the arm model using the skills checklist.

DAY 2 SESSIONS

SESSON 5
RIGHTS-BASED SEXUAL AND REPRODUCTIVE HEALTH CARE

↓

SESSION 6
INFECTION PREVENTION FOR PROVISION OF LARC SERVICES

↓

SESSION 7
PRE-PRACTICE SKILLS ASSESSMENT, VIDEO & DEMONSTRATION

↓

SESSION 8
SKILLS LAB – IUD AND IMPLANT INSERTION AND REMOVAL PRACTICE

NOTES

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

- Describe the fundamental principles of rights-based sexual and reproductive health care.
- Provide rights-based sexual and reproductive health care in crisis settings.

Sara's Story*

Sara was the oldest of six children. She had one sister and four brothers. She attended school regularly and was an enthusiastic and capable student. When Sara turned 13 years old, she was ready to begin high school but could not return to school because a crisis arose in her village and girls were not allowed to go to school.

When she was 14, she received a marriage proposal and was forced to marry because her family could not continue to support her. She became pregnant within the first month of her marriage and had two more babies over the next three years, all daughters.

Sara was always tired. Her children were not healthy. She had heard about family planning and wanted to take a rest before having the next child, but the clinic was very far from her home and she could not go out without a male member. Her husband wanted to have at least six children and he was disappointed he did not yet have a male heir. He was not interested in family planning as it is against his religion. Sara believed she had no choice because she relied on her husband for food and income and soon she was pregnant again. Sara had a difficult time with her fourth child and was taken to a nearby hospital, where she had to undergo an emergency cesarean section. The doctor ligated her fallopian tubes during the procedure without informing her and taking any written consent.

Sara's husband was very annoyed with her for getting her tubes ligated and wanted to divorce her after the procedure. She felt trapped, but she assumed her situation was no different from that of many women.

WHICH OF SARA'S BASIC RIGHTS WERE VIOLATED?

WHO WERE THE PERSONS RESPONSIBLE AND WHY?

HOW CAN YOU, BEING A SERVICE PROVIDER, HELP HER?

IN RELATION TO HER THREE PREGNANCIES, WHEN, WHERE, AND WHAT COULD YOU AND THE HEALTH SYSTEM HAVE DONE TO HELP?

WHAT OPPORTUNITIES MAY EXIST TO OFFER FAMILY PLANNING SERVICES, PARTICULARLY LARCS?

WHAT OPPORTUNITIES EXIST IN YOUR SETTING?

* Adapted from USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Lily's Story." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package. Module 2: Family Planning Counseling*, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

RIGHTS-BASED APPROACH FOR SEXUAL AND REPRODUCTIVE HEALTH CARE[23]

A rights-based approach is an approach that emphasizes fundamental values to respect clients and their reproductive decisions. This approach takes advantage of the international human rights treaty system and policies to shape humane and effective reproductive health programs and policies. It provides tools to analyze the root causes of health problems and inequities in service delivery.

FUNDAMENTAL PRINCIPLES OF RIGHTS-BASED APPROACH FOR SEXUAL AND REPRODUCTIVE HEALTH

Human Right	Reproductive Health Obligations
Right to life and survival	• Prevent avoidable maternal deaths • End female feticide and infanticide • Screen for cancers that can be detected early and treated • Ensure access to dual-protection contraceptive methods
Right to liberty and security of the person	• Eliminate female genital cutting • Obtain informed consent for all procedures, including HIV testing, sterilization, and abortion • Encourage clients to make independent reproductive health decisions • Stop sexual trafficking
Right to freedom from inhuman and degrading treatment	• Protect and care for survivors of sexual assault and domestic abuse and prosecute the perpetrators • Prohibit involuntary abortion and sterilization • Eliminate rape as an instrument of war
Right to marry and found a family	• Prevent early or coerced marriages • Provide access to infertility services to women and men • Prevent and treat reproductive tract infections that cause infertility
Right to decide the number and spacing of one's children	• Provide access to a range of contraceptive methods • Help people choose and use a family planning method • Provide access to safe abortion services, where legal
Right to the highest attainable standard of health	• Provide access to affordable, acceptable, and comprehensive reproductive health services • Provide high-quality care • Allocate available resources fairly • Provide access to effective approaches to cervical cancer screening /early treatment
Right to the benefits of scientific progress	• Fund research on women's as well as men's health needs • Provide access to emergency contraception • Provide access to antiretroviral treatment for AIDS • Provide access to obstetric care that can prevent maternal deaths
Right to non-discrimination and respect for difference	• Offer reproductive health services to all groups, including adolescents, unmarried women, and refugees • Ensure that a husband's or parent's consent is not required for reproductive health services • Offer services that meet women's, men's, and gender non-conforming persons' distinctive reproductive health needs
Right to receive and impart information	• Make family planning information freely available • Offer sufficient information for people to make good reproductive health decisions

23. Cook, Rebecca J., Bernard M. Dickens, and Mahmoud F. Fathalla. *Reproductive Health and Human Rights: Integrating Medicine, Ethics, and Law*. Issues in Biomedical Ethics. Oxford ; New York: Clarendon Press, 2003. International Planned Parenthood Federation. "IPPF Charter Guidelines on Sexual and Reproductive Rights," 2003. www.ippf.org/resource/IPPF-Charter-Sexual-and-Reproductive-Rights. *OUTLOOK* Volume 20, Number 4 published by PATH.

Human Right	Reproductive Health Obligations
Right to freedom of thought, conscience, and religion	• Do not limit sexual and reproductive health services, such as emergency contraception, on religious grounds • Do not allow providers to refuse to offer contraceptive and abortion services on the grounds of conscience where referrals are possible and treatment in emergency situations is protected
Right to privacy	• Keep clients' information confidential • Ensure privacy for all services

A rights-based approach to sexual and reproductive health is especially powerful because all human rights, including reproductive rights, are universal, inalienable, indivisible, and interdependent. They guide almost every aspect of the delivery of care, defining what services must be offered, to whom and in what fashion.

There are three key and fundamental principles for a rights-based approach for reproductive health:

1. Based on the rights to liberty, to marry and found a family, and to decide the number and spacing of one's children, individuals have the right to control their sexual and reproductive lives and make reproductive decisions without interference or coercion.
2. The right to non-discrimination and respect for difference requires governments to ensure equal access to health care for everyone and to address the unique health needs of women and men.
3. To fulfill people's rights to life and health, governments must make comprehensive reproductive health services available and remove barriers to care.

NOTES

SESSION 6: INFECTION PREVENTION FOR PROVISION OF LARC SERVICES

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

- Describe standard precautions for infection control and prevention.
- Demonstrate the steps for handling and processing instruments.
- Explain how to handle, segregate, and dispose of contaminated and non-contaminated waste.
- Describe infection prevention practices recommended for the provision of LARC services.

WHAT ARE STANDARD PRECAUTIONS?

WHAT STANDARD PRECAUTIONS DO YOU USE DAILY?

NOTES

General Infection Prevention and Control Guidelines During COVID-19[24]

If the training is taking place in the context of the COVID-19 pandemic or other major infectious disease outbreak or pandemic, it is important to keep in mind and emphasize the following:

FACILITY-LEVEL PROTOCOLS FOR COVID-19 INFECTION PREVENTION AND CONTROL (IPC)

- Robust IPC measures during the COVID-19 pandemic are critical.
- Basic set of IPC practices should be used, at a minimum, in preventing the spread of infectious agents to all individuals working in a healthcare facility.
- Risk assessment is critical for all activities, including assessing each healthcare activity and determining the personal protective equipment (PPE) that is needed for adequate protection.
- Limit the number of people in the facility by requesting that only clients be allowed to enter.
- Provide soap and water or hand sanitizer stations at the facility entrance for all who enter.
- If possible, check temperature and ask about recent symptoms or illnesses for all clients and staff entering facility.
- Ensure everyone visiting the facility is wearing a mask.
- Maintain social distance (2 meters) in the client waiting area and adapt patient flow to support this.
- Ensure availability and use of PPE, including eye protection and googles, facemasks, gloves, gowns, and shoe coverings as and when needed.
- Ensure staff continue to promote and maintain client confidentiality and privacy.
- Ensure staff continue to treat clients with dignity and respect.

24. Refer to IPC guidelines during COVID-19 and World Health Organization, Reproductive Health and Research, and K4Health. "Preventing Infection at IUD Insertion." In *Family Planning: A Global Handbook for Providers*. Geneva; Baltimore: World Health Organization, Department of Reproductive Health and Research ; John Hopkins Bloomberg School of Public Health, Center for Communication programs, Knowledge for Health Project, 2018. www.fphandbook.org/preventing-infection-iud-insertion

COVID-19 IPC GUIDELINES FOR PROVISION OF LARC SERVICES

- Wash hands with soap and water or hand sanitizer before and after provision of LARC services.
- Maintain social distancing during interaction with client and wear mask and gloves during service provision.
- Use high-level disinfected instruments for each procedure.
- Use sterilized instruments when coming in contact with non-intact skin or body tissue such as during implant removal.
- Use sterile gauze and sponges during procedure, preparing skin or vagina beforehand.
- Use "no-touch" technique for IUD insertion.

"NO-TOUCH" IUD INSERTION TECHNIQUE

- Always handle instruments by the end that they do not come into contact with the client.
- The instrument should not come contact with a contaminated surface before or during insertion of IUD through the woman's cervix.
- Use "no-touch" technique throughout loading of the IUD (Loading within sterile package without touching the Cu-T device).
- The tenaculum or uterine sound should not touch providers' gloves, a woman's vaginal walls, or speculum.
- Do not pass the uterine sound or the loaded IUD inserter more than once through the cervical canal.

GLOVE REQUIREMENTS FOR IUD OR IMPLANT INSERTION AND REMOVAL[25]

Task or Activity	Are Gloves Needed?	Preferred Gloves
Pelvic examination (if necessary)	**YES**	New clean examination gloves
Interval IUD insertion/removal ("no-touch" technique)	**YES**	New clean examination gloves
Postpartum IUD	**YES**	HLD/sterile
Implant insertion and removal		
Two-rod insertion	**YES**	Sterile surgical
One-rod insertion		New clean examination gloves
Removal (one-rod and two-rod)		Sterile surgical
Handling and cleaning instruments	**YES**	Utility
Handling contaminated waste	**YES**	Utility
Cleaning blood or body fluid spills	**YES**	Utility

NOTES

25. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Module 5: Infection Prevention for Long-Acting Reversible Contraceptive Methods, 'Glove Requirements for IUD or Implant Insertion/Removal.'" In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

SKILLS LAB STATION A: HANDWASHING AND WEARING GLOVES CHECKLIST[26]

Instructions: Write "Yes" if the step or task is performed satisfactorily; write "No" if the step or task is not performed satisfactorily, or "N/O" if not observed.

