MANUAL

FOR THE

TRAINING OF COMMUNITY HEALTH EXTENSION WORKERS (CHEWS)

ON

LONG-ACTING REVERSIBLE CONTRACEPTIVE (LARC) METHODS (IUDs and Contraceptive Implants)

· Trainers' Manual

FOREWORD

The unacceptably poor maternal and child health indices in Nigeria have been of much concern to various governments at all levels in the country. In efforts to address these unfavorable indices, Family Planning which is one of the pillars of safe motherhood is being vigorously implemented through series of interventions. Notable amongst these, is the introduction of Task Shifting policy for Community Health Extension Workers, CHEWS to provide Injectables with mentoring for ensuring wider coverage of FP services in the country. The success being achieved led stakeholders to seek for Federal Government's approval for the provision of Long Acting Reversible Contraceptive Methods (IUDs and contraceptive Implants) which was approved by the National Council on Health in 2014.

To this end the Federal Ministry of Health, Marie Stopes International Organisation Nigeria (MSION), Clinton Health Access Initiative (CHAI), United Nations Population Fund (UNFPA), and other partners met and developed a draft Training Manual, Participant Reference Book and Supervisory Checklist for impacting knowledge and skills on CHEWS to provide quality family planning services to clients who need IUDs and implant contraceptives. This intervention is expected to reduce the high unmet need for services and accelerate achievement of the target Family Planning Blueprint of 36 percent Contraceptive Prevalence Rate by the year 2018.

The Federal Ministry of Health recognizes and appreciates all the development partners, especially Marie Stopes Nigeria, for their efforts in making all these interventions realizable and assures partners of government supports for further efforts at improving the health and well-being of our women and children in the country.

May I say that it is one thing to develop valuable documents and it is another to make effective use of them. Therefore, it is my expectation that all stakeholders will make the best use of these manuals and checklist to improve skills of service providers for provision of quality family planning services in Nigeria.

I thank you all while strongly recommending the National Long Acting Reversible Contraceptive (LARC) Manuals and Supervisory Checklists for use to support provision of quality family planning services in the country.

Professor Isaac Folorunso Adewole FAS, FSPSP, D.Sc (Hons)
Honourable Minister of Health

November, 2015

ACKNOWLEDGEMENT

The 2015 Training Manual for Community Health Extension Workers (CHEWs) on Long – Acting Reversible Contraceptive (LARC) methods (IUDS & Implants) in Nigeria is the first of its kind developed in equipping Community Health Extension Workers (CHEWs) with required knowledge and skills for provision of Long Acting Reversible Contraceptive (LARC) methods in the country

A number of individuals and organizations had been involved in the rigorous process that culminated in the successful production of the Training Manual and they all deserve special commendation.

In this regards, I wish to express my appreciation to the staff of the Federal Ministry of Health who relentlessly put on efforts at developing the Training Manuals and Supervisory Checklists under the exemplary leadership of the Head Reproductive Health Division, Dr. Kayode Afolabi and the entire staff of the Reproductive Health Division of Family Health Department in the Federal Ministry of Health.

While conveying my sincere gratitude to Marie Stopes International Organisation Nigeria led by the Country Director Mr Effiom Effiom and the Chief of Party, Mr Onoriode Ezire, I appreciate the support of CHAI, SFH, USAID, JHPIEGO, USAID/DELIVER, NURHI, Pathfinder International, UNFPA and other partners not mentioned for their technical and financial supports. I also thank various State Ministries of Health and FCT as well as Regulatory Bodies particularly Community Health Practitioners' Registration Board and Nursing and Midwifery Council of Nigeria for their involvement in making the entire process a success.

There is also no gainsaying, the expertise knowledge and skills of the Consultants who developed the Manuals, Prof Adeyemi Adekunle and Dr. Kayode Osungbade have produced valuable documents for provision of quality family planning services on a wider coverage in the country, for which I am very grateful.

May I, in conclusion, emphasize that making effective use of this document by all concerned will be the only way of appreciating the efforts of stakeholders who produced these valuable Materials.

Thank you all.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCS	Balanced Counseling Strategy
BCS+	Balanced Counseling Strategy Plus
CBO	Community Based Organization
CSO	Civil Society Organization
FMOH	Federal Ministry of Health
GON	Government of Nigeria
HCT	HIV Counseling and Testing
HIV	Human Immunodeficiency Virus
IEC	Information Education and Communication
LGA	Local Government Area
M&E	Monitoring and Evaluation
MIS	Management Information System
NACA	National Agency for the Control of AIDS
NDHS	Nigeria Demographic and Health Survey
NGO	Non-Governmental Organization
NPopC	National Population Commission
PLWHA	Persons Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
RTI	Reproductive Tract Infections
SDP	Service Delivery Point
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
SOPs	Standard Operating Procedures/Standards of Practice
VCT	Voluntary Counseling and Testing
WHO	World Health Organisation

COURSE OVERVIEW

TRAINING GOAL

The overall goal of the training programme is to provide participants (Community Health Extension Workers) with the attitude, knowledge and skills necessary to provide quality Long Acting Reversible Contraceptives (IUD and Implants) services.

Overall Objective:

To develop skills of service providers in the administration of long-acting reversible contraceptives (LARC)

Specific Objectives:

Specifically, by the end of the workshop, participants should be able to:

- Describe the mechanism of action, effectiveness and side effects of IUDs and implants
- Describe the essentials of client Counseling and follow-up
- Demonstrate the preparation and care of the clients before, during, and after insertion and removal procedures.
- Demonstrate insertion and removal skills of IUD and implants using sterile techniques and following standard protocols;
- Insert 5 IUDs each using the standard protocol and remove 5 implants each using the standard protocol
- Demonstrate actions to be taken in the event of complications and procedures for follow up care
- Describe the management skills needed to provide quality IUD and implant services.

MODULE ONE

OVERVIEW OF TASK SHIFTING/SHARING AND FAMILY PLANNING IN NIGERIA

Session 1: Overview of Task Shifting/Sharing

Session 2: Overview of Family Planning In Nigeria

Module One - Session 1: Overview of Task Shifting/Sharing

Time: 1 Hour

Learning Objectives:

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

- Define Task Shifting
- Discuss three Rationales for Task Shifting
- Factors that facilitate the success of implementing Task Shifting

Methods

- Brainstorming
- Presentation
- Group work
- Discussion

Materials

- Flip chart
- Markers
- LCD Projector
- Laptop

Module One - Session 1: Overview of Task Shifting/Sharing in Nigeria

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Overview of Task Shifting/Sharing	1 hour	× Define Task Shifting × Discuss three Rationales for Task Shifting × Discuss three factors that facilitate the success of implementing Task Shifting	× Brainstorming × Presentation × Group work × Discussion	× Flip chart × Markers × LCD Projector × Laptop

Module One - Session 1: Overview of Task Shifting/Sharing in Nigeria

SESSION PRESENTATION

A. Introduction (10 minutes)

- The Trainer starts the session by explaining that:

  - One of the major constraints to meeting the unmet family planning needs of women in their reproductive age is the shortage of healthcare providers and this is compounded by either lack of access to health facilities or unavailability of health services.
  - The goal of task shifting or sharing is simply **"to get the right workers with the right skills in the right places doing the right things."**

  - "**Task shifting is not a replacement** for, or a design to slow down the development of a professional training. It is **merely an emergency measure necessary to immediately ameliorate** the current awful suffering of our people" *P**rof. Shima Gyoh, Former DG, FMOH May** 2011 In* **Africa Health**

  - As a solution to these identified problems, Task Shifti**ng is one of the essential interventions identified to help address t**hese issues.

  - This will not only increase *utilization but also contraceptive prevalenc***e which has r**emained low at 10%.

  - It is pertinent to note that Family planning is an inexpensive and cost-effective intervention but health workforce shortages and restrictive policies on the roles of mid and lower-level cadres limit access to effective delivery of contraceptive methods in many settings.

Definition of Task Shifting

- The Trainer asks the participants to brainstorm on their understanding of Task Shifting and notes their responses.

- The Trainer clarifies all issues and provide the definition of Task Shifting as follows:

  WHO describes Task Shifting as involving "**the rational redistribution of tasks among health workforce teams**."
  - Specific tasks are moved, where appropriate, from highly qualified health workers to health workers with shorter training and fewer qualifications in order to make more efficient use of the available human resources for health" (NTSP, 2014 page 18).
  - It is the process of enabling additional cadres of health workers to provide specific health intervention.

  - Task shifting is defined in the WHO guidelines as *"the rational redistribution of clinical and other tasks among health care workers, according to their skills rather than their roles."*

- The Trainer provides additional information that by re-organizing the workforce, Task Shifting presents a viable solution for:

    - Improving health care coverage;
    - Making more efficient use of human resources such as the CHEWs; and
    - Strengthening the capacity of nurses, midwives and Community Health Officers to train the Community Health Extension Workers.

A. Rationale for Task Shifting (25 minutes)

- The Trainer informs the participants that:

    - Expanding the task of providing contraceptive methods to other health worker cadres can significantly improve access to contraception.

    - Rural Kenya and Zambia are examples of how many countries have already enabled mid- and lower-level cadres of health workers to deliver a range of contraceptive methods, utilizing these cadres either alone or as part of teams within communities and/or health care facilities.

S/He explains further that:

- Based on the need to bridge the identified gaps of shortage of Family Planning service providers as well as increase access to the services and family planning facilities, there is need for adequate and equitable redistribution of the health workforce to enable women access contraceptive services.

- The National Council on Health approved that Community Health Extension Workers (CHEWs) should provide Long Acting Reversible Contraceptives (LARC) at the Community/Primary Health Care (PHC) setting.

- In pursuance of the above, the government of Nigeria with support from Marie Stopes International Organisation of Nigeria (MSION) is committed to the training of CHEWs on the provision of LARC services in health facilities as part of a broader strategy to expand access with the aim of achieving the goal of 36% contraceptive prevalence rate by 2018.

Group Work

The trainer:
- divides participants into 3 groups to discuss the rationale for Task Shifting for 3 minutes;
- recalls groups for 2-minute presentations;
- jots down points on Flip chart and
- commends participants for their contributions.

- The Trainer states that the rationales for Task Shifting is as a result of:

    - Limited access to services by either overall shortage of health workers qualified to provide specific methods or their uneven distribution across a country or region;

    - Difficulties in ensuring staff retention of higher cadres in certain settings such as rural areas;

- Lower salary levels of mid or lower-cadre health workers which can usefully reduce the budgetary cost of providing family planning services without compromising quality of service and client safety; and

- Availability of free time for higher cadre health workers which would enable them to better focus on the provision of services requiring a higher level of technical proficiency.

♦ S/he explains further that:

- Task Shifting as an intervention will optimize the health workers' roles to improve access to key maternal, newborn and child health interventions;

- In the case of Family Planning, Task Shifting is a strategy for improving access to contraceptive methods, thus contributing to the achievement of health related MDGs especially MDGs 4 and 5 and the subsequent SDGs in Nigeria.

B. Factors that facilitate the successful implementation of Task Shifting (20 minutes)

♦ The Trainer divides participants into 3 groups to discuss the factors that enhance the successful implementation of Task Shifting (3 minutes)

♦ S/he recalls groups for a 2-minute presentation per group

♦ The Trainer jots down points on a flip chart and commends participants for their responses.

♦ S/he adds the following as factors:

- Providing initial and on-going training for service providers, their supervisors and trainers.
- Supplying drugs and other Family Planning commodities;
- Providing Supportive Supervision;
- Establishing a line of referrals for other methods and management of complications and an effective follow-up mechanism for clients;
- Ensuring that monitoring and evaluation systems are functional and effective.

♦ The Trainer concludes by emphasizing that:

- Health system arrangements and specific socio-cultural and political factors will shape the implementation of these recommendations in particular settings if appropriately planned, implemented and periodically evaluated.

Summary/Evaluation (5 minutes)

- The Trainer summarizes the session by emphasizing that:

  - The importance of Task-Shifting in Reproductive Health/Family Planning service delivery cannot be overemphasized;

  - It has been widely accepted as an intervention critical to improving access to Reproductive Health/Family Planning services initially with injectable method;

  - The ongoing Training of Trainers will go a long way in meeting the Reproductive Health/Family Planning unmet needs of women especially those in hard to reach areas, thus, contributing to increasing the contraceptive prevalence rate (CPR), and most importantly reducing maternal morbidity and mortality rate and improving the quality of life.

Evaluation

- Define Task-Shifting
- Discuss 3 indications for Task-Shifting
- Discuss 3 considerations for Task-Shifting

Module One - Session 2: Overview of Family Planning In Nigeria

Time: 1 hour 40 minutes

Learning Objectives:

At the end of the session participants should be able to:

- Define family planning;
- Explain the relevance of family planning to maternal health;
- Discuss with clients/community members the benefits of family planning to the Woman, Child, Man, Community and Nation;
- Describe Nigeria's rapid population growth and the Age Structure of Nigeria's population;
- Describe the following basic concepts in Family Planning (FP): - Contraceptive Prevalence Rate (CPR), Unmet needs for family planning;
- Discuss the trends in Nigeria's Contraceptive Prevalence Rates (CPR);
- Discuss the trends in Nigeria's Fertility Rates and how they impact development;
- Explain the consequences of population growth on different sectors of the economy - Education, Health, Agriculture, Economy and Security;
- State the contribution of unsafe abortion to maternal mortality;
- Classify the different types of modern contraceptive methods; and
- Discuss the barriers to the use of modern contraception in Nigeria;

Session Overview

- Definition of family planning
- Relevance of family planning to maternal health
- Benefits of family planning
- Nigeria's Rapid Population Growth
- Age Structure of Nigeria's population
- Contraceptive prevalence rate (CPR)
- Unmet needs for family planning
- Trends in Nigeria's Fertility Rates and how they impact development
- Consequences of population growth on different sectors on the economy
- Contribution of unsafe abortion to maternal mortality
- Classification of the different types of modern contraceptives methods
- The barriers to the use of modern contraception in Nigeria

Methods

- Lecture
- Presentation
- Discussion
- Brainstorming
- Exercises

Materials

- Flip chart
- Markers
- LCD Projector
- Laptop

Module One - Session 2: Overview of Family Planning In Nigeria

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Overview of Family Planning In Nigeria	1 Hour 40 minutes	▪ Define family planning ▪ Explain the relevance of family planning to maternal health ▪ Discuss with clients/community members the benefits of family planning to the Woman, Child, Man, Community. and Nation ▪ Describe Nigeria's rapid population growth and the Age Structure of its population; ▪ Describe the following basic concepts in FP:- Contraceptive Prevalence Rate (CPR), Unmet needs for family planning; ▪ Discuss the trends in Nigeria's Contraceptive Prevalence Rates (CPR); ▪ Discuss the trend in Nigeria's Fertility Rates and how they impact development	▪ Lecture ▪ Presentation ▪ Discussion ▪ Brainstorming ▪ Exercises	▪ Flip chart ▪ Markers ▪ Liquid Crystal Display (LCD) Projector ▪ Laptop

		▪ Explain the consequences of population growth on different sectors of the economy - Education, Health, Agriculture, Economy and Security; ▪ State the contribution of unsafe abortion to maternal mortality; ▪ Classify the different types of modern contraceptives methods; ▪ Discuss the barriers to the use of modern contraception in Nigeria;		

Module One: Session 2: Overview of Family Planning In Nigeria

SESSION PRESENTATION

A. Introduction (5mins)

- The Trainer displays the session's objectives and reads each objective out to participants
- S/he asks one participant to read out the objectives and encourages other participants to comment
- The Trainer responds to the comments

B. Definition of Family Planning (5 minutes)

- The Trainer asks participants to brainstorm on the definition of Family Planning and jots down responses on the flip chart.
- S/he clarifies and defines Family Planning as follows:
  - Family Planning is the decision taken by the individual or couple on the number of children to have and when to have them in order to be able to cater for the family needs. Family Planning also assists infertile couple to be investigated and treated.

C. Relevance of Family Planning to Maternal Health (10 minutes)

- The Trainer starts the topic by explaining that high risk pregnancies are those occurring:
  i. before age 18 or after age 35 years;
  ii. women with more than four births and pregnancies that occur at less than 2 years interval;
  iii. women who have unplanned pregnancies sometimes risk the danger of having illegal unsafe abortion and its complications.
- S/he asks participants to brainstorm on the major causes of maternal death and notes the responses on a flip chart. S/he fills in the missing points as follows:
  - Haemorrhage (bleeding)
  - Obstructed labour/prolonged labour
  - Infection
  - Eclampsia (fits during pregnancy)
  - Anaemia (shortage of blood)
  - Abortion (miscarriage)
- The Trainer guides the discussion on the role of family planning in ensuring the good health of the mother and preventing maternal death, notes responses and fills in the missing information as follows:
  - Reduce the number of pregnancies which occur at too early an age, pregnancies at very short intervals,
  - pregnancies at too old an age; and
  - too many pregnancies, thereby preventing death of mothers (maternal morbidity (death).

D. Benefits of Family Planning to the woman, child, man, community, and Nation (20 minutes)

- The Trainer facilitates this session through small group discussions
- S/he asks the participants:
  - Who benefits from Family Planning? Facilitate the responses until you have the following:
    - Woman
    - Child
    - Husband
    - Family
    - Community
    - LGA/State/Nation

Small Group Work/Discussion – Benefits of Family Planning

- Tell participants that they will be breaking up into small groups to discuss the different benefits
- Divide participants into small groups using any group formation method.
- Assign working space to each group.
- Write Woman, children, husband, etc. on pieces of paper and invite group representatives to pick note one by one.
- Discuss whatever topic they pick.

TASK

How will:

- × Woman
- × Child
- × Man
- × Family
- × Community
- × LGA/State
- × Nation

Each benefit from Family Planning
Time: 10 minutes
Then the Trainer summarizes benefits

Presentation/Discussion: 3 minutes per group (time allotted = **18minutes)**

- **The Trainer invites the** groups to present one after the other
- After each presentation, s/he asks other groups if they have questions, clarifications additions or omissions.

A. Nigeria's rapid Population Growth and its Age Structure (10 minutes)

- **The Trainer asks** participants: “How many children does the average couple have in their communities?”

- S/he takes the number that seems consistent. The average for Nigeria is 6-7.

- The Trainer asks participants: “Why do people have many children?”

  Possible responses:

  - Belief in the value of large family;
  - Ignorance of child spacing services;
  - Desire for a particular sex;
  - Security in old age;
  - Contraceptive failure;
  - Polygamy (competition among wives);
  - Use for farm work and looking after other children;

- The Trainer displays the slides containing Figure 1.1 – “Population of Nigeria – Rapid Growth.

- S/he emphasizes that:

  - The country has tripled its population between 1963 and 2011 (48 years) with:
    - Sustained Fertility Rate of 5.7, and
    - Growth Rate of 3%

- The Trainer displays the slides containing Figures 1.2and 1.3 – “Age Structure of Nigeria's Population” and emphasize the following:

  - The ratio of people who are in the working age to people who are too young or old to work (dependents) is low, about 1:4;
  - That is, every working age person is feeding at least four dependants, and little is left to grow its economy, such as investing in economic activities, business, and more education;
  - This implies that the more dependants a population has, the harder it is to grow its economy because all the money is spent on just trying to help these dependents survive.

F. Basic concepts in FP: - Contraceptive Prevalence Rate (CPR)/Unmet needs for family planning (Figures 1.4 – 1.8) (5 minutes)

- The Trainer asks Participants to answer True or False: Are all women who want to do FP actually doing so?
- Provide reasons for your answer
- S/he notes their responses

- Discuss and explain the unmet need for FP

  - People who want to practice FP but do not have the means to do. Out of every 100 women who are supposed to do FP, only 10 women practice FP while 20 are looking for where to get the service. The 10 is referred to as the CPR while the 20 are referred to as unmet need for family planning.

- The Trainer stresses that this is why some of them resort to abortion when they find that they are pregnant. They should note the contribution of abortion to maternal death.

G. Trends in Nigeria's Fertility Rates and how they impact development (5 minutes)

- The Trainer displays the slide containing Figures 1.9 – 1.11 – "Current Fertility Rates by Zones", and notes that:

  - The average woman in Nigeria gives birth to about six children.
  - There is a regional variation in Nigeria; it is higher in the North—up to seven (7) children per woman; and in the South a little under five (5). So, 5.7 is the National average.

- S/he emphasizes to participants that this is also contributing to the rapid population growth and poor development of the country.

- S/he provides the participants with following information:

  - Fertility decline helps many families out of poverty;
  - "Slower population growth has encouraged overall economic growth in developing countries";
  - It is known that fertility can relate to development because if families have fewer children per woman, then they have fewer dependants to feed.
  - At the family level, having fewer dependants to feed could help to reduce poverty and free more money to educate or help each child;
  - And many analysts, including UNFPA analysts, have done research which show that lower population growth reduces poverty at the national level.

H. Consequences of population growth on different sectors of the economy (10 minutes)

- The Trainer asks participants: Are there problems that can result from having too many children?

- S/he notes responses on a flip chart and fills in missing points as follows:

  Some Expected responses:

  - Crowded living space;
  - Inadequate food for the family;
  - Inadequate funds to cater for daily needs;
  - inadequate funds for school fees;
  - Poor health of family members;
  - Inadequate land space

- The Trainer explains the consequences of high fertility rates as it affects:

  - Education:
    - High Fertility leads to increased population of students, need for more schools, more teachers

    - Low Fertility will lead to fewer students, less pressure to build more schools.

- Health
  - High Fertility Scenario => More strain on the nation's health system and health workers
  - Low Fertility Scenario => Less strain on the nation's health system and health workers.
- Agriculture
  - High Fertility Scenario => Food requirements increase leading to more food importation.
  - Low Fertility Scenario => Less money needed to pay for food Importation.
- ***Economy***

- High Fertility Scenario => More people, average GPD will not grow very fast.
- Low Fertility Scenario => Fewer people, the nation can invest in them, Spread the wealth among fewer people; GPD per person will grow faster.

I. Contributions of unsafe abortion to maternal mortality (10 minutes)

- The Trainer asks the participants to brainstorm on the contributions of abortion to maternal mortality.

J. Different types of modern contraceptives methods (5 minutes)

- The Trainer displays the slide on **“**“Types of Modern Family Planning Methods available in Nigeria”
- S/he emphasizes that:
  - The wide choice of family planning methods now available allows health programmes to offer an appropriate method to each individual.
  - Most family planning methods are virtually without risk and in addition, offer substantial benefits besides preventing pregnancies.

K. Barriers to the use of modern contraception in Nigeria (10 minutes)

- The Trainer asks the participants to brainstorm on what they consider as barriers to the use of modern contraceptive methods in their communities.
- S/he displays the slide of Figure 1.6 – “Barriers to the use of Contraception” showing the various barriers and fills in the gaps

Summary (5 minutes)

- The Trainer ends this session by emphasizing that Family Planning helps everyone.
  - helps women to protect themselves from unwanted pregnancies;
  - saves the lives of children by helping women space births;
  - helps men – and women – care for their family;
  - improves family wellbeing;
  - helps the nation develop;
  - Gives everyone a better opportunity for a better life;
  - Prevents abortion

L. Evaluation

- What is Family Planning?
- Explain the relevance of Family Planning to maternal health.
- State 4 benefits of Family Planning to the woman

MODULE TWO

FEMALE REPRODUCTIVE SYSTEM

Session 1: Anatomy and Physiology of the Female Reproductive System

Session 2: Ovulation, Menstruation, Fertilization and Conception

Module Two: Session 1: Anatomy and Physiology of the Female Reproductive System

Time: 1 hour

Learning Objectives:

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

- Identify on a diagram the names of the external and internal organs of the female reproductive system;
- Mention the functions of each of the female reproductive organs;

Session Overview

- Introduction
- External Female Reproductive Organs
- Internal Female Reproductive Organs

Methods

- Lecture
- Discussion
- Brainstorming

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector and Laptop
- Full Diagram of the Female Reproductive Organs
- Unlabeled diagram of the Female Reproductive Organs
- Pelvic Models

Module Two: Session 1: Anatomy and Physiology of the Female Reproductive System

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Anatomy of the Female Reproductive System	I hour	▪ Identify on a diagram the names of the external and internal organs of the female reproductive system ▪ Mention the functions of each of the female reproductive organs	× Lecture × Presentation × Discussion × Brainstorming × Exercises	× Flip chart × Markers × LCD Projector × Laptop

Module Two: Session 1: Anatomy of the Female Reproductive System

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays and introduces the session objectives
- The Trainer explains the objectives to the participants
- The Trainer displays the full diagram of the female body depicting the anatomy and informs the participants that:
  - The female reproductive system is the part of a woman responsible for producing a baby.
  - The system consists of two parts:
    - The external female reproductive organs

B. The External Female Reproductive Organs (50 minutes)

- The Trainer displays the diagram of the external genitalia and asks the participants to brainstorm, identify and name the external organs.
- The trainer clarifies the participants' responses and points to each organ while s/he describes and explains the functions of each organ as follows:

Mons pubis (Fatty pad)

- This is spread over the pubic bone and becomes covered with hair at puberty.
- It protects the external organs

Labia majora (Big lips)

- These are two thick outer lips immediately below the fatty pad.
- They protect the vagina

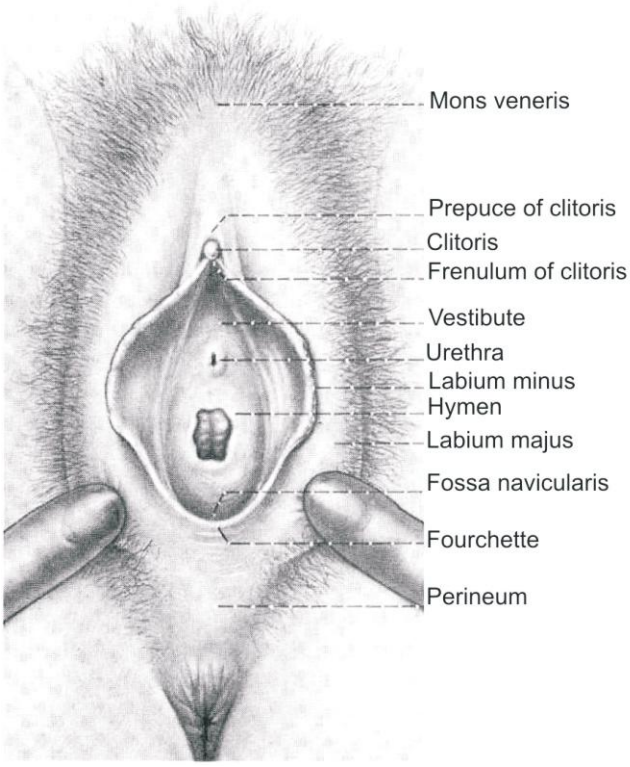
Labia minora (Small lips)

- These are two thin soft inner lips, pinkish in colour and very sensitive.
- They cover and protect the opening of the urine tube (urethra) and the opening to the inner body (vagina).

Clitoris

- The clitoris lies between the upper part of the big and small lips, just above the opening of the inner body (vagina)

Figure 2.1.1: The Female External Reproductive Organs



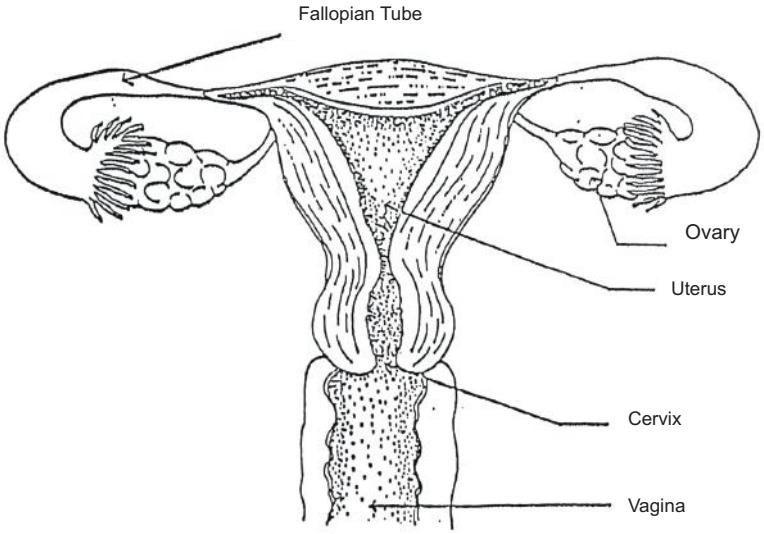
- It is the most sensitive part of a woman and responds to sexual stimulation
- This is the part that is erroneously cut and removed during female circumcision (genital mutilation/genital cutting).
- It is the centre of female sexual excitement

♦ The trainer requests a participant to come forward and repeats the process.

C. Internal Female Reproductive Organs

♦ The Trainer explains that the internal organs cannot be seen.

Figure 2: The Female Internal Reproductive Organs (Internal Genitalia)



- S/he displays the diagram of the internal organs of the female reproductive system, naming each organ and describing its function as follows:

Vagina (Opening to the inner body)

- It is the opening to the mouth of the womb (cervix) and other reproductive organs.
- It serves as an outlet for menstruation
- It holds the penis during intercourse
- It serves as a passage for the baby
- It also serves as a route for drug administration.

Bartholin's gland (Lubricator of vagina)

- These are two small glands situated under the big lips of the vagina
- They release drops of lubricant into the small lips when a woman is sexually stimulated and this prevents friction and discomfort during sexual intercourse.

Hymen

- This is thin membrane that coves the vagina when a girl is a virgin but is torn during first exposure to sexual intercourse (the process may be painful and may cause bleeding). The hymen may also be torn during vigorous exercise or use of tampons.
- It protects the vagina from infection before puberty.

Urethra (Urine carrying tube)

- This is the opening situated between the vagina and the clitoris
- It serves as a passage for urine.

Cervix (Mouth of the womb)

- The cervix is the mouth of the womb that protrudes into the vagina. In a non-pregnant woman, it feels like the tip of the nose when touched.
- It opens up (dilates) during labour to allow the baby to be delivered (born)
- It is the passage for menstruation
- It produce a secretion (mucus) which helps the sperm to move
- It is the passage through which the IUD is placed into the womb.

Womb

- The womb is a bigger sac that lies in the pelvic cavity behind the bladder and in front of the rectum.
- It accommodates and protects the fertilized egg that gets implanted there until it is fully developed into a baby and delivered
- During labour, it helps to push the baby out
- It is the place where an IUD, a family planning method, is placed.

Fallopian tubes (Egg carrying tubes)

- They are two in number and are located on each side of the womb near the top (fundus) of the egg bag. Each has a finger-like structure (fimbria) at both ends to assist in drawing the ripe egg into the Fallopian tube.
- It serves as a meeting place for the male's seed and the female egg.
- It serves as a place for the male's seed and female's egg to unite (fertilization).
- It serves as the passage for the united egg and sperm (fertilized egg) to move to the womb

Ovaries (Egg bags)

- They are two small egg-shaped bags on each side of the egg-carrying tube (Fallopian tube)
- They produce ripe eggs once a month.
- They produce the female sex hormone that make a woman look like a female and keep the reproductive system in good order

Ovum (Egg)

- This is the female sex cell. It is about the size of a pinhead.
- A ripe egg is released each month into the egg carrying tube (Fallopian tube) for fertilization by the male's seed. If not fertilized, it dissolves and is absorbed into the body.