- **SATISFACTORY:** Performs the step or task according to the standard procedure or guidelines.
- **UNSATISFACTORY:** Unable to perform the step or task according to the standard procedure or guidelines.
- **NOT OBSERVED:** Step or task or skill not performed by learner during evaluation by clinical trainer.

SKILLS LAB STATION CHECKLIST: HANDWASHING AND WEARING GLOVES

SCENARIO: You work in a health facility. You are going to practice washing your hands and putting on gloves before inserting an IUD in a client.

Task	Step	Observations (Yes, No, N/O)	Comments
Wet your hands	Open the tap for running water or ask someone to pour water on your hands up to the wrist Thoroughly wet both hands with clean water		
Apply soap	Apply enough soap to cover all hand surfaces		
Rub soap on the palms	Rub hands palm to palm		
	Rotationally rub right palm over left dorsum with interlaced fingers		
	Rotationally rub left palm over right dorsum with interlaced fingers		
	Rub palm over palm with interlaced fingers		
Rub soap on fingers	Rub back of fingers of both hands to opposing palms with interlocked fingers (right and left)		
Rub soap around the thumb	Clasp left thumb in right palm and rub rotationally		
	Clasp right thumb in left palm and rub rotationally		
Rub fingertips over palms	Rub clasped fingers of right hand backward and forward over left palm		
	Rotationally rub clasped fingers of left hand backwards and forwards over the right palm		
Rinse hands	Rinse hands with clean water from the tap or poured water		
Dry hands	Dry hands with single used towel or paper towel		
Close the faucet	Close the faucet with paper towel or single used towel		
Wear gloves	Pick up the sleeve of the left glove with the right thumb and index finger		
	Lift the glove and insert the pointed fingers of the left hand		
	Pull the sleeves of the gloves to the wrists		
	Point and insert fingers 2–5 of the gloved left hand under the inverted sleeve of the right glove and lift the right glove		
	Carefully insert the pointed fingers of the right hand into the right glove—avoid touching the gloved left thumb with the ungloved fingers of the right hand		
Take off gloves	Gently peel off the cuff toward the fingertips of one hand—but not completely off—and then use those still-covered fingers to grasp the glove on the other hand and remove both gloves together		
	Drop both gloves in the waste bag or over the wrapper at the same time		

26. World Health Organization. "How to Handwash," 2009. www.who.int/campaigns/save-lives-clean-your-hands. Tietjen, Linda, Débora Bossemeyer, and Noel McIntosh. *Infection Prevention: Guidelines for Healthcare Facilities with Limited Resources*. Baltimore, Md: Jhpiego Corp, 2003. Cureless, Melanie S., Chandrakant S. Ruparelia, Elizabeth Thompson, and Polly A. Trexler. *Infection Prevention and Control: Reference Manual for Health Care Facilities with Limited Resources*. Baltimore, Maryland: Jhpiego, 2018. resources.jhpiego.org/resources/infection-prevention-and-control-reference-manual-health-care-facilities-limited-resources

SKILLS LAB STATION B: CLEANING INSTRUMENTS AND OTHER ITEMS CHECKLIST[27]

Instructions: Write "Yes" if the step or task is performed satisfactorily; write "No" if the step or task is not performed satisfactorily, or "N/O" if not observed.

- **SATISFACTORY:** Performs the step or task according to the standard procedure or guidelines.
- **UNSATISFACTORY:** Unable to perform the step or task according to the standard procedure or guidelines.
- **NOT OBSERVED:** Step or task or skill not performed by learner during evaluation by clinical trainer.

SKILLS LAB STATION CHECKLIST: CLEANING INSTRUMENTS AND OTHER ITEMS

SCENARIO: You work in a health facility. You have just collected the instrument buckets containing used instruments and surgical gloves from point of use. You need to clean them thoroughly.

Task	Step		Observations (Yes, No, N/O)	Comments
Preparing for the procedure	Put on the proper personal protective equipment	Utility gloves		
		Face shield or mask and protective eyewear		
		Plastic apron		
		Closed-toe shoes		
Cleaning instruments	Fill a plastic container (or utility sink) with clean water			
	Using a brush and liquid or powder detergent, scrub instruments and other items under the surface of the water, removing all blood and other foreign matter			
	Separate cannulated and sharp instruments and place them on top. Make sure delicate instruments are secured in their holders			
	Disassemble instruments and other items with multiple parts and clean the grooves, teeth and joints with a brush			
	Thoroughly rinse the instruments and other items with clean water			
Cleaning surgical gloves	Wash the inside and outside of the gloves in soapy water			
	Rinse in clean water until no soap remains			
	Test gloves for holes by inflating them by hand and holding them under water. (Air bubbles will appear if there are holes)			
Drying cleaned instruments and other items	Air-dry instruments and other items or dry them with a clean towel			
	Remove all personal protective equipment			
Hand hygiene after cleaning	Wash hands for 10-15 seconds with soap and running (or poured) water Dry with a clean, individual towel or paper towel, or allow hands to air-dry OR Rub hands with 3-5 ml of an alcohol-based solution until the hands are dry (if hands are not visibly soiled)			

27. Tietjen, Linda, Débora Bossemeyer, and Noel McIntosh. *Infection Prevention: Guidelines for Healthcare Facilities with Limited Resources*. Baltimore, Md: Jhpiego Corp, 2003.

PUTTING-ON AND REMOVING GLOVES[28]

Gloves

Must be worn to avoid contact with blood, body fluids, secretions, and excretions and the transmission of infectious material found in these substances.

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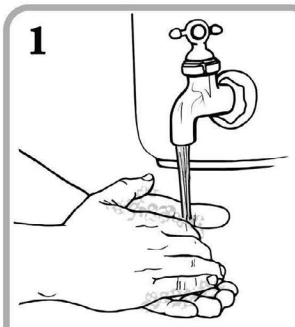
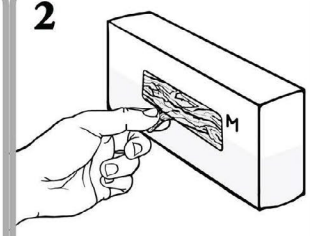
PUTTING GLOVES ON

1



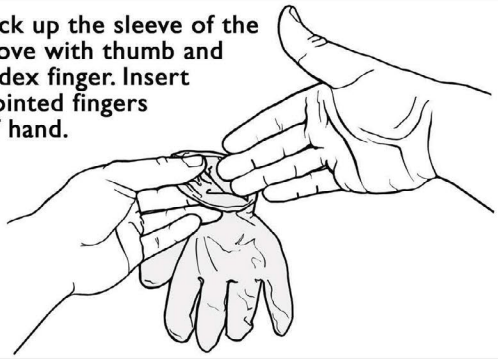
Wash hands thoroughly.

2



Select the appropriate size gloves.

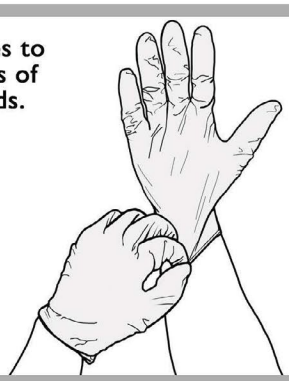
3 Pick up the sleeve of the glove with thumb and index finger. Insert pointed fingers of hand.



4 Use gloved hand to pick up second glove by lifting from underneath the inverted sleeve. Insert pointed fingers of the ungloved hand into glove.

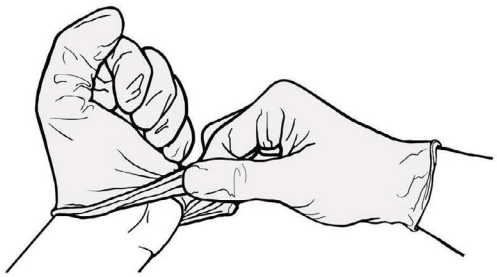
Avoid touching gloved fingers to the ungloved hand.

5 Pull gloves to the wrists of both hands.



TAKING GLOVES OFF

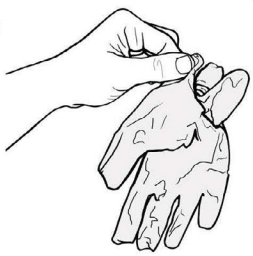
1 Remove the gloves by grasping the cuff of the other gloved hand.



2 Avoiding skin contact, peel the glove inside out towards the fingers and place it in palm of the gloved hand.

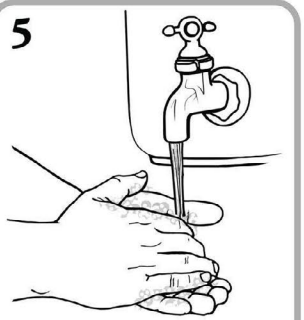
3 Lift the glove on the inside of the cuff and pull the glove inside out, towards the fingertips.

4



Dispose of both gloves by dropping them into a waste bin.

5



Wash hands thoroughly.

28. Reprinted with permission from USAID Maternal & Child Survival Program (MCSP). "Putting on and Removing Gloves," 2016.

PROVIDING LNG-IUDS WITH APPROPRIATE INFECTION PREVENTION PRACTICES[29]

INFECTION PREVENTION PRACTICES DURING LNG-IUD INSERTION AND REMOVAL

Infection prevention (IP) during insertion and removal of IUDs involves using aseptic technique and adherence to Infection Prevention practices throughout the procedures to minimize the risk of post procedure infection.

INFECTION PREVENTION TIPS: IUD INSERTION

- Exclude clients who are by history and physical examination at risk for STIs.
- Wash hands thoroughly with soap and water before and after each procedure.
- Wear examination/HLD/sterile gloves on both hands.
- When possible, have the client wash her vaginal area before the pelvic examination.
- Use high-level disinfected or sterilized instruments.
- Thoroughly clean the vaginal walls and cervix with an antiseptic solution at least two times before starting the procedure.
- Use "no-touch" technique to reduce contamination of the uterine cavity (i.e., do not pass the uterine sound or loaded IUD through the cervical os more than once).
- After completing the procedure at point of use and while still wearing gloves:
  - Wipe the used (non-disposable/ reusable) instruments with a wet cloth or soak in a bucket of tap water at point of use to remove any tissue or blood and to prevent drying of tissue or blood on the instruments before further cleaning and processing. **Note:** *Soaking of instruments for decontamination in 0.5% chlorine solution or any other disinfectant before cleaning is no longer recommended.**
  - Dispose of contaminated objects (gauze, cotton, and other waste items) in a properly marked leak-proof container with a tight-fitting lid or in a plastic bag.
  - Wipe all surfaces that could have been contaminated by blood or discharge with 0.5% chlorine solution.
  - Carefully transport the non-disposable/ reusable instruments to the processing area.
- Carefully remove gloves by inverting and place them in the appropriate waste container.

INFECTION PREVENTION FOR IUD REMOVAL SHOULD BE PERFORMED WITH SIMILAR CARE AS INSERTION

PROCESSING OF REUSABLE ITEMS:

Cleaning, Rinsing and Drying

- Wear appropriate protective attires such as, utility gloves, mask, face cover, plastic gown, covered footwear.
- Ensure all instruments are open and disassembled.
- Thoroughly clean with water, liquid soap or a mild detergent, using a soft brush, taking care to brush all teeth, joints and surfaces of instruments.
- Rinse well after cleaning to remove all detergent (some detergents can render chemical disinfectants inert).
- Dry instruments with a soft cloth or air dry before further processing.

STERILIZATION OR HIGH-LEVEL DISINFECTION (HLD) AND STORAGE:

Sterilization

- Sterilization is the preferred method for destroying all micro-organisms, including bacterial spores from instruments and other reusable items.
- Autoclave items at 121oC [250oF] and 106 kPa [15lb /in2] for 20 minutes if unwrapped and 30 minutes if wrapped.
- Unwrapped instruments must be used immediately. Wrapped instruments, gloves, and drapes can be stored for up to one week if the package remains dry and intact, one month if sealed in a plastic bag.

High-Level Disinfection

When autoclaves are not available, High-Level disinfection through boiling for 20 min is the recommended practice.

- Completely submerge cleaned items in water in a boiler or a container with a lid.
- Start timing when boiling begins. Keep at rolling boil for 20 minutes.
- Do not add or remove any item once boiling begins.
- Boiled items should be removed using HLD forceps, cool and stored in an HLD tray with a tight lid. Alternatively,
- Instruments can be soaked in a high-level disinfectant for 20 minutes (or depending on manufacturer's instructions), e.g. in 0.55% Ortho-phthaladehyde, 2% glutaraldehyde or 7.5% Hydrogen peroxide. Rinse well with HLD water and cool before use.

29. USAID, World Health Organization, and United Nations Population Fund. "Levonorgestrel Intrauterine Devices (LNG-IUDs) Handout #13: Providing LNG-IUDs With Appropriate Infection Prevention Practices." In *Training Resource Package for Family Planning*. Hormonal Intrauterine Device, 2021. fptraining.org/resources/levonorgestrel-intrauterine-devices-lng-iuds-handout-13-providing-lng-iuds-appropriate. Refer for more details to Cureless, Melanie S., Chandrakant S. Ruparelia, Elizabeth Thompson, and Polly A. Trexler. *Infection Prevention and Control: Reference Manual for Health Care Facilities with Limited Resources*. Baltimore, Maryland: Jhpiego, 2018. resources.jhpiego.org/resources/infection-prevention-and-control-reference-manual-health-care-facilities-limited-resources

* Note: Soaking of instruments in 0.5% chlorine solution or any other disinfectant before cleaning is not recommended for the following reasons: 1. It may damage/corrode the instruments. 2.The disinfectant may be inactivated by blood and body fluids, which could become a source of microbial contamination and formation of biofilm. 3. Transportation of contaminated items soaked in chemical disinfectant to the decontamination area may pose a risk to health-care workers and result in inappropriate handling and accidental damage. 4. May contribute to the development of antimicrobial resistance to disinfectants. WHO 2016.

Adapted from Blouse A, Kinzie B, McIntosh N. *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual, 3rd ed.* Baltimore, MD: JHPIEGO, 2006.
apps.who.int/iris/bitstream/handle/10665/250232/9789241549851eng.pdf;jsessionid=D1491511C20FB36BA52BC71DD829B26E?sequence=1
resources.jhpiego.org/system/files/resources/IPC_M6_Instruments.pdf

INFECTION PREVENTION PRACTICES FOR CONTRACEPTIVE IMPLANT INSERTION AND REMOVAL SERVICES[30]

- Insertion and removal of rod/rods are minor surgical procedures and careful infection prevention procedures must be followed with every client.
- Infection prevention (IP) during insertion and removal involves using aseptic technique throughout the procedures.
- Adherence to IP practices minimizes the chance of blood-borne infections such as HIV and hepatitis B and of infections at the insertion site that may require early removal or spontaneous expulsion of rod/rods.
- Soaking of instruments for decontamination in 0.5% chlorine solution or any other disinfectant before cleaning is not recommended-WHO 2016
- Reusable instruments such as scalpels and needles are cleaned thoroughly, dried and then processed by sterilization in an autoclave or high-level disinfected.

Getting Ready
1. Have the woman wash her entire arm (in which the implant will be inserted) with soap and water, rinse well, and dry with a clean towel or air-dry.
2. Cover the procedure table and arm support with a clean cloth.
3. Prepare a clean instrument tray and open the sterile instrument pack without touching the instruments or other items.
4. Before Insertion: For *Jadelle* carefully open the sterile pouch containing the rods by pulling apart the sheets of the pouch and, without touching the rods, allowing them to fall into a sterile cup or bowl. For *Implanon NXT*, remove sterile applicator with preloaded implant from the package by allowing it to fall on the sterile tray without touching it.
Before Procedure
5. Wash hands thoroughly with soap and water and dry with clean towel or air-dry.
6. Clean the procedure site thoroughly with a cotton or gauze soaked in antiseptic solution and held in a sterile or high-level disinfected forceps.
7. Put sterile or high-level disinfected gloves on both hands.
8. Use sterile surgical/clean drape with a hole in it to cover the arm.
9. When giving local anesthetic, use a new disposable syringe and needle.
10. During Insertion: *Two Rod Implant:* To minimize risk of infection and/or expulsion, make sure that the ends of the rods nearest to the incision are not too close (not less than 5 mm) to the incision. If the tip of the rod protrudes from or is too close to the incision, it should be carefully removed and reinserted in the proper position. *Implanon NXT:* If the rod falls out of the needle accidentally or if otherwise contaminated, use a new package with a new sterile applicator.
After Procedure
11. Clean the area around the procedure site with antiseptic solution on a swab.
12. Apply a sterile gauze with a surgical tape over the site and then wrap arm with a pressure bandage.

30. USAID, World Health Organization, and United Nations Population Fund. "Implants Handout #12: Checklist: Providing Implants, With Appropriate Infection Prevention Practices." In *Training Resource Package for Family Planning. Contraceptive Implants*, 2018. fptraining.org/resources/implants-handout-12-checklist-providing-implants-appropriate-infection-prevention. Refer for more details to Cureless, Melanie S., Chandrakant S. Ruparelia, Elizabeth Thompson, and Polly A. Trexler. *Infection Prevention and Control: Reference Manual for Health Care Facilities with Limited Resources*. Baltimore, Maryland: Jhpiego, 2018. resources.jhpiego.org/resources/infection-prevention-and-control-reference-manual-health-care-facilities-limited-resources

13. While still wearing gloves · After Insertion: Dispose the single use applicator for Implanon NXT and single use trocar for Jadelle, and syringe and needle in a sharp's container. · After Removal; Dispose the removed rod/s as per local guidelines. · Wipe the non-disposable instruments with a wet cloth or soak in water at point of use to remove any tissue or blood before further cleaning and processing. · Dispose of contaminated objects (gauze, cotton, and other waste items) in a properly marked leak-proof container with a tight-fitting lid or in a plastic bag. · Decontaminate all surfaces that could have been contaminated by blood, such as the procedure table or instrument stand, by wiping them down with 0.5% chlorine solution.
14. Carefully remove gloves by inverting and place them in the waste container.
15. Wash hands with soap and water and dry with clean towel or air-dry.
Processing of re-usable items
16. Carefully transport the pre-cleaned instruments from point of use to the processing area.
17. Thoroughly clean instruments with a brush, using water and either liquid soap or detergent.
18. While cleaning, wear appropriate PPE such as utility gloves, mask, eye cover, plastic apron.
19. Rinse and dry the items.
20. Sterilize instruments and gloves in a steam autoclave at15lbs pressure, 121°C for 20 mins for unwrapped and 30 mins for wrapped items or a dry-heat oven at 170°C for 60 mins. If sterilization is not possible or practical, high-level disinfect (HLD) them by boiling, steaming, or with chemicals for 20 minutes.
21. Cool, use unwrapped instruments immediately and wrapped items within 7 days.

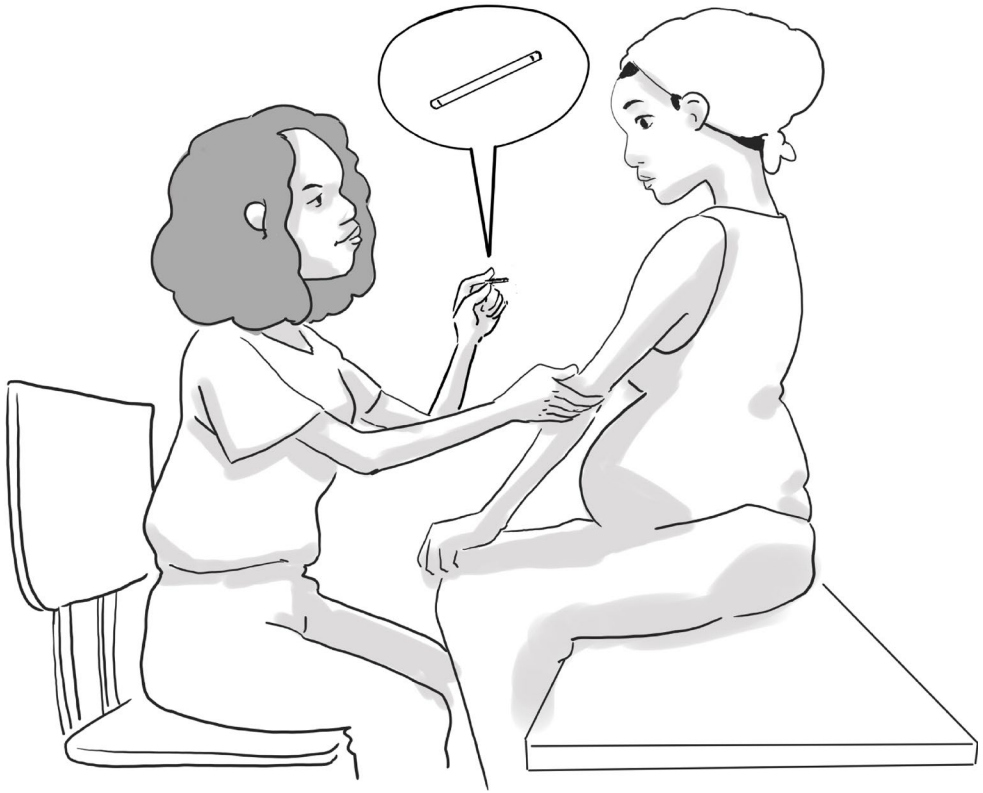
NOTES

UNIT 2

SESSION 7: PRE-PRACTICE SKILLS ASSESSMENT, VIDEO & DEMONSTRATION

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

- Review procedure checklists with the facilitator.
- Observe the demonstration steps of loading, insertion, and removal of copper IUDs in the interval period through a video and on the anatomical model using a checklist.
- Observe the demonstration steps of one-rod /two-rod Implant insertion and removal through a video and on the arm model using a checklist.