D. Summary/Evaluation (5 minutes)

- Name the external parts of the female reproductive organs
- Name the internal parts of the female reproductive organs
- Display the diagram of the female reproductive organs and ask the participants to name and describe each organ you point to each
- Describe the functions of each organ

Module Two: Session 2: Ovulation, Menstruation and Fertilization/Conception

Time: 1 hour

Learning Objectives:

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

- Explain the meaning of ovulation
- Understand how ovulation occurs
- Explain what menstruation is
- Describe the process of fertilization and conception
- Discuss the type of health education necessary during menstruation

Session Overview

- Introduction
- Ovulation
- Definition of menstruation
- Menstrual process and cycle
- Useful information for women when menstruating
- Fertilization/Conception
- Definition of fertilization
- Process of fertilization
- Implantation

Methods

- Lecture
- Discussion
- Brainstorming

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector and Laptop

Module Two: Session 2: Ovulation, Menstruation and Fertilization/ Conception

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Ovulation, Menstruation and Fertilization/ Conception	I hour	▪ Explain the meaning of ovulation ▪ Understand how ovulation occurs ▪ Explain what menstruation is ▪ Describe the process of fertilization and conception ▪ Discuss the type of health education necessary during menstruation	× Lecture × Presentation × Discussion × Brainstorming × Exercises	× Flip chart × Markers × LCD Projector × Laptop

Module Two: Session 2: Ovulation, Menstruation and Fertilization/Conception

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays the session objectives, reads them out and encourages the participants to comment.

- The Trainer displays the diagram of the female internal reproductive organs.

B. Ovulation (10 minutes)

- The Trainer asks the participants to discuss how ovulation happens and how it is related to menstruation.
- S/he notes the responses on a flip chart and clarifies by illustrating with a diagram of a female reproductive organs as follows:

Ovulation

- Ovulation is the release of a matured egg from the ovaries (egg bags) into the Fallopian tubes (egg tubes).
- It usually happens once every month after a girl reaches puberty.
- This period is known as the fertile period, when a woman can become pregnant if she has sexual intercourse.
- Ovulation usually occurs 14 days before a woman sees her next menses. Therefore, in women with a 28 days cycle, ovulation occurs in the middle of the menstrual cycle.

C. Definition of Menstruation (5 minutes)

- The Trainer asks the participants to brainstorm on menstruation and discuss the process.

- The Trainer clarifies the response as follows:

  - Menstruation is the process whereby the lining of the womb that has prepared itself to welcome a fertilized egg peels off or sheds off because fertilization has not occurred.
  - This results in a flow of blood through the vagina.
  - The flow of blood is referred to as menstruation or “period”.

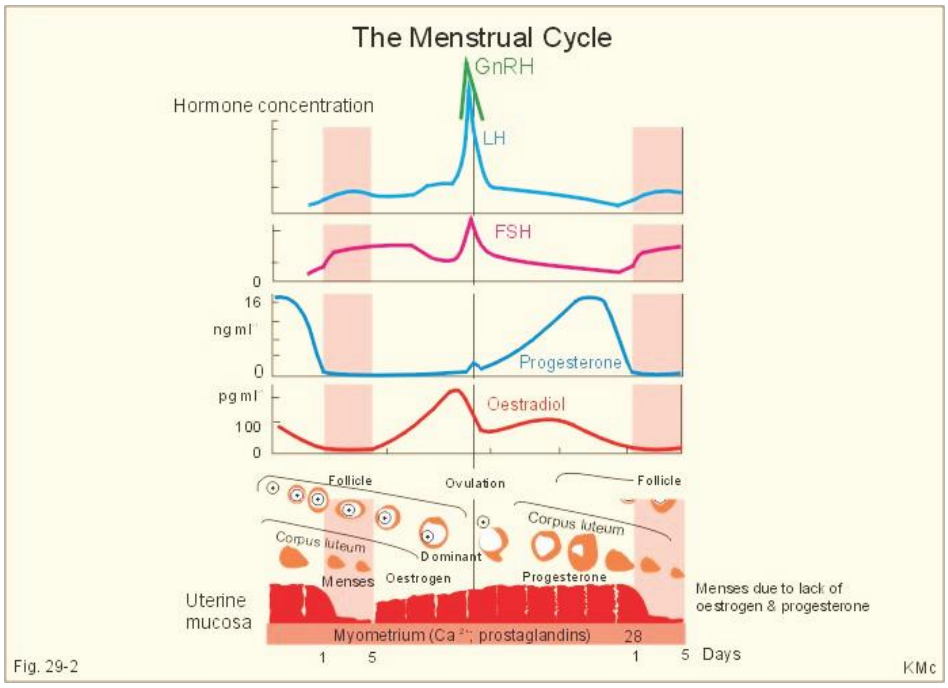
When menstruation begins:

- The Trainer explains that:
  - Menstruation normally starts when a girl reaches between 10 and 14 years of age.
  - Menstruation occurs every 21 to 35 days and lasts 3 to 7 days.

D. Menstrual Process and Cycle (10 minutes)

- The trainer displays the diagram of the menstrual cycle and explains the menstrual cycle.

Figure 2.2.2: The Menstrual Cycle



- S/he asks a volunteer to explain the menstrual cycle and clarifies as follows:

28 day menstrual cycle

Day 1 – 5

- Menstrual bleeding occurs. This normally lasts for 3 to 7 days. The first day of menstrual period is referred to as "day 1" of the menstrual cycle.

Day 5 – 7

- Each month after the last bleeding, the body begins to produce secretions (hormones) which help the eggs in the egg-bag to begin to grow.

Day 7 – 11

- The lining of the womb starts to build up to receive the female's egg in case it is united with the male seed (sperm).

Day 11 – 14

- A ripe egg is released from the ovary. This is known as ovulation.

Day 14 – 21

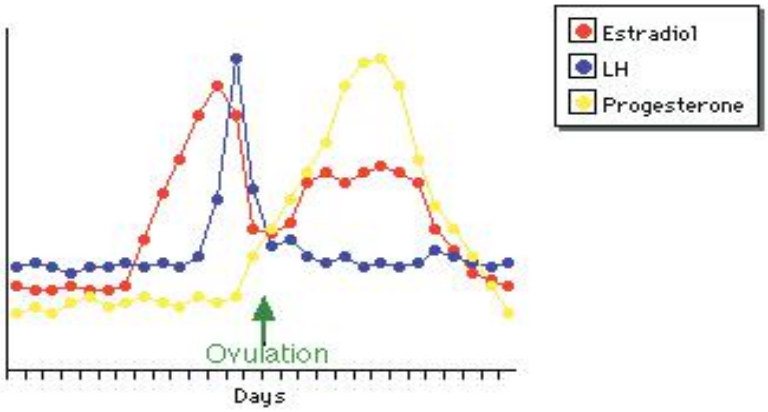
- The released ripe egg moves to the egg-carrying tube (Fallopian tube). The body makes sure that the lining of the womb is nourished and filled with blood to ensure that the fertilized egg survives.

Day 21 – 28

- If the male seed (sperm fails to reach and unite with the female egg, the prepared lining of the womb will start peeling or shedding off.

At the end of the cycle, this shedding comes in the form blood called “period” or menstruation. When this happens, a new cycle starts.

Figure 2.2.2: Hormonal Factors in Ovulation



E. Fertilization/Conception (10 minutes)

- The Trainer conducts the following: S/he

- Briefly reviews the female reproductive organs
- Reviews the process of ovulation (release of egg)
- Reviews the process of ejaculation, the journey of the sperm to the Fallopian tube and the fusion of male seed and the female egg in the Fallopian tube.

F. Process of Fertilization (10 minutes)

- The Trainer describes the process of fertilization illustrating with the diagram below:

Step 1:

- Every 14th day (of a 28 days cycle) in the month, when ovulation occurs, a ripe egg leaves one of the ovaries where thousands of eggs are stored.
- The ripe egg moves into the fallopian tube (egg-carrying tube) to wait for the male seed (sperm).

Step 2:

- Likewise, the man's seed (sperm) that is produced by the testes gets released in millions into the male seed carrying tube (vas deferens).
- During intercourse, the man ejaculates and deposits his seeds into the vagina.

Step 3:

- The male seed (sperm) which is very active and fast, swims through the mouth of the womb (cervix) into the womb (uterus).
- If intercourse occurs during or near the time of ovulation when a ripe egg is ready and live sperm meets a ripe egg in one of the tubes, fertilization occurs.
- This can happen within 1 hour to 1l/2 hours after ejaculation.

- The male's seed or female egg may also arrive in the Fallopian tube to await each other. The sperm has an average life span of 2 to 3 days (48 – 72 hours) to fertilize the female egg within the woman's body.
- Likewise, the ovum (female egg) can only survive for 40 hours after ovulation.
- Therefore, fertilization can only occur if a woman has sexual intercourse during the period of ovulation (peri-ovulatory period, i.e., two to three days before ovulation or one to two days after ovulation)
- If fertilization fails to happen, the egg is absorbed into the body.

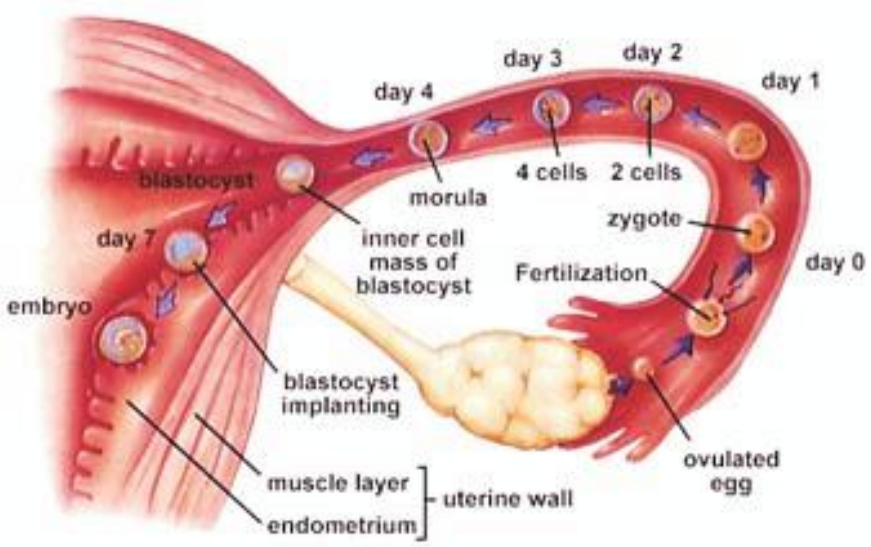
Step 4:

- Fertilization then occurs. A single sperm is usually responsible for fertilizing the female egg
- If fertilization fails to happen, the egg is absorbed into the body.

G. Implantation (5 minutes)

♦ The Trainer describes the process of implantation as follows:

Figure 2.2.3: The Process of Implantation



- Implantation of the fertilized egg occur when it attaches itself to the upper part of the uterus (womb).
- That is when pregnancy or conception has occurred
- The attached fertilized egg now develops inside the womb for the next 40 weeks until it is delivered as a baby.

Summary/Evaluation (5 minutes)

♦ The Trainer requests participants to answer the following questions:

- What is ovulation?
- Describe how it occurs.
- What is menstruation?
- What is fertilization?
- Explain how pregnancy occurs.

MODULE THREE

INTRODUCTION TO INTRAUTERINE CONTRACEPTIVE DEVICE (IUD) AND CONTRACEPTIVE IMPLANTS

Session 1: Product Profile and Medical Eligibility Criteria for CuT 380A and Medical Eligibility Criteria of IUDs

Session 2: Product Profile and Medical Eligibility Criteria for Jadelle®, Implanon® and Implanon NXT™

Module Three Session 1: Product Profile of CuT 380A and Medical Eligibility Criteria for IUDs

Time: 1 hour

Learning Objectives:

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

- Define the Intrauterine Contraceptive Device (IUD) and classify the types available;
- Mention the mechanism of action, effectiveness, advantages and the disadvantages;
- Discuss the Medical Eligibility Criteria for use of IUDs.

Session Overview

- Definition of the IUDs
- Classification of the types available
- Mechanism of action, effectiveness, advantages and disadvantages
- Medical Eligibility Criteria for the use of IUDs

Methods

- Lecture
- Presentation
- Discussion
- Brainstorming
- Exercises

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector
- Laptop
- Samples of IUDs
- Hand models

Module Three Session 1: Product Profile of CuT 380A and Medical Eligibility Criteria for IUDs

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Product Profile of CuT 380A and Medical Eligibility Criteria for IUDs	1 hour	▪ Define the IUD an d classify the types available; ▪ Mention the mechanism of action, effectiveness, advantages and the disadvantages ▪ Discuss the Medical Eligibility Criteria for use of IUDs	▪ Lecture ▪ Presentation ▪ Discussion ▪ Brainstorming ▪ Exercises	▪ Flip chart ▪ Markers ▪ LCD Projector ▪ Laptop

Module Three Session 1: Product Profile of CuT 380A and Medical Eligibility Criteria for IUDs

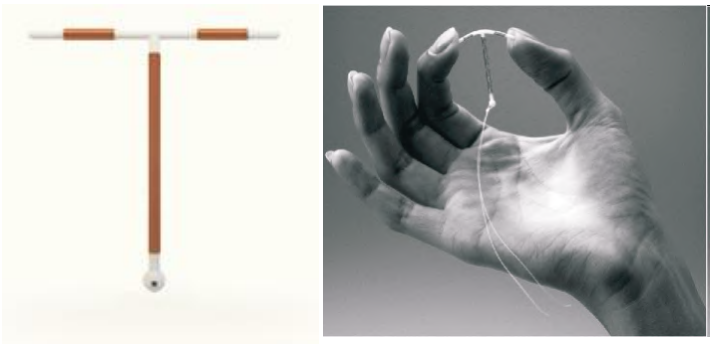
SESSION PRESENTATION

A. Introduction

Define the IUD and classify the types available

- The Trainer displays and reviews the learning objectives for this module.
- The Trainer requests the participants to define IUDs and notes the answers on the flip chart.
- The Trainer clarifies the participants' responses by defining IUDs as “small flexible devices made of metal and/or plastic that can prevent pregnancy when inserted into a woman's uterus through her vagina.”
- Similarly, the Trainer requests the participants to name the types of IUDs available in Nigeria and notes the answers on the flip chart.
- The Trainer displays the slide containing Figure 3.1.1 – “The Copper T 380A” and describes it as:

Figure 3.1.1: Copper T 380A



- A T-shaped intrauterine device (IUD), measuring 32 mm horizontally and 36 mm vertically, with a 3 mm diameter bulb at the tip of the vertical stem.
- A thread is tied through the tip, resulting in two white threads, each at least 10.5 cm in length, to aid in detection and removal of the device.
- The T-frame is made of materials to aid in detecting the device under x-ray.
- The Trainer displays the slide containing Figure 3.1.2 – “The Levonorgestrel IUS (Mirena)” and briefly describes it.

Figure 3.1.2: Levonorgestrel Intra-uterine System (Mirena)

- S/he displays Figure 3.1. 3 – "Presentation in the package" and informs the participants that:

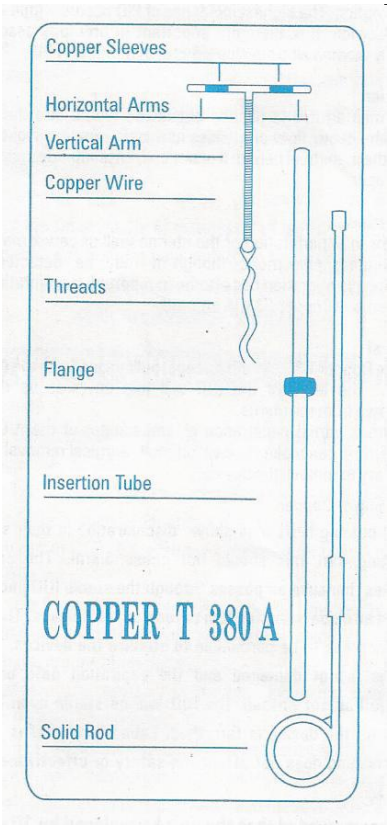
  - Cu T 380A also contains copper: approximately 176 mg of wire coiled along the vertical stem and a 68.7 mg collar on each side of the horizontal arm.

  - The total exposed copper surface area is 380 ± 23 mm^2. One unit weighs less than 1g.

  - Each Cu T 380A is packaged together with an insertion tube and solid white rod in a sterilized pouch.

  - A moveable flange on the insertion tube aids in gauging the depth of insertion through the cervical canal and into the uterine cavity.

Figure 3.1.3: Presentation in the package



B. Mention the mechanism of action, effectiveness, advantages and the disadvantages

♦ The Trainer requests the participants to brainstorm on the following and notes their responses:

- Mechanism of Action of Cu T 380A
- Effectiveness
- Advantages of Copper-bearing IUDs
- Disadvantages of Copper-bearing IUDs

♦ S/he clarifies the participants' responses as follows:

Mechanism of Action of CuT 380A

- **The mechanism of action remains unknown.**
- Possible mechanism(s) by which copper enhances contraceptive efficacy include interference with sperm transport or fertilization
- Prevention of implantation.
- The contraceptive effectiveness of CuT 380A is enhanced by copper continuously released into the uterine cavity.

Effectiveness

Less than one pregnancy occurs per 100 women using an IUD over the first year (6–8 per 1,000 women). Over 10 years of IUD use: about two pregnancies per 100 women.

Advantages of Copper-bearing IUDs

- IUDs are highly effective and safe for a majority of women
- They are reversible
- They are independent of intercourse
- They are private
- No day-to-day action is required
- IUDs are easily available
- They have no effect on lactation
- There is no drug interaction
- IUDs may help protect from endometrial cancer
- They are long-acting (CuT-380A is effective for as long as 12 years)

Disadvantages of Copper-bearing IUDs

- They have common side effects (usually diminish after the first three months of use)
  - prolonged and heavy monthly bleeding
  - irregular bleeding
  - more cramps and pain during monthly periods
  - IUDs do not protect against STIs/HIV
  - They require a trained provider to insert and remove
- Complications are rare, but may occur:
  - expulsion of IUD, which may lead to pregnancy
  - uterine perforation
  - Pelvic Infection (if inserted while infected with gonorrhoea or chlamydia)

C. Discuss the Medical Eligibility Criteria for use of IUDs

♦ The Trainer describes the WHO Medical Eligibility Criteria (MEC) as:

> "A document that reviews the medical eligibility criteria for use of contraception, offering guidance on the safety of use of different methods for women and men with specific characteristics or known medical conditions."

♦ The Trainer displays the slide on the Table on "How to select a contraceptive method using the WHO MEC and explains the content to the participants.

♦ S/he requests for any clarifications and addresses the concerns of the participants (if any).

♦ The Trainer then requests the participants to read out (in turns) indications specified under each of the four categories.

- *WHO Category 1:* Women who can use IUDs without restriction
- *WHO Category 2:* Women who can generally use IUDs; some follow up may be needed
- *WHO Category 3:* Use of IUDs is not recommended in these women
- *WHO Category 4:* Women who should not use IUDs.

Category	Description	When clinical judgment is available
1.	No restriction to use	Use method under any circumstance
2.	Benefits generally outweigh the risks	Generally use the method
3.	Risks generally outweigh the benefits	Use of the method not usually recommended except if other methods are unavailable/unacceptable
4.	Unacceptable health risks	Method not to be used

♦ The Trainer requests the participants to read through the criteria and explains difficult disease conditions:

How to select contraceptive method using WHO MEC for IUDs

Women who can use IUDs without restriction (WHO Category 1)
Women who:

- are 20 years or older
- have had children
- are within the first 48 hours postpartum
- are more than 4 weeks postpartum, regardless of breastfeeding status
- have past ectopic pregnancy
- have hypertension
- have Deep Vein Thrombosis (DVT)
- have current or history of cardiovascular disease
- have stroke
- ischemic heart disease
- multiple risk factors
- have headaches (migrainous and non migrainous)
- have diabetes

- have any type of liver disease: tumour or hepatitis
- take certain drugs – anti-tuberculosis drugs e.g. (rifampicin, rifambutin), anticonvulsants (e.g. Phenytoin) or anti-retroviral agents (e.g. ritonavir)
- are obese
- have uterine fibroids (without distortion of uterine cavity)
- have cervical ectopy
- have current breast cancer
- have cervical intra epithelial neoplasm (CIN)
- have past pelvic inflammatory disease with subsequent pregnancy
- smoke irrespective of age
- had first trimester abortion (no sepsis)

Refer to higher level of care
Women who can generally use IUDs; some follow up may be needed (WHO category 2)

Women who:

- have menarche up to <18 years
- are nulliparous
- had second trimester abortion
- have heavy or prolonged vaginal bleeding pattern
- have endometriosis
- have severe dysmenorrhoea
- have pelvic inflammatory disease without subsequent pregnancy
- have iron-deficiency anemia
- have current STI other than gonorrhoea or chlamydia
- was diagnosed with chlamydia or gonorrhoea while already using IUD (continuation only)
- have vaginitis including Trichomonas vaginalis and bacterial vaginosis (initiation and continuation)
- have increased risk for STIs (e.g. have multiple sexual partners, but report consistent condom use, or live in the area with high prevalence of gonorrhoea and chlamydia)
- developed AIDS while using IUD and are not on antiretroviral therapy (continuation only)
- have HIV infection or have AIDS and are on antiretroviral therapy (clinically well)

Refer to higher level of care
Use of IUDs usually not recommended in these women (WHO Category 3)

Women who:

- are at increased individual risk of STIs, e.g. have multiple sex partners and don't use condoms consistently, or have partner with multiple sex partners (initiation only)
- are between 48 hours and 4 weeks postpartum
- have AIDS and not on ARV therapy or are not clinically well on ARV therapy (initiation only)
- have ovarian cancer (initiation only; women who are diagnosed with ovarian cancer while using IUD can continue while awaiting treatment)
- have benign gestational trophoblastic disease (GTD)

Refer to higher level of care
Women who should not use IUDs (WHO Category 4)

Women who:

- are pregnant
- have current PID (initiation only)
- have current STIs such as gonorrhoea and chlamydia, or purulent cervicitis (initiation only)
- have sepsis – puerperal and post-abortion
- have cervical cancer (pre-treatment)
- have endometrial cancer (initiation only; women who are diagnosed with endometrial cancer while using IUD can continue while awaiting treatment
- have unexplained vaginal bleeding (initiation only)
- have uterine fibroids with cavity distortion
- have pelvic tuberculosis

♦ The Trainer addresses the concerns of the participants regarding the WHO MEC for IUDs

D. Summary/Evaluation

♦ The Trainer reminds the participants that:
  - IUDs are effective and reversible contraceptive methods that are acceptable to many women in Nigeria.
  - CuT 380A is the current copper-bearing IUD being used in Nigeria.
  - Most side effects and other health problems associated with the use of IUDs are not serious.
  - Changes in the menstrual bleeding pattern, especially some increase in the amount and duration of menstrual bleeding, are the most common adverse effects.

♦ The trainer requests the participants to provide answers to the following questions:

  - Mention the three types of IUDs available worldwide?
  - What are the advantages and disadvantages of IUDs?
  - Mention the four categories of WHO MEC for IUDs.

Module Three Session 2: Product Profile of Contraceptive Implants and Medical Eligibility Criteria (MEC) for Implants

Time: 1 hour

Learning Objectives:

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

- Describe the types, characteristics, effectiveness and mechanism of action of implants
- List the advantages and disadvantages of contraceptive implants
- Mention the special characteristics of Jadelle^{R}, Implanon^{R} and Implanon NXT^{TM}
- Discuss the MEC for Implant use
- Observe the insertion and removal of Jadelle^{R} ,Implanon^{R} and Implanon NXT^{TM} on video

Session Overview

- Types, characteristics, effectiveness and mechanism of action of implants
- Advantages and disadvantages of contraceptive implants
- Special characteristics of Jadelle^{R}, Implanon^{R} and Implanon NXT^{TM}
- MEC for Implant use
- Video of insertion and removal of Jadelle^{R} , Implanon^{R} and Implanon NXT^{TM}

Methods

- Lecture/Presentation
- Discussion
- Brainstorming

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector and
- Laptop

Module Three - Session 2: Product Profile of Contraceptive Implants and Medical Eligibility Criteria for Implants

MODULE PLAN

Title	Duration	Objectives	Methods	Materials
Product Profile of Contraceptive Implants and Medical Eligibility Criteria for Implants	I hour	▪ Describe the types, characteristics, effectiveness and mechanism of action of implants; ▪ List the advantages and disadvantages of contraceptive implants; ▪ Mention the special characteristics of Jadelle^{R}, Implanon^{R} and Implanon NXT^{TM} ▪ Discuss the Medical Eligibility Criteria for Implant use; ▪ Observe the insertion and removal of Jadelle^{R} and Implanon^{R} on Video	× Lecture × Presentation × Discussion × Brainstorming × Exercises	× Flip chart × Markers × LCD Projector × Laptop

Module Three Session 2: Product Profile of Contraceptive Implants and Medical Eligibility Criteria (MEC) for Implants

SESSION PRESENTATION

A. Introduction:

Describe the types, characteristics, effectiveness and mechanism of action of implants;

- The Trainer displays and reviews the learning objectives for this module
- The Trainer requests the participants to define Contraceptive Implants and notes the answers on the flip chart.
- The Trainer clarifies the participants' responses by defining Implants as:
  - Progestin-only contraceptives inserted under the skin of a woman's upper arm by a minor surgical procedure.
  - A blood level of the progestin sufficient to prevent conception is reached within a few hours after placement of the implants and is maintained at an effective level for at least 3 to 5 years.
- Similarly, the Trainer requests the participants to classify Contraceptive Implants and notes the answers on the flip chart.
- Again, the Trainer clarifies the participants' responses by classifying Contraceptive Implants as:
  - Jadelle® — two silicon rods; each containing 75 mg levonorgestrel. It is an improved version of Norplant. Jadelle® is effective for 5 years.
  - Implanon® —one rod containing a progestin called etonogestrel. Implanon® is effective for 3 years.
  - Norplant® — six soft plastic rods that each contain 36 mg levonorgestrel. Effective for 5-7 years. **Norplant has been discontinued due to the availability of newer and better implants, but there are still women using it who will be due for removal over the next few years.**

Product Profile of Jadelle®

- The Trainer displays the slide containing Figure 3.2.1 – “The Jadelle Implant” and briefly describes it as:

Figure 3.2.1: The Jadelle® Implant

- An implant system that provides effective, long-acting, reversible contraception for women.
- Two thin, flexible rods made of silicone tubing and filled with levonorgestrel, a synthetic progestin, are inserted just under the skin of a woman's upper inner arm in a minor surgical procedure.
- Protection from pregnancy is provided within 24 hours, when insertion is performed during the first week of a woman's menstrual cycle.
- The woman rapidly returns to her normal fertility when the implants are removed. Since Jadelle® does not contain estrogen, the most common side effects are changes in menstrual bleeding patterns.
- Most other common side effects are similar to those experienced by women who use other hormonal contraceptives."
- The outer part of the Jadelle® rod is silicone rubber tubing, similar to the material used in catheters and heart valves since the 1950s. It is also the same kind of material used in Norplant® capsules, another contraceptive implant system.
- The rods release levonorgestrel, a synthetic progestin that has been used in combined oral contraceptives and in progestin-only pills for more than 30 years.
- The delivery system, can provide contraceptive protection for up to five years. The levonorgestrel diffuses out of the silicon rubber at a constant rate every day for five years.
- The Jadelle® system consists of two rods, unlike the Norplant® system that has six capsules. Because there are fewer implants, Jadelle® is easier to insert and remove than Norplant.
- Each Jadelle rod is 43mm long and 2.5mm in diameter.

Mechanism of Action:

♦ The Trainer requests the participants to brainstorm on the following, and notes their responses:

- Mechanism of Action of Jadelle®
- Effectiveness of Jadelle®

♦ S/he clarifies the participants' responses.

Mechanism of Action

- Pregnancy is prevented in Jadelle® users by a combination of mechanisms. The most important are the:
  - Inhibition of ovulation
  - Thickening of the cervical mucus, making it impermeable to sperm.
- Other mechanisms may add to these contraceptive effects.

Effectiveness

- Jadelle® is one of the most effective reversible contraceptives available.
- The cumulative pregnancy rate in clinical trials was 0.3% for three years and 1.1% for five years.
- Jadelle® has a lower failure rate than the pill and most IUDs.
- Its efficacy is comparable to that of surgical sterilization. The implant has also been approved for 5 years' use.

Product Profile of Implanon®

♦ The Trainer displays the slide containing Figures 3.2.3 and 3.2.4 – "The Implanon® (classic) and Implanon NXT™ Implants" and briefly describes as

Figure 3.2.3: Implanon® (classic) Package

Figure 3.2.4: Implanon NXT™ Package

- A reversible, long-acting hormonal, subdermal contraceptive that contains etonorgestrel.

- It is a single-rod system with a disposable applicator. A newer version of Implanon is also available. It is called Implanon NXT™ which can be seen on X-ray, making it possible for checking the location of the implant.

- Implanon NXT™ **also has a preloaded, sterile applicator** which is for single use and disposable. Inserters familiar with the applicator for Implanon® need to familiarize themselves with the one for Implanon NXT™

- Each Implanon implant contains 68mg of etonorgestrel.

♦ The Trainer requests the participants to brainstorm on the following, and notes their responses:

- Mechanism of Action of Implanon
- Effectiveness of Implanon

S/he clarifies the participants' responses as follows:

Mechanism of Action

- The contraceptive effect of Implanon® is primarily achieved by inhibition of ovulation.
- Besides inhibition of ovulation, Implanon® also causes changes in the cervical mucus, which hinders the passage of spermatozoa.

Effectiveness

- Less than one pregnancy per 100 women (1 per 1,000 women) for over three years use of Implanon.
- The contraceptive efficacy of Implanon® is comparable with that known for combined OCs.

B. Mention the advantages and the disadvantages of Contraceptive Implants

- The Trainer requests the participants to brainstorm on the Advantages of contraceptive implants and notes the responses on the flip chart.

- S/he summarizes and clarifies their responses as follows:

Advantages of Implants

- No repeated visits to the clinic are required
- Contraceptive implants are effective immediately if inserted within the first 7 days of menstrual cycle (5 days for Implanon)
- They are very effective in preventing pregnancy and safe for majority of women
- They are long-acting
- They may help prevent iron deficiency anemia, symptomatic pelvic inflammatory disease and ectopic pregnancy
- They do not disturb breast milk production
- Less likely to cause headaches or raised blood pressures than estrogen-containing contraceptives
- No increased risk of cardio-vascular complications

- The Trainer requests the participants to brainstorm on the disadvantages of contraceptive implants and notes the responses on the flip chart.

- S/he summarizes and clarifies their responses as follows:

Disadvantages of Contraceptive Implants

- Contraceptive implants have common side effects:
  - may cause spotting and irregular vaginal bleeding for 60–70% of users;
  - amenorrhea (less common than irregular bleeding with all implants, but Implanon)
  - headaches, abdominal pain, weight gain, breast tenderness, dizziness, nausea, mood change and acne
  - some women may develop enlarged ovarian follicles
- Insertion and removal involve minor surgical procedures and therefore may be associated with bruising (discolouration of the arm), infection or bleeding

- The client cannot discontinue the method on her own

- Outline of the rods may be visible under the skin of some women, especially when the skin is stretched

- Contraceptive implants do not protect a woman from STIs/HIV

C. Discuss the Medical Eligibility Criteria (MEC) for use of Implants

♦ The Trainer reminds the participants about the WHO MEC which is:

"A document that reviews the MEC for use of contraception, offering guidance on the safety of use of different methods for women and men with specific characteristics or known medical conditions."

♦ The Trainer again displays the slide which shows the Table on "How to select a contraceptive method using the WHO MEC and explains the content to the participants.

♦ S/he requests for any clarifications and addresses the concerns of the participants (if any).

Category	Description	When clinical judgment is available
1	No restriction to use	Use method under any circumstance
2	Benefits generally outweigh the risks	Generally use the method
3	Risks generally outweigh the benefits	Use of the method not usually recommended except if oth er methods are unavailable/unacceptable
4	Unacceptable health risks	Method not to be used

- *WHO Category 1:* Women who can use Contraceptive Implants without restriction

- *WHO Category 2:* Women who can generally use Contraceptive Implants; some follow up may be needed

- *WHO Category 3:* Use of Contraceptive Implants is not recommended in these women

- *WHO Category 4:* Women who should not use Contraceptive Implants

♦ The Trainer then requests the participants to read out (in turns) indications specified under each of the four categories.