NOTES

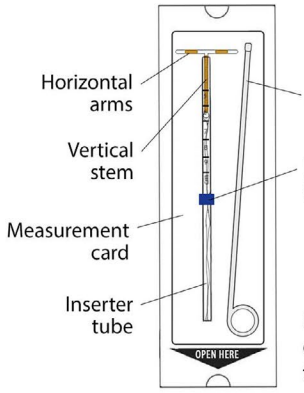
INSTRUCTIONS FOR LOADING THE COPPER T 380A IN THE STERILE PACKAGE[31]

Copper Intra-Uterine Device (Cu-T)[1]

Do not start this loading procedure more than 10 minutes before inserting into the uterus. The arms of Cu-T will not straighten out easily if they are left within inserter tube too long.

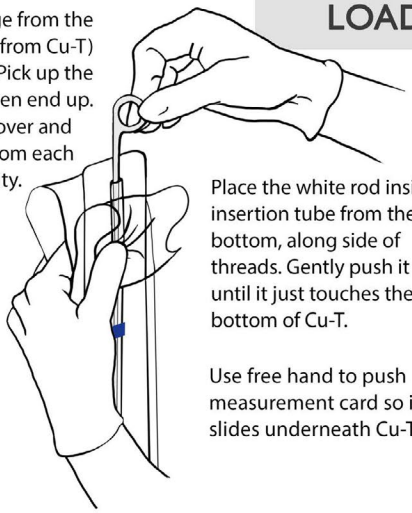
USE NO-TOUCH TECHNIQUE THROUGHOUT LOADING

1 Adjust the contents of the package through the clear plastic cover. Confirm the vertical stem of Cu-T is fully inside inserter tube.



Place the package on a clean, flat surface.

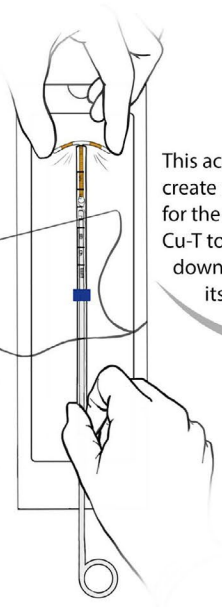
2 Open the package from the bottom (end farthest from Cu-T) one-third of the way. Pick up the package with the open end up. Bend clear plastic cover and white backing away from each other to maintain sterility.



Place the white rod inside insertion tube from the bottom, along side of threads. Gently push it up until it just touches the bottom of Cu-T.

Use free hand to push measurement card so it slides underneath Cu-T.

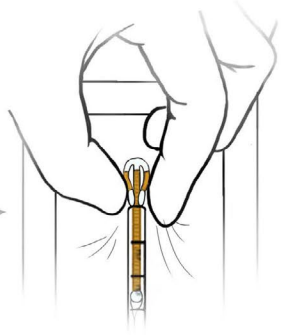
3 Through the plastic cover, stabilize Cu-T in place by putting thumb and index finger over ends of its horizontal arms.



With the other hand, push inserter tube towards Cu-T.

This action will create resistance for the arms of Cu-T to bend down towards its stem.

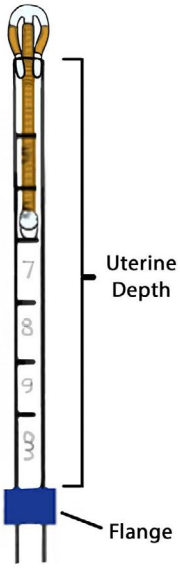
4 Fold arms enough to touch sides of inserter tube, then pull tube out slightly from under tips of arms.



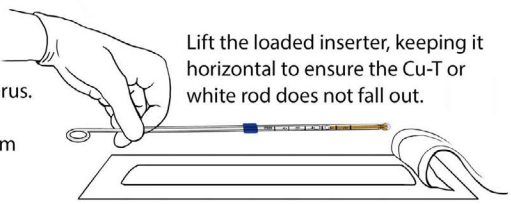
Push and rotate tube over tips of the arms only enough to retain arms inside tube next to the stem.

5 Adjust blue flange to the depth of uterus, measured with uterine sound. Ensure the longest side of the flange is parallel with arms of Cu-T.

The sterile card in package may also be used to set flange according to the premeasured uterine depth.



6 Cu-T is now ready to be placed in the woman's uterus. Carefully peel clear plastic cover of package away from the white backing.



Lift the loaded inserter, keeping it horizontal to ensure the Cu-T or white rod does not fall out.

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Maternal and Child Survival Program

Source: [1]IUD Guidelines for Family Planning Service Programs: A Problem Solving Reference Manual, 3rd edition Jhpiego

31. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Job Aid 6-5: Instructions for Loading the Copper T 380A in the Sterile Package." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*. Module 6: Copper Intrauterine Device (Copper T 380A), 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

IUD INSERTION AND REMOVAL PRACTICE CHECKLIST[32]

Participant: _____

Facilitator: _____

Instructions: Write "Yes" if the step or task is performed satisfactorily; write "No" if the step or task is not performed satisfactorily, or "N/O" if not observed.

- **SATISFACTORY:** Performs the step or task according to the standard procedure or guidelines.
- **UNSATISFACTORY:** Unable to perform the step or task according to the standard procedure or guidelines.
- **NOT OBSERVED:** Step or task or skill not performed by learner during evaluation by clinical trainer.

If IUD Insertion	Practice Session Assessment Score				
	1	2	3	4	5
1. Review the client's eligibility for IUD insertion using WHO MEC Wheel/Chart					
2. Ensure that equipment and supplies are available and ready to use					
3. Have the client empty her bladder and wash her perineal area					
4. Tell the client what is going to be done and ask her if she has any questions					
5. Wash hands thoroughly and dry them					
6. Palpate the abdomen					
7. Wash hands thoroughly and dry them again					
8. Put clean examination gloves on both hands					
9. Inspect the external genitalia *Note:* · *If findings are normal, perform the bimanual exam first and the speculum exam second* · *If there are potential problems, perform the speculum exam first and a bimanual exam second*					
10. Perform a bimanual exam (see Note above)					
11. Perform a speculum exam (see Note above) *Note: If laboratory testing is indicated and available, take samples now*					
Skill/Activity Performed Satisfactorily					

32. Bluestone J, Chase R, and Lu ER. *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual*. Third. Baltimore, Maryland: Jhpiego, 2006. resources.jhpiego.org/resources/reference-manual-iud-guidelines-family-planning-service-programs-learning-resource-package. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. *Long-Acting Reversible Contraception (LARC) Learning Resource Package*, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

Pre-Insertion and Insertion Steps (Using aseptic, "no-touch" technique throughout)	Practice Session Assessment Score				
	1	2	3	4	5
1. Provide an overview of the insertion procedure. Remind her to let you know if she feels any pain.					
2. Gently insert the HLD (or sterile) speculum to view the cervix (if not already done). Cleanse the cervical os and vaginal wall with antiseptic at least twice.					
3. Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.					
4. Insert the HLD (or sterile) sound as instructed, using the "no-touch" technique.					
5. Stop when you feel the resistance felt at the fundus. Do not try to push or overcome the resistance.					
6. Load the IUD in its sterile package using "no-touch" technique. *Note: Do not start loading more than 10 minutes before insertion*					
7. Set the blue depth-gauge to the measurement of the uterus.					
8. Carefully insert the loaded IUD and release it into the uterus using the "withdrawal" technique.					
9. Gently push the insertion tube upward again until you feel a slight resistance at the fundus. Be careful do not push the insertion tube.					
10. Withdraw the rod and partially withdraw the insertion tube until the IUD strings can be seen.					
11. Use HLD (or sterile) sharp Mayo scissors to cut the IUD strings to 3-4 cm length while still inside the inserter tube.					
12. Gently remove the tenaculum.					
13. Examine the cervix for bleeding. If no bleeding, gently remove the speculum.					
14. Ask how the client is feeling and begin performing the post-insertion steps.					
Skill/Activity Performed Satisfactorily					

Post-Insertion Steps	Practice Session Assessment Score				
	1	2	3	4	5
1. Before removing the gloves, clean any blood or secretion from the used instruments at the point-of-use before transporting them to the instrument processing area.					
2. Properly dispose of waste materials.					
3. Wash hands thoroughly and dry them.					
Skill/Activity Performed Satisfactorily					

Removing the IUD	Practice Session Number				
	1	2	3	4	5
1. Provide an overview of the removal procedure. Remind her to let you know if she feels any pain.					
2. Gently insert the HLD (or sterile) speculum to see the strings and cleanse the cervical os and vaginal wall with antiseptic twice.					
3. Alert the client immediately before you remove the IUD.					
4. Grasp the IUD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.					
5. Apply steady but gentle traction, pulling the strings toward you, to remove the IUD. **Do not use excessive force.**					
6. Show the IUD to the client.					
7. If the woman is having a new IUD inserted, insert it now if appropriate. (If she is not having a new IUD inserted, gently remove the speculum).					
8. Ask how the client is feeling and begin performing the post-removal steps.					
Skill/Activity Performed Satisfactorily					

Post-Insertion Steps	Practice Session Number				
	1	2	3	4	5
1. Before removing the gloves, clean all used instruments and the IUD at point of use before transporting them to processing area.					
2. Properly dispose of waste materials.					
3. Wash hands thoroughly and dry them.					
4. If the woman has had a new IUD inserted, review key messages for IUD users. (If the woman is starting a different method, provide the information she needs to use it safely and effectively – and a backup method, if needed)					
Skill/Activity Performed Satisfactorily					

TRAINER CERTIFICATION

Participant is: □ Qualified □ Not Qualified to deliver IUD services, based on the following criteria: _____

	With Models		With Clients	
Clinical skills performed competently:	□ Yes	□ No	□ Yes	□ No

Trainer's Signature: _____ Date: _____

ONE-ROD (NEXPLANON) IMPLANT INSERTION PRACTICE CHECKLIST[33]

Participant: _____

Facilitator: _____

Instructions: Write "Yes" if the step or task is performed satisfactorily; write "No" if the step or task is not performed satisfactorily, or "N/O" if not observed.

- **SATISFACTORY:** Performs the step or task according to the standard procedure or guidelines.
- **UNSATISFACTORY:** Unable to perform the step or task according to the standard procedure or guidelines.
- **NOT OBSERVED:** Step or task or skill not performed by learner during evaluation by clinical trainer.

Getting Ready	Practice Session Assessment Score				
	1	2	3	4	5
1. Determine that required materials and the one-rod implant are present					
2. Wash hands thoroughly and dry them completely					
3. Ask the client to thoroughly wash and rinse her arm (if water and soap are available)					
4. Tell the client what is going to be done and encourage her to ask questions					
5. Positions the woman's arm with the elbow flexed and her hand behind her head. Places a clean, dry cloth under her arm.					
6. Marks the position on the arm for insertion of rod 8-10 cm proximal to the medial epicondyle and 3-5 cm posterior to the arm sulcus, above the triceps.					
7. Put on a pair of clean examination gloves					
Skill/Activity Performed Satisfactorily					

Pre-Insertion Tasks	Practice Session Assessment Score				
	1	2	3	4	5
1. Prep insertion site with antiseptic solution					
2. Inject 1-2 mL of 1 percent lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Gently massage the area of infiltration.					
Skill/Activity Performed Satisfactorily					

33. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "One-Rod (Implanon NXT) Implant Clinical Skills: Insertion." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*. Module 10: Contraceptive Implants, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

Insertion	Practice Session Assessment Score				
	1	2	3	4	5
1. Using the "no-touch" technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)					
2. Visually verify the presence of the implant inside the metal part of the needle.					
3. Stretch the skin around the insertion site with thumb and index finger or **alternatively**, stretch the insertion site skin by slightly pulling with thumb.					
4. Using the needle, puncture the skin at a 30° angle and insert only up to the bevel of the needle.					
5. Release the skin. Lower the applicator to a horizontal position.					
6. Gently advance, while lifting the skin, forming a tent, until inserting the full-length of the needle without using force. Keep the applicator parallel to the surface of the skin.					
7. Break the seal of the applicator. Turn the obturator 90 degrees.					
8. Fix the obturator with one hand against the arm and with the other hand slowly pull the needle out of the arm; never push against the obturator.					
9. Remove the needle and apply pressure to the opening site.					
10. Palpate to check that the rod is in place.					
Skill/Activity Performed Satisfactorily					

Post-Insertion Tasks	Practice Session Number				
	1	2	3	4	5
1. Wipe the client's skin with alcohol					
2. Bring the edges of the incision together and close it using surgical tape; then cover it with a Band-Aid® or tape on a sterile gauze (2x2)					
3. Optionally, ask the client to palpate the implant prior to dressing					
4. Apply pressure dressing snugly					
5. Before removing gloves, dispose of materials by: · Placing used needle (without capping) and trocar in a sharps container · Placing waste materials in a leakproof container or plastic bag					
6. Remove gloves by turning them inside out and place them in a leakproof container or plastic bag close to the point of use					

Post-Insertion Tasks	Practice Session Number				
	1	2	3	4	5
7. Wash hands thoroughly and dry them completely					
8. Complete the client record, including drawing the position of the rod					
Skill/Activity Performed Satisfactorily					

TRAINER CERTIFICATION

Participant is: □ Qualified □ Not Qualified to deliver IUD services, based on the following criteria: _____

	With Models		With Clients	
Clinical skills performed competently:	□ Yes	□ No	□ Yes	□ No

Trainer's Signature: _____ Date: _____

NOTES

TWO-ROD IMPLANT (JADELLE AND SINO-IMPLANT [II]/LEVOPLANT) INSERTION PRACTICE CHECKLIST[34]

Participant: _____

Facilitator: _____

Instructions: Write "Yes" if the step or task is performed satisfactorily; write "No" if the step or task is not performed satisfactorily, or "N/O" if not observed.

- **SATISFACTORY:** Performs the step or task according to the standard procedure or guidelines.
- **UNSATISFACTORY:** Unable to perform the step or task according to the standard procedure or guidelines.
- **NOT OBSERVED:** Step or task or skill not performed by learner during evaluation by clinical trainer.

Getting Ready	Practice Session Assessment Score				
	1	2	3	4	5
1. Determine that the required sterile or high-level disinfected instruments and the two implant rods are present					
2. Wash hands thoroughly and dry them completely					
3. Ask the client to thoroughly wash and rinse her arm with soap and water (if soap and water available)					
4. Tell the client what you are going to do and encourage her to ask questions					
5. Position the woman's arm and place a clean, dry cloth under her arm					
6. Mark the position on the client's arm for insertion of rods 6cm to 8cm above the elbow fold (this should form a "V" pattern)					
7. Put on a pair of sterile gloves					
Skill/Activity Performed Satisfactorily					

34. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Checklist 10-6: Two-Rod Implant Insertion Clinical Skills: Insertion." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*. Module 10: Contraceptive Implants, 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

Pre-Insertion Tasks	Practice Session Assessment Score				
	1	2	3	4	5
1. Set up the sterile field and place the implant rods and trocar on it					
2. Prep the insertion site with antiseptic solution					
3. Place a sterile or high-level disinfected drape over the client's arm (optional)					
4. Inject 2 mL of 1 percent lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5cm along the insertion track. Inject 1 mL of local anesthetic along the track as you withdraw					
5. Without removing the needle, reorient to the second insertion track, advance up to 5 cm and again inject 1 mL of local anesthetic along the track as you withdraw the needle. Gently massage the area of infiltration					
Skill/Activity Performed Satisfactorily					

Insertion	Practice Session Assessment Score				
	1	2	3	4	5
1. Insert the trocar directly (sub-dermally and superficially)					
2. While tenting the skin, advance the trocar and plunger to mark (1) nearest the hub of the trocar					
3. Remove the plunger and load the first rod into the trocar with gloved hand or forceps					
4. Reinsert the plunger and advance it until you feel resistance					
5. Hold the plunger firmly in place with one hand and slide the trocar out of the incision until it reaches the plunger handle					
6. Withdraw the trocar and plunger together until mark (2) nearest the trocar tip, just clear of incision (do not remove the trocar from the skin)					
7. Move the tip of the trocar away from the end of the rod and hold the rod out of the path of the trocar					
8. Redirect the trocar about 15° and advance the trocar and plunger to mark (1)					
9. Insert the second rod using the same technique					
10. Palpate the rods to check that two rods have been inserted in a V-distribution					
11. Palpate the incision to check that both rods are 5 mm clear of the incision					
12. Remove the trocar only after insertion of the second rod					
Skill/Activity Performed Satisfactorily					

Post-Insertion Tasks	Practice Session Assessment Score				
	1	2	3	4	5
1. Remove the drape and wipe the client's skin with alcohol					
2. Bring the edges of the incision together and close it using surgical tape; then cover it with a Band-Aid® or tape on a sterile gauze (2x2)					
3. Optionally, ask the client to palpate the two rods prior to dressing					
4. Apply the pressure dressing snugly					
5. Before removing gloves, dispose of materials at the point of use by: · Placing the used needle (without capping) and the trocar in a sharps container, and · Placing the waste materials in a leakproof container or plastic bag					
6. Remove gloves by turning them inside out and place them in a leakproof container or plastic bag					
7. Wash hands thoroughly and dry them completely					
8. Complete the client record, including drawing the position of the rods					
Skill/Activity Performed Satisfactorily					

TRAINER CERTIFICATION

Participant is: ☐ Qualified ☐ Not Qualified to deliver IUD services, based on the following criteria: _____

	With Models		With Clients	
Clinical skills performed competently:	☐ Yes	☐ No	☐ Yes	☐ No

Trainer's Signature: _____ Date: _____

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_____ _____
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STANDARD IMPLANT REMOVAL CHECKLIST[35]

Participant: _____

Facilitator: _____

Instructions: Write "Yes" if the step or task is performed satisfactorily; write "No" if the step or task is not performed satisfactorily, or "N/O" if not observed.

- **SATISFACTORY:** Performs the step or task according to the standard procedure or guidelines.
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Before the Implant Removal	Practice Session Assessment Score				
	1	2	3	4	5
1. Greet the client respectfully and with kindness					
2. Listen carefully to the client's response for reason for removal to determine if she wants another method, is hoping to get pregnant, or wants to replace her implant					
3. Confirm with the client what her intentions are. Provide family planning counseling, if appropriate.					
4. Describe the removal procedure and what to expect. If she intends to have another implant, discuss with her where it will be inserted.					
5. Ensure that the client is not allergic to the topical antiseptic or the local anesthetic that is available					
Skill/Activity Performed Satisfactorily					

35. Family Planning Division Ministy of Health and Family Welfare, Government of India. *Postpartum Intrauterine Contraceptive Device (PPIUCD): Reference Manual*. New Delhi, India: Jhpiego, 2010. resources.jhpiego.org/resources/postpartum-intrauterine-contraceptive-device-ppiucd-reference-manual

Getting Ready	Practice Session Assessment Score				
	1	2	3	4	5
1. Determine that sterile instruments and other required materials for removal are available. Make sure new implants are available if reinserting new implants					
2. Check that the client has thoroughly washed and rinsed her arm					
3. Tell the client what is going to be done and encourage her to ask questions					
4. Position the woman's arm and place a clean, dry cloth under her arm *If removing an Implanon NXT rod which was inserted into the new location above the triceps, place the woman's hand behind her head*					
5. Palpate the rod(s) to determine the point for removal *In case of Nexplanon notes that it may be necessary to palpate both possible insertion sites (the prior site over the sulcus and the new site 3-5 cm posterior, over the triceps) to locate the rod*					
6. With a waterproof marker, mark the client's arm where the tip of the rod(s) is palpated					
Skill/Activity Performed Satisfactorily					

Pre-Removal Tasks	Practice Session Assessment Score				
	1	2	3	4	5
1. Wash hands thoroughly and dry them completely					
2. Put sterile gloves on both hands					
3. Arrange instruments and supplies					
4. Prep removal site with antiseptic solution twice					
5. Inject a small amount of local anesthetic (1% without epinephrine) at the incision site and under the end of the rod(s)					
6. Check for anesthetic effect before making skin incision					
Skill/Activity Performed Satisfactorily					

Implant Removal	Practice Session Assessment Score				
	1	2	3	4	5
1. Push down the proximal end of the implant to stabilize it; a bulge may appear indicating the distal end of the implant					
2. Make a small (2mm) incision below the end of the rod					
3. Push the end of the rod toward the incision to remove it					
4. Grasp the end of the rod with a curved (mosquito or Crile) forceps					
5. Use sterile gauze (or scalpel—dull side) to clean off the fibrous tissue sheath that covers the tip of the rod					
6. Grasp the exposed end of the rod with a second forcep; gently remove and inspect to ensure that the rod is intact before placing it in a bowl containing 0.5% chlorine solution for decontamination*					
7. Ensure that the **complete** rod has been removed; show it to the client					
8. If this is a two-rod system, repeat steps 1-7					
Skill/Activity Performed Satisfactorily					

Note: WHO's 2016 Infection Prevention Guidelines no longer recommend soaking instruments in disinfectant prior to cleaning. Please refer to in-country guidelines for this step.