Women who can use implants without restriction (WHO Category 1)
Women who:

- are of any age and parity, including nulliparous
- obese

[1]Implants start to lose effectiveness sooner for heavier women (>70kg): these women may have to replace their implants earlier.

- have uterine fibroids
- are breastfeeding within six weeks to six months postpartum
- have puerperal and post-abortion sepsis
- have pelvic inflammatory disease (previous and present)
- have increased risk of STIs or current STIs, including gonorrhoea or chlamydia
- have HIV infection or AIDS, but are not on ARV therapy
- are smoking at any age
- have hypertension below 160/100 mmHg
- have non-migrainous headaches
- have depressive disorders
- have endometrial or ovarian cancer
- have iron-deficiency anemia or sickle cell disease
- have acute or flare hepatitis, chronic hepatitis, or carrier
- have mild (compensated cirrhosis)
- take broad-spectrum antibiotics, antifungal or antiparasitic medication

Women who can generally use implants; some follow up may be needed (WHO Category 2)
Women who have:

- drug interactions such as Rifampicin, Rifambutin, certain anti-convulsants, e.g. Phenytoin, ARVs
- cervical cancer (pre-treatment) or cervical intraepithelial neoplasia
- hypertension higher than 160/100 mm Hg
- history of DVT or current DVT while established on anticoagulant therapy
- major surgery with prolonged immobilization
- multiple risk factors for cardiovascular disease
- history or current ischaemic heart disease or stroke (for initiation only)
- migraine with aura at any age (for initiation only)
- diabetes with or without complications
- rheumatic disease, such as systemic lupus erythematosus if negative for antiphospholipid antibodies
- irregular or heavy vaginal bleeding patterns
- gall-bladder disease
- liver tumour, such as focal nodular hyperplasia

Use of implants usually not recommended in these women (WHO Category 3);
Women who:

- have unexplained vaginal bleeding
- have deep vein thrombosis (acute)
- have liver tumour other than focal nodular hyperplasia
- have severe (decompensated) cirrhosis
- are breastfeeding up to six weeks postpartum
- have rheumatic disease, such as systemic lupus erythematosus with positive or unknown antiphospholipid antibodies
- have history of breast cancer and no evidence of current disease for 5 years
- noticed their migraines with aura getting worse while using contraceptive implants
- were diagnosed with ischaemic heart disease or stroke while using implants

Women who should not use *contraceptive implants (WHO Category 4)*

- Women who have current breast cancer

♦ The Trainer addresses the concerns of the participants regarding the WHO MEC for Contraceptive Implants.

D. Summary/Evaluation

♦ The Trainer reminds the participants that:

- Since contraceptive implants are progestin-only methods, they are suitable for a wide range of women.
- They make family planning possible throughout reproductive life.
- They may be used to postpone a first pregnancy or used to 'space' pregnancies.
- They may also be used to provide long-term contraception when the desired family size is reached.
- Since implants do not contain estrogen, they can be used in women who do not want to or cannot use combined oral contraceptives (COCs).
- The contraceptive actions of implants are reversible which is apparent from the rapid return of the normal menstrual cycle after removal of the implants.

♦ The trainer requests the participants to provide answers to the following questions:

- Mention the three types of Contraceptive Implants available in Nigeria?
- What are the advantages and disadvantages of Contraceptive Implants?
- Mention the four categories of WHO MEC for Contraceptive Implants.

MODULE FOUR

USING LEARNING GUIDES DURING MODEL AND CLINICAL PRACTICE

Time: 1 Hour

Learning Objectives

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

- Discuss the terms associated with skill acquisition
- Explain the use of learning guides and checklist
- Discuss the advantages and disadvantages of competency-based skill assessment instruments
- Demonstrate the use of competency-based skill assessment instrument
- Discuss the care of anatomic models

Session Overview

- Terms associated with skill acquisition
- Description of learning guides and checklist
- Advantages and disadvantages of competency-based skill assessment instruments
- Demonstration of the use of competency based-skill assessment instrument
- Care of anatomic models

Methods

- Illustrated Lecture
- Discussion
- Group work
- Demonstration & Return Demonstration

Materials

- Projector
- Laptop
- Markers
- Flip Charts
- Anatomic models
- Video

Varieties of clinical skills Learning Guides and Checklists

- *Sample 3.1:* Learning Guide for IUD Insertion Techniques
- *Sample 3.2:* Learning Guide for IUD Counseling Skills
- *Sample 3.3:* Learning Guide for Implant (Jadelle^{R})Insertion Techniques
- *Sample 3.4:* Learning Guide for Implant (Implanon^{R}) Insertion Techniques
- *Sample 3.5:* Learning Guide for Implant Removal Skills (All Implants)

Module Four: Using Learning Guides during Model and Clinical Practice

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Using Learning Guides during Model and Clinical Practice	1 Hour	▪ Discuss the terms associated with skill acquisition ▪ Explain the use of learning guides and checklist ▪ Discuss the advantages and disadvantages of competency-based skill assessment instruments ▪ Demonstrate the use of competency-based skill assessment instrument ▪ Discuss the care of anatomic models	▪ Illustrated Lecture ▪ Discussion ▪ Group work ▪ Demonstration & Return Demonstration	▪ Projector ▪ Laptop ▪ Markers ▪ Flip Charts ▪ Anatomic models ▪ Video

Module Four: Using Learning Guides during Model and Clinical Practice

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays and introduces the session's objectives
- He reads out the objectives and explains each objective to the participants
- The Trainer encourages participants to comment on their understanding of the objectives and respond to comments

B. Terms associated with skill acquisition (15 minutes)

- The Trainer asks the participants to brainstorm on the following terms:
  - Skill Acquisition
  - Skill Competency
  - Skill Proficiency
- S/he notes their responses and provides clarifications as necessary.

- S/he explains to the participants that:

  - In the past, deciding whether a participant was competent (qualified) to perform a skill or activity during and most importantly after clinical training was often extremely difficult.

  - This was due in part to the fact that competency was tied to the completion of a specified number of supervised procedures or activities.

  - Unfortunately, unless participant performance is objectively measured relative to a predetermined standard, it is difficult to determine competency.

  - Competency-based skill assessments (learning guides and checklists), which measure clinical skills or other observable behaviours relative to a predetermined standard, have made this task much easier.

  - While learning guides are used to facilitate learning the steps or tasks (and sequence, if necessary) in performing a particular skill or activity, checklists are used to evaluate performance of the skill or activity objectively.

- The Trainer emphasizes to the participants that:

  - Progress in the skill area is measured with reference to various levels or stages of performance.

  - The three levels of performance in acquiring a new skill are:

    - *Skill Acquisition* –Is defined as an act of getting the knowledge of a skill.

      This represents the **initial phase** in learning a new skill or activity. Assistance and coaching are necessary to achieve correct performance of the skill or activity.

- *Skill Competency* –Is defined as a skill that a person needs for a particular task.

  This represents an **intermediate phase** in learning a new skill or activity. The participant can perform the required steps in the proper sequence (if necessary) but may not progress from step to step efficiently.

- *Skill Proficiency* –Is defined as the ability to do something well because of training and practice.

  This represents the **final phase** in learning a new skill or activity. The participant efficiently and precisely performs the steps in the proper sequence (if necessary).

♦ The Trainer uses the following examples of tasks to illustrate the three levels of skill area:
  - Counseling a client
  - Inserting contraceptive implants
  - Inserting a CuT 380A IUD
  - Putting on sterile gloves

C. Use of Learning Guides and Checklists (10 minutes)

♦ The Trainer explains to the participants that the important uses of Learning Guides and Checklists are as follows:

Learning Guides

- A learning guide contains the individual steps in sequence (if necessary) required to perform a task or activity in a standardized way.

- Learning guides are designed to help the participant learn the correct steps and sequence in which they should be performed **(skill acquisition)**, and measure progressive learning in small steps as the participant gains confidence and skill **(skill competency).**

- Learning guides can be used as a self-or peer assessment tool. Examples of how learning guides can be used at different stages of the course are given below.

♦ The Trainer further explains to participants that they are not expected to perform all the steps correctly the first time they practice them. Instead the learning guides are intended to:

- Assist the participant in learning the correct steps and sequence in which they should be performed (*skill acquisition*)

- Measure progressive learning in small steps as the participant gains confidence and skill (*skill competency).*

- The Trainer explains to participants the step by step process of using the learning guides as follows:

  - Initially, participants can use the learning guides to follow the steps as the clinical trainer role-plays counseling a client or demonstrates a clinical procedure using anatomic models.

  - Subsequently, during the classroom sessions in which participants are paired, one "service provider" participant performs the procedure while the other participant uses the learning guide to prompt the "service provider" on each step.

  - During these sessions, the clinical trainer(s) can circulate from group to group to monitor how learning is progressing and check to see that the participants are following the steps outlined in the learning guide.

  - After participants become confident in performing the skill or activity (e.g. inserting an IUD in the pelvic model), they can use the learning guide to rate each other's performance. This exercise can serve as a point of discussion during a clinical conference before participants provide services to clients.

  - Before the first clinic session, participants again are paired. Here, one "service provider" participant performs the procedure while the other observes and uses the learning guide to remind the "service provider" of any missed steps. During this session, the clinical trainer circulates, coaching the participants as necessary as they perform the procedure.

Checklist

- The Trainer describes the Checklist to participants as follows:

  - The *Checklist* generally is derived from a learning guide. Unlike learning guides, which are by necessity quite detailed, competency-based checklists should contain only sufficient detail to permit the clinical trainer evaluate and record the overall performance of the skill or activity.

  - If a checklist is too detailed, it can distract the clinical trainer from the primary purpose, which is to observe the overall performance of the participant objectively.

- The Trainer explains to the participants the important uses of Checklists as follows:

Using checklists in competency-based clinical training

  - Ensures that participants have mastered the clinical skills and activities first with models and then with clients

  - Ensures that all participants will have their skills measured according to the same standard

  - Forms the basis for follow up observations and evaluations

D. Advantages and disadvantages of competency-based skill assessment instruments(10 minutes)

The Trainer discusses the advantages of competency-based skill assessment instruments as follows:

- The single greatest advantage of a competency-based skill assessment is that it can be used to facilitate learning a wide variety of skills or activities and measure participant behaviour in a **realistic job-related situation.**

- Competency-based assessment instruments such as learning guides

  - Focus on a skill that the participant typically would be expected to perform on the job

  - Break down the skill or activity into the essential steps required to complete the procedure.

♦ The Trainer further tells participants that using competency-based clinical training:

- Ensures that training is based on a standardized procedure
- Standardizes training materials and audiovisual aids
- Forms the basis of classroom or clinical demonstrations as well as participant practice sessions.

Ask participants to brainstorm on the disadvantages of competency-based skill assessment instruments. Note their responses. Add the following to their responses:

- It will take time and energy first to develop the instruments/tools and then to apply them to each participant.

- An assessment can be applied only by a clinical trainer who is proficient in the clinical procedure or activity being learned.

- An adequate number of skilled clinical trainers must be available to conduct the training because competency-based clinical training usually requires a one-on-one relationship.

E. Use of competency based Skill Assessment Instrument(10 minutes)

♦ The Trainer demonstrates the use of one or two of the following learning guides on a task performed on an anatomic model:

Sample 3.1: Learning Guide for IUD Insertion Techniques

Sample 3.2: Learning Guide for IUD Counseling Skills

Sample 3.3: Learning Guide for Implant (Jadelle^{R}) Insertion Techniques

Sample 3.4: Learning Guide for Implant (Implanon^{R}) Insertion Techniques

Sample 3.5: Learning Guide for Implant Removal Skills (All Implants)

F. Care of anatomic models(5 minutes)

- The Trainer shows the participants the pelvic and arm models and demonstrate their care.

- S/he emphasizes the guidelines for:
  - Handling models during use
  - Dismantling the arm models to retrieve inserted implants

G. Summary and Evaluation (5 minutes)

The Trainer summarizes the module by stating that:

- Providing participants with good Counseling and clinical skills is one of the central purposes of most family planning training courses.

- Being able to measure learning progress satisfactorily and evaluate performance objectively are extremely important elements in the process of improving the quality of clinical training.

- The checklists can be used to measure a wide variety of participant skills and behaviours in realistic job-related situations.

Evaluation

The Trainer asks the participants to respond to the following questions:

- What are the terms associated with learning?

- What is a competency-based training?

- State three advantages of using the learning guide during training.

SAMPLE LEARNING GUIDES

Sample 4.1: Learning Guide for IUD Insertion and Removal Techniques

LEARNING GUIDE FOR IUD CLINICAL SKILLS

(To be used by Participants)

Rate the performance of each step or task observed using the following rating scale:

Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

LEARNING GUIDE FOR IUD CLINICAL SKILLS						
STEP/TASK		**CASES**				
CLIENT ASSESSMENT						
1.	Greet client respectfully and with kindness					
2.	Determine that client has been counseled for insertion procedure					
3.	Take a reproductive health hist ory. Ask for and record the following information to determine if the IUD is an appropriate choice for the client: Date of last menstrual period, menstrual interval (days) and bleeding pattern History of ectopic pregnancy Severe dysmenorrhea (painful periods) Severe anemia (Hb < 9g/dl or HCT < 27) Recent history of sexually transmitted genital tract infections (GTIs), PID (in last 3 months) or other STDs (HBV/HIV) Multiple sexual partners (either partner) Known or suspected cancer of genital tract					
General Physical Examination						
4.	Inform the client that you want to examine her generally					
5.	Check for pallor and jaundice					
6.	Examine the neck for any swelling					
7.	Examine the breasts for lumps, nipple discharge					
Abdominal Examination						
8.	Check that client has recently emptied her bladder and washed and rinsed her genital area if necessary					
9.	Tell client what is going to be done and encourage her to ask questions					
10.	Help client onto examination table					
11.	Wash hands t horoughly with soap and water and dry with clean, dry cloth or air dry					
12.	Palpate abdomen and check for lower abdominal, especially suprapubic tenderness and masses or other abnormalities					

Pelvic Examination						
13.	Drape the woman appropriately for pelvic examination					
14.	Provide adequate light to see cervix					
15.	Open high -level disinfected instrument pan or sterile pack without touching instruments					
16.	Put new examination or high -level disinfected surgical gloves on both hands.					
17.	Arrange instruments and supplies on high -level disinfected or sterile tray.					
18.	Inspect external genitalia and urethral opening					
19.	Palpate Skene's and Bartholin's glands for tenderness or discharge					
20.	Swab the vulva					
21.	Perform bimanual exam: Determine if there is cervical motion tenderness Determine size, shape and position of uterus Rule out pregnancy or any uterine abnormality Check for enlargement or tenderness of adnexa					
22.	Perform rectovaginal exam only if: Position or size of uterus is questionable Possible mass behind the uterus					
23.	If performing rectovaginal exam, keep gloves on and go to steps 21a & 21b					
24.	If not performing rectovaginal exam, immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out If disposing of gloves, place in leak proof container or plastic bag					
25.	After completing rectovaginal exam, immerse both gloved hands in 0.5% chlorine solution, remove gloves by turning inside out and dispose of gloves in leak proof container or plastic bag.					
26.	Put on another pair of examination gloves					
27.	Insert vaginal speculum					
28.	Perform speculum exam: Check for vaginal lesions or discharge Inspect cervix Obtain vaginal and cervical and/or urethral specimens for microscopic examination if indicated (and testing is available)					
Refer to higher level of care if infection is suspected						
INSERTION						
Pre-Insertion Tasks						
1.	Tell client what is going to be done and encourage her to ask questions					
Insertion Tasks						
2.	Put new examination or high -level disinfected surgical gloves on both hands					
3.	Apply antiseptic solution two times to the cervix, especially the os, and vagina					

4.	Gently grasp cervix with tenaculum					
5.	While gently pulling on the tenaculum and without touching the side walls of the vagina or speculum blades, gently pass uterine sound through the cervix to the fundus of the uterus					
6.	Confirm whether the position of the uterus is anterior or posterior. Remove the uterine sound					
7.	Determine the depth of the uterine cavity					
8.	Load CuT 380A in a sterile package: Partially open package and bend back white backing flaps Put white rod inside inserter tube Place package on flat surface Slide I.D card underneath arms of the IUD Hold tips of IUD arms and push on the inserter tube to start bending arms When arms touch sides of inserter tube, pull tube away from the folded arms of IUD Elevate inserter tube and push and rotate to catch tips of arms in tube. Push folded arms into inserter tube to keep them fixed in the tube					
9.	Set depth gauge to measure uterine depth with IUD still in sterile package, then completely open package					
10.	Check to be sure the folded arms and the depth gauge are lying flat against the card					
11.	Remove loaded inserter tube without touching anything that is not sterile; be careful not to push the white rod toward IUD					
12.	Hold blue depth gauge in horizontal position. While gently pulling on tenaculum, pass loaded ins erter tube through the cervix until depth gauge touches cervix or resistance is felt.					
13.	Hold tenaculum and white rod stationary in one hand					
14.	Release arms of Copper T380A IUD using withdrawal technique (pull inserter tube toward you until i t touches thumb grip of white rod).					
15.	Remove white rod and carefully push in on the inserter tube until slight resistance is felt (to ensure device is in place)					
16.	Partially withdraw the inserter tube and cut IUD strings to 3 - 4cm length					
17.	Remove inserter tube					
18.	If cutting is not performed, tuck the strings around the cervix in the fornices					
19.	Gently remove the tenaculum and place in 0.5% chlorine solution for 10minutes for decontamination					
20.	Examine cervix and i f there is bleeding at the tenaculum puncture site(s), place cotton (or gauze) swab over bleeding and apply gentle pressure for 30-60 seconds.					
21.	Gently remove speculum and place in 0.5% chlorine solution for 10minutes for decontamination					

POST INSERTION TASKS						
22.	Before removing gloves, place all instruments in 0.5% chlorine solution for 10minutes for decontamination					
23	Dispose of waste materials such as cotton balls or gauze by placing in a leak proof container or plastic bag.					
24.	Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out, place in leak proof container or plastic bag					
25.	Wash hands thoroughly with soap and water and dry with clean, dry cloth or air-dry					
26.	Check to be sure client is not having excessive cramping and answer any questions					
27.	Teach client how and when to check for strings – fortnightly and especially after menses					
28.	Discuss what to do if client experiences any side effects or problems					
29.	Provide follow-up visit instructions (the first follow -up visit is 1 month), and answer any questions					
30.	Remind the client that IUD does not protect against HIV/STIs					
31.	Assure client that she can have the IUD removed at any time					
32.	Observe client for at least 15 to 20 minutes before sending her home					
33.	Complete IUD card and record in client record					
REMOVAL OF THE COPPER T380A IUD						
1.	Greet client respectfully and with kindness					
2.	Check to be sure client has emptied her bladder and washed and rinsed her genital area if necessary					
3.	Tell the client what is going to be done and encourage her to ask questions					
4.	Help client onto examination table					
5.	Wash hands thoroughly with soap and water and dry with clean, dry cloth or air-dry					
6.	Put new examination or high -level disinfected surgical gloves on both hands					
7.	Perform bimanual exam: Determine if there is cervical motion tenderness Determine size, shape and position of uterus Palpate adnexa for abnormalities or enlargements					
8.	Insert vaginal speculum to see cervix and IUD strings					
9.	Apply antiseptic solution two times to the cervix, especially the os, and vagina					
10.	Grasp strings close to the cervix with heamostat or other narrow forceps, or long artery forceps, or sponge holding forceps.					
11.	Pull on strings slowly but firmly to remove IUD					
12.	Show IUD to client					
13.	Immerse IUD in 0.5% chlorine solution and dispose of in a leak proof container or plastic bag					
14.	Gently remove speculum and place in 0.5% chlorine solution for 10minutes for decontamination					

POST REMOVAL TASKS						
15.	Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination					
16.	Dispose of waste materials by placing in leak proof container or plastic bag					
17.	Immerse both gloved hands in 0.5% chlorine solution. Remove gloves by turning inside out, place in leak proof container or plastic bag					
18.	Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry					
19.	Record IUD removal in client record					

Sample 4.2: Learning Guide for IUD Counseling Skills

LEARNING GUIDE FOR IUD COUNSELING SKILLS
(To be used by Participants)

Rate the performance of each step or task observed using the following rating scale:

Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

	LEARNING GUIDE FOR IUD COUNSELING SKILLS					
	STEP/TASK	**CASES**				
COUNSELING (INSERTION)						
Initial Interview (Client Reception Area)						
1.	Greet client respectfully and with kindness					
2.	Establish purpose of the visit and answer questions					
3.	Provide general information about family planning					
	Give the woman information about the contraceptive choices available and the benefits and limitations of each: Show where and how the method is used Explain how the method works and its effectiveness Explain possible side effects and other health problems Explain the most common side effects					
5.	Explain what to expect during the clinic visit					
	Method-Specific Counseling (Counseling Area)					
6.	Assure necessary privacy					
7.	Obtain biographic information (name, address, etc.)					
8.	Ask the client about her reproductive goals (Does she want to space or limit births?) and need for protection against GTIs and other STDs					
9.	Explore any attitudes or religious beliefs that either favor or rule out one or more methods					
10.	Discuss the client's needs, concerns and fears in a thorough and sympathetic manner					
11.	Help the client begin to choose an appropriate method					
Client chooses an IUD						
12.	Screen the client carefully to make sure there is no medical condition that would be a problem (compare client screening checklist)					
13.	Explain potential side effects and make sure that each is fully understood					

Pre-Insertion Counseling (Examination/Procedure Area)						
14.	Review Client Screening Checklist to determine if the IUD is an appropriate choice for the client and if she has any problems that should be monitored while the IUD is in place					
15.	Inform client about required physical and pelvic examination					
16.	Check that client is within 7 days of onset of menstrual period					
17.	Check for pregnancy if beyond day 7 (Non-medical counselors should refer client for further evaluation)					
18.	Describe the insertion procedure and what she should expect during the insertion and afterward					
Post-insertion Counseling						
19.	Teach client how and when to check for strings					
20.	Discuss what to do if the client experiences any side effects or problems					
21.	Provide follow up visit instructions					
22.	Remind client of 12-year effectiveness of the Copper T 380A IUD					
23.	Assure client she can return to the same clin ic at any time to receive advice or medical attention and if desired, to have the IUD removed					
24.	Ask the client to repeat instructions					
25.	Answer client questions					
26.	Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.					

COUNSELING (REMOVAL)						
Pre-removal Counseling (Client Reception Areas)						
	STEP/TASK	**CASES**				
		1	2	3	4	5
1.	Greet client respectfully and with kindness					
2.	Establish purpose of visit and answer any questions					
Method-Specific Counseling (Counseling Areas)						
3.	Ask client her reason for removal and answer any questions					
4.	Ask client about her reproductive goals (Does she want to continue spacing or limiting birth?) and need for protection against GTIs and other STIs					
5.	Describe the removal procedure and what she should expect during the removal and afterward					
Post-removal Counseling						
6.	Discuss what to do if the client experiences any problems (e.g. prolonged bleeding or abdominal or pelvic pain)					
7.	Ask client to repeat instructions					
8.	Answer any questions					
9.	If client wants to continue spacing or limiting births using another method, review general and method-specific information about family planning methods					
10.	Help client obta in new contraceptive method or provide temporary (barrier) method until method of choice can be started.					
11.	Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.					

Sample 4.3: Learning Guide for Implant (Jadelle^{R}) Insertion Techniques

LEARNING GUIDE FOR JADELLE^{R} CLINICAL SKILLS

(To be used by **Participants)**

Rate the performance of each step or task observed using the following rating scale:

Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

Task/Activity		Number of Cases				
PRE-INSERTION COUNSELING		**1**	**2**	**3**	**4**	**5**
1.	Greet woman respectfully and with kindness					
2.	Ask woman about her reproductive goals					
3.	If Jad elle^{R} counseling has not been done, arrange for counseling prior to performing the procedure					
4.	Determine that the woman's contraceptive choice is Jadelle^{R}					
5.	Review Client Screening Checklist to determine if the woman is an appropriate candidate for Jadelle^{R}					
6.	Perform (or refer for) further evaluation, if indicated					
7.	Assess woman's knowledge about Jadelle^{R} 's major side effects					
8.	Respond to client's needs and concerns about Jadelle^{R}					
9.	Describe insertion process and what to expect					
INSERTION OF JADELLE^{R} CAPSULES						
10	Ensure that client has thoroughly washed her arm with soap and water					
11	Select and positions woman's arm correctly					
12	Determine the correct area on arm for insertion					
13	Determine that required sterile or high level disinfected (HLD) instruments and the 2 Jadelle^{R} capsules are present					
	PRE-INSERTION TASKS	**1**	2	3	4	5
14.	Wash hands with soap and water					
15.	Put on sterile or HLD gloves					
16.	Correctly, prepare insertion site with antiseptic solution					
17.	Place sterile or HLD drape over arm					
18.	Inject local anaesthesia just under skin; raise a small wheal					
19.	Advance needle to its hub and inject about 1 ml of local anaesthetic in e ach of 2 subdermal tracks (checks for anaesthetic effect)					

INSERTING JADELLE^{R} CAPSULES						
20.	Insert trocar directly subdermally at an angle of 45^{0}					
21.	While tenting the skin, advance trocar and plunger to mark (1) near hub of trocar					
22.	Remove plunger and load the first capsule into trocar (with gloved hand or forceps)					
23.	Reinsert plunger and advance it until resistance is felt.					
24.	Holds plunger firmly in place with one hand and slides trocar out of incision until it reaches plunger handle					
25.	Withdraw trocar and plunger together until mark (2) near trocar tip just clears the insertion wound (does not remove trocar from skin)					
26.	With finger holding previously -placed capsule, guide insertion of trocar and plunger to mark (1)					
27.	Withdraw trocar only after insertion of second capsule					
28.	Palpates capsule to check that the two capsules have been inserted in a fan distribution (20^{0} apart)					
29.	Palpates puncture site to check that two capsule s are well clear of puncture site.					

POST-INSERTION TASKS		**1**	**2**	**3**	**4**	**5**
30.	Close the puncture wound with gauze, band aid or plaster after applying slight iodine solution to the gauze dressing					
31.	Apply pressure dressing snugly					
32.	Properly dispose of waste materials					
33.	Remove reusable gloves correctly and immerse them in chlorine solution					
34.	Wash hands with soap and water					
POST-INSERTION COUNSELING						
35.	Draw the location of capsules in clients record and notes anything unusual					
36.	Instruct the client regarding wound care and return visit					
37.	Assure the client that she can have capsules removed at any time if she desired					

Sample 4.4: Learning Guide for Implant (Implanon^{R}) Insertion Techniques

LEARNING GUIDE FOR IMPLANT (IMPLANON^{R}) INSERTION TECHNIQUES

Rate the performance of each step or task observed using the following rating scale:

Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

	Task/Activity	Number of Cases				
PRE-INSERTION COUNSELING		**1**	**2**	**3**	**4**	**5**
1.	Greet the client respectfully and with kindness					
2.	Ask the client about her reproductive goals					
3.	If Implanon^{R} Counseling not done, arrange for Counseling prior to performing procedure					
4.	Determine that the client's contraceptive choice is Implanon^{R}					
5.	Review the Client Screening Checklist to determine if she is an appropriate candidate for Implanon^{R}					
6.	Perform (or refer for) further evaluation, if indicated					
7.	Assess the client's knowledge about Implanon^{R} major side effects					
8.	Respond to the client's needs and concerns about Implanon^{R}					
9.	Describe the insertion procedure and what to expect					
	GETTING READY					
10.	Check to be sure client has thoroughly washed her arm with soap and water					
11.	Select and position woman's arm correctly					
12.	Mark correct area on arm for insertion					
13.	Determine that required sterile or high level disinfected (HLD) instruments and Implanon^{R} applicator					
PRE-INSERTION TASKS						
	Tasks/Activity	**1**	**2**	**3**	**4**	**5**
14.	Wash hands with soap and water					
15	Put on sterile or HLD gloves					
16	Correctly clean the removal site with antiseptic solution					
17	Place sterile or HLD drape over arm					
18	Inject local anaesthesia just under skin; raise a small wheal					
19.	Advance needle to its hub and inject about 2 ml of local anaesthetic along insertion or removal					

INSERTING IMPLANON CAPSULES						
20.	Stretch skin at insertion site with thumb and index finger and insert tip of needle angled at 20×					
21.	Advance needle to its full length while lifting the skin					
22.	Break the seal of applicator and turn the obturator to 90×					
23.	Fix the obturator w ith one hand against the arm and retract the cannula out of arm					
24.	Check the needle for absence of the Implant					
25.	Palpate to verify presence of implant					
POST-INSERTION TASKS						
26.	Apply sterile gauze with a pressure bandage					
27.	Fill out user card and hands it to client					
28.	Draw position of implant in client record					
29.	Drop applicator in sharps disposal container					
	POST-INSERTION COUNSELING					
30.	Instruct client regarding wound care and return visit					
31.	Assure client that she can have the capsule removed at any time if she desires					
32.	Observe client for at least 5 minutes before sending home					

Sample 4.6: Learning Guide for Implant Removal Skills

LEARNING GUIDE FOR IMPLANT REMOVAL TECHNIQUES (ALL IMPLANTS)

Rate the performance of each step or task observed using the following rating scale:
Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

	Task/Activity	Number of Cases				
PRE-REMOVAL COUNSELING		**1**	**2**	**3**	**4**	**5**
1.	Greet woman respectfully and with kindness					
2.	Ask client her reasons for removal and answer any questions					
3.	Review client's present reproductive goals					
4.	Describe the removal procedure and what to expect					
REMOVAL OF IMPLANT CAPSULES						
GETTING READY						
1.	Check to be sure client has thoroughly washed her arm with soap and water					
2.	Position the client's arm correctly and palpate the capsul es to determine point for removal incision					
3.	Determine that the required sterile or HLD instruments and supplies are present					
PRE-REMOVAL TASKS						
4.	Wash hands with soap and water					
5.	Put on sterile or HLD gloves					
6.	Correctly clean removal site with antiseptic solution					
7.	Place sterile or HLD drape over arm					
8.	Inject small amount of anaesthetic at the incision site and under the end of the capsules (check for anaesthetic effect)					

REMOVAL IMPLANT CAPSULES (STANDARD METHOD)						
	Tasks/Activity	**1**	**2**	**3**	**4**	**5**
9.	Make a small (3 -4 mm) incision with scapel at tip of capsules					
10.	Locate easiest capsules to remove and gently push it towards the incision until the tip is visible					
11.	Grasp end of capsule with small forceps					
12.	If necessary, open fibrous sheath with scapel and remove capsules					
13.	Inject more anaesthetic if required					

DIFFICULT REMOVALS						
14.	If capsules are not close to incision, grasp distant capsule with tips of curved forceps and properly rotate (flips and/or twists) forceps to expose capsules					
15.	Clean fibrous sheaths from implant with scalpel blade, gauze or forceps tip					
16.	Grasp exposed capsule with second forceps and removes it					

REMOVING CAPSULES (POP-OUT METHOD)						
	Tasks/Activity	1	**2**	**3**	**4**	**5**
17.	Push on proximal end of capsules (nearest the shoulder) to cause distal tip (nearest the elbow) to protrude (push up skin)					
18	Open fibrous sheaths over tip with scapel if needed					
19.	Gently squeeze tip into the incision and ''pop out'' capsule through the incision.					
20.	After removal of all the capsules, count again to be sure six complete capsules have been removed and show them to the client					

REMOVING CAPSULES (''U'' TECHNIQUE METHOD)		**CASES**				
	Tasks/Activity	1	**2**	**3**	**4**	**5**
21.	Make a vertical 4 mm incision about 5 mm from the disposal end of the rods between the two implant (or one in case of Implanon^{R} and Implanon NXT^{TM}					
22.	Insert the implant holding forceps through the incision					
23.	Stabilize the closest rod with index finger					
24.	Grasp the rod and pulls towards incision					
25.	Clean off fibrous sheath with gauze or scalpel					
26.	Remove the rod with Crile/Mosquito forceps					
POST-REMOVALS TASKS						
	Tasks/Activity	**1**	**2**	**3**	**4**	**5**
27.	Bring the edges of incision together and place a gauze slightly soaked with iodine on top of it					
28.	Close it with a butterfly bandage, band aid or surgical tape					
29.	Place all instruments in chlorine solution for decontamination					
30.	Property dispose of wastes materials					
31.	Wash hands with soap and water					
POST-REMOVALS COUNSELING						
	Tasks/Activity	1	**2**	**3**	**4**	**5**
32.	Instruct the client regarding wound care and return visit					
33.	Discuss what to do if any problems					
34.	Counsel the client regarding new contraceptive method if desired					
35.	Assist the client in obtaining new contraceptive method or provide temporary (barrier) method until method of choice can be started					
36.	Observe cl ient for at least five minutes before sending home					

COUNSELING (REMOVAL)						
Pre-removal Counseling (Client Reception Areas)						
	STEP/TASK	**CASES**				
1.	Greet client respectfully and with kindness	1	2	3	4	5
2.	Establish purpose of visit and answer any questions					
Method-Specific Counseling (Counseling Areas)						
3.	Ask client her reason for removal and answer any questions					
4.	Ask client about her reproductive goals (Does she want to continue spacing or limiting birth?) and need for protection against GTIs and other STIs					
5.	Describe the removal procedure and what she should expect during the removal and afterward					
Post-removal Counseling						
6.	Discuss what to do if the client experiences any problems (e.g. prolonged bleeding or abdominal or pelvic pain)					
7.	Ask client to repeat instructions					
8.	Answer any questions					
9.	If client wants to continue spacing or limiting births using another method, review general and method -specific information about family planning methods					
10.	Help client obtain new contraceptive method or provide temporary (barrier) method until method of choice can be started.					
11.	Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.					