Re-Inserting Implant (one or two rods)	Practice Session Assessment Score				
	1	2	3	4	5
1. The new implant rod(s) can be re-inserted along the same track as the recently removed implant (if the woman choses to have a new implant inserted)					
2. Provide additional local anesthesia by infiltrating 1% lidocaine along the track(s) of the previously removed implant rods					
3. Wait for 1–2 minutes for the anesthetics to take effect					
4. Insert the one- or two-rod implant as per insertion steps (including post-insertion steps and post-insertion counseling)					
Skill/Activity Performed Satisfactorily					

Post-Removal Tasks	Practice Session Assessment Score				
	1	2	3	4	5
1. Wipe the client's skin with an antiseptic					
2. Bring the edges of the incision together and close it using surgical tape; then cover it with a Band-Aid® or tape on a sterile gauze (2x2)					
3. Apply pressure dressing snugly					
4. Before removing gloves, dispose of materials by: · Placing the used needle (without capping) and the trocar in a sharps container, and · Placing waste materials in a leakproof container or plastic bag					
5. Remove gloves by turning them inside out and place them in a leakproof container or plastic bag					
6. Wash hands thoroughly and dry them completely					
7. Complete the client record					
Skill/Activity Performed Satisfactorily					

Post-Removal Counseling	Practice Session Assessment Score				
	1	2	3	4	5
1. Instruct the client about wound care and make a return visit appointment, if needed					
2. Discuss what to do if any problems occur and answer any questions					
3. Counsel the client about a new contraceptive method and provide one, if desired					
4. Observe the client for at least 15-20 minutes before sending her home					
Skill/Activity Performed Satisfactorily					

TRAINER CERTIFICATION

Participant is: □ Qualified □ Not Qualified to deliver IUD services, based on the following criteria: _____

	With Models		With Clients	
Clinical skills performed competently:	□ Yes	□ No	□ Yes	□ No

Trainer's Signature: _____ Date: _____

UNIT 2

SESSION 8: SKILLS LAB – IUD AND IMPLANT INSERTION AND REMOVAL PRACTICE

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

- Practice correct steps of loading a Copper T 380A in its sterile package correctly using the "no-touch" technique.
- Practice correct steps of insertion and removal of copper IUD on an anatomical model using a checklist.
- Practice correct steps of insertion and removal of one-rod/two-rod implants on an arm model using a checklist.

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UNIT 3

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

- Self-assess and understand how providers' opinions, values, and attitudes can affect, positively or negatively, their relationships with their clients.
- Manage common side effects and potential complications with LARC methods.
- Address rumors and common misconceptions about IUDs and implants.
- Practice and assess skills for how to insert and remove the IUD and implant correctly on a model.
- Develop an action plan for post-training follow-up and service provision.

DAY 3 SESSIONS

SESSON 9
VALUES CLARIFICATION AND EXAMINING ATTITUDES

↓

SESSION 10
MANAGING SIDE EFFECTS AND POTENTIAL COMPLICATIONS, AND ADDRESSING MYTHS AND RUMORS ABOUT LARC METHODS

↓

SESSION 11
SKILLS LAB - IUD AND IMPLANT INSERTION AND REMOVAL PRACTICE

↓

SESSION 12
KNOWLEDGE AND POST-PRACTICE SKILLS ASSESSMENT

↓

SESSION 13
NEXT STEPS AND CLOSING

NOTES

SESSION 9: VALUES CLARIFICATION AND EXAMINING ATTITUDES

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

- Comprehend how the provider's opinions, values, and attitudes can affect, positively or negatively, their relationship with the client.
- Become aware of their own beliefs, values, and attitudes to avoid imposing them on the client or obstructing communication.

NOTES

WHAT ARE MY VALUES?

WHY DO MY VALUES MATTER?

SESSION 10: MANAGING SIDE EFFECTS AND POTENTIAL COMPLICATIONS, AND ADDRESSING MYTHS AND RUMORS ABOUT LARC METHODS

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

- Manage common side effects and potential complications with LARC methods.
- Address rumors and misconceptions associated with IUDs and implants.

NOTES

COMMON SIDE EFFECTS: IUDs

COMMON SIDE EFFECTS: IMPLANTS

MANAGING SIDE EFFECTS AND POTENTIAL COMPLICATIONS OF IUDs[36]

Thorough counseling about bleeding changes and some cramping following insertion must be done prior to IUD insertion. Counseling about bleeding changes may be the most important message to help a woman to keep using the method.

COMMON SIDE EFFECTS

Changes in bleeding pattern: Prolonged and heavy monthly bleeding, irregular bleeding, cramps and pain during monthly bleeding.

Explain these side effects to clients:

- Bleeding changes are not a sign of illness
- Usually subside after the first few (3–6) months
- Client can come back anytime if side effects are bothersome

MANAGEMENT OF COMMON SIDE EFFECTS

For change in menstrual bleeding patterns, manage as appropriate based on findings:

- If bleeding is mild and less than three months after insertion and no evidence of any pathology or pregnancy, reassure the client that this is not harmful and usually subsides on its own. Give iron and folic acid tabs for a month.
- If menstrual bleeding lasts twice as long or is twice as heavy than usual, refer to a doctor or specialist for further evaluation and treatment.
  - For modest, short-term relief – provide tranexamic acid tabs 500 mg three times daily (total of 1500 mg daily) for three days, then 1,000 mg once daily for two days,

36. Source: Reprinted with permission from USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Handout 6-4: Managing Side-Effects and Potential Complications of IUDs." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package*. Module 6: Copper Intrauterine Device (Copper T 380A), 2017. resources.jhpiego.org/resources/Modular_LARC_LRP

beginning when heavy bleeding starts. Alternatively, you may provide nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen 600-800 mg orally, three times a day with food for five days beginning when heavy bleeding starts.
  - Provide iron tablets and tell her it is important for her to eat iron-rich foods.

If her menstrual bleeding changes have continued beyond 3-6 months after IUD insertion and a gynecologic problem is suspected, refer to a doctor or specialist for further evaluation and treatment.

- Irregular bleeding (bleeding at unexpected times that bothers the client):
  - Reassure the client that many other IUD users experience irregular bleeding. It is not harmful and usually diminishes or stops after the first several months of use.
  - For modest, short-term relief – provide NSAIDs such as ibuprofen (600 mg-800 mg) or indomethacin (25 mg) two times daily after meals for five days.
  - If her menstrual bleeding changes are very bothersome to the woman and she wishes to have the IUD removed, remove it and counsel her for other methods and give her another method of her choice.

CRAMPING AND PAIN

Increased cramping or pain associated with menstruation is another common side effect among users of copper-bearing IUDs.

- If these symptoms are bothersome, severe, or associated with other signs/symptoms that suggest they are not related to menstruation, refer or conduct appropriate assessment (including pelvic examination) to identify or rule out other possible causes of the symptoms, such as infection, partial IUD expulsion, uterine perforation, and pregnancy/ectopic pregnancy.
- When other possible causes of the symptoms are ruled out, manage as appropriate based on findings. If cramping or pain, provide reassurance and recommend paracetamol (500 mg every 4-6 hours) or another NSAID immediately before and during menstruation to help reduce symptoms. If it persists, remove the IUD. Give her another method of her choice.

POTENTIAL COMPLICATIONS OF AN IUD:

Most of the IUD insertion-related complications can be prevented by careful screening of clients, strict adherence to correct infection prevention techniques and meticulous attention to standard insertion technique.

Potential Complications of an IUD

Complications	Risk	Linked to	Reduced through	Management
Perforation	Very Rare	Skill and experience of provider	Supervised training and using correct insertion technique	Usually occurs during insertion and usually heals without treatment. Stop the procedure immediately and gently remove the instruments. Keep client under observation for approximately 2 hours, and monitor vital signs. Look for signs of shock, if she is having severe pain, fainting, rapid pulse, low blood pressure. Manage for shock immediately. If not recovering and symptoms aggravating, refer immediately to higher level facility for management and ultrasound. Advise follow-up in a week, or as needed. If uterine perforation is suspected within 6 weeks after insertion, or if it is suspected later and is causing symptoms, refer the client for management and ultrasound to a clinician experienced at removing such IUDs.
Infection	Rare	Lack of infection prevention practices during insertion	Use of aseptic and "no-touch" techniques	Assess vital signs, abdominal and pelvic examination, and appropriate laboratory tests (pregnancy test, CBC, cultures) to rule out other problems: endometritis; appendicitis; partial IUCD expulsion; uterine perforation; pregnancy/ectopic pregnancy; or urinary tract infection. Begin treatment immediately with an appropriate antibiotic. If diagnosis of pelvic inflammatory disease (PID) confirmed, treat or refer immediately; give appropriate antibiotic therapy; no need to remove IUD if she wants to continue using it.
Expulsion	Rare	Provider's skill	Careful screening, examination, and insertion technique (fundal placement)	Do an assessment including pelvic examination to rule out pregnancy If complete expulsion of the IUD is confirmed (e.g., seen by the woman, confirmed by X-ray or ultrasound): insert IUD if desired after assessing the client for excluding pregnancy and infection or counsel for another family planning method. If IUD is found outside uterine cavity: refer her immediately for further management by an expert. If partial IUD expulsion is confirmed (e.g., felt/seen by the woman or clinician): remove the IUD and provide another IUD if desired and appropriate (not pregnant or infected) or counsel for another family planning method. If the IUD appears to be embedded in the cervical canal and cannot be easily removed by the standard technique, refer the woman for IUD removal to a specialist. Note: Ultrasound is never recommended as a routine for placement under normal conditions.

Complications	Risk	Linked to	Reduced through	Management
Pregnancy with IUD in situ	Rare	Failures occur with IUD in position. Undetected existing pregnancy prior to insertion, partial expulsion.	Careful screening to rule out early pregnancy and proper insertion technique (fundal placement)	If a woman is diagnosed with pregnancy with IUD in situ, rule out ectopic pregnancy When ectopic pregnancy has been ruled out, and if the pregnancy is in the first trimester: Counsel the woman on the risks of immediate removal of the IUD: removing the IUD slightly increases the risk of abortion; and leaving the IUD in place can cause second trimester abortion, infection, and preterm delivery. If the woman requests removal, proceed with immediate removal if the strings are visible and the pregnancy is in the first trimester. If the strings are not visible, do an ultrasound to determine whether the IUD is still in the uterus or has been expelled. If the IUD is still in place, do not try to remove it. If the woman declines removal, provide antenatal care, close monitoring of the pregnancy by a qualified provider. Stress the importance of returning to the clinic immediately if she experiences signs of spontaneous abortion or infection (e.g., fever, low abdominal pain, and/or bleeding) or any other warning signs. Ensure that IUD is removed at delivery.
Missing Thread				Rule out pregnancy. Conduct speculum examination to visualize thread; if not visible, then conduct X-ray/ultrasound for localization of the IUD. Once pregnancy has been ruled out: Probe the cervical canal using a high-level disinfected (or sterile) long artery forceps or cyto-brush to locate the strings, and gently draw them out so that they are protruding into the vaginal canal. If the strings are not located in the cervical canal (or cannot be drawn out), and the woman does not want to keep the IUD, refer her for IUD removal by a specially trained provider. A specially trained provider can do an ultrasound to check whether the IUD is in place or has been expelled. If the IUD is still in place, the strings can be drawn out using a long artery forceps or alligator forceps.

Sources: WHO, JHSPH, USAID. *Family Planning: A Global Handbook for Providers*. Geneva: WHO, 2011; Bluestone J, Chase R, Lu ER, eds. *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual.* Third Edition. Baltimore, MD: Jhpiego, 2006. *IUCD Reference Manual for Medical Officers and Nursing Personnel, September 2013, MOHFW Govt of India.*

MANAGING OF SIDE EFFECTS AND POTENTIAL COMPLICATIONS OF IMPLANTS[37]

MANAGEMENT OF VAGINAL BLEEDING PROBLEMS

Irregular bleeding and prolonged spotting or bleeding (eight days or more) are common and expected in contraceptive implant users—over 65 percent experienced this during the first year. In addition, moderate menstrual bleeding more than twice as long as a normal menses occurs in 20%–30% of implants users during the first three to six months.

For a woman with prolonged spotting or moderate bleeding, the first approach should be counseling and reassurance. It should be explained that in the absence of other causes (e.g., cervicitis or cervical polyp), this type of bleeding is not harmful, even if it is prolonged for several weeks. Furthermore, these prolonged bleeding or spotting episodes typically become lighter and shorter in succeeding months.

MANAGEMENT OF IRREGULAR BLEEDING

Reassure the woman, if she is still unhappy with the irregular bleeding but wants to continue using two-rod implants, she may try a short course (1–3 cycles) of combined oral contraceptives (COCs), using:

- A low-dose COC (30–35 µg ethynyl estradiol [EE]) once daily for 21 days.

If COCs are not appropriate for personal or medical reasons, try:

- Ibuprofen (or another non-steroidal anti-inflammatory drug [NSAID]) up to 800 mg, three times daily after meals for five days.

COCs control or stop bleeding by rebuilding the endometrium, while ibuprofen, which blocks prostaglandin synthesis, decreases uterine contractions and blood flow to the endometrium.

MANAGEMENT OF HEAVY BLEEDING

Heavy bleeding (twice as long or twice as much as normal) is very uncommon with contraceptive implants. If it happens, manage with low-dose COCs (with or without ibuprofen).

If the bleeding is not reduced in 3-5 days or is much heavier (1-2 pads or cloths per hour):

- Determine whether there are other causes for the uterine bleeding
- Give 2 low-dose COC pills per day for the remainder of the cycle (at least 3-7 days), followed by one cycle (1 pill per day) of COCs
- Alternatively (if available), give a 50 µg EE-containing COC or 1.25 mg conjugated estrogen (Premarin®) for 14-21 days

Note: Check to be sure vaginal bleeding has decreased within three days.
If COCs or estrogens fail to correct the bleeding problem, the implants may need to be removed for medical reasons (excessive bleeding) or to comply with the client's wishes.

Do not perform a dilation and curettage procedure unless another medical condition (e.g., endometrial polyp or incomplete abortion) is suspected. (If uterine evacuation is necessary, manual vacuum aspiration, not a dilation and curettage procedure, is the preferred method for emptying the uterine cavity.)

For anemia, give nutritional advice on the need to increase iron intake. Use oral iron treatment (one tablet containing at least 100 mg elemental iron, FeSO4, daily for one to three months) if hemoglobin ≤9 g/dl or hematocrit ≤27.

It is also possible that the woman is experiencing amenorrhea, or the absence of monthly bleeding. In this case, first rule out possible pregnancy. Once it is established that she is not pregnant, you should reassure her that her reproductive system is still functioning normally and that the absence of monthly bleeding will not cause problems.

37. USAID Maternal & Child Survival Program (MCSP), and Jhpiego. "Handout 10-6: Management of Side-Effects and Potential Problems." In *Long-Acting Reversible Contraception (LARC) Learning Resource Package.* Module 10: Contraceptive Implants, 2017. http://resources.jhpiego.org/resources/Modular_LARC_LRP

MANAGEMENT OF OTHER SIDE EFFECTS

Problem	Assessment	Management
Acne	Ask how and how often she cleans her face. Ask if she is under great stress.	In some women, use of implants can make acne worse. Recommend cleaning the face twice a day and avoiding use of heavy facial creams. Counsel as appropriate. If the condition is not tolerable, help the client choose another (non-hormonal) method.
Breast fullness or tenderness (mastalgia)	• Check breasts for: lumps, cysts and discharge or galactorrhea (leakage of milk-like fluid), if not breastfeeding. • If she is breastfeeding and breast(s) is tender, examine for breast infection.	• If physical examination shows lump or discharge suspicious for cancer (e.g., firm, non-tender or fixed and does not change during menstrual cycle), refer to appropriate source for diagnosis. If no abnormality, reassure. • If breast(s) is not infected, recommend a bra that provides additional support. • If breast infection is present, use warm compresses and advise to continue breastfeeding. Give antibiotics as appropriate. • For any of the above conditions, do not remove rods/capsules unless the client requests it after counseling.
Chest pain (especially if it occurs with exercise)	Assess for possible cardiovascular disease (CVD). Also, check blood pressure (BP) and heart for irregular beats (arrhythmias).	If evidence for CVD, refer for further evaluation. Low-dose progestins do not increase the risk of CVD; therefore, removal of implants is not necessary unless the client requests it.
Mood changes, loss of interest in sex, depressive symptoms	Discuss changes in mood or libido.	Depression and loss of interest in sex may both be associated with use of hormonal contraception; therefore, if the client is exhibiting depressive symptoms or she thinks her depression has worsened, help to explore available options (e.g., seeking treatment for depression and/or choosing a different method that is non-hormonal).
Excess hair growth (hirsutism) or hair loss	Review history, before and after insertion.	Pre-existing conditions such as excess facial or body hair might be worsened by use of implants. Changes usually are not excessive, may improve over time and do not require rod/capsule removal unless the client requests it after counseling.
Headache	Ask if there has been a change in pattern or severity of headaches since insertion of implants.	If headaches are mild or moderate and without aura, treat with analgesics and reassure. Re-evaluate after one month if mild headaches persist. If client feels uncomfortable and insists on removal, then remove it.
Migraine with aura (also known as headache with visual and/or auditory effects)	Ask if there has been a change in pattern or severity of headaches since insertion of implants.	If headaches are preceded or accompanied by aura, and/or with numbness or tingling, loss of speech, visual changes, or blurred vision, remove implants and help client choose another (non-hormonal) method.
High BP (>160/100 mm Hg)	• Ask if this is the first time anyone has told her she has high BP. • Ideally, ask the client to return in 24 hours and repeat the BP reading. • If unable to return, ask the client to lie down and rest in a quiet area and then reassess BP in 30 minutes.	• Counsel client that a mild increase in BP (<160/100) does not require removal of implants unless requested. If requested, help the client choose another method. In addition, tell her that high BP usually goes away within 1-3 months. Take BP monthly to be sure it returns to normal. If after three months it has not returned to normal, refer for further evaluation. • If BP is >160/100 or the client has arterial vascular problems (e.g., heart attack, stroke, kidney failure or retinopathy), then remove the implants. Help the client choose another method.

MANAGEMENT OF OTHER SIDE EFFECTS (CONT.)

Problem	Assessment	Management
Rod/capsule coming out	Check for partial or complete expulsion of rod(s)/capsule(s).	• Remove partially expelled rod(s)/capsule(s). Check to determine if remaining rod(s)/capsule(s) are in place. • If the area of insertion is not infected (no pain, heat and redness), replace the rod/capsule. • If the area of insertion is infected: · Remove the remaining rod(s)/capsule(s), · Insert a new set in the other arm, or · Help the client choose another method.
Infection at the insertion site	Check the area of insertion for infection (pain, heat and redness), pus or abscess.	• If infection (not abscess), clean the area with antiseptic solution and give an appropriate oral antibiotic for seven days. • Do not remove the rod(s)/capsule(s). Ask the client to return after one week. If no improvement, remove the rod(s)/capsule(s) and insert a new set in the other arm or help the client choose another method. • If abscess: · Prep with antiseptic. · Incise and drain. · Do not remove rod(s)/capsule(s). · Perform daily wound care. · Give oral antibiotics for seven days. • Remove the implant if infection does not subside.
"Missing" rod(s)/capsule(s)	Usually due to rod(s)/capsule(s) being inserted too deep (not palpable) or rarely, a rod/capsule is spontaneously expelled and forgotten by the client.	Can be detected by sonography (or for Implanon NXT, by X-ray). If regular sonography is used, the focal length needs to be increased to about 15cm to focus accurately. Rods/capsules are best seen in cross-section (transverse) as a shadow (echo-free area) underneath each rod/capsule. If all rods or capsules are present, note this in the client's chart. If implants are deep and difficult removal is expected, then an expert in implants removal should be consulted.
Jaundice	• Acute jaundice occurring after insertion is not method-related. • Check for: · Active liver disease (hepatitis) · Gall bladder disease · Benign or malignant liver tumors	Limited studies suggest no significant elevation of liver enzymes. Further medical evaluation is recommended to rule out liver and/or gallbladder disease.
Nausea, dizziness and/or vomiting	Check for pregnancy by checking symptoms, performing a pelvic examination (speculum and bimanual), and a pregnancy test (if indicated and available).	If not pregnant, reassure that this is not a serious problem and that these symptoms usually disappear with time.
Thromboembolic disorders (including blood clots in legs, lungs or eyes)	Assess for active blood clotting problem.	Levonorgestrel implants do not increase the risk of blood clotting problems; therefore, remove rod(s)/capsule(s) only at client's request. If there is strong evidence of a blood clotting disorder, refer for further evaluation.

COUNTERACTING RUMORS AND MISCONCEPTIONS ABOUT IUDs[38]

Rumors are **unconfirmed** stories that are transferred from one person to another by word-of-mouth.