Sample 4.3: Learning Guide for Implant (Jadelle^{R}) Insertion Techniques

LEARNING GUIDE FOR JADELLE^{R} CLINICAL SKILLS

(To be used by **Participants)**

Rate the performance of each step or task observed using the following rating scale:

> **Needs Improvement:** Step or task not performed correctly or out of sequence (if necessary) or is omitted
>
> **Competently performed:** Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently
>
> **Proficiently performed:** Step or task efficiently and precisely performed in the proper sequence (if necessary)

Task/Activity		**Number of Cases**				
PRE-INSERTION COUNSELING		**1**	**2**	**3**	**4**	**5**
1.	Greet woman respectfully and with kindness					
2.	Ask woman about her reproductive goals					
3.	If Jade lle^{R} Counseling has not been done, arrange for Counseling prior to performing the procedure					
4.	Determine that the woman's contraceptive choice is Jadelle^{R}					
5.	Review Client Screening Checklist to determine if the woman is an appropriate candidate for Jadelle^{R}					
6.	Perform (or refer for) further evaluation, if indicated					
7.	Assess woman's knowledge about Jadelle^{R}'s major side effects					
8.	Respond to client's needs and concerns about Jadelle^{R}					
9.	Describe insertion process and what to expect					
INSERTION OF JADELLE^{R} CAPSULES						
10.	Ensure that client has thoroughly washed her arm with soap and water					
11.	Select and position woman's arm correctly					
12.	Determine the correct area on arm for insertion					
13.	Determine that required sterile or high level disinfected (HLD) instruments and the 2 Jadelle^{R} capsules are present					
	PRE-INSERTION TASKS	**1**	2	3	4	5
14.	Wash hands with soap and water					
15.	Put on sterile or HLD gloves					
16.	Correctly, prepare insertion site with antiseptic solution					
17.	Place sterile or HLD drape over arm					
18.	Inject local anaesthesia just under skin; raise a small wheal					
19.	Advance needle to its hub and inject about 1 ml of local anaesthetic in each of 2 su bdermal tracks (check for anaesthetic effect)					

INSERTING JADELLE^{R} CAPSULES						
20.	Insert trocar directly subdermally at an angle of 45^{0}					
21.	While tenting the skin, advance trocar and plunger to mark (1) near hub of trocar					
22.	Remove plunger and load the first capsule into trocar (with gloved hand or forceps)					
23.	Reinsert plunger and advance it until resistance is felt.					
24.	Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle					
25.	Withdraw trocar and plunger together until mark (2) near trocar tip just clears the insertion wound (does not remove trocar from skin)					
26.	With finger holding previously -placed capsule, guide insertion of trocar and plunger to mark (1)					
27.	Withdraw trocar only after insertion of second capsule					
28.	Palpate capsule to check that the two capsules have been inserted in a fan distribution (20^{0} apart)					
29.	Palpate puncture site to check that two capsules are well clear of puncture site.					

POST-INSERTION TASKS		**1**	**2**	**3**	**4**	**5**
30.	Close the puncture wound with gauze, , band aid or plaster after applying slight iodine solution to the gauze dressing					
31.	Apply pressure dressing snugly					
32.	Properly dispose of waste materials					
33.	Remove reusable gloves correctly and immerse them in chlorine solution					
34.	Wash hands with soap and water					
POST-INSERTION COUNSELING						
35.	Draw the location of capsules in clients record and notes anything unusual					
36.	Instruct the client regarding wound care and return visit					
37.	Assure the client that she can have capsules removed at any time if she desired					

Sample 4.4: Learning Guide for Implant (Implanon^{R}) Insertion Techniques

LEARNING GUIDE FOR IMPLANT (IMPLANON^{R}) INSERTION TECHNIQUES

Rate the performance of each step or task observed using the following rating scale:

Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

Task/Activity		Number of Cases				
PRE-INSERTION COUNSELING		**1**	**2**	**3**	**4**	**5**
1.	Greet the client respectfully and with kindness					
2.	Ask the client about her reproductive goals					
3.	If Implanon^{R} Counseling not done, arrange for Counseling prior to performing procedure					
4.	Determine that the client's contraceptive choice is Implanon^{R}					
5.	Review the Client Screening Checklist to determine if she is an appropriate candidate for Implanon^{R}					
6.	Perform (or refer for) further evaluation, if indicated					
7.	Assess the client's knowledge about Implanon ^{R} major side effects					
8.	Respond to the client's needs and concerns about Implanon^{R}					
9.	Describe the insertion procedure and what to expect					
	GETTING READY					
10.	Check to be sure client has thoroughly washed her arm with soap and water					
11.	Select and position woman's arm correctly					
12.	Mark correct area on arm for insertion					
13.	Determine that required sterile or high level disinfected (HLD) instruments and Implanon^{R} applicator					
PRE-INSERTION TASKS						
	Tasks/Activity	**1**	**2**	**3**	**4**	**5**
5.	Wash hands with soap and water					
6.	Put on sterile or HLD gloves					
7.	Correctly, clean the removal site with antiseptic solution					
8.	Place sterile or HLD drape over arm					
8.	Place sterile or HLD drape over arm					
9.	Inject local anaesthesia just under skin; raises a small wheal					
10.	Advance needle to its hub injects about 2 ml of local anaesthetic along insertion or removal					

INSERTING IMPLANON CAPSULES						
11.	Stretch skin at insertion site with thumb and index finger and insert tip of needle angled at 20×					
12.	Advance needle to its full length while lifting the skin					
13.	Break the seal of applicator and turn the obturator to 90×					
14.	Fix the obturator with one hand against the arm and retract the cannula out of arm					
15.	Check the needle for absence of the Implant					
16.	Palpate to verify presence of implant					
POST-INSERTION TASKS						
17.	Apply sterile gauze with a pressure bandage					
18.	Fill out user card and hand it to client					
19.	Draw position of implant in client record					
20.	Drop applicator in sharps disposal container					
	POST-INSERTION COUNSELING					
21.	Instruct client regarding wound care and return visit					
22.	Assure client that she can have the capsule removed at any time if she desires					
23.	Observe client for at least 5 minutes before sending home					

Sample 4.6: Learning Guide for Implant Removal Skills

LEARNING GUIDE FOR IMPLANT REMOVAL TECHNIQUES (ALL IMPLANTS)

Rate the performance of each step or task observed using the following rating scale:
Needs Improvement: Step or task not performed correctly or out of sequence (if necessary) or is omitted

Competently performed: Step or task performed correctly in proper sequence (if necessary) but participant does not progress from step to step efficiently

Proficiently performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)

	Task/Activity	Number of Cases				
PRE-REMOVAL COUNSELING		**1**	**2**	**3**	**4**	**5**
1.	Greet woman respectfully and with kindness					
2.	Ask client her reasons for removal and answers any questions					
3.	Review client's present reproductive goals					
4.	Describe the removal procedure and what to expect					
REMOVAL OF IMPLANT CAPSULES						
GETTING READY						
1.	Check to be sure client has thoroughly washed her arm with soap and water					
2.	Position the client's arm correctly and palpate the capsules to determine point for removal incision					
3.	Determine that the required sterile or HLD instruments and supplies are present					
PRE-REMOVAL TASKS						
4.	Wash hands with soap and water					
5.	Put on sterile or HLD gloves					
6.	Correctly, clean removal site with antiseptic solution					
7.	Place sterile or HLD drape over arm					
8.	Inject small amount of anaesthetic at the incision site and under the end of the capsules (checks for anaesthetic effect)					

REMOVAL IMPLANT CAPSULES (STANDARD METHOD)						
	Tasks/Activity	**1**	**2**	**3**	**4**	**5**
9.	Make a small (3 -4 mm) incision with scalpel at tip of capsules					
10.	Locate easiest capsule to remove and gently push it towards the incision until the tip is visible					
11.	Grasp end of capsule with small forceps					
12.	If necessary, open fibrous sheath with scalpel and remove capsules					
13.	Inject more anaesthetic if required					

DIFFICULT REMOVALS						
14.	If capsules are not close to incision, grasp distant capsule with tips of curved fo rceps and properly rotate (flip and/or twist) forceps to expose capsules					
15.	Clean fibrous sheaths from implant with scalpel blade, gauze or forceps tip					
16.	Grasp exposed capsule with second forceps and remove it					

REMOVING CAPSULES (POP-OUT METHOD)						
	Tasks/Activity	1	**2**	**3**	**4**	**5**
17.	Push on proximal end of capsules (nearest the shoulder) to cause distal tip (nearest the elbow) to protrude (push up skin)					
18	Open fibrous sheaths over tip with scalpel if needed					
19.	Gently squeeze tip into the incision and ''pops out'' capsule through the incision.					
20.	After removal of all the capsules, count again to be sure six complete capsules have been removed and show them to the client					

REMOVING CAPSULES (''U'' TECHNIQUE METHOD)		**CASES**				
	Tasks/Activity	1	**2**	**3**	**4**	**5**
21.	Make a vertical 4 mm incision about 5 mm from the disposal end of the rods between the two implant (or one in case of Implanon^{R} and Implanon NXT^{TM}					
22.	Insert the implant holding forceps through the incision					
23.	Stabilize the closest rod with index finger					
24.	Grasp the rod and pulls towards incision					
25.	Clean off fibrous sheath with gauze or scalpel					
26.	Remove the rod with Crile/Mosquito forceps					
POST-REMOVALS TASKS						
	Tasks/Activity	**1**	**2**	**3**	**4**	**5**
27.	Bring the edges of incision together and place a gauze slightly soaked with iodide on top of it					
28.	Close it with a butterfly bandage, band aid or surgical tape					
29.	Place all instruments in chlorine solution for decontamination					
30.	Properly dispose of wastes materials					
31.	Wash hands with soap and water					
POST-REMOVALS COUNSELING						
	Tasks/Activity	1	**2**	**3**	**4**	**5**
32.	Instruct the client regarding wound care and return visit					
33.	Discuss what to do if any problems arise					
34.	Counsel the client regarding new contraceptive method, if desired					
35.	Assist the client in obtaining new contraceptive method or provide temporary (barrier) method until method of choice can be started					
36.	Observe c lient for at least five minutes before sending home					

MODULE FIVE

INSERTION AND REMOVAL TECHNIQUES FOR IUD AND IMPLANTS

Session 1: CuT 380A Insertion Techniques

Session 2: Jadelle^{R} Implants Insertion Techniques

Session 3: Implanon^{R} and Implanon NXT^{TM} Insertion Technique

Session 4: IUD CuT 380A Removal Techniques

Session 5: Implant (Jadelle^{R}, Implanon^{R} and Implanon NXT^{TM}) Removal Techniques

Module Five - Session 1: IUD Insertion Techniques

Time: 1 hour

Learning Objectives

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

- Identify the equipment and materials for IUD insertion procedures
- State timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods
- Demonstrate the correct steps in the IUD insertion procedure and explain the rationale for each step.
- Demonstrate loading of the CuT 380A IUD in the package.
- Explain the instructions to be given to clients after insertion.
- Schedule follow-up appointments with the clients after the procedure.

Session Overview

- **Equipment and materials for CuT 380A IUD insertion procedures**
- Timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods
- Demonstration of loading of the CuT 380A IUD in the package.
- Demonstration of the correct steps in the CuT 380A IUD insertion procedure and the reasons for each step.
- Instructions to be given to clients after insertion.
- Scheduling follow-up appointments with the clients after the procedure.

Methods

- Lecture/Presentation/Video clip
- Demonstration and Return Demonstration
- Discussion
- Brainstorming

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector and Laptop
- CuT 380 A IUDs
- Hand Models
- Pelvic Models (Madam Zoe)
- Learning Guide for IUD Insertion Techniques

Module Five - Session 1: IUD Insertion Techniques

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
IUD Insertion Techniques	I hour	▪ Identify the equipment and materials for IUD insertion procedures ▪ State the timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods ▪ Demonstrate the correct steps in the IUD insertion procedure and explain the rationale for each step. ▪ Demonstrate loading of the IUD in the package. ▪ Explain the instructions to be given to clients after insertion. ▪ Schedule follow-up appointments with the clients after the procedure.	▪ Lecture/Presentation ▪ Video clip ▪ Demonstration and Return Demonstration ▪ Discussion ▪ Brainstorming ▪ Exercises	▪ Flip chart ▪ Markers ▪ LCD Projector ▪ Laptop ▪ Hand models ▪ Pelvic Models ▪ Learning Guide for IUD Insertion Techniques

SESSION PRESENTATION

A. Introduction

State the timing of insertion with regard to menstruation, postpartum, post-abortion and lactation periods

- The Trainer displays and reviews the learning objectives for this module.
- The Trainer informs the participants that:
  - Many of the problems associated with CuT 380A IUDs (expulsion, infection and perforation) are due to improper or careless insertion.
  - To minimize post-insertion problems, all phases of the insertion process must be performed carefully and gently.
- The Trainer displays the slide on "Time of Insertion" and emphasizes the following:

Interval and postpartum: IUD can be inserted:

- anytime during the menstrual cycle, provided pregnancy has been ruled out
- if woman is within the first 12 days of her menstrual cycle, no need for a pregnancy test or other means to rule out pregnancy
- if it is more than 12 days after the start of monthly bleeding, provider should rule-out pregnancy by other means (pregnancy checklist, pregnancy test, etc.)
- no back-up method is needed after IUD insertion regardless of timing
- immediately or within the first 12 days after abortion if there is no infection
- four to six weeks after a vaginal delivery or Caesarean section (if not inserted within the first 48 hours postpartum)

Postpartum IUD (PPIUD) can be inserted only by trained personnel:

- within 10 minutes post-delivery of placenta — ***post-placental***
- after 10 minutes but within 48 hours of delivery — ***pre-discharge***
- during caesarean section — ***trans-Caesarean***

B. Identify the equipment and materials for IUD insertion procedures

- The Trainer displays the equipment and materials for IUD insertion procedures and requests the participants to identify each, including the following:

  - Examination couch/insertion couch
  - Light source (torch or angle-poised lamp)

- A trolley containing the following:
  - Speculum (various sizes)
  - Tenaculum/Bonney Stops forceps
  - Sponge holding forceps
  - Uterine sound (plastic preferably)
  - A pair of scissors
  - Sterile gloves
  - Plastic dilators
  - Straight artery forceps
  - Gallipots (2)
  - IUDs
  - Inserters and introducers (where applicable)
  - Antiseptic lotion (e.g. *Savlon*, *Hibitane*, *Purit, 10% Povidone Iodine)*
  - Sterile receiver with cover containing 1 in 2500 iodine solution or 75% alcohol
  - Bowl with lid, swabs, pads, sterile towel
  - Sodium hypochlorite bleach (e.g. *Jik*, *Parozone*) 0.5% Solution

♦ The Trainer emphasizes that:

If the instruments come in a sterile or HLD pack, do not open the pack before the screening pelvic examination has been completed and a final decision to insert the IUD has been made.

C. Demonstration of the correct steps in the IUD insertion procedure and explaining the rationale for each step including loading of the IUD in the package.

♦ The Trainer demonstrates the following steps:

- Client preparation
- General examination (including breasts and abdomen)
- Pelvic examination (including speculum examination)
- Cleaning of the vagina
- Placement of the tenaculum
- Passage of uterine sound

Procedure

Client preparation

- Screen client for eligibility using the **screening checklist for initiation of IUD.**
- Explain the procedure of IUD insertion to the client to ensure her cooperation and relaxation
- Demonstrate the procedure with a hand held uterine or pelvic model (where available)
- Ensure that she has emptied her bladder

Steps

- Do a general physical examination of the:
  - breasts for abnormal masses and discharge
  - abdomen for masses and tenderness
- Perform a pelvic examination wearing sterile gloves
  - external genitalia — lesions, abnormal discharge
  - bimanual examination

- note shape, size, position, tenderness, and mobility of the uterus
- feel for the adnexa — whether ovaries are enlarged or fallopian tubes thickened and tender

- Perform speculum examination to exclude abnormal vaginal discharge, cervicitis. If infection is found/suspected, postpone insertion
- Take a pap smear (if none has been done in the past two years)

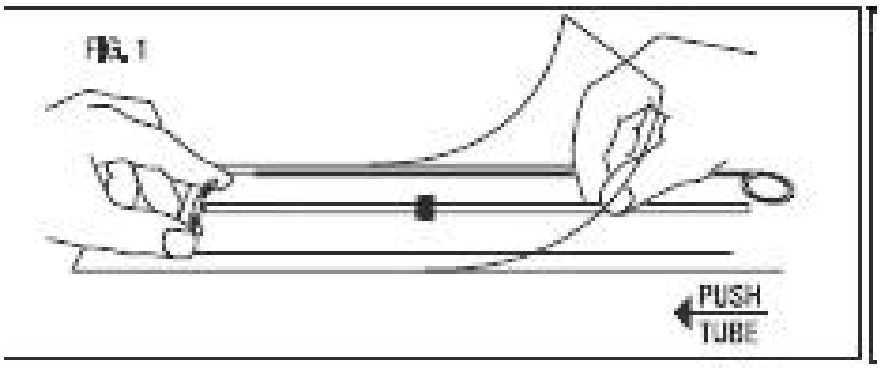
If all the above are normal

- Leave clean Cusco's/Graves speculum in the vagina
- Clean the vagina and cervix with antiseptic solution (*Savlon* or mixture of Chlorhexidine and *Savlon*)
- Grasp anterior lip of the cervix with a tenaculum (at 10 o'clock and 2 o'clock positions to minimize bleeding)
- Gently place traction on the cervix with the tenaculum to reduce the angle between the uterine body and the cervix
- While maintaining traction on the tenaculum, gently pass a uterine sound into the uterine cavity until contact is made with the fundus
- Measure the depth from the external os to the top of the fundus by withdrawing the sound and looking at the level of blood or mucus on the sound or by marking the level of the external os on the uterine sound with your index finger before withdrawing the sound.
- If depth is less than 6cm or greater than 9cm, discontinue procedure.
- Load the device into the inserter

Loading the IUD in the package:

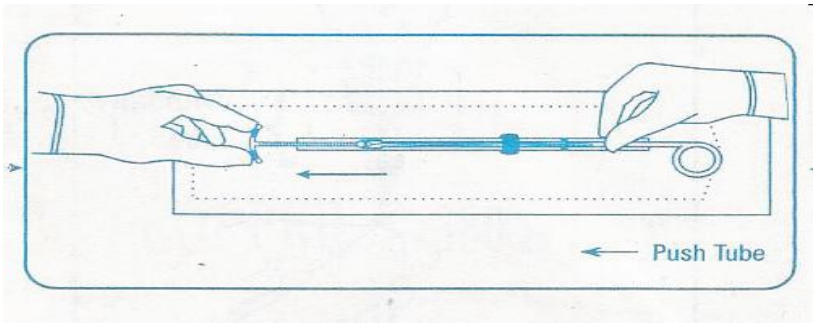
♦ The Trainer displays the slide containing Figure 5.1.1– "Loading the IUD in the package" and demonstrates the activity as s/he displays the slides containing Figures 5.1.2 (Bending the T-arms and pushing into the tube), Figure 5.1.2 (Pushing the T-arms into the Tube), and Figure 5.1.3 (IUD loaded in the package; ready for insertion).

Figure 5.1.1: Loading the IUD in the Package



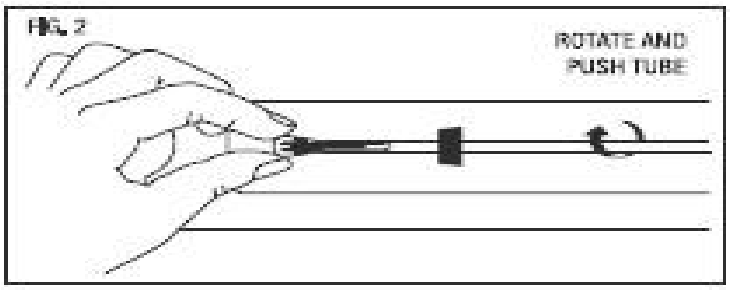
Bring the thumb and index finger closer together to continue bending the arms until they are alongside the stem. Use the other hand to withdraw the insertion tube just enough so that the insertion tube can be pushed and rotated onto the tips of the arms. Your goal is to secure the tips of the arms inside the tube (Fig. 5.1.3).

Figure 5.1.2: Loading the IUD in the Package; Bend the T arms and push into the tube



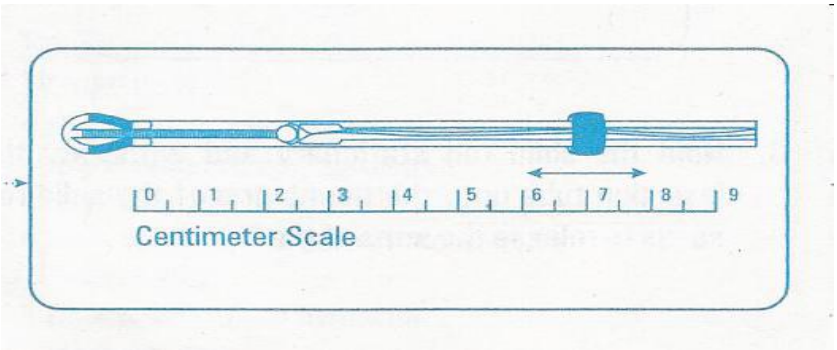
Note: Insert the arms no further than necessary to insure retention

Figure 5.1.3: Loading the IUD in the Package, Push the T arms into the Tube



Introduce the solid white rod into the insertion tube from the bottom, alongside the threads, **until it touches the bottom of the CuT 380A.**

Figure: 5.1.4: IUD loaded in the Package; ready for Insertion



- The Trainer explains and demonstrates the steps for intra-uterine placement of the pre-loaded CuT 380A as she displays the slides containing Figures 5.1.4 (Introducing loaded IUD into the uterus), Figure 5.1.5 (Withdrawing the tube to release the T-arms), Figure 5.1.6 (Pushing the tube up without moving the rod), 5.1.6 (Holding the tube steady while withdrawing the white rod) and Figure 5.1.7 (IUD correctly placed in the uterine cavity).

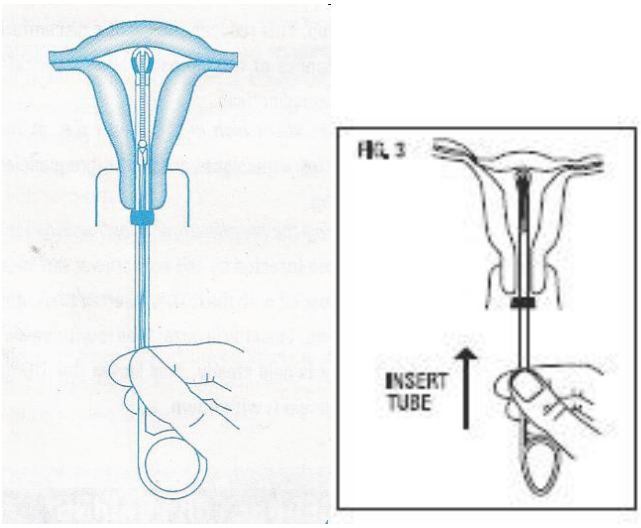
STEPS FOR INTRAUTERINE PLACEMENT OF THE PRE-LOADED Cu T 380A

Note: To introduce the loaded inserter using the withdrawal method, observe the no-touch technique in all steps, (i.e. loading the **IUD** in the inserter inside the sterile package):

- Clean the cervix with antiseptic
  - be careful not to touch the vaginal wall or speculum with the uterine sound or loaded IUD/inserter
  - pass either the uterine sound or the loaded **IUD** inserter, **only once,** through the cervical canal

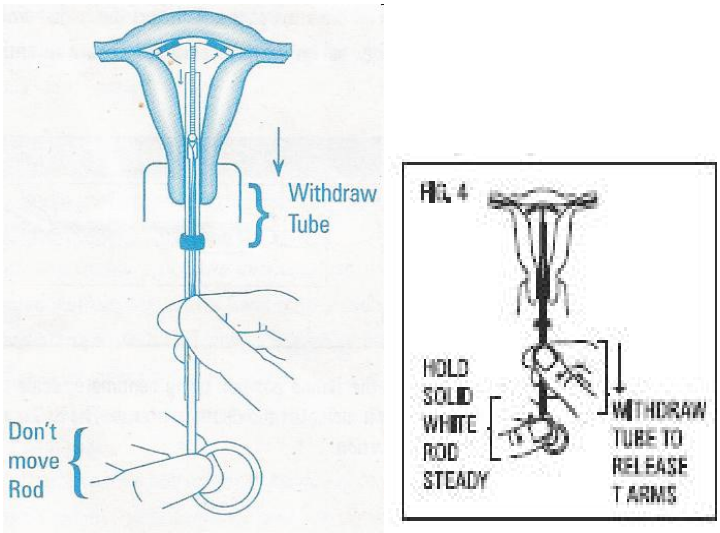
- Grasp the insertion tube at the open end of the package; adjust the blue flange so that the distance from the top of the Cu T 380A (where it protrudes from the inserter) to the blue flange is the same as the uterine depth that you measured with the sound.
- Rotate the insertion tube so that the horizontal arms of the T and the long axis of the blue flange lie in the same horizontal plane (Fig. 5.1.5).
- Now pass the loaded insertion tube through the cervical canal until the Cu T 380A just touches the fundus of the uterus. The blue flange should be at the cervix in the horizontal plane.

Figure 5.1.5: IUD Insertion: Introduce loaded IUD into the uterus



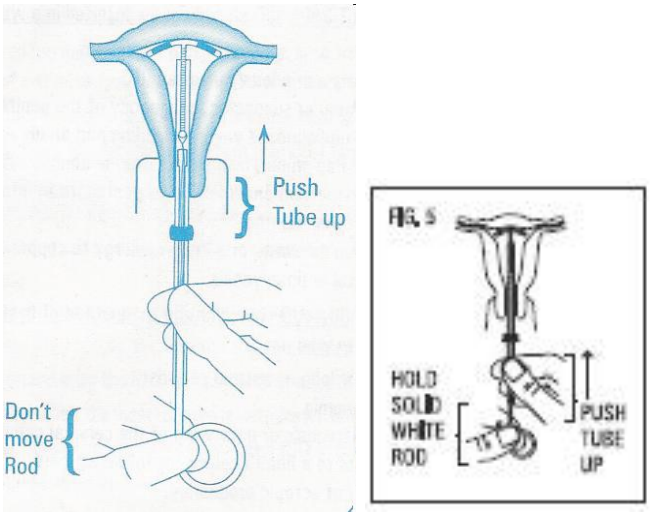
- To release the arms of Cu T 380A, hold the solid white rod steady and withdraw the insertion tube no more than one centimeter. This releases the arms of Cu T 380A high in the uterine fundus (Fig.3)

Figure 2: Keep the rod steady; withdraw the Tube to release the T-arms



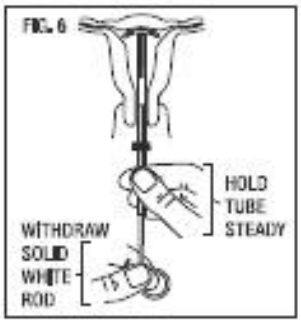
- Gently and carefully move the insertion tube upward toward the top of the uterus, until slight resistance is felt. This will ensure placement of the T at the highest possible position within the uterus (Fig. 5).

Figure 3: Pushing the Tube up: Don't Move Rod



- Hold the insertion tube steady and withdraw the solid white rod (Fig. 6).

Figure 4: Hold the tube steady; withdraw the white rod

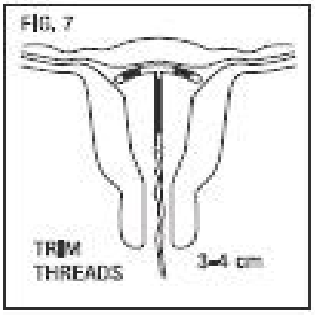


- Gently and slowly withdraw the insertion tube from the cervical canal. Only the threads should be visible protruding from the cervix. (Fig. 7).

- Wrap the threads around the client's cervix. DO NOT TRIM THE THREAD.

Note: If you suspect that the Cu T 380A is not in the correct position, check placement (with ultrasound, if necessary). If the Cu T 380A is not positioned completely within the uterus, remove it and replace it with a new Cu T 380A.
Do not reinsert an expelled or partially expelled CU T380A IUD.

Figure 5: IUD correctly placed in the uterine cavity.



D. Explanation of the instructions to be given the clients after insertion

♦ The Trainer demonstrates the Post-Insertion Procedure for CuT 380A as follows:

- o Asks the client about pain, fainting attacks, or any other discomfort
- o Allows the client to rest on the couch for a few minutes and then helps her down
- o Records findings and gives 4–6 weeks appointment

♦ The Trainer should emphasize that participants must inform the client that there may be increased bleeding and/or cramping for a few days and that these are normal.

♦ S/he advises the client as follows:

- o Heavier menstrual bleeding, and possible bleeding between periods is common for the first 3–6 months after insertion;
- o Inspect all sanitary pads or panties during menses because expulsion is more common during menstruation.
- o Check for string after each menstrual period (recommended, but not required if woman is uncomfortable inserting fingers into vagina);
- o If at risk of STIs (e.g. multiple sexual partners, or partner with multiple partners), use condoms in addition to IUD for dual protection
- o Tell the client that she may have sexual intercourse as soon as it is comfortable for her;
- o Report to the nearest family planning clinic if you notice any of the following:
  - **P** - period late or abnormal bleeding
  - **A** - abnormal pain or pain with intercourse
  - **I** - infection exposure, such as gonorrhoea, abnormal discharges
  - **N** - not feeling well, fever or chills
  - **S** - strings missing, shorter or longer
- o Inform your physician of the presence of an IUD if you are going for any gynaecological surgical procedure
- o Maintain good personal hygiene

E. Schedule follow-up appointments with the clients after the procedure

♦ The Trainer displays the slide on “Follow-up Visits” and outlines the instructions as follows:

First visit (4–6 weeks after insertion)

- o Ask the client about her health generally
- o Ask about any complaints
- o Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting, excessive blood loss, and painful menstruation

- Ask her when she last felt the strings of the device (if she checks the strings)
- Carry out abdominal and pelvic examination
- Inspect the cervix to confirm the presence of strings, if long, trim
- Note any cervical discharge
- Palpate for pelvic tenderness
- Advise client on personal hygiene

Schedule of subsequent follow-ups (if all is well):

- Yearly visits until the client wishes to have the device removed or the life span of the device expires - CuT-380A — 12 years;
- Repeat the activities of first visit at each subsequent visit;
- Encourage a pap smear every two years

F. Summary/Evaluation

♦ The Trainer summarizes the session by stating that:

- Long-term success, as defined by satisfied clients and high continuation rates, will occur only if CuT 380A IUD insertion is properly conducted and the provider recognizes the importance of providing follow-up care (including Counseling) and prompt management of side effects as well as other problems should they occur.

♦ The Trainer requests the participants to respond to the following questions:

- Mention the steps of the correct procedure for Cu T380A IUD insertion;
- Present the post-insertion instructions and correct procedure for follow-up visits.
- State the warning signs a client must report

Module Five- Session 2: Jadelle[R] Implant Insertion Techniques
Time: 1 hour 30 minutes

Learning Objectives

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

- List the timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods
- Identify the equipment and materials for Jadelle[R] Implants insertion procedures
- Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants
- Demonstrate the unique insertion techniques of Jadelle[R] implants
- Demonstrate the correct application of dressing after insertion.
- Explain the instructions to be given to clients after insertion.
- Schedule follow-up appointments with the clients after the procedure.

Session Overview

- Equipment and materials for Jadelle[R] implants' insertion procedures
- Timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods
- Demonstration of the correct insertion technique for Jadelle[R] implants with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants
- Demonstration of the correct application of dressing after insertion.
- Instructions to be given to clients after insertion.
- Scheduling follow-up appointments with the clients after the procedure.

Methods

- Lecture/Presentation/video clip
- Demonstration and Return Demonstration
- Discussion
- Brainstorming

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector and Laptop
- Jadelle[R] implants
- Arm Models
- Learning Guide for Jadelle[R] implants' Insertion Techniques

Module Five- Session 2: Jadelle[R] Implants' Insertion Techniques

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Jadelle[R] and Implants' Insertion Techniques	I hour 30 minutes	♦ List the timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods; ♦ Identify the equipment and materials for Jadelle[R] Implants insertion procedures; ♦ Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants; ♦ Demonstrate the unique insertion techniques of Jadelle[R] and Zarin[R] implants; ♦ Demonstrate the correct application of dressing after insertion; ♦ Explain the instructions to be given to clients after insertion; ♦ Schedule follow-up appointments with the clients after the procedure.	× Lecture/Presentation × Video clip × Discussion × Brainstorming × Demonstration and Return Demonstration	× Flip chart × Markers × LCD Projector × Laptop × Jadelle[R] Implants × Learning Guide for Jadelle[R] Implants' Insertion Techniques

Module Five- Session 2: Jadelle^{R} Implants' Insertion Techniques

A. Introduction

State the timing of insertion with regard to menstruation, postpartum, post-abortion and lactation periods

- The Trainer displays and reviews the learning objectives for this module.
- The Trainer informs the participants that:
  - Insertion techniques involve correct subdermal placement of the implants.
  - The insertion procedure for Implanon is slightly different from those of Jadelle and is described separately.
- The Trainer displays the slide on "Time of Insertion" and emphasizes the following:

Having menstrual cycles

- Any time it is reasonably certain that she is not pregnant; *If she is not at risk of pregnancy (for example, has not had sex since last menstrual period), she may start using Implants at any time she wants;*
- If starting during the first 7 days after menstrual bleeding starts, and she is still bleeding, no back-up method is needed for extra protection;
- If she is not bleeding or she is starting on or after day 8 of her menstrual period, she should use condoms or avoid sex for 48 hours after insertion. If possible, give her condoms.

Breastfeeding

- Immediately or at any time after childbirth
- Fully or nearly fully breastfeeding effectively prevents pregnancy for at least 6 months or until she has a menstrual period, whichever comes first, implants can give her extra protection if she wants it.
- If only partially breastfeeding and child receives much other food or drink, 6 weeks after childbirth is the best time to start using implants. If she waits longer, fertility may return.
- If menstrual periods have returned, she can start implant any time it is reasonably certain that she is not pregnant. See "Having Menstrual Cycles", above

After Childbirth, if not Breastfeeding

- Immediately or at any time in the first 6 weeks after childbirth. No need to wait for her menstrual period to return;

- After 6 weeks, any time it is reasonably certain, that she is not pregnant. If not reasonably certain, she should avoid sex or use condom until her first period begins and then start Jadelle Implant.

After Miscarriage or Abortion

- Immediately or in the first 7 days after either first or second – trimester miscarriage or abortion
- Later, any time it is reasonably certain that she is not pregnant

When stopping another method

- Immediately

B. Identifying equipment and materials for Jadelle[R] Implants insertion procedures

♦ The Trainer displays the equipment and materials for Jadelle insertion procedures and requests the participants to identify each, including the following:

- One set of implant capsules
- Trocar and cannula as supplied
- Sterilized surgical drapes
- Sterile gloves preferably devoid of talcum powder
- Antiseptic solution like *Savlon, Hibitane* or *Betadine*
- Local anesthetic agent like *Xylocaine* 1%
- Syringe and needle
- Sterile gauze*/c*otton wool
- Plaster
- Artery forceps (2)
- Scalpel and blade (size 12) (optional)
- Examination couch with arm rest
- Disinfectant solution, e.g. *Jik*
- Plastic bowl

C. Demonstrating the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants

Client Preparation

♦ The Trainer demonstrates the following steps as *Client preparation*

- Give clear information about probable changes in bleeding pattern during the menstrual cycle and other possible side effects;

- Describe the insertion and removal procedures and what the client should expect during and afterwards;

- Ensure client's cooperation and relaxation;

- Review client assessment data to determine if the client is an appropriate candidate for implants or if she has any problems that should be monitored more frequently while the implants are in place;

- Do a general examination;

- Do a pelvic examination *if needed or requested by client* (pelvic examinations are not necessary for safe implant initiation and use, but may be indicated for other reasons and are part of the preventive medicine practices and health promotion);

  - Instruct the client to lie on the couch with arm stretched out comfortably

  - Support client's arm with arm rest

  - Use proper infection prevention procedure

  - Wash hands

  - Ask the patient to lie down on the examination table with her non-dominant arm extended on a sterile cloth on the other table, at right angles to her body.

  - Clean the area of insertion with antiseptic solution: iodine (if available) and finally with spirit

  - Apply sterile drapes exposing the insertion area only (under the skin of the upper arm).

D. Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants

♦ The Trainer explains and demonstrates the steps for the correct and subdermal placement of Jadelle^{R} as s/he displays the relevant slides:

Steps for inserting contraceptive implant

- Instruct the client to lie on the couch with arm stretched out comfortably
- Support arm with arm rest
- Use proper infection prevention procedure
- Wash hands
- Ask the patient to lie down on the examination table with her non-dominant arm extended on a sterile cloth on the other table, at right angles to her body. The implants will be inserted subdermally in the shape of a narrow V, opening towards the armpit.
- Clean the area of insertion with antiseptic solution: iodine (if available) and finally with spirit
- Apply sterile drapes exposing the insertion area only (under the skin of the upper arm).

Figure 5.2.1: Subdermal placement of Jadelle^{R} implants

- Clean the client's upper arm with an antiseptic solution, and cover the arm with either two sterile clothes or a dry sterile fenestrated drape. The optimal insertion area is in the medial aspect of the upper arm about 6 – 8 cm above the fold of the elbow.

- Open the Jadelle^{R} pouch by pulling apart the films of the pouch and let the two implants drop on a sterile cloth. Do not touch the inside of the package or its contents with bare hands. There should be two implants.

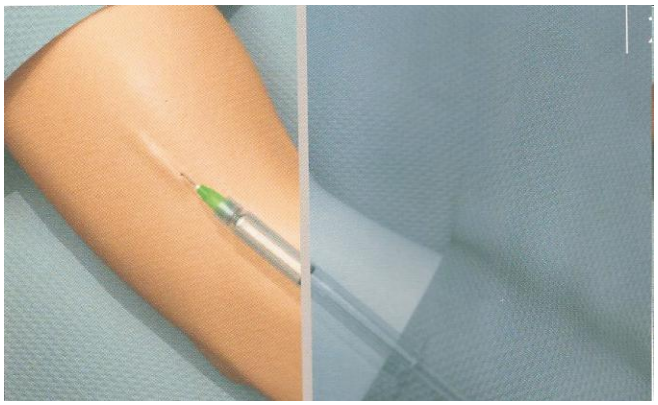
Note: Always use sterile gloves or forceps when handling the rods. If an implant is contaminated, e.g. falls on the floor, leave it for later disposal. Open a new package and continue with the procedure.

- First determine the absence of known allergies to the anaesthetic agent or related drugs. Fill the syringe with 2 – 4 mls of local anaesthetic.

- Anaesthetize the insertion area by inserting the needle just under the skin about 4 to 5.5 cm in the direction where you are planning to introduce the trocar.

- Insert the trocar directly through the skin without making an incision with a scalpel.

Figure 5.2.2: Anaesthetizing the insertion area



- The trocar has two marks. The mark close to the handle indicates how far the trocar should be introduced under the skin before loading the implant. The mark closest to the tip indicates how much of the trocar should be left under the skin following the insertion of the first implant. When inserting the trocar, avoid touching the part of the trocar that will go under the skin.

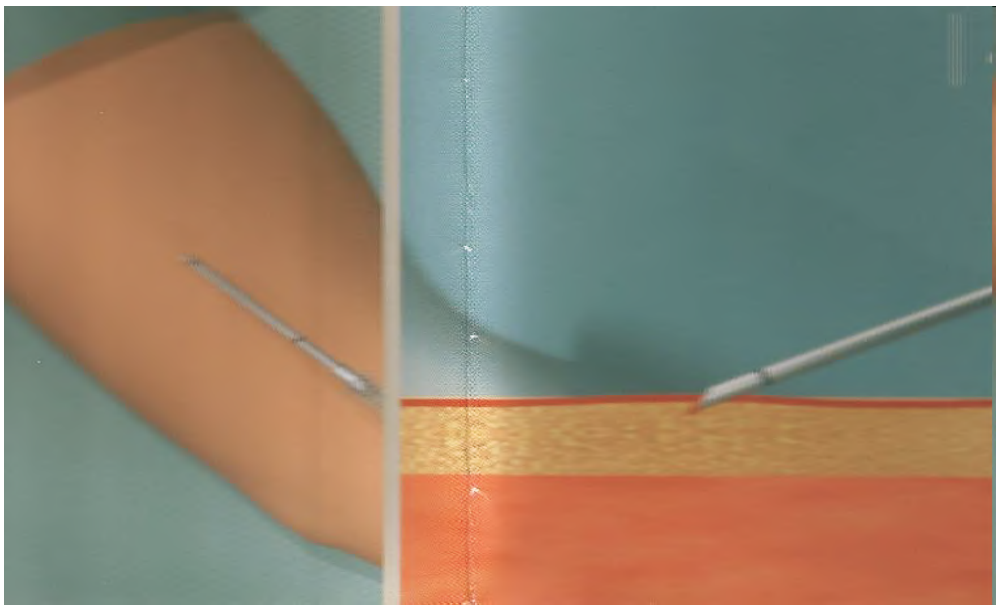
Figure 5.2.3: Marks on the Trocar

- Once the tip of the trocar is beneath the skin, it should be directed along the skin horizontally by pointing slightly upwards toward the raising on the skin (tenting) to keep the implant in the subdermal plane. Throughout the insertion procedure, the trocar should be oriented with the bevel up.

Note: It is important to keep the trocar subdermal by tenting the skin with the trocar, as failure to do so may result in deep placement of the implants causing a more difficult removal.

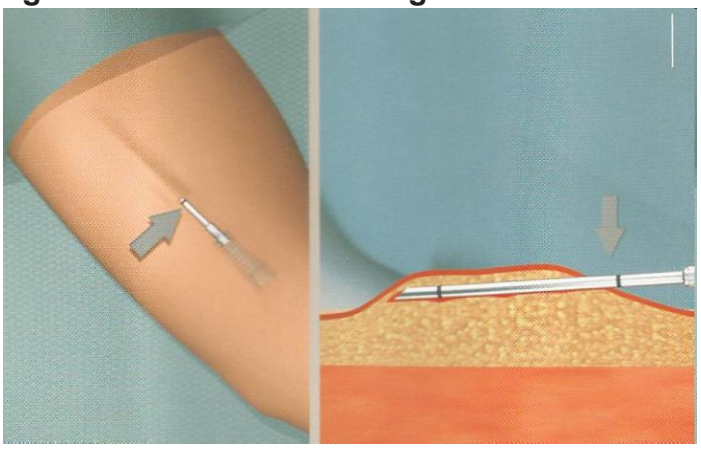
Do not force the trocar, and if you feel any resistance, try another direction.

Figure 5.2.4: Introducing the trocar just beneath the skin



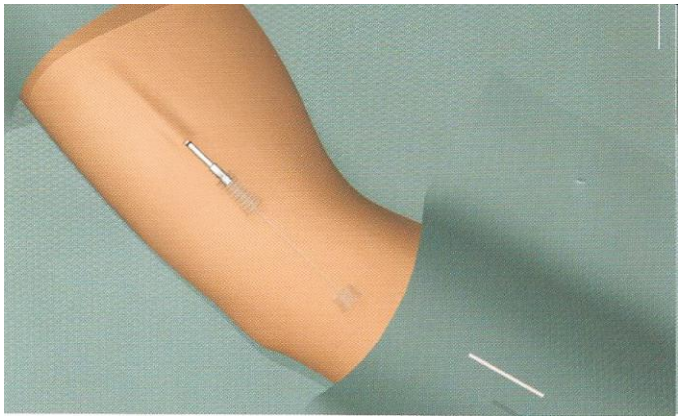
- Advance the trocar beneath the skin about 5.5 cm from the incision to the mark closest to the handle of the trocar

Figure 5.2.5: Advancing to the mark while tenting



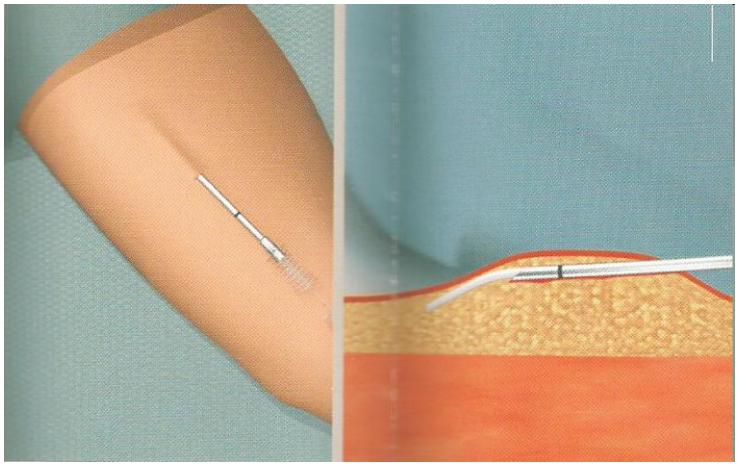
- Remove the plunger when the trocar is advanced to the correct mark (Figure 5.2.6.
- Load the first implant into the trocar either with tweezers or fingers.
- Push the implant gently with the plunger to the tip of the trocar until resistance is felt. Never force the plunger.

Figure 5.2.6: Removing the plunger and loading the first implant



- Hold the plunger steady and pull the trocar back along it until it touches the handle of the plunger. Do not completely remove the trocar until both implants have been placed. The trocar is withdrawn only to the mark closest to its tip.

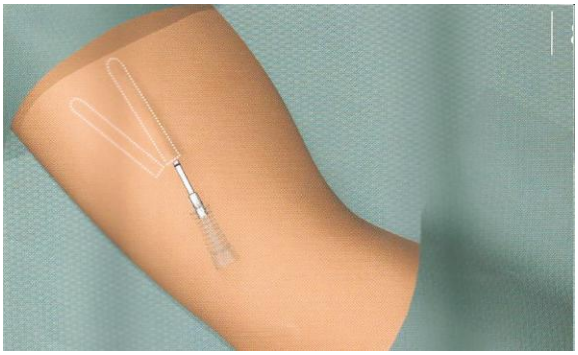
Figure 5.2.7: Holding the plunger steady and pulling the trocar to the mark near the tip



Note: It is important to keep the plunger steady and not to push the implant into the tissue

- When you can see the mark near the tip of the trocar in the incision, the implant has been released and will remain in place beneath the skin. You can check by palpation.
- Insert the second implant next to the first one to form a V-shape. Advancing again to the mark.

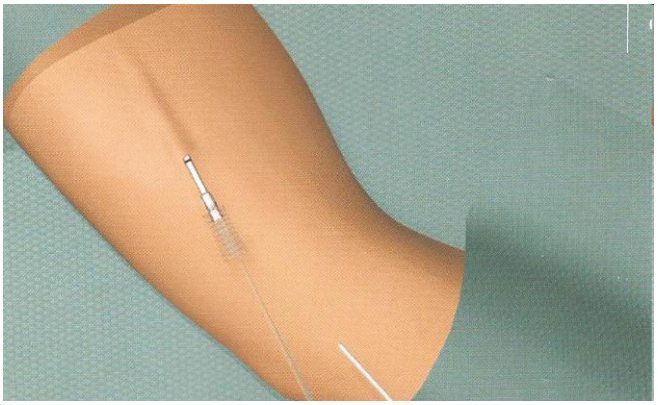
Figure 5.2.8: Inserting the second implant. Advancing again to the mark forming a narrow "V"



- Fix the position of the first implant with the left fore-finger and advance the trocar along the side of the finger. This will ensure a suitable distance between implants.

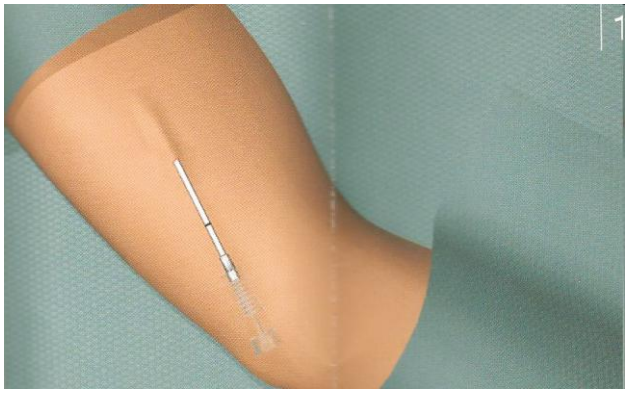
- Remove the plunger and load the second implant.

Figure 5.2.9: Loading the second implant



- Hold the plunger steady while pulling the trocar back (figure 4.2.10).

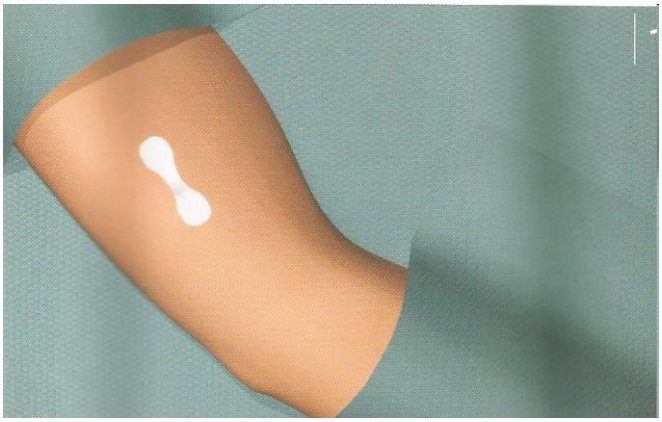
Figure 5.2.10: Holding the plunger steady while pulling the trocar back



- To prevent expulsion, leave a distance of about 5 mm between the puncture sites and the ends of the implants. Their correct position can be checked by cautious palpation of the insertion area.

- After the insertion, apply a small gauze slightly soaked in iodine solution before covering with plaster/Elastoplast.

Figure 5.2.11: Closing the incision



- Observe the client at the clinic for a few minutes for signs of syncope or bleeding from the incision before she is discharged.

F. Instructions to the service provider following the insertion of the implants

♦ The Trainer informs the participants that the client should be observed at the clinic for 10 – 15 minutes for signs of syncope or bleeding from the incision before she is discharged.

♦ The Trainer provides the participants with clear instructions regarding *Waste Disposal and Decontamination* as follows:

- Before removing gloves, place instruments into a container filled with 0.5% chlorine solution for decontamination.
- The surgical drape (if used) must be washed before reuse. Place in a dry covered container and remove to the designated washing area.
- While still wearing gloves, place all 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.
- Immerse both gloved hands briefly in chlorine solution and then carefully remove gloves by turning inside out and place in the waste container;
- Wash hands thoroughly with soap and water.
- All waste materials should be disposed of by burning or burying

G. Client Care after the procedure

- Place a note in the client's record indicating the location of the capsules and specifying any unusual events that may have occurred during insertion. (A simple drawing showing the approximate location of the capsules in the client's arm is helpful).
- Observe the client for at least 15 to 20 minutes for bleeding from the incision or adverse effects before sending her home. She should be given written post insertion care instructions (if available) as appropriate.

H. Client's instructions for wound care at home

- There may be bruising, swelling or tenderness at the insertion site for a few days. This is normal.
- Keep the area around the insertion site dry and clean for at least 48 hours. The incision could become infected if the area gets wet while bathing.
- Leave the gauze pressure and plaster in place for 48 hours and the bandage or surgical tape in place until the incision heals (i.e. normally 3 to 5 days).
- Routine work can be done immediately. Avoid bumping the area, carrying heavy loads or applying unusual pressure to the site.
- After healing, the area can be touched and washed with normal pressure.
- If signs of infection occur, such as fever with inflammation (redness plus heat) at the site, or if there is persistent arm pain for several days, return to the clinic.

I. Schedule follow-up appointments with the clients after the procedure

♦ The Trainer displays the slide on “Follow-up Visits” and outlines the instructions as follows:

First visit (3 – 5 days after insertion)

- Ask the client about her health generally;
- Inspect the wound at the insertion site.
- Ask about any complaints

Third Month after insertion

- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.

Schedule of subsequent follow-ups (if all is well):

- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.
- Yearly visits until the client wishes to have the device removed or the life span of the device expires – at 5 years
- Repeat the activities of first visit at each subsequent visit;
- Encourage a pap smear every two years

J. Summary/Evaluation

- The Trainer summarizes the session by stating that:
  - Insertion techniques involve paying attention to asepsis, anaesthesia, as well as the length and location of the puncture site.
  - Careful subdermal placement ensures easy removal thereafter.
  - Standard insertion techniques are similar for Jadelle while Implanon has a single use pre-loaded applicator as will be discussed in the next session.
- The Trainer requests the participants to respond to the following questions:
  - Mention the steps of the correct procedure for Jadelle insertion technique.
  - List the post-insertion instructions given to the client.
  - State the correct procedure for follow-up visits.
  - State the warning signs a client must report after implant insertion

Module Five - Session 3: Implanon^{R} (Classic) and Implanon NXT^{TM} Contraceptive Implants Insertion Techniques

Time: 1 hour

Learning Objectives

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

- State the timing of insertion of Implanon^{R} (classic) and Implanon NXT^{TM} implants with regard to menstruation, postpartum, post abortion and lactation periods.
- Identify the equipment and materials for Implanon^{R} (classic) and Implanon NXT^{TM} Implants insertion procedures.
- Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants
- Demonstrate the unique insertion techniques of Implanon^{R} (classic) and Implanon NXT^{TM} implants.
- Demonstrate the correct application of dressing after insertion.
- Explain the instructions to be given to clients after insertion.
- Schedule follow-up appointments with the clients after the procedure.

Session Overview

- Equipment and materials for Implanon^{R} (classic and Implanon NXT^{TM}) implants insertion procedures.
- Timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods.
- Demonstration of the correct insertion technique for Implanon^{R} implants with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants.
- Demonstration of the correct application of dressing after insertion.
- Instructions to be given to clients after insertion.
- Scheduling follow-up appointments with the clients after the procedure.

Methods

- Lecture/Presentation/Video clip
- Demonstration and Return Demonstration
- Discussion
- Brainstorming

Materials

- Flip chart/Newsprint
- Markers
- LCD Projector and Laptop
- Implanon^{R} (classic and Implanon NXT^{TM} Implants)
- Arm Models
- Learning Guide for Implanon^{R} (classic) and Implanon NXT^{TM} implants' Insertion Techniques

Module Five- Session 3: Implanon^{R} (classic) and Implanon NXT™ Contraceptive Implants' Insertion Techniques

SESSIONPLAN

Title	Duration	Objectives	Methods	Materials
Implanon^{R} (classic) and Implanon NXT ™ Contraceptive Implants Insertion Techniques	1 hour	♦ State the timing of insertion with regard to menstruation, postpartum, post abortion and lactation periods ♦ Identify the equipment and materials for Implanon^{R} (classic) and Implanon NXT™ Implants insertion procedures ♦ Demonstrate the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implants ♦ Demonstrate the unique insertion techniques of Implanon^{R} implants ♦ Demonstrate the correct application of dressing after insertion. ♦ Explain the instructions to be given to clients after insertion. ♦ Schedule follow-up appointments with the clients after the procedure.	× Lecture/Presentation × Video clip × Discussion × Brainstorming × Demonstration and Return Demonstration	× Flip chart × Markers × LCD Projector × Laptop × Implanon^{R} (classic) and Implanon NXT™ Implants × Learning Guide for Implanon^{R} (classic) and Implanon NXT™ Implants Insertion Techniques

Module Five- Session 3: Implanon^{R} (classic) and Implanon NXT^{TM} Contraceptive Implants' Insertion Techniques

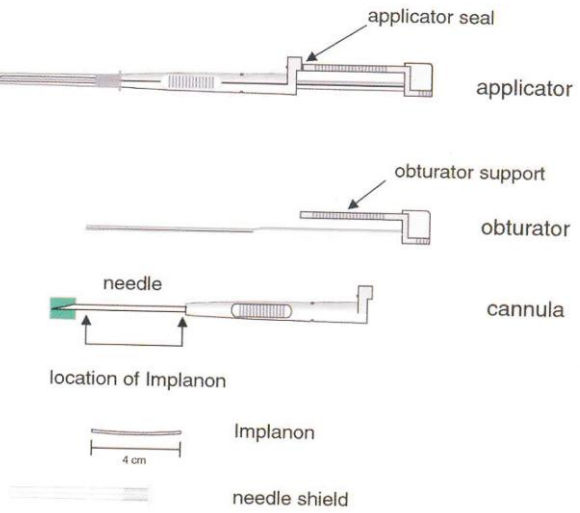
SESSION PRESENTATION

A. Introduction

State the timing of insertion with regard to menstruation, postpartum, post-abortion and lactation periods.

- The Trainer displays and reviews the learning objectives for this module.
- The Trainer informs the participants that:
  - Only a provider who is trained and familiar with the procedure of Implanon and Implanon NXT^{TM} insertion should undertake the procedure and it must be done under aseptic conditions.
- The Trainer states that both the insertion of Implanon and Implanon NXT^{TM} implants are performed with the specially designed applicator (Figure 4.3.1 and 4.3.2).

Figure 4.3.1: Components of an Implanon Applicator



- The Trainer identifies the different components of each applicator and stresses to the participants that the procedure used for insertion of Implanon is opposite to giving an injection. When inserting Implanon the obturator must remain fixed while the cannula (needle) is retracted from the arm. For normal injections the plunger is pushed and the body of the syringe remains fixed.
- The Trainer displays the slide on “Time of Insertion” and notes that it is similar to that described for Jadelle earlier.

B. Identifying the equipment and materials for Implanon Implants insertion procedures.

- The Trainer displays the equipment and materials for Implanon^{R} and Implanon NXT^{TM} insertion procedures.

- S/he also displays the slide containing Figure 5.3.2 – "Materials required for Implanon and Implanon NXT™ insertion" and requests the participants to identify each, including the items listed below, with the numbers with which they are labeled in parenthesis:

  - One set of implant capsules
  - Examining table for the patient to rest her arm on
  - Sterile cloth (1)
  - Marker pen (2)
  - Antiseptic solution (3)
  - Sterile gloves (4)
  - Local anaesthetic spray, or injection of 1ml lidocaine [Xylocaine] (5)
  - Preloaded, sterile Implanon applicator containing a single rod (6)
  - Sterile gauze and compress (7)

C. Demonstrating the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the implanon® (classic) and Implanon NXT™ Implants

Client Preparation

- The Trainer demonstrates the following steps as *Client preparation*

  - Give clear information about probable changes in bleeding pattern during the menstrual cycle and other possible side effects;
  - Describe the insertion and removal procedures and what the client should expect during and afterwards;
  - Ensure client's cooperation and relaxation;
  - Review client assessment data to determine if the client is an appropriate candidate for Implanon® implants or if she has any problem that should be monitored more frequently while the implants are in place;
  - Do a general examination;
  - Do a pelvic examination if needed or requested by client (pelvic examinations are not necessary for safe implant initiation and use, but may be indicated for other reasons and are part of the preventive medicine practices and health promotion);
  - Instruct the client to lie on the couch with arm stretched out comfortably
  - Support client's arm with arm rest
  - Use proper infection prevention procedure
  - Wash hands
  - Ask the patient to lie down on the examination table with her non-dominant arm extended on a sterile cloth on the other table, at right angles to her body.
  - Clean the area of insertion with antiseptic solution: 10% Povidone iodine (if available) and finally with spirit
  - Apply sterile drapes exposing the insertion area only (under the skin of the upper arm).

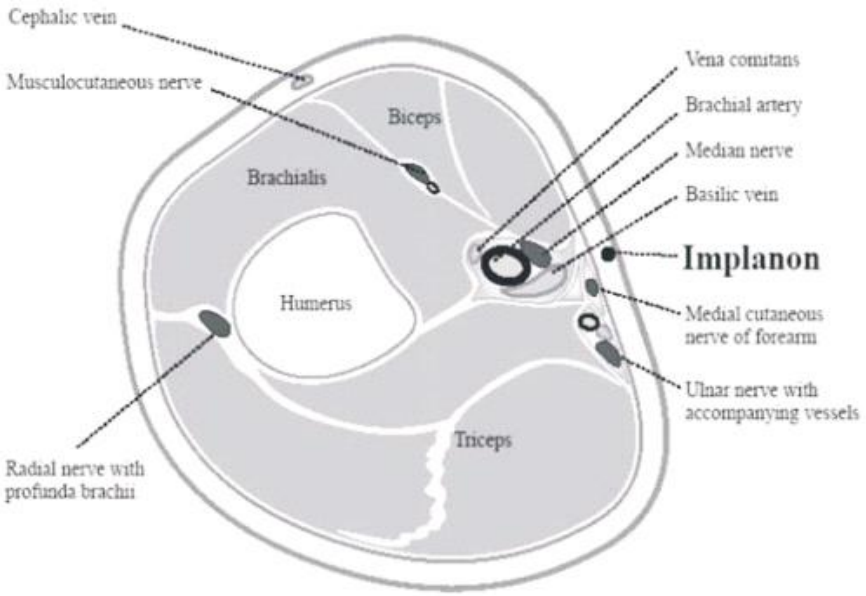
Figure 5.3.2: Materials Required for Implanon and Implanon NXT™ Insertion

D. Demonstrating the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the *Implanon*[R] *(classic)*

♦ The Trainer explains and demonstrates the steps for the correct and subdermal placement of Implanon[R] (classic) as s/he displays the following slides containing:

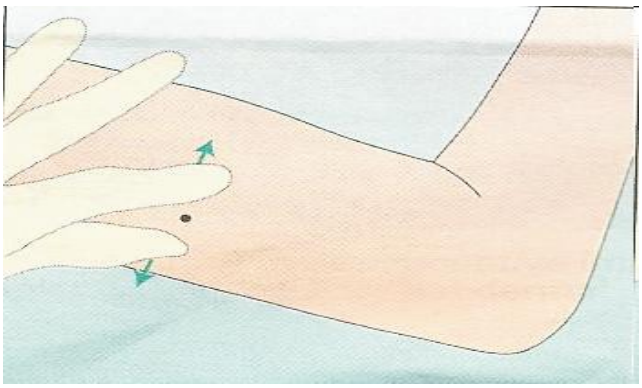
- Allow the subject to lie on her back with her non-dominant arm (the arm which the woman does not use for writing) turned outwards and bent at the elbow. If preferred, a sitting position can be taken.
- Arrange the materials and instruments so that they are accessible.
- To minimize the risk of neural or vascular damage, Implanon should be inserted at the inner side of the upper arm (non-dominant arm) about 6-8 cm above the elbow crease in the groove between the biceps and the triceps *(sulcus bicipitalis medialis).*

Figure 5.3.3: Correct subdermal placement of Implanon



Note: When Implanon is inserted too deeply (intramuscularly or in the fascia) this may cause neural or vascular damage. Too deep insertions have been associated with paraesthesia (due to neural damage) and migration of the implant (due to intramuscular or fascial insertion), and in rare cases with intravascular insertion. Moreover, when the implant is inserted too deeply, it may not be palpable and the localization and/or removal can be difficult later on.

Figure 5.3.4: Inserting the implant at the inner side of the upper arm



- Mark the insertion site.
- Prepare the insertion site with a cotton swab soaked with antiseptic.
- Anaesthetize with an anaesthetic spray, or with 2ml of lidocaine (Xylocaine 1%) applied just under the skin along the “insertion canal.”
- Carefully remove the sterile disposable applicator carrying the Implanon from its blister.
- While keeping the shield on the needle, visually verify the presence of the implant, seen as a white body inside the needle tip. If the implant is not seen, tap the top of the needle shield against a firm surface to bring the implant into the needle tip, following visual confirmation, the implant should be lowered back into the needle by doing the opposite. The needle shield can now be removed.

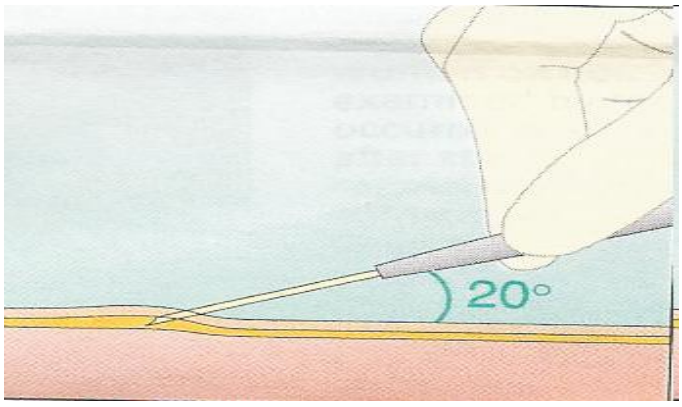
Note: The implant can fall out the needle prior to insertion. Therefore, always hold the application in the upward position (i,e with the needle pointed upwards) until the time of insertion. This is to prevent the implant from dropping out.

Keep the needle and the implant sterile. If contamination occurs, a new package with a new sterile applicator must be used.

- Always hold the applicator in the upward position (i.e. with the needle pointed upward) until the time of insertion. This prevents the implant from dropping out.

- Stretch the skin around the insertion site with thumb and index finger (Figure 5.3.4 above).
- Insert first only the tip of the needle, slightly angled (- 20^0).

Figure 5.3.5: Inserting the needle at 20^0



- Release the skin.
- Lower the applicator to a horizontal position (Figure 5.3.6)
- Lift the skin with the tip of the needle, but keep *the needle in the subdermal* connective tissue.
- Gently insert, while lifting the skin, the needle to its full length without using force to ensure superficial insertion (Figure 5.3.6).
- Keep the applicator parallel to the surface of the skin
- Break the seal of the applicator (Figure 5.3.7).
- Turn the obturator 90° (Figure 5.3.8).
- Fix the obturator with one hand against the arm and with the other hand slowly retract the cannula (needle) out of the arm (Figure 4.3.8).

Figure 5.3.6: Lowering the applicator to the horizontal position

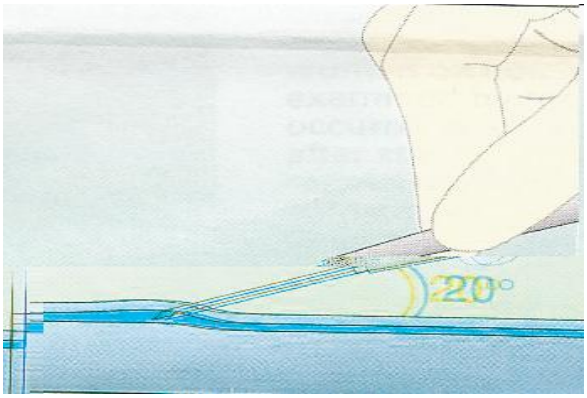


Figure 5.3.7: Lifting the skin with the needle during insertion

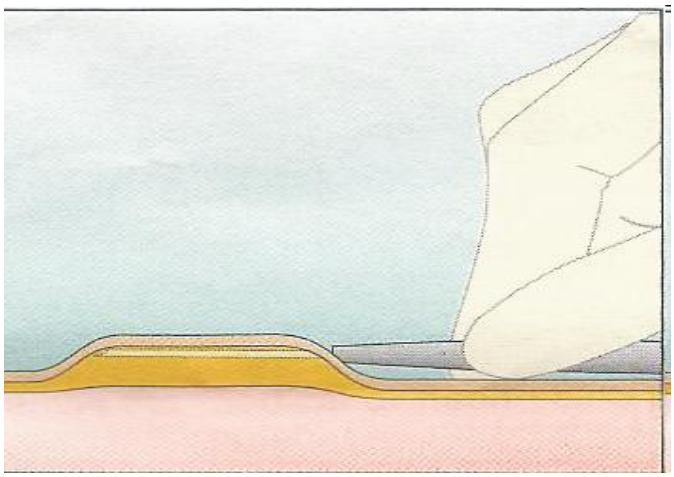


Figure 5.3.8: Breaking the seal of the applicator

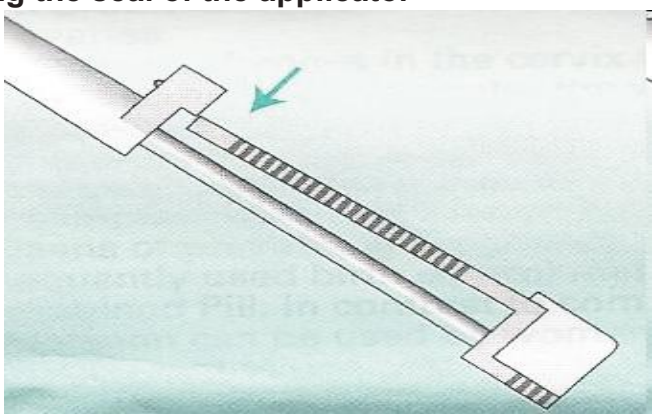


Figure 5.3.9: Turning the obturator 90^{0}

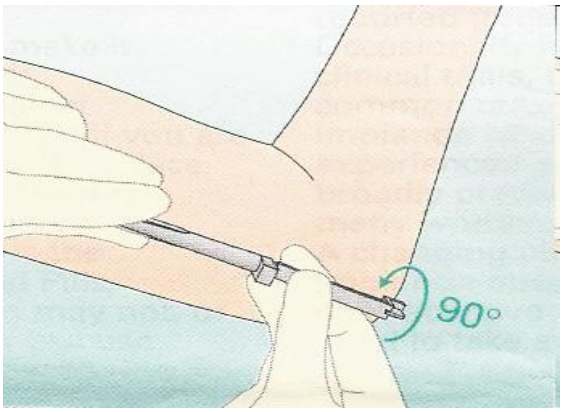
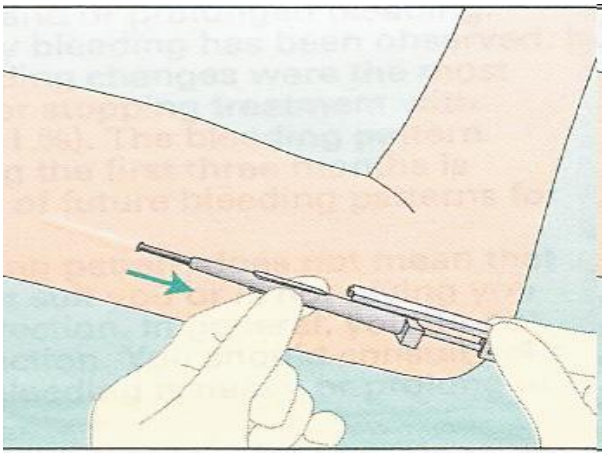


Figure 5.3.10: Retracting the cannula (needle) out of the skin



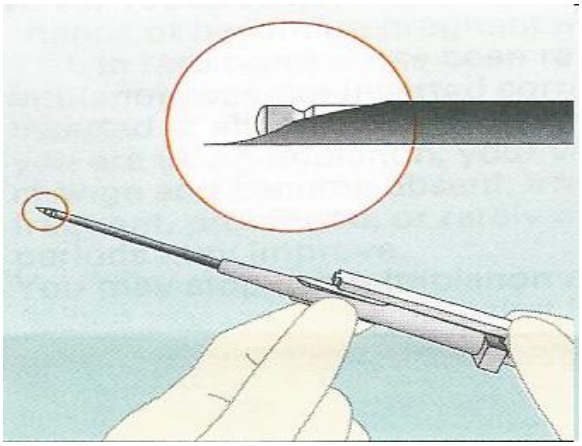
Note: Never push against the obturator.

- Check the needle for the absence of the implant. Do not confuse the protruding end of the obturator with the implant (same colour). (Figure 5.3.10)

Note: This procedure is opposite to giving an injection, where the plunger is pushed and the syringe is fixed. By keeping the obturator in its place and simultaneously pulling the cannula, the implant will remain in the upper arm.

- Always verify the presence of the implant by palpation and have the woman palpate it herself.
- Apply sterile gauze with a pressure bandage to prevent bruising

Figure 5.3.11: Checking the needle for the absence of the implant.



Note: In case the implant cannot be palpated or when the presence of the implant is doubtful, other methods must be applied to confirm its presence. Suitable methods to locate the implant are, first of all, ultrasound (USS) and secondly, magnetic resonance imaging (MRI). Prior to the application of USS or MRI for the localization of Implanon, it is recommended that Organon be consulted for instructions. In case these imaging methods fail, it is advised to verify the presence of the implant by measuring the etonorgestrel level in a blood sample of the subject. In this case Organon will also provide the appropriate procedure.

Until the presence of Implanon has been confirmed, a contraceptive barrier method must be used.

- Apply sterile gauze with a pressure bandage to prevent bruising.

♦ The Trainer provides the participants with clear instructions regarding *Waste Disposal and Decontamination* as follows:

  - Properly discard the Implanon[R] Inserter.
  - Before removing gloves, place any used instrument into a container filled with 0.5% chlorine solution for decontamination.
  - The surgical drape (if used) must be washed before reuse. Place in a dry covered container and remove to the designated washing area.
  - While still wearing gloves, place all 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.
  - Immerse both gloved hand briefly in chlorine solution and then carefully remove gloves by turning inside out and place in the waste container;
  - Wash hands thoroughly with soap and water.

- Fill out the User Card and hand it over to the subject to facilitate removal of the implant later on (Fill also the client's record which is kept in the facility).

Note: The applicator is for single use only and must be adequately disposed of in accordance with local regulations governing the handling of biohazardous waste.

E. Demonstrating the correct insertion technique with regard to asepsis, anaesthesia, location of incision, and careful correct placement of the *Implanon NXT*™

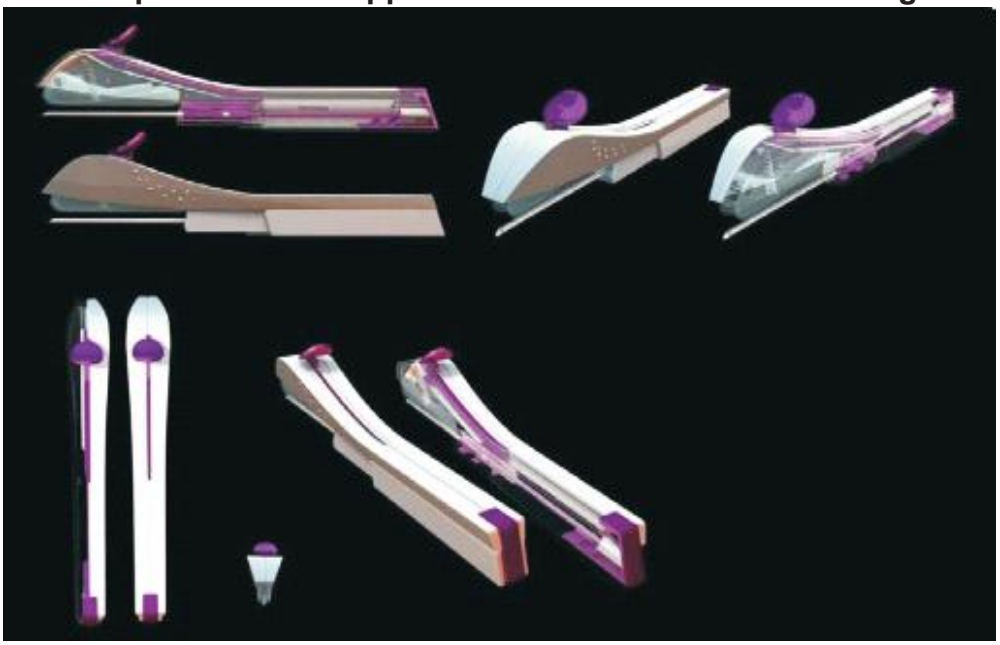
♦ The Trainer reminds the participants that:

  - Implanon [R] is a subdermal, long-acting hormonal contraceptive, effective for up to 3 years.
  - It is a progestogen-only implant preloaded in a disposable applicator
  - Implanon NXT™ is radiopaque and comparable to Implanon[R]
  - It has a preloaded, sterile applicator which is for single use and disposable. Inserters familiar with the applicator for Implanon[R] need to familiarize themselves with the one for Implanon NXT™

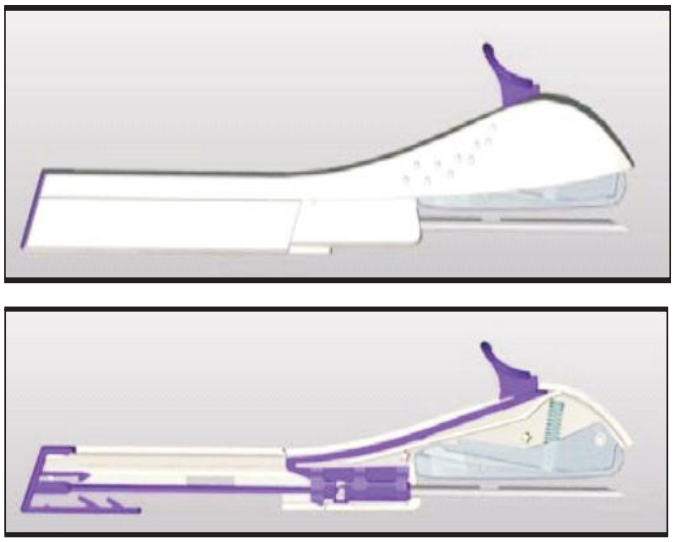
Figure 5.3.12: Applicators of Implanon NXT™ and Placebo

Implanon NXT™ Placebo

Figure 4.3.13: Implanon NXT™ Applicators viewed from different angles



- The Trainer informs the participants that the Applicator design elements include:
  - Cap-blocking mechanism with cap/lever
  - Implant retained in needle before insertion
  - Single-handed movement with slider
  - Needle partly visible
  - Preloaded for single use only

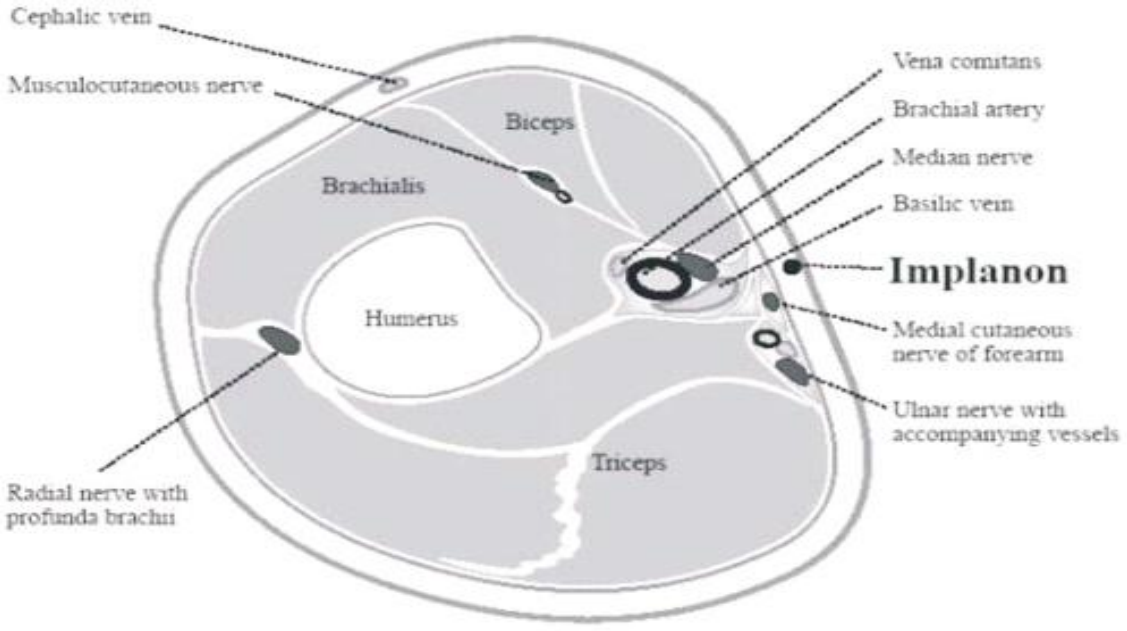


Preparation for insertion

- The Trainer informs the participants that:

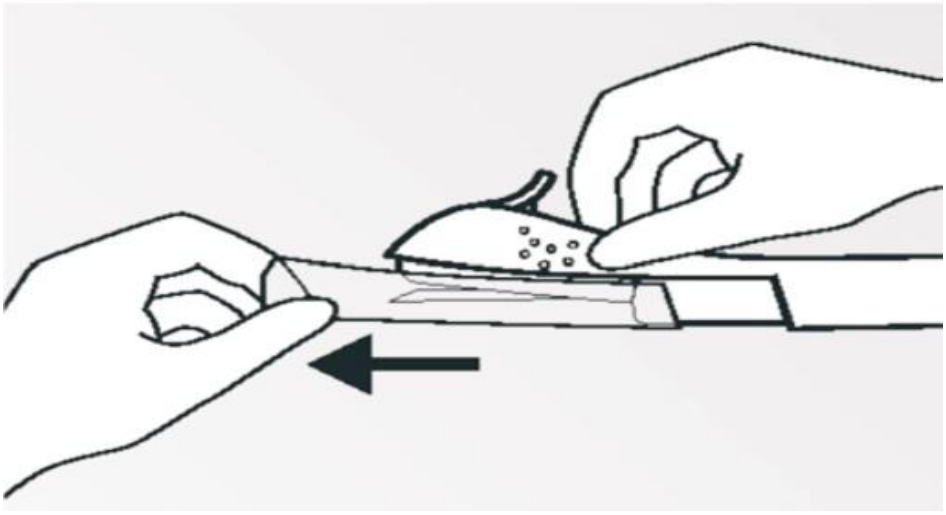
  - Insertion of IMPLANON NXT™ **should be performed under aseptic conditions**
  - Insertion of the implant **should only be performed with the preloaded applicator**
  - It is recommended that the health care provider performs the procedure in a sitting position
  - Confirm no allergies to antiseptic and anesthetic
  - Allow the woman to lie on her back with her non-dominant arm turned outwards and bent at the elbow
  - To minimize the risk of neural or vascular damage, the implant **should be inserted subdermally at the inner side of the non-dominant upper arm about 8-10 cm above the medial epicondyle of the humerus** in order to avoid the large blood vessels and nerves that lie deeper in the subcutaneous tissue in the sulcus between the triceps and biceps muscles

Figu



- Make 2 marks: one at insertion site and a second one a few centimeters above the insertion site to be used as direction guide during insertion
- Clean the insertion site with an antiseptic
- Anesthetize the insertion area (for example, with anesthetic spray or by injecting 2 ml of 1% lidocaine just under the skin along the planned insertion tunnel)
- Remove the sterile disposable applicator carrying the implant from its blister

Figure 5.3.15: Removing the sterile disposable applicator carrying the implant from its blister

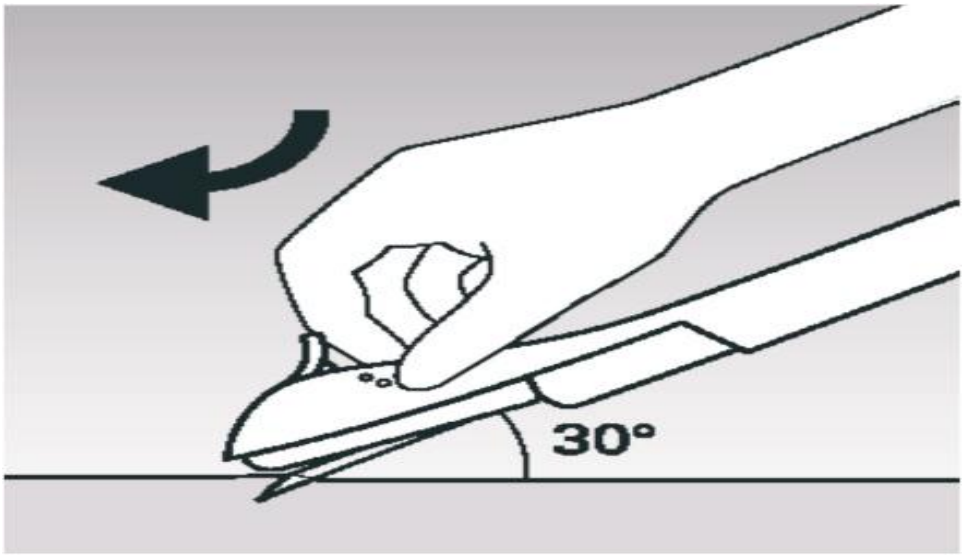


- Keep the needle and the implant sterile (if contamination occurs, a new package with a new sterile applicator must be used)
- Implanon NXT™ **should be inserted subdermally**

♦ The Trainer should emphasize that:

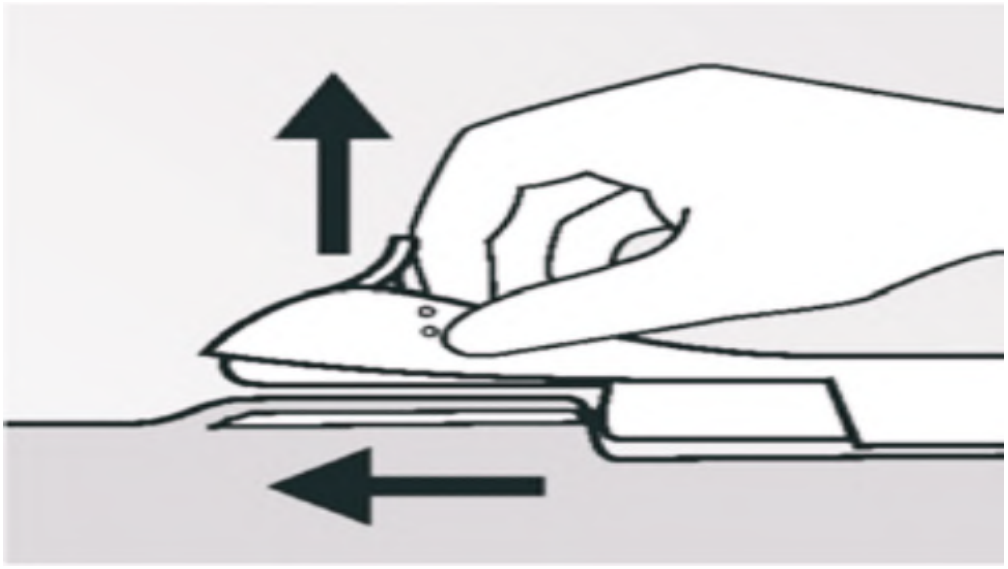
- If the implant is inserted too deeply, neural or vascular damage may occur. Too deep or incorrect insertions have been associated with paresthesia (due to neural damage) and migration of the implant (due to intramuscular or fascial insertion), and in rare cases with intravascular insertion. Moreover, when the implant is inserted too deeply, it may not be palpable and the localization and/or removal can be difficult.
- Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap from the needle which contains the implant
- **If the cap does not come off easily the applicator should not be used and must be replaced**
- You may see the white colored implant by looking into the tip of the needle
- **Do not touch the purple slider until you have fully inserted the needle subcutaneously, as it will retract the needle and release the implant from the applicator**
- Stretch the skin around the insertion site with thumb and index finger
- Puncture the skin with the tip of the needle angled about 30°

Figure 5.3.16: Puncture the skin with the tip of the needle angled about 30°



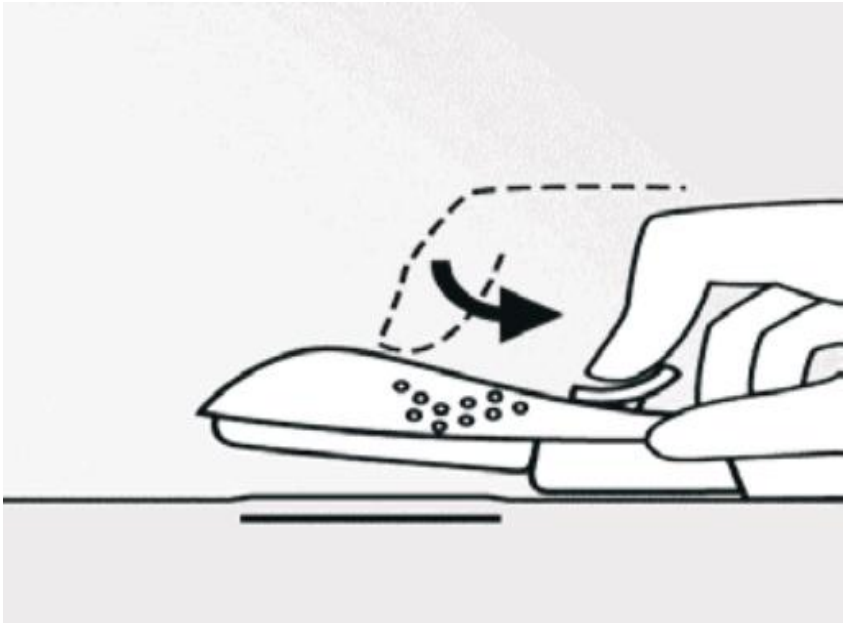
- **During the entire insertion procedure you will be able to see the insertion site and the movement of the needle**
- Lower the applicator to a horizontal position
- While lifting the skin with the tip of the needle, slide the needle to its full length

Figure 5.3.16: Sliding the needle to its full length



- You may feel slight resistance but do not exert excessive force
- **If the needle is not inserted to its full length, the implant will not be inserted properly**
- **While keeping the applicator in the same position and the needle inserted to its full length, unlock the purple slider by pushing it slightly down**

Figure 5.3.17: Unlocking the purple slider by pushing it slightly down



- Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator
- Now the implant is in its final subdermal position
- Inserting the needle to its full length is crucial; failure to do so will result in a partly visible implant protruding from the skin
- If partial protrusion occurs, discard the implant and reinsert a new sterile implant using a new applicator
- Remove the applicator

E. Post-Insertion Steps

- Apply a small adhesive bandage over the insertion site
- Apply a sterile gauze with a pressure bandage to minimize bruising. The woman may remove the pressure bandage after 24 hours and the small bandage after 3-5 days
- Complete the User Card and give it to the woman to keep and complete the adhesive labels and affix to the woman's medical record
- The applicator is for single use only and must be disposed of the inserting physician in accordance with local regulations for biohazardous waste

Confirmation immediately after insertion

- Always **verify the presence of the implant by palpation**

Figure 5.3.18: Confirmation of the implant immediately after insertion

- If the implant is not palpable, confirm its presence in the arm with imaging techniques as soon as possible
- The woman must use a backup method of contraception until the presence of the implant has been confirmed

♦ The Trainer provides the participants with clear instructions regarding *Waste Disposal and Decontamination* as follows:

- Properly discard the Implanon NXT™ Applicator.
- Before removing gloves, place any used instrument into a container filled with 0.5% chlorine solution for decontamination.
- The surgical drape (if used) must be washed before reuse. Place in a dry covered container and remove to the designated washing area.
- While still wearing gloves, place all 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.
- Immerse both gloved hands briefly in chlorine solution and then carefully remove gloves by turning inside out and place in the waste container;
- Wash hands thoroughly with soap and water.
- Fill out the User Card and hand it over to the subject to facilitate removal of the implant later on (Fill also the client's record which is kept in the facility).
- **If you cannot feel the Implant or are in doubt of its presence:**
  - Check the applicator. The needle should be fully retracted and only the purple tip of the obturator should be visible. In any other case, the insertion must be considered to not have been complete. If in doubt, refer.

Note that other methods can be used to confirm the presence of the implant. Suitable methods are: **two-dimensional X-ray, ultrasound scanning (USS)** with a high-frequency linear array transducer (10 MHz or greater), computerized tomography scan (**CT scan**), or magnetic resonance imaging (**MRI**). Prior to the application of X-ray, USS, CT, or MRI for the localization of the implant, it is recommended, to consult the local supplier of Implanon NXT™ for instructions

- In case these imaging methods fail, it is advised to verify the presence of the implant in the arm by measuring the etonogestrel level in a blood sample of the subject. In this case, the local supplier will provide the appropriate procedure

- **Until you have verified the presence of the implant, a non-hormonal contraceptive method must be used**

G. Explain the instructions to be given to the client after insertion

♦ The Trainer demonstrates the following procedure to be followed after the insertion of the implant:

Client Care

- Place a note in the client's record indicating the location of the capsule and specifying any unusual events that may have occurred during insertion. (A simple drawing showing the approximate location of the capsule in the client's arm is helpful).

- Observe the client for at least 15 to 20 minutes for bleeding from the incision or adverse effects before sending her home. She should be given written post insertion care instructions (if available) as appropriate.

Client's instructions for wound care at home

- There may be bruising, swelling or tenderness at the insertion site for a few days. This is normal.

- Keep the area around the insertion site dry and clean for at least 48 hours. The site could become infected if the area gets wet while bathing.

- Leave the gauze pressure and plaster in place for 48 hours and the band-aid or surgical tape in place until the incision heals (i.e. normally 3 to 5 days).

- Routine work can be done immediately. Avoid bumping the area, carrying heavy loads or applying unusual pressure to the site.

- After healing, the area can be touched and washed with normal pressure.

- If signs of infection occur, such as fever with inflammation (redness plus heat) at the site, or if there is persistent arm pain for several days, return to the clinic.

H. Schedule follow-up appointments with the clients after the procedure

♦ The Trainer displays the slide on "Follow-up Visits" and outlines the instructions as follows:

First visit (3 – 5 days after insertion)

- Ask the client about her health generally.
- Inspect the wound at the insertion site.
- Ask about any complaints.

Third Month after insertion

- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.

Schedule of subsequent follow-ups (if all is well):

- Ask about variations in her menstrual cycle, including inter-menstrual bleeding or spotting and excessive blood loss.
- Yearly visits until the client wishes to have the device removed or the life span of the device expires – at 5 years
- Repeat the activities of first visit at each subsequent visit;
- Encourage a pap smear every two years

I. Summary/Evaluation

♦ The Trainer summarizes the session by stating that:

- As in the Jadelle Insertion techniques, attention must be paid to asepsis, anaesthesia, as well as the length and location of the puncture site.
- Careful subdermal placement ensures easy removal thereafter.
- Implanon and Implanon NXT™ have single use pre-loaded applicators unlike Jadelle implants.

♦ The Trainer requests the participants to respond to the following questions:

- Mention the steps of the correct procedures for Implanon and Implanon NXT™ insertions.
- List the post-insertion instructions given to the client.
- State the correct procedure for follow-up visits following Implanon insertion.
- State the warning signs a client must report after Implanon and Implanon™ insertions.

Module Five – Session 4: IUD Removal Techniques

Time: I hour

Learning Objectives:

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

- Identify the indications for removal of IUDs.
- Identify the equipment and materials for IUD removal procedures
- Demonstrate the correct removal techniques with regards to asepsis, and removal procedure.
- List what to do when difficulties arise during removal.
- List appropriate steps for reinsertion, if needed.
- Demonstrate post-removal Counseling techniques.

Session Overview:

- Indications for removal of IUDs.
- Equipment and materials for IUD removal procedures
- Demonstration of the correct removal techniques with regards to asepsis, and removal procedure.
- What to do when difficulties arise during removal.
- Appropriate steps for reinsertion, if needed.
- Demonstration of post-removal Counseling techniques

METHODS

- Lecture
- Discussion
- Demonstration and Return Demonstration

MATERIALS

- Training Arm
- Video Films or Removal Techniques and VCR
- Removal Kit
- Overhead Projector
- Plaster and Dressing

- Antiseptic Solution
- Sterile Gloves

Module Five – Session 4: IUD Removal Techniques

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
IUD Removal Techniques	I hour	× Identify the indications for removal of IUDs. × Identify the equipment and materials for IUD removal procedures; × Demonstrate the correct removal techniques with regards to asepsis, and removal procedure. × List what to do when difficulties arise during removal. × List appropriate steps for reinsertion, if needed. × Demonstrate post-removal Counseling techniques.	× Brainstorming × Lecture/Presentation × Video clip × Discussion × Demonstration and Return Demonstration	× Flip chart × Markers × LCD Projector × Laptop × Pelvic Model × CuT 380A IUD × Learning Guide for CuT 380A IUD Insertion Techniques

Module Five – Session 4: IUD Removal Techniques

SESSION PRESENTATION

A. Introduction

Identify the indications for removal of CuT 380A IUD

- The Trainer displays and reviews the learning objectives for this module.
- The Trainer informs the participants that:
  - Copper-releasing IUDs such as CuT 380A can be removed/replaced after 12 years.
  - Unless an IUD is being removed for a medical reason or at the client's request, a new IUD can be inserted immediately after removing the old, if the client so desires.
  - IUD removal is usually a routine, uncomplicated and painless procedure provided the provider is gentle and careful.
  - For routine removals, especially if the client wants a replacement, it may be easier to remove the IUD during the menses.
  - To avoid breaking the strings, the provider should apply gentle, steady traction and remove the IUD slowly.
  - As with IUD insertion, to minimize the risk of infection with IUD removal, the same infection prevention practices must be followed.
- The Trainer requests the participants to mention the indications for removal of CuT 380A IUD, and notes their responses on the flip chart.
- The Trainer displays the slide on “Reasons for Removal of IUDs” and clarifies the responses of the participants as follows:

Reasons for removal

- Client desires pregnancy
- Menopause, no need for contraception
- Client desires another method of contraception
- Life of IUD has expired
- Accidental pregnancy
- Client is not able/willing to tolerate side effects
- Dyspareunia (painful intercourse)
- Partial expulsion of the device
- Cervical perforation
- Uterine perforation

- The Trainer requests the participants to identify when to remove CuT 380A IUD, and notes their responses on the flip chart.

- The Trainer clarifies the participants' responses by stating that:
  - IUDs can be removed whenever a client insists on having it removed or when there are indications for removal.
  - The best time to remove is during menses, because the cervix is slightly dilated, soft and removal is less uncomfortable.

B. Identify the equipment and materials for CuT 380A IUD removal procedures.

- The Trainer displays the equipment and materials for CuT 380A IUD removal procedures.
- The Trainer informs the participants that
  - The instruments and equipment for removal are the same as for insertion.
  - In addition, an alligator forceps and a retrieval hook should be available. All instruments should be high-level disinfected (or sterilized).

C. Demonstrate the correct removal techniques with regards to asepsis.

- The Trainer demonstrates the removal procedure for CuT 380A as follows using a pelvic model:
  - Explains the removal procedure to the client to ensure her cooperation and relaxation.
  - Ensures that the client has emptied her bladder
  - Places the client in the dorsal position with the legs flexed at the hip and knees;
  - With sterile-gloved hand, parts the labia and gently passes a Cusco's speculum;
  - Visualises the cervix;
  - Cleans the cervix and fornices with antiseptic solution;
  - Tells the client that you are going to remove the IUD.
  - Asks her to take slow, deep breaths and relax.
  - Informs her that there may be some cramping, which is normal.
  - Grasps the IUD strings near the external os with long artery forceps and applies gentle and steady traction to remove device.
  - To avoid breaking the strings, applies steady, but gentle, traction and remove the IUD slowly;
  - If the strings break off, but the IUD is still visible, grasps the device with the forceps and remove it.

- Checks that no part has broken off the device;
- Shows device to the client;
- Cleans the cervix with an antiseptic solution;
- Applies a perineal pad.

♦ The Trainer emphasizes to the participants that:

- The device can usually be removed without difficulty and excessive force should not be applied.

D. What to do when difficulties arise during removal:

- **REFER**
- The trainer informs the participants that only trained family planning doctors should conduct difficult removals of IUDS.

E. Summary/Evaluation

♦ The Trainer summarizes the session by stating that:

- IUD removal is usually a routine, uncomplicated and painless procedure provided the provider is gentle and careful.
- For routine removals, especially if the client wants a replacement, it may be easier to remove the IUD during the menses.
- To avoid breaking the strings, the provider should apply gentle, steady traction and remove the IUD slowly.
- As with IUD insertion, to minimize the risk of infection with IUD removal, the same infection prevention practices must be followed.

♦ The Trainer requests the participants to respond to the following questions:

- List the essential steps in standard removal technique.
- List 5 key points for a successful removal.
- Enumerate indications for removal.

Module Five - Session 5: Implant Removal Techniques

Time: 1 Hour

Learning Objectives

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

- List the indications for removal.
- Identify the equipment and materials for implant removal procedures.
- Demonstrate the correct removal techniques with regards to asepsis, anaesthetic, length and location of incision, and removal procedure.
- List what to do when difficulties arise during removal.
- List appropriate steps for reinsertion.
- Demonstrate post-removal Counseling techniques.

Session Overview

- Indications for removal.
- Equipment and materials for implant removal procedures.
- Demonstration of the correct removal techniques with regards to asepsis, anaesthetic, length and location of incision, and removal procedure.
- What to do when difficulties arise during removal.
- Appropriate steps for reinsertion.
- Demonstration of post-removal Counseling techniques.

Methods

- Brainstorming
- Lecture
- Discussion
- Demonstration and Return Demonstration

Materials

- Training Arm
- Video Films or Removal Techniques and VCR
- Removal Kit
- Overhead Projector

- Plaster and Dressing
- Antiseptic Solution
- Sterile Gloves

Module Five - Session 5: Implant Removal Techniques

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Implant Removal Techniques	I hour	× List the indications for removal. × Identify the equipment and materials for implant removal procedures × Demonstrate the correct removal techniques with regards to asepsis, anaesthetic, length and location of incision, and removal procedure. × List what to do when difficulties arise during removal. × List appropriate steps for reinsertion. × Demonstrate post-removal Counseling techniques.	× Brainstorming × Lecture/Presentation × Video clip × Discussion × Demonstration and Return Demonstration	× Flip chart × Markers × LCD Projector × Laptop × Arm Model × Learning Guide for Implant Insertion Techniques

Module Five - Session 5: Implant Removal Techniques

MODULE PRESENTATION

A. Introduction

List the indications for removal of contraceptive Implants.

- The Trainer displays and reviews the learning objectives for this module.
- The Trainer informs the participants that:
  - Unlike insertion, removal of implants does not have to be timed to the menses and can be done at any time.
  - Correct insertion – with the capsules placed subdermally – makes the removal procedure much easier.
  - While all types of clinicians (physicians, nurses and midwives) can be trained to insert and remove the capsules, a clinician skilled in removal should be consulted if difficulty in removing the capsules is anticipated.
  - Service providers need to work gently, carefully and patiently when removing capsules.
  - As with insertion, using the recommended practices for the prevention of infection is essential for minimizing the risk of disease transmission and infections following removal of the implants.
  - Removal requires more patience and skill than insertion. Moreover, with atypically placed capsules (i.e., those inserted too deep and/or in an irregular pattern), removal using any technique takes longer and is associated with more blood loss than insertion.
- The Trainer requests the participants to mention the indications for removal of Implants, and notes their responses on the flip chart.
- The Trainer displays the slide on "Indications for Removal of IUDs" and clarifies the responses of the participants as follows:

Indications for Removal

Medical Reasons

- Excessive bleeding
- Pregnancy
- Jaundice
- Seizure
- Migraine
- Severe headache
- Blurred vision
- Weight problems

Personal Reasons

- **Planned pregnancy**
- **Client dissatisfaction (her reason to stop)**
- **At the end of 3-5 years depending on the type being used.**

♦ The Trainer emphasizes to the participants that:

- The indication for removal may be personal or medical.
- Providers may perceive implants as 3-5 years method, however clients need constant reassuring that the implant may be removed at any time and for any reason.
- One of the advantages of Implant is that when the implanted capsules are removed, the woman's fertility returns to normal almost immediately.
- If the woman wishes to have the implant removed, it is important that access to removal is readily available.
- Experience shows that in some instances, where the providers have been trained to do insertion only, they may be hesitant about doing removal thus preventing easy access to removal for the client.

♦ The Trainer informs the participants that they should offer *Pre-removal Counseling* which includes:

- Before removing the capsules, talk with the client about her reason for removal and answer any questions.
- Ask the client about her present reproductive goals (e.g. does she want to continue spacing or limiting births?).
- Briefly describe the removal process and what she should expect both during the removal and afterwards.

B. Identify the equipment and materials for implant removal procedures

♦ The Trainer displays the equipment and materials for implant removal procedures. They include:

Figure 5.5.1: Basic items required for removal of implants

- Examining table for the woman to lie on
- Arm support or side table
- Soap for washing the arm
- Sterile (or clean), dry surgical drape
- Three bowls (one for the antiseptic solution, one for cotton balls soaked in boiled or sterile water to remove the talc from gloves and one containing 0.5% chlorine solution for decontaminating removed capsules);
- Pairs of sterile (or high-level disinfected) surgical gloves;
- Antiseptic solution
- Local anaesthetic - 1:5 concentration without epinephrine (adrenaline)
- Syringe (5 or 10 ml) and 2.5 to 4cm (1 – 1 ½ inches) long needle (22 gauge)
- Scalpel with #11 blade
- Curved and straight forceps (mosquito and Crile)
- Jadelle holding forceps
- Ordinary and straight forceps (mosquito and Crile)
- Ordinary band-aid or sterile gauze with surgical tape or plaster
- Sterile gauze and compresses
- Epinephrine (Adrenaline) readily available for emergency use in anaphylactic shock.

♦ The Trainer displays the slide containing Figure 5.5.1 to emphasize the “Basic items required for removal of implants.”

C. Demonstrate the correct removal techniques with regards to asepsis.

♦ The Trainer explains and demonstrates the steps for the removal of implants as follows: (s/he displays Slides 4.5.2 to 4.5.10 as s/he demonstrates)

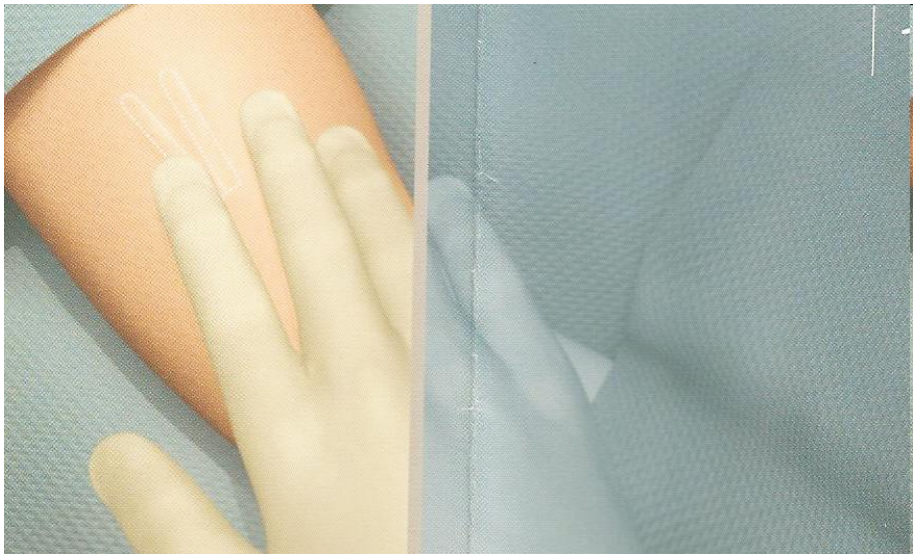
- Ask the client to lie on the table so that the arm with the capsules rests on the table or arm support. Her arm should be well supported and should be comfortable when extended straight or kept slightly bent, as the clinician prefers.

- Locate the two capsules Jadelle or one capsule of Implanon or Implanon NXT™ by palpation.

- To gauge where to make the incision, palpate the end of the capsule(s) with bare (ungloved) fingers. (If it is difficult to find the capsules, refer to the client's file where the original capsule placement should have been recorded and a diagram may be available.)

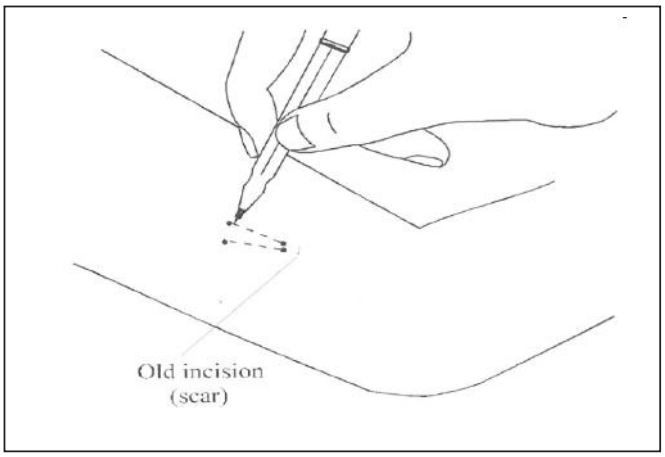
TIP: To make locating the capsules easier, moisten fingertips with a small amount of soapy water or antiseptic solution such as Betadine or Savlon. Doing this decreases friction between the clinician's fingertips and the client's skin and allows the capsules to be more easily felt.

Figure 5.5.2: Locating the Capsules by Palpation



- Confirm the position of each capsule by making a mark at both ends of the capsules (tip) using a ballpoint or marking pen.

Figure 5.5.3: Marking the Position of the Capsules

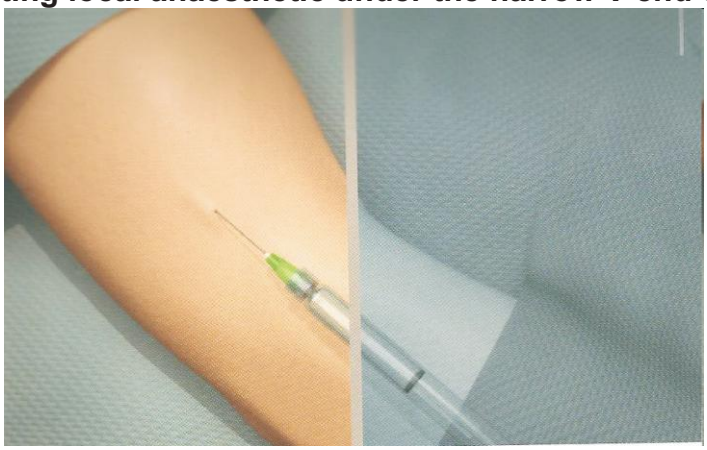


- Prepare an instrument tray and open the sterile instrument pack without touching the instruments and other items.
- Wash hands thoroughly with soap and water and dry them with a clean cloth.
- Put sterile or high-level disinfected gloves on both hands. (A separate pair of gloves must be worn for each client to avoid cross-contamination)

Note: Do not use gloves with powder. The tiny granules (talc) may fall into the removal site and cause scarring (fibrous reaction). If gloves are powdered, wipe off the fingers with sterile gauze soaked with sterile or boiled water.

- Arrange supplies and instruments so that they are easily accessible.
- Prepare the removal site with an antiseptic solution. Use a sterile or high-level disinfected sponge forceps to hold a cotton or gauze swab soaked with antiseptic solution. (If preparation is done with a gloved hand, care must be taken not to contaminate the glove by touching any unprepared skin). Begin wiping at the incision site and move outward in a circular motion for 8 to 13 cm (3 to 5 inches) and allow to air dry before proceeding. Wipe off excess antiseptic only if necessary to see pen marks.
- If a sterile surgical drape with a hole in it is available, it should be used to cover the arm. The hole should be large enough to expose the area where the capsules are located.
- Again, locate the two capsule(s) by palpating.
- After determining the absence of known allergies to the anaesthetic agent or related drugs, fill a syringe with about 3 ml of a local anaesthetic (1% Lignocaine without adrenaline).
- Insert the needle just under the skin where the incision will be made. Next pull back on the plunger to be sure the needle is not in a blood vessel (aspirate). Inject a small amount of anaesthetic to raise a small wheal (raised area).

Figure 5.5.4: Injecting local anaesthetic under the narrow V-end of the implants



- Gently advance the needle under the first capsule, about one third of its length (1 cm). Slowly withdraw the needle while injecting anaesthetic (about 0.5 ml) to raise the end of the capsule.

Remember: Correctly injecting the local anesthetic under the tips of the capsules is critical to an easy and rapid removal.

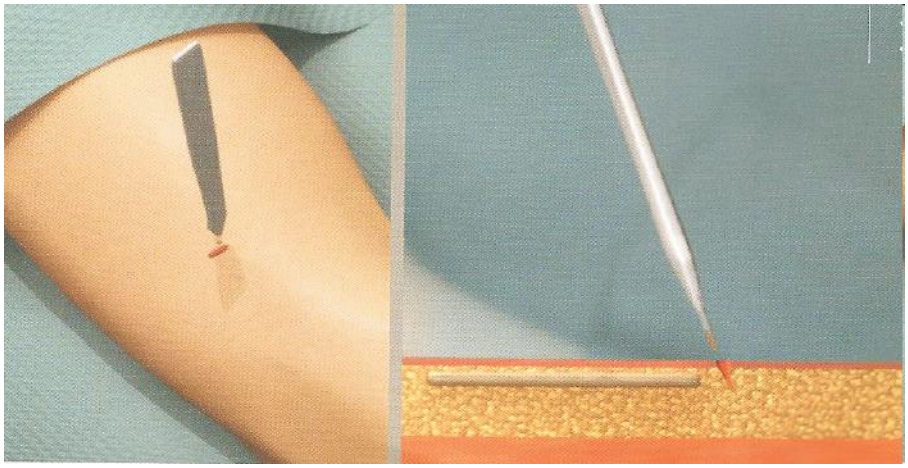
- Without removing the needle, slide the tip over and insert it under the next capsule (if Jadelle implants only).

Note: Never put anaesthetic over the capsules because the tissue swelling makes it difficult to palpate the capsules. If necessary, additional small amounts of anaesthetic can be added as the removal process continues.

- Before starting, gently touch the incision site with the hypodermic needle or scalpel to be sure the anaesthetic is working.

Note: To prevent local anaesthetic toxicity, the total dose should not exceed 10ml (10 grams/litre) of a 1% local xylocaine without adrenaline.

Figure 4.5.6: Making an incision



- Choose a point for the incision that is equidistant from the ends of both capsules and which is close to and about 5 mm below the distal (toward the elbow) ends of the capsules.

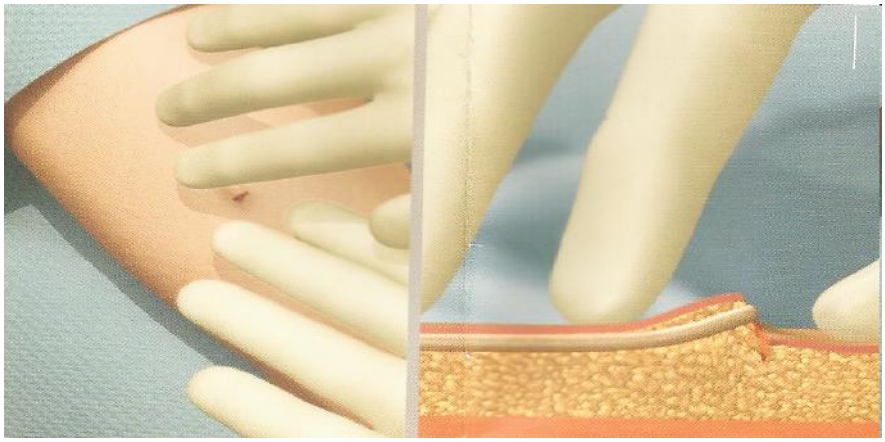
- If appropriate, the removal incision may be made at the point of the previous scar. Before selecting this site, however, make sure that neither of the capsule ends are under the old scar. (This avoids the possibility of cutting though the capsules)

- At the site chosen, make a small transverse incision of about 4 mm or less with a scalpel. Do not make a large incision.

Note: If another set of capsules is to be inserted, usually the same incision can be used for both removal and insertion of a new set (see Second Insertion in this module).

- Begin by selecting the capsule closest to the surface or nearest the incision.
- Push the tip of the capsule gently toward the incision with the gloved fingers of one hand until it can be seen at the incision. When the tip is visible in the incision, insert the curved forceps (mosquito or Crile) with the jaws curving up and grasp the end of the capsule.

Figure 5.5.6: Pushing the implant with the fingers gently towards the incision



Note: If the capsules cannot be easily moved into the incision, this may be due to scarring (fibrous tissue formation) around the tips of the capsules.

- Insert the curved forceps through the incision with the jaws pointed up toward the skin and advance until they are below the ends (tips) of the capsules nearest the elbow.

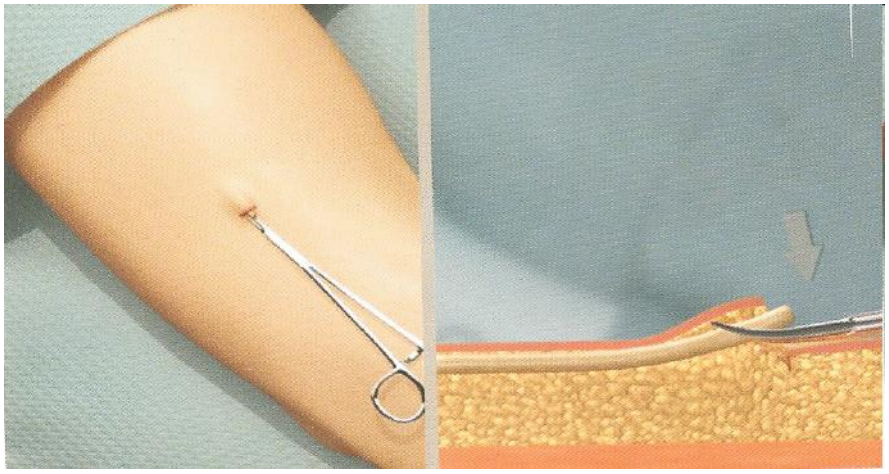
- Then open and close the forceps jaws (blunt dissection) to break up the scar tissue surrounding the tip of the capsule. Repeat until the tips of the two capsules are free (easily moveable).

- Next, push the tip of the first capsule as close to the incision as possible. While pressing on (stabilizing) the capsule with the first (forefinger) and middle fingers of one hand.

- Re-insert the curved forceps under the end of the capsule (jaws pointing up toward the skin)

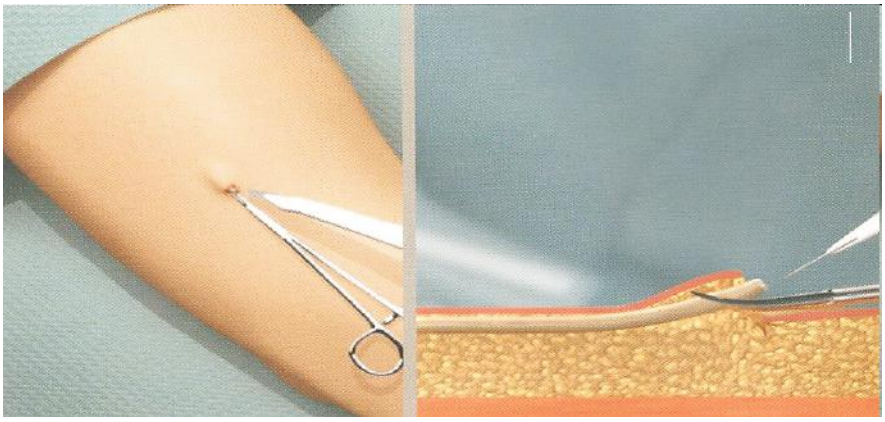
- Grasp the capsule near the tip (5 to 10mm) and gently pull it into the incision

Figure 5.5.7: Inserting the curved mosquito forceps



- Clean off and open the fibrous tissue sheath surrounding the capsule by rubbing vigorously with sterile gauze to expose the tip of the capsule.

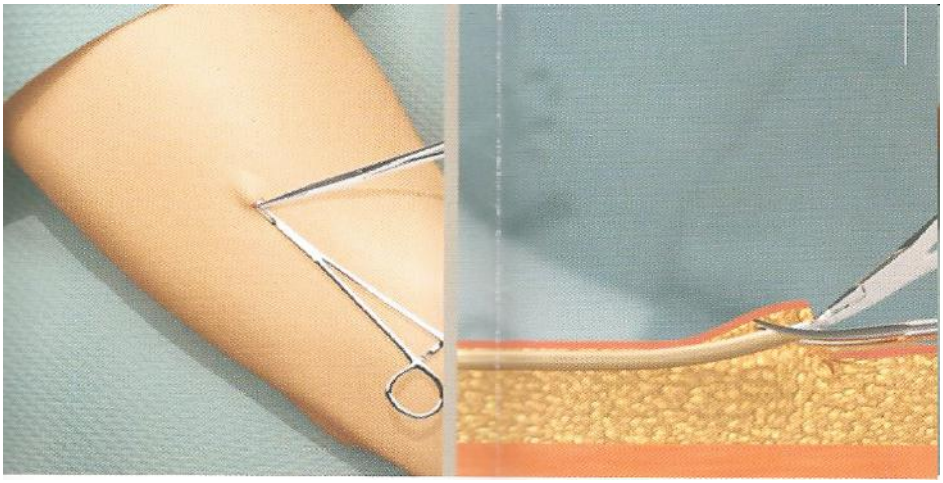
Figure 5.5.8: Opening the tissue capsule



- Alternatively, if rubbing the fibrous tissue sheath will not open it, the scalpel can be used). To avoid cutting the capsule, use the backside (non-sharp edge) of the scalpel

- Grasp the freed tip of the capsule with a second pair of forceps. Release the first forceps and slowly and gently remove the capsule with the second forceps.

Figure 5.5.9: Grasping the end of implant with the Crile forceps

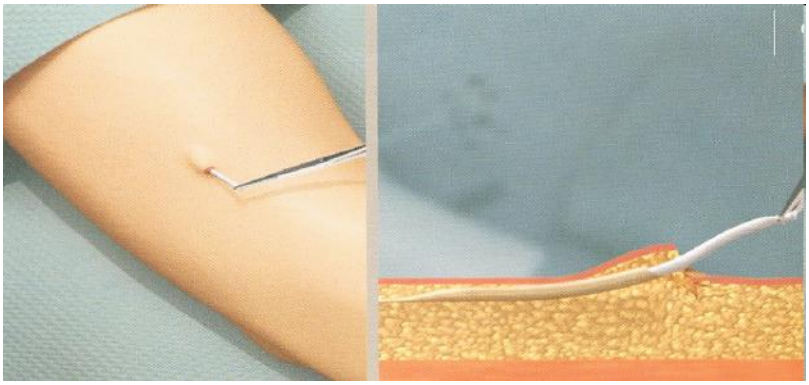


- Since tissue usually does not adhere to silicone rubber, the capsule should slide out easily. If for some reason the capsule does not come out easily, remove any remaining fibrous tissue from the capsule by gently rubbing with sterile gauze or scarping with the scalpel blade.

Note: As capsules are removed, place them in a small bowl containing 0.5% chlorine solution for decontamination prior to disposal. In addition, by looking at the capsules in the bowl, the clinician can tell whether or not the capsules are broken – *undamaged capsules will float; broken capsules will sink gradually to the bottom.*

- If additional anaesthetic is required, inject it only under the capsule so as not to obscure them.

Figure 5.5.10: Release the mosquito forceps and remove the implant gently



- Repeat using the same technique to remove the remaining capsule.
- It is important to show the client the capsules to reassure her.

Figure 5.5.11: Be sure that both implants (for Jadelle and 1 implant for Implanon^{R} and Implanon NXT^{TM}) are removed

♦ The Trainer informs the participant about the following procedures to be followed immediately after removal of implant:

*Covering the Incisio*n.

o If the client does not want another set of implants, clean the area around the incision site with a small amount of antiseptic solution applied to a cotton or gauze swab.

o Use the forceps to hold the edges of the incision together briefly (10 to 15 seconds). This will help reduce bleeding from the incision. Then apply gauze soaked in slight iodine solution to the incision area.

o With the edges of the incision together, close with a band-aid, or surgical tape with sterile cotton. Sutures are not necessary and may increase scarring. Check for any bleeding.

Waste Disposal Decontamination

- Before removing gloves, gently place instruments into a container filled with a 0.5% chlorine solution for decontamination. Soak all items for 10 minutes, then rinse immediately with clean water to avoid discoloration or corrosion of metal items.
- While still wearing gloves, place all contaminated objects (capsules, gauze, cotton and other waste items) in a properly marked, leak-proof container with a tight-fitting lid or in a plastic bag.
- Immerse both gloved hands briefly in chlorine solution and then carefully removed gloves by turning inside out and place in the waste container.
- Wash hands thoroughly with soap and water
- All waste materials should be disposed of by burning or burying.

♦ The Trainer informs the participants that the client should be observed at the clinic for 10 – 15 minutes for signs of syncope or bleeding from the incision before she is discharged.

D. What to do when difficulties arise during removal of implants.

- **Once the provider cannot palpate the Implant, please REFER**
- The trainer informs the participants that only trained family planning Doctors should conduct difficult removals of Implants.

♦ The trainer requests the participants to mention what to do when difficulties arise during removal and notes their responses on the flip chart.

♦ S/he displays the slides on “Removing Hard-to-Retrieve Capsules” and clarifies the responses of the participants as follows:

Removing Hard-to-Retrieve Capsules

- Feel both tips of the capsule with the forefinger and middle finger. Keeping the middle finger on the tip of the capsule nearest the client's shoulder and the forefinger on the tip nearest elbow, push the capsule as close to the incision as possible.
- Insert the forceps (curved mosquito or Crile) into the incision until the jaws are well beneath the capsule. At the same time keep pressure on the capsule with your fingers to stabilize it.
- Firmly grasp the capsule from below with the jaws of the curved forceps.
- Although 1 to 2 cm of the forceps is now inside the incision, do not try to pull the capsule out. Instead, while continuing to push the capsule toward the incision, flip the handle of the forceps 180^0 toward the client's shoulder and grasp the handle with the opposite hand.
- If the capsule does not become visible after flipping, twist the forceps 180^0 around its main axis. With gentle pulling, the tip of the capsule should then become visible in the incision on the opposite side of the forceps.

- Clean off and open the fibrous tissue sheath surrounding the capsule by rubbing with sterile gauze to expose the tip of the capsule. Alternatively, if rubbing with gauze does not open the fibrous tissue sheath, the scalpel can be used.

- After opening the fibrous sheath, use the second forceps to grasp the part of the capsule that becomes visible. Release the first forceps and gently remove the capsule.

♦ The Trainer informs the participants to note that remaining "difficult-to-remove" capsule can be removed using the same technique. If necessary, inject additional small amounts of local anaesthetic under any remaining capsules.

♦ The Trainer informs the participants that only trained family planning service providers should conduct the removal of implants.

E. List the appropriate steps for re-insertions.

♦ The Trainer informs the participants that if the client wants to continue using implants, a new set of capsules can be inserted at the time the current set is removed. The provider should note the following:

- The capsules may be placed through the same incision in the same general direction as the previous set.

- Alternatively, the capsules can be inserted in the opposite direction. Be sure the tips of the capsules do not lie so close to the elbow fold as to interfere with movement.

- A new incision should be necessary only if there is too much soft tissue trauma (bruising) in the area of the original insertion or if there is not enough room between the incision and the elbow fold.

- In the unlikely event that the removal site is unsuitable, or at the client's request, the new set can be inserted in the other arm.

F. Demonstrate post-removal Counseling techniques for implants

♦ The Trainer displays the various slides on "Procedure to follow after removal of capsules" and discusses the following issues:

Client Care

- Place a note in the client's record indicating the date of removal and specifying any unusual events that may have occurred during removal

- Observe the client for at least 15 to 20 minutes for bleeding from the incision or adverse effects before sending her home.

Client Instructions for Wound Care at Home

- There may be bruising swelling or tenderness at the insertion site for a few days. Clients should be reassured that this is normal.

- Keep the area around the removal site dry and clean for at least 48 hours. (The incision could become infected if the area gets wet while bathing)

- If used, leave the gauze pressure and plaster in place for 48 hours and the band-aid or surgical tape in place until the incision heals (i.e. normally 3 to 5 days)

- Routine work can be done immediately. Avoid bumping the area, carrying heavy loads or applying unusual pressure to the site.

- After healing, the area can be touched and washed with normal pressure.

- If signs of infection occur, such as fever, inflammation (redness plus heat) at the site or persistent arm pain for several days, return to the clinic

- The client should be told when to come back for a follow-up visit, if needed.
- Discuss what to do if she experiences any problems. Answer any questions.

♦ The Trainer informs the participants to note that:

- The fibrous sheaths in the arm (tracks where the capsules were located) may be felt for some time.
- This sensation will disappear within a few months.

E. Summary/Evaluation

♦ The Trainer summarizes the session by stating that:
- Correct removal techniques involve paying proper attention to asepsis, adequate anaesthesia and appropriate location of the incision.

- The provider needs to work gently, carefully and patiently. Removal procedures take longer time than insertions.

- The removal procedure can be interrupted if difficulties are encountered and the client asked to return after 4-6 weeks for completion of the removal of remaining capsule(s).

- Clients should always be given instructions for wound care at home on discharge.

♦ The Trainer requests the participants to respond to the following questions:

- List the essential steps in standard removal technique of implants.

- List 5 key points for successful removal of implants.

- Enumerate indications for removal of contraceptive implants.

MODULE SIX

MODEL AND CLINICAL PRACTICE

Module Six: Model and Clinical Practice

Time: 1 hour 10 minutes

Learning Objectives

- By the end of this session, participants should be able to:
- Explain the rationale for the use of models during IUD and implant training
- Discuss the “Clients' Rights” during clinical training
- List the guidelines for clinical observation and practice and decorum in the clinical area
- Mention “Infection Prevention Reminders”
- Discuss the guidelines for the daily Post-practice sessions
- List the guidelines for completing the “Clinical Procedures Record Sheet”

Session Overview

- Rationale for the use of models during IUD and implant training
- “Clients' Rights” during clinical training
- Guidelines for clinical observation and practice, and decorum in the clinical area
- “Infection Prevention Reminders”
- Guidelines for the daily Post-practice sessions
- Guidelines for completing the “Clinical Procedures Record Sheet”

Methods

- Illustrated lecture
- Discussion
- Brainstorming

Materials

- Flip Chart and Stand
- Markers
- LCD Projector
- Laptop

Module Six: Model and Clinical Practice

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Model and Clinical Practice	I hour 10 minutes	▪ Explain the rationale for the use of models during IUD and implant training; ▪ Discuss the "Clients' Rights" during clinical training; ▪ List the guidelines for clinical observation and practice and decorum in the clinical area; ▪ Mention "Infection Prevention Reminders" ▪ Discuss the guidelines for the daily Post -practice sessions; ▪ List the guidelines for completing the "Clinical Procedures Record Sheet"	▪ Brainstorming ▪ Lecture/Presentation ▪ Video clip ▪ Discussion ▪ Demonstration and Return ▪ Demonstration	▪ Flip chart ▪ Markers ▪ LCD Projector ▪ Laptop ▪ Arm Models ▪ Pelvic Models ▪ Trocar and cannula ▪ Jadelle^{R}, Implanon^{R} and Implanon^{TM} Implants ▪ Learning Guide for Implant Insertion Techniques

Module Six: Model and Clinical Practice

MODULE PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays and introduces the session's objectives
- S/he reads out the objectives and explains each objective to the participants
- S/he also encourages the participants to comment on their understanding of the objectives while responding to comments

B. Rationale for the use of models during IUD and implant training (15 minutes)

The Trainer introduces this session to the participants by informing them that:

- This module includes guidance on the clinical practice for this training programme.
- Most of the participants' time will be spent on clinical practice.
- Since this is a competency-based course, the participants will practice IUD and implant insertion and removal skills on models first, observe these same procedures on clients and then perform them under supervision on clients.
- A major component of humanistic training is the use of anatomic models, which simulates the human body, and other learning aids such as slide sets and videotapes. The effective use of models:
  - Facilitates learning,
  - Shortens training time, and
  - Helps participant correct mistakes in technique that could hurt the client.

- The Trainer provides the participants with information on the procedures that will be adopted for the clinical practice, which are:
  - Before a participant attempts a clinical procedure with a client, two learning activities should occur:
    - The clinical trainer should demonstrate the required skills and client interactions several times using an anatomic model and appropriate audiovisual aids (e.g. slide sets or videotapes).
    - While being supervised, the participant should practice the required skills and client interactions using the model and actual instruments in a simulated setting which is as similar as possible to the real situation.
  - The participants will practice using the Learning Guides for Clinical Skills in IUD and Implant Insertion and Removal Techniques on models;

- The trainer(s) will evaluate each participant's performance using the Observation Checklist. Once the participant passes the assessment on the model, she/he will be allowed to practice on clients.

- The final skills evaluation will be done while the participant is performing IUD and Implant Insertion and Removal Techniques on clients.

- The participants must be supervised by the trainers at all times during the clinical practice.

- The number of procedures each participant must perform on models or clients before achieving competency will vary according to the participant's skill and experience.

- Only when skill competency and some degree of skill proficiency have been demonstrated with models, however, should participants have their first contacts with clients.

C. "Clients' Rights" during clinical training (10 minutes)

♦ The Trainer displays the slide on "Clients' Rights during Training" and informs the participants that:

- Client safety and client satisfaction are the goals of this training in long-acting contraceptive services.

- Therefore, the client's rights of privacy and confidentiality are a part of clinical training.

- In ensuring "Clients' Rights during Training", the following must be noted:

  - The client's permission must be obtained before any participant observer assists with or performs any services. The client should understand that she has the right to refuse care from a participant (provider-in-training) without loss or postponement of services. If the client should refuse participant assisted or performed services, the trainer or other staff members should perform the procedure.

  - Clients who consent to participate in training should be informed in advance that they will receive care from a trainee under the direct supervision of a qualified trainer.

  - When conducting counseling, performing a physical examination or giving services, an environment that protects the client's bodily privacy and confidentiality of speech must be created and maintained.

  - Communication between the participant and the trainer during feedback encounters or coaching must be discreet.

  - Corrective feedback should be limited to situations that could harm or cause discomfort to the client.

- The client's right to confidentiality must be protected. This may be challenging to maintain strictly during training situations when specific cases are used in learning exercises. However, such discussion should take place in private areas out of hearing of other staff and clients; no reference should be made to any client by her name. Hallways, corridors, waiting areas, and other public areas are not appropriate places for discussions of clients.

♦ The Trainer concludes this section by seeking for clarifications from participants and providing appropriate responses.

D. Guidelines for clinical observation and practice, and decorum in the clinical area (10 minutes)

♦ The Trainer displays the slide on “Guidelines for clinical observation and practice” and informs the participants that the most important concerns during clinical observation/practice are ensuring the client's comfort and providing a safe, effective procedure.

♦ S/he explains to the participants that achieving client's comfort and providing a safe, effective procedure requires the following guidelines:

- The operating clinician (whether a trainer or a participant) should give a running commentary to the other participants throughout the procedure.
- If a participant performing a procedure wants the trainer to take over the procedure, he or she should make a straightforward request such as "I need help" or "Please, show me again how to do this".
- If a participant notices a complication that is unobserved by the operator, he or she has a responsibility to report the situation immediately to the trainer. This should be done in a way that does not alarm the client.
- If a complication arises during any procedure, the trainer is responsible for managing the situation and will complete the procedure.
- If the trainer wants to take over the procedure from a participant, he or she will say something like "Let me help you with this step" or "Perhaps, I can show you an easier or better way to do this" or “the client is uncomfortable, so I'll finish the procedure. You can watch and do the next case”.
- The participants who are observing the procedure should not interfere with the work of the participant conducting the procedure.
- The participants who are observing should hold all questions and comments until after the procedure is completed and until they are not in the presence of the client.
- The participant performing the procedure should answer the client's questions.
- If the client becomes impatient, angry, anxious, or restless during the procedure and if the participant is unable to reassure her, the trainer should take over the procedure.

- If complications arise during the procedure, the trainer must be in charge. The trainer may choose to permit a participant to manage the complication, as a learning experience, but only under supervision.

- If a participant notices a problem or a break in sterile technique that was unobserved by the trainer, that participant is responsible for reporting the situation to the trainer immediately in a way that does not alarm the client.

♦ The Trainer seeks for any clarifications from the participants and addresses any concerns raised by them.

E. Highlights of Client-Provider Interaction

♦ The Trainer display the slide on "Client-Provider Interaction Highlights" and clarify the following:

- When performing IUD or implant insertion and removal procedures, it is important to remember the principles of effective client-provider interaction. Clients will be concerned about the procedure and the amount of pain they may feel. By using gentle techniques, providers can avoid giving women more pain.

- The provider can do several things to minimize the client's tension and maximize her comfort, which will contribute to the safe and efficient performance of the procedure.

- Some clients like to be informed of each step of the procedure, while others prefer to be distracted. Ask the client what will help her to relax.

- Inform the client that she might feel some discomfort. Request that she tells you if she feels any discomfort or pain.

- Before, during, and after the procedure, be aware of the client's need for privacy and her concerns about modesty.

F. "Infection Prevention Reminders" (5 minutes)

♦ The Trainer displays the slide on "Infection Prevention Reminders" and emphasize the following points to the participants:

Before the procedure:

- Insertion and removal of IUD or implants can be performed in an examination room or a special room. Wash hands thoroughly before putting on gloves and after each client.

During the procedure:

- Use instruments, gloves, and drapes that have been sterilized or high-level disinfected. Maintain asepsis.

After the procedure:

- While still wearing gloves, dispose of contaminated wastes (gauze, cotton, and other waste items) in a covered, leak-proof container of plastic bag.

- Ensure that instruments and reusable items are decontaminated in a 0.5% chlorine solution for 10 minutes immediately after use, while they are still in the procedure room.

- Ensure that the examination table, instrument stands, and other surfaces contaminated during the procedure are decontaminated by wiping with a cloth soaked in a 0.5% chlorine solution. If organic material remains after decontamination, wash with detergent and water. Decontamination and cleaning of the examination tables and couches between clients is important.

- Wash hands after removing gloves.

G. Expectations from the participants during Clinical Observation (5 minutes)

♦ Inform the participants what the Clinical Trainer expects from them during clinical observation and emphasize that:

- They will all have the opportunity to observe procedures performed by the trainer and by other participants during the training programme.

- In addition to insertion and removal techniques, they will also observe, whenever possible, pre-procedure activities (such as client assessment) and post-procedure activities (such as giving instructions to the client). The goal is for them to have a comprehensive understanding of all the service-delivery steps.

- During observation of cases, participants should follow along with the IUD or Implant Clinical Skills Learning Guides.

- In addition to watching for the steps of insertion and or removal, they will also observe how the provider interacts with the client and what the provider does in terms of infection prevention practices.

H. Guidelines for supervised clinical practice (5 minutes)

♦ The Trainer discusses the guidelines for supervised clinical practice as follows:

- Once their skills have been evaluated as satisfactory on the models, they may insert IUDs or implant under the trainer's supervision. The participants should not perform an insertion on a client until the trainer has evaluated their skills on the model using the appropriate IUD or Implant Clinical Skills Learning Guide.

- The following tips may help a participant with clinical practice:
  - Depending on his/her prior clinical experience, a participant may begin by observing an IUD or implant insertion, assisting the trainer in performing an insertion, or performing an insertion with the trainer's guidance.
  - The participant must exercise patience. The participant should realise that s/he is learning a new technique, and it will take repetitive performance on the model and on clients before s/he feels comfortable with the technique.
  - The participant should start with model practice and continue model practice during the early portion of his/her training to help fine-tune the skills and help him/her correct problems he/she is having in clinical practice.
  - During clinical training, the trainer is present to provide the participant with support and guidance. He/she should ask questions and seek help if needed, being careful not to cause the client any extra concern.
  - After each practice session, all participants will have time to review and discuss the cases with the trainers and other observers. The trainer will provide the participants with coaching as needed during this post-practice session.
  - When the trainer determines that a participant is ready, the trainer will evaluate his/her performance using the appropriate IUD or Implant Clinical Skills Checklist.

♦ The Trainer concludes the session by seeking clarifications from the participants and addressing their concerns (if any).

I. Guidelines for the daily Post-practice sessions (10 minutes)

♦ The Trainer starts this session by displaying the slide on "Guidelines for the daily post-practice sessions" and requests the participants to note that:

- At the post-practice meeting, the trainers will provide an opportunity for self-assessment in relation to the focus for the day.
- The participants may use the Learning Guide to assess their own performance.
- The trainers will use the post-practice meeting to give feedback to the entire group, and to jointly develop problem-solving approaches for skills' difficulties.
- During the post-practice meeting, use the following questions to review the day's experience:
  - What went well?
  - What new learning needs did you have?
  - What new skill(s) did you learn?
  - What did not go well?

- What do you think would have helped to make the procedures go better?
- How could problems, which arose, have been avoided?
- What was done to solve the problem?
- How did the team members work together? How could they have worked more effectively?
- Are there steps that you want to review before the next clinical practice session?
- The feedback should highlight the positive aspects and address the mistakes.

♦ The Trainer concludes this session by seeking clarifications from the participants and addressing their concerns (if any).

J. Guidelines for completing the "Clinical Procedures Record Sheet" (5 minutes)

♦ The Trainer starts this session by displaying the slide on "Guidelines for completing the participant's Clinical Service Procedures Record Sheet". and informs the participants to note that:

- The participants' Clinical Service Record Sheet is to assist each participant to keep a track of all the procedures observed or performed during the training programme.
- These record sheets are not expected to replace the clinic Client Record Form that must be completed for each client by the participant.

K. Summary and Evaluation (5 minutes)

♦ The Trainer summarizes the session by stating that:

- This module provides the information and guidelines as to how the model and clinical practice sessions of this training programme will be conducted so that IUDs and Implants will be correctly inserted and/or removed safely.
- The ultimate goal is to provide high quality IUD and Implant services both during and after the training programme. The client's right to confidentiality must be protected. The priority concerns during clinical observation and practice are the client's comfort as well as safety and performing an effective procedure.

Evaluation

♦ The Trainer asks the participants to respond to the following questions:

- Why are models used during IUD and Implant training programmes?
- Mention the rights of the client during clinical training programme.
- Why must decorum be maintained in the clinical area during training?
- Mention four "infection prevention reminders" during clinical practice.

MODULE SEVEN

COUNSELING FOR IUDS AND IMPLANTS

Session 1: Introduction to Counseling

Session 2: Counseling for IUDs and Implants

Module Seven - Session 1: Introduction to Counseling

Time: 1 hour 30 Minutes

Learning Objectives:

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

- Define counseling
- State the objectives of counseling in Family Planning
- Discuss the qualities of a successful counselor
- Mention the types of counseling required for IUD and Implant services
- Discuss the concerns and perceptions of potential users of IUDs and Implants
- Explain the term “Informed Choice”
- Discuss the “Rights of the Client”

Session Overview

- Definition of counseling
- Objectives of counseling in Family Planning
- Qualities of a successful counselor
- Types of counseling required for IUD and Implant services
- Concerns and perceptions of potential users of IUDs and Implants
- “Informed Choice”
- “Rights of the Client”

Methods

- Brainstorming
- Presentation
- Discussion
- Demonstration and Return Demonstration
- Role Play

Materials

- Flip chart
- Markers
- LCD Projector
- Laptop
- CuT 380A IUD
- Jadelle^{R}, Implanon^{R} and Implanon NXT^{TM} implants
- Learning Guide for IUD Counseling Techniques
- Learning Guide for Implant Counseling Techniques
- Video Clip

Module Seven - Session 1: Introduction to Counseling

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
Introduction to Counseling	I hour 30 minutes	▪ Define Counseling ▪ State the objectives of Counseling in Family Planning ▪ Discuss the qualities of a successful counselor ▪ Mention the types of Counseling required for IUD and Implant services ▪ Discuss the concerns and perceptions of potential users of IUDs and Implants ▪ Explain the term "Informed Choice" ▪ Discuss the "Rights of the Client"	▪ Brainstorming ▪ Presentation ▪ Discussion ▪ Demonstration ▪ and Return ▪ Demonstration ▪ Role Play	▪ Flip chart ▪ Markers ▪ LCD Projector ▪ Laptop ▪ CuT 380A IUD ▪ Jadelle^{R}, Implanon^{R}and Implanon^{TM}Im plants ▪ Learning Guide for IUD Counseling Techniques ▪ Learning Guide for Implant ▪ Counseling ▪ Techniques

Module Seven - Session 1: Introduction to Counseling

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays and introduces the session's objectives.
- S/he reads out the objectives and explains each objective to the participants and encourages them to comment on their understanding of the objectives
- S/he responds to comments

B. Definition of Counseling

- The Trainer asks the participants to brainstorm on the definition of Counseling and notes their responses on a flip chart.
- S/he clarifies their responses and define Counseling as follows:
  - A form of interpersonal communication in which the counselor helps the client to identify, clarify and resolve problems, makes informed decision and act on the decision.
  - A process of communication/interaction between two or more people in which one person assists the other to identify, clarify, resolve problems and make informed decision on issue(s) of concern.
  - The Trainer emphasizes that:
  - Counseling refers to providing the client with information and support to allow her make a decision regarding her immediate reproductive health needs, for example, by describing to the woman (and sometimes her partner as well) the contraceptive options available to her, the benefits and risks of the methods, and what side effects to expect.
  - It is important for health care providers to be equipped with the necessary knowledge and skill to counsel clients for the uptake of family planning methods.
  - Good counseling helps clients to choose and use family planning methods that suit them. Best counseling is tailored to meet the individual client's need.

C. Objectives of Counseling in Family Planning (5 minutes)

- The Trainer asks the participants to brainstorm on the objectives of counseling and note their responses on the flip chart.
- S/he clarifies their responses and states the objectives of counseling as follows:
  - To provide complete and accurate information in terms which the client can understand;
  - To identify and discuss any concerns or fears a client may have;
  - To help the client choose the best family planning method for her; and
  - To inform the client adequately about effectiveness, side effects, benefits, and risks on available methods.

D. Qualities of a successful Counselor(10 minutes)

- The Trainer asks the participants to brainstorm on the qualities of a successful Counselor and notes their responses on the flip chart

- The clarifies their responses and states that a successful Counselor has the following attributes:

  - A sensitivity (i.e. ability to understand other people's feelings) that earns the trust of the client;

  - A good understanding of all available family planning methods, not only IUDs and subdermal implants;

  - An understanding of the cultural and psychological factors that affect a woman's or a couple's decision to use IUD or subdermal implants or other family planning methods;

  - A non-judgmental approach, treating the client with respect and kindness;

  - A way of encouraging clients to ask questions;

  - An ability to listen;

  - The ability to recognize when he or she cannot sufficiently help a client and to refer the client to other professionals;

  - An appreciation of non-verbal communication (body language).

- The Trainer emphasizes to the participants that:

  - When counseling is done effectively, women will be more satisfied with their choices and less likely to discontinue use after a short period of time or because of unexpected bleeding disturbances.

  - Sound knowledge and good communication skills are essential if the counselor is to discuss IUDs or subdermal implants (and other methods) appropriately and to reduce the number of women who discontinue the method because of ignorance or unnecessary anxiety.

E. Types of Counseling required for IUD and Implant services (25 minutes)

- The Trainer starts the session by displaying the slides on “What types of counseling are required?”

- S/he informs the participants that CuT 380A and subdermal implant users will need three stages of counseling as follows:

Pre Insertion Counseling

- This is given prior to a decision to use IUD and subdermal Implants
- It involves a discussion of the woman's (or couple's) fertility intentions.
- It provides information on all available contraceptive methods,
- It presents an overview of CuT 380A and subdermal implants regarding:
  - facts,
  - reversibility,
  - advantages and disadvantages including side-effects (particularly those related to menstrual irregularities),
  - the timing of insertion,
  - the contraceptive to use until insertion, and
  - the freedom of the client to discontinue the method whenever desired.

Post-Insertion Counseling

- Though, this is usually given immediately after the insertion of the IUD or implant, some elements of post-insertion Counseling should be given earlier and reinforced at this time (e.g. post-insertion care).
- It provides information on a follow-up schedule and indications for a quick return to the clinic must be provided.

Follow-up Counseling

- Information given during post-insertion counseling should be reinforced at each visit.
- Counselors need to listen attentively and be prepared to answer questions on the problems the patient has encountered. Answering questions helps a client to cope with any problem or side effects.
- Again, counselors should reassure clients that removal is available on demand.

F. Myths, misconceptions and perceptions of users of IUDs and Implants (15 minutes)

♦ The Trainer introduces the session by asking the participants to brainstorm on the myths, misconceptions and perceptions of users of IUDs and Implants.

♦ Note their responses on the flip chart and clarifies their responses by going through the following as additions:

Myths and Misconceptions of Potential Users of IUDs and Implants

- The device or capsule can travel in the body
- Belief that insertion/removal is a major surgical procedure
- Returning to the clinic (distance and time) for insertion and removal at proper time
- Inconvenience (time and cost) of follow-up visits

- With foreign object in the womb or the arm, soul cannot leave body after death
- Family/friends will notice and women will have the stigma of using family planning
- Religious/traditional/cultural reasons
- Never knowing when spotting will occur
- For Implants, sites can become unattractive
- No way to hide use of method from husband
- Rumours that women are being used as guinea pigs
- Chance of losing fertility, sex drive etc.
- Fear that the device or capsules will cause weakness and/or ill health to self and/or husband
- Traditional dislike for surgical procedures
- Amenorrhoea causes a permanent build-up of blood in uterus that must be "drained" periodically, or illness will result (for subdermal implants).
- It makes a woman lean/or a woman's stomach to become big

♦ She addresses any issues or concerns raised by the participants.

G. "Informed Choice" (10 minutes)

♦ The Trainer asks the participants to define "Informed Choice" and notes their responses on the flip chart.

♦ S/he clarifies their responses and explains that **"Informed"** means that:

- Clients have the clear, accurate, and specific information they need to make their own reproductive choices including a choice among family planning methods.

- Good quality family planning programmes emphasise the need for FP providers to explain each family planning method as needed, without information overload and can help clients use each method effectively and safely.

- It is important that all FP methods are available to see or feel as this will enable her make an informed choice.

♦ The Trainer explains that **"Choice"** means that:

- Clients having a range of family planning methods to choose from. Good quality family planning services offer different methods to suit people's differing needs – not just 1 or 2 methods. If programmes cannot provide a method or service, they refer clients somewhere else for that method.

♦ S/he emphasizes that:

- Clients make their own decisions. Family planning providers help clients think through their decisions, but they do not pressure clients to make a certain choice or to use a certain method.

H. "Rights of the Client" (10 minutes)

- The Trainer asks the participants to brainstorm on the "Rights of the Client".

- S/he informs the participants that the health provider must endeavour to respect the rights of the client seeking family planning and reproductive health services by providing them with relevant information concerning their reproductive health.

    - Such rights include:

        - Information
        - Access to services
        - Informed Choice
        - Safe services
        - Privacy and Confidentiality
        - Dignity, comfort and expression of opinion

- The Trainer discusses these issues and address any concerns raised by the participants.

I. Summary/Evaluation (5 minutes)

The Trainer summarizes the session by stating that:

- Counseling provides clients with information that would help her make informed choice.

- A good counselor is sensitive to the clients' needs and is ready to address user concerns regarding future reproductive goals, choice of contraceptive method and adverse effect of the chosen method.

Evaluation

- The Trainer asks the participants to respond to the following questions:

    - What is counseling?

    - Why is counseling important?

    - What types of counseling are mandatory when providing IUD and implant services?

Module Seven - Session 2: The Balanced Counseling Strategy

Time: 2 hours

Learning Objectives:

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

- Define the Balanced Counseling Strategy
- State the objectives of the Balanced Counseling Strategy
- Discuss the tools and job aids necessary for offering Balanced Counseling Strategy
- Discuss the steps in the Balanced Counseling Strategy
- Effectively counsel family planning clients using the steps, tools and job-aids in the Balanced Counseling Strategy

Session Overview

- Definition of the Balanced Counseling Strategy
- Objectives of the Balanced Counseling Strategy
- Tools and job aids necessary for offering Balanced Counseling Strategy
- Steps in the Balanced Counseling Strategy
- Demonstration of Counseling family planning clients using the steps, tools and job-aids in the Balanced Counseling Strategy

Methods

- Brainstorming
- Presentation
- Discussion
- Demonstration and Return Demonstration
- Role Play

Materials

- Flip chart and flip chart stand
- Markers
- LCD Projector
- Laptop
- Tools and Job Aids of The Balanced Counseling Strategy

Module Seven - Session 2: The Balanced Counseling Strategy

SESSION PLAN

Title	Duration	Objectives	Methods	Materials
The Balanced Counseling Strategy	2 hours	▪ Define the Balanced Counseling Strategy ▪ State the objectives of the Balanced Counseling Strategy ▪ Discuss the tools and job aids necessary for offering Balanced Counseling Strategy ▪ Discuss the steps in the Balanced Counseling Strategy ▪ Effectively counsel family planning clients using the steps, tools and job-aids in the Balanced Counseling Strategy	▪ Brainstorming ▪ Presentation ▪ Discussion ▪ Demonstration and Return ▪ Demonstration ▪ Role Play	▪ Flip chart and flip chart stand ▪ Markers ▪ LCD Projector ▪ Laptop ▪ Tools and Job Aids of Balanced Counseling Strategy

Module Seven - Session 2: The Balanced Counseling Strategy

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays and introduces the session's objectives.
- S/he reads out the objectives and explains each objective to the participants while encouraging the participants to comment on their understanding of the objectives.
- The Trainer responds to comments.

B. The Balanced Counseling Strategy (BCS) (10 minutes)

- Ask the participants to brainstorm on the definition of the Balanced Counseling Strategy (BCS) and note their responses on the flip chart.
- S/he clarifies their responses and provides the participants with the definition of the Balanced Counseling Strategy (BCS) as follows:
  - A practical, interactive, and client-friendly strategy for improving counseling within family planning consultations. This strategy comprises a series of steps to determine the contraceptive method that best suits the client according to her/his preferences and needs.
  - This strategy improves the quality of the provider's counseling and allows the client to take ownership of the decision.

C. Objectives of the Balanced Counseling Strategy (5 minutes)

- The Trainer inform the participants about the objectives of the Balanced Counseling Strategy as follows:
  - The BCS assumes that the motive of a client's visit is for family planning and the strategy ensures that the client has ownership of any decision made to use family planning.
- S/he clarifies any issues raised by the participants.

D. Tools and job aids necessary for offering Balanced Counseling Strategy (30minutes)

- The Trainer informs the participants that the BCS uses the following three key job aids for Counseling clients about family planning:
  - An algorithm to guide the provider through the Counseling process,
  - A set of counseling cards for contraceptive methods, and
  - Corresponding brochures for each method

The BCS Algorithm

- This summarizes the 13 steps recommended to implement the BCS during a family planning consultation.
- The steps are organized under three stages of the consultation: pre-choice needs assessment; method choice; and post-choice actions.
- During each stage of the consultation, the provider is given step-by step guidance on how to use the BCS job aids. Depending on the client's response to the issues discussed, the algorithm outlines which action to take.

The Counseling Cards

- These are the cards that a provider uses during a counseling session. There are 15 counseling cards.
    - The first card contains 6 questions that the service provider asks to rule out whether a client is pregnant.
    - There are 14 method-specific cards that contain information about each family planning method.
    - Each method card has an illustration of the contraceptive method on the front side of the card. The back of the card contains a list 5 to 7 key features of the method and describes the method's effectiveness.
    - These cards are used to first exclude those methods that are inappropriate for the client's reproductive intentions and then to narrow down the choice to reach a final decision.

Method Brochures

- These brochures provide information on each of the 14 contraceptive methods and are designed to help the client better understand the method chosen.
- The provider gives the client the brochure of the selected method and a brochure with information on condoms to take home.
- Providers should encourage low-literate clients to take the brochure home so that their partner or other trusted friend can review the brochure with them again.

E. Steps in the Balanced Counseling Strategy (20 minutes)

♦ The Trainer informs the participants that:

- The BCS is divided into three counseling stages. Each stage contains a sequence of steps to follow:

Pre-Choice Stage

- During this stage, the provider creates the conditions that help a client select a family planning method.

Method Choice Stage

- During this stage, the provider offers more extensive information about the methods that have not been set aside, including their effectiveness.
- This helps the client select a method suited to his/her reproductive needs.
- Following the steps in the BCS algorithm, the provider continues to narrow down the number of counseling method cards until a method is chosen.

Post-Choice Stage

- During this stage, the provider uses the method brochure to give the client complete information about the method that has been chosen.
- If the client has conditions where the method is not advised or is not satisfied with the method, the provider returns to the Method Choice Stage to help the client select another method.

F. Effective Counseling of family planning clients using the steps, tools and job-aids in the Balanced Counseling Strategy (25 minutes)

♦ The Trainer demonstrates (through a Role Play) and facilitates return demonstration by participants on how to effectively counsel family planning clients using the Algorithm for Balance Counseling Strategy (BCS).

Pre-Choice Stage

- *Step 1:* Establish and maintain a warm, cordial relationship. Listen to the client's contraceptive needs.
- *Step 2:* Rule out pregnancy using the pregnancy checklist card with 6 questions.
- *Step 3:* Display all of the method cards. Determine whether the client wants a particular method.
- *Step 4:* Ask questions using the displayed method cards. Set aside cards based on the client's responses.

Method Choice Stage

- *Step 5:* Give information on the methods that have not been set aside and indicate their effectiveness.
- *Step 6:* Ask the client to choose the method that is most convenient for her/him.
- *Step 7:* Using the method-specific brochure, determine whether the client has any conditions for which the method is not advised.

Post-Choice Stage

- *Step 8:* Discuss the method chosen with the client using the method brochure as a counseling