In general, rumors arise when:

- An issue or information is important to people, but it has not been clearly explained
- There is nobody available who can clarify or correct the incorrect information
- The original source is perceived to be credible
- Clients have not been given enough options for contraceptive methods
- People are motivated to spread them for political reasons

A **misconception** is a **mistaken interpretation of ideas or information**. If a misconception is imbued with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumor.

Unfortunately, rumors or misconceptions are sometimes spread by health workers who may be misinformed about certain methods or who have religious or cultural beliefs pertaining to family planning that they allow to have an impact on their professional conduct.

The **underlying causes** of rumors have to do with people's knowledge and understanding of their bodies, health, medicine, and the world around them. Often, rumors and misconceptions about family planning make rational sense to clients and potential clients. **Immediate causes** (e.g., confusion about anatomy and physiology) are usually the basis for people's belief in a given rumor or piece of misinformation.

METHODS FOR COUNTERACTING RUMORS AND MISINFORMATION

1. When a client mentions a rumor, always listen politely. Do not laugh.
2. Define what a rumor or misconception is.
3. Find out where the rumor came from and talk with the people who started it or repeated it. Check whether there is some basis for the rumor.
4. Explain the facts.
5. Use strong scientific facts about family planning methods to counteract misinformation.
6. Always tell the truth. Never try to hide side effects or problems that might occur with various methods.
7. Clarify information with the use of demonstrations and visual aids.
8. Give examples of people who are satisfied users of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
9. Reassure the client by examining her and telling her your findings.
10. Counsel the client about all available family planning methods.
11. Reassure and let the client know that you care by conducting home visits.

Rumor or Misinformation	Facts and Realities: Information to Combat Rumors
The thread of the IUD can trap the penis during intercourse.	The strings of the IUD are soft and flexible, cling to the walls of the vagina, and are rarely felt during intercourse. If the string is felt, it can be cut very short (leaving just enough string to be able to grasp with a forceps). The IUD cannot trap the penis because the IUD is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot injure it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.)
A woman who has an IUD cannot do heavy work.	Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD.
The IUD might travel inside a woman's body to her heart or her brain.	• There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and—unless it is accidentally expelled—stays there until a trained health care provider removes it. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. • The provider can teach the client how to feel for the string, if the client is comfortable doing so.

38. Solter, Cathy. "Participant Handout 1.6.1: Rumors and Misconceptions." In *Intrauterine Devices (IUDs): Trainer's Guide, Second Edition*. Watertown, MA: Pathfinder International, 2008. www2.pathfinder.org/site/DocServer/IUD2E_combined.pdf?docID=11263

A woman cannot get pregnant after using an IUD.	A woman's fertility returns to normal very soon after the IUD is removed. Studies have shown that most women who discontinue the IUD become pregnant as rapidly as those who have never used contraception.
If a woman with an IUD becomes pregnant, the IUD gets embedded in the baby's forehead.	The baby is very well protected by the sac filled with amniotic fluid inside the mother's womb. If a woman gets pregnant with an IUD in place, the health provider will remove the IUD immediately due to the risk of infection. If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth.
The IUD deteriorates in the uterus after prolonged use.	Once in place, if there are no problems, the IUD can remain in place for up to 12 years. The IUD is made of materials that cannot deteriorate. The client can keep it longer, if she desires, without any risk.
Note: The information and misconceptions below apply more directly to health workers	
An IUD cannot be inserted until six weeks postpartum.	• A trained provider can insert the IUD immediately after delivery (within 10 minutes of delivery of the placenta), during a cesarean section or up to 48 hours following delivery. Postpartum insertion of an IUD has been shown to be safe, effective, and convenient for women, just like the regular or interval IUD. Postpartum insertion appears to have a lower chance of perforation as instrument used is blunt and uterine wall is thick just after the pregnancy. • After the 48-hour postpartum period, a Copper T 380A may be safely inserted at four or more weeks postpartum. • It has been shown that IUDs do not affect breast milk and can be safely used by breastfeeding women postpartum.
The IUD causes ectopic pregnancy.	• There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. Studies have shown the risk of ectopic pregnancy to be the same for all women (with or without an IUD). • However, if client becomes pregnant while using an IUD, ectopic pregnancy must be excluded.
An IUD that is discolored in the package is dangerous and cannot be used.	The copper on IUDs sometimes changes color in the package as it oxidizes (reacts to air). The IUD can still be used and is safe as long as the package is not torn or broken open and as long as it is not past the expiration date printed on the packaging.
Women who have never given birth cannot use an IUD.	Women using the IUD who have never been pregnant may have an increased rate of expulsion and may experience more pain during insertion. However, the IUD is still safe for them to use. WHO carefully reviewed all the literature before listing nulliparity as Category 2, (generally use; some follow-up may be needed).
Women infected with HIV cannot use an IUD.	IUD use appears to be safe for HIV-infected women who are well and for women with AIDS who remain well on antiretroviral treatment (ART). As per WHO Medical Eligibility Guidelines, if the woman with a Copper IUD/LNG-IUD develops HIV, she can continue using it during treatment (Category 3A).
IUDs increase the risk of pelvic inflammatory disease (PID) and must be removed when it occurs.	Many studies have confirmed that the risk of infection and infertility among IUD users is very low (Hatcher 2004). However, studies also indicate that the insertion process—and not the IUD or its strings—poses the temporary risk of infection. Good infection prevention procedures should be practiced. Antibiotic prophylaxis should not be used routinely prior to insertion. The risk of infection following IUD insertion returns to a very low or normal level after 20 days (Farley et al. 1992). As per WHO Medical Eligibility Guidelines, if condition develops while using method, a woman can continue using it during treatment (Category 4A).

COUNTERACTING RUMORS AND MISCONCEPTIONS ABOUT IMPLANTS[39]

Rumor or Misinformation	Facts and Realities: Information to Combat Rumors
I have heard that you can remain infertile after removal of implants.	Implants stop working once they are removed. Their hormones do not remain in your body. The implant will not affect your ability to have another child. You can become pregnant again once your implant is removed.
I am afraid the implant will move from my arm to other parts of my body.	If placed correctly, it is highly unlikely that they can move. They remain where they are inserted until they are removed. In rare cases, a rod may start to come out of the skin, usually during the first four months after insertion. This typically happens because the implants were not inserted well or because of an infection at the insertion site. If the implant does come out, you should return to the clinic as soon as possible and use a backup family planning method in the meantime. Your health care provider can replace the implant.
It stops my bleeding so that blood cannot leave my body.	Changes in menstrual bleeding—like spotting, prolonged bleeding, or no menstrual bleeding—are common. These side effects are normal and are not a sign of sickness. Blood does not build up in your body. There is no need to have a monthly period if you are not trying to get pregnant. Your regular periods will return within a few months of removing the implant and you can become pregnant even before they return.
Implants cannot be used following an abortion.	Implants are appropriate for use immediately post abortion (spontaneous or induced), in either the first or second trimester. They should be initiated within the first seven days post abortion or anytime the provider can be reasonably sure the client is not pregnant. Ovulation returns almost immediately post abortion: within two weeks for first-trimester abortion and within four weeks for second-trimester abortion. Within six weeks after an abortion, 75 percent of women have ovulated.
I heard that an implant may cause an abortion if you are pregnant when it is inserted.	Implants do not cause an abortion. There is good evidence that the implant will not harm a baby if you are already pregnant when the implant is put in. Your provider will check carefully to make sure you are not pregnant before the implant is inserted.
I have heard that the implant is very painful to have inserted, sometimes it causes an infection and it is hard to remove once it has been inserted.	Health providers who insert implants have been specially trained to insert them. The provider will give you a small injection in your arm so that you do not feel the insertion. The incision is very small and does not require stitches. Your arm may be a bit sore for a few days, but this will go away. Infection can occur after implants have been inserted, but this is very rare. If it happens, you should return to your provider to be treated. To have your implant removed, visit the provider who inserted it or another nearby health facility so that they can remove it themselves or refer you to a provider who can do it.
You might get cancer or go blind if you have an implant inserted.	You will not get cancer or go blind because of using implants. After an implant is inserted, you may have changes in your menstrual bleeding. In some cases, women complain of headaches, abdominal pain, or breast tenderness. These are not signs of illness and will usually go away within the first year of use.

39. USAID, World Health Organization, and United Nations Population Fund. "Implants Handout #10: Correcting Rumors and Misconceptions about Implants." In *Training Resource Package for Family Planning*. Contraceptive Implants Module, 2018. www.fptraining.org/resources/iuds-handout-3-fact-sheet-copper-iuds. Solter, Cathy. *Intrauterine Devices (IUDs): Trainer's Guide*. Second. Watertown, MA: Pathfinder International, 2008. www2.pathfinder.org/site/DocServer/IUD2E_combined.pdf?docID=11263

COMMON RUMORS:

WAYS TO ADDRESS THESE RUMORS:

NOTES

UNIT 3

SESSION 11: SKILLS LAB - IUD AND IMPLANT INSERTION AND REMOVAL PRACTICE

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

- Practice correct steps of loading a Copper T 380A in its sterile package correctly using the "no-touch" technique.
- Practice correct steps of insertion and removal of copper IUD on an anatomical model using a checklist.
- Practice correct steps of insertion and removal of one-rod/two-rod implants on an arm model using a checklist.

NEW SKILLS I LEARNED AND WANT TO REMEMBER

NOTES

UNIT 3

SESSION 12: KNOWLEDGE AND POST-PRACTICE SKILLS ASSESSMENT

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

- Complete a knowledge assessment.
- Have their post-training skills assessed for IUD and implant insertion and removal techniques.
- Plan for supervised clinical practice after the training.

SKILLS I WANT TO CONTINUE TO PRACTICE

NOTES

UNIT 3

SESSION 13: NEXT STEPS AND CLOSING

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

- Discuss options for ongoing skills practice and post-training activities (such as peer to peer, clinical drills, mentorship, and on the job coaching).
- Explain the use of training resources and job aids.
- Develop a simple action plan for LARC service provision.
- Explain how the training met their expectations and course objectives.

NOTES

NOTES

PLAN FOR PROVISION OF LARC SERVICES IN CRISIS-AFFECTED CONTEXTS: ACTION PLAN[40]

GAP / CHALLENGE	TYPE OF GAP			ACTION ITEM	PERSON RESPONSIBLE	SUPPORT NEEDED	DEADLINE
	Internal	Resource	External				
1.							
2.							
3.							
4.							
5.							
6.							
7.							
8.							
9.							
10.							

40. Source: Jhpiego and U.S. Centers for Disease Control and Prevention (CDC). "Appendix V. Sample Action Plan." In *Gender-Based Violence Quality Assurance Tool: Facilitation Guide*, 2018. resources.jhpiego.org/resources/GBV-QA-tool

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IAWG Inter-Agency Working Group on Reproductive Health in Crises

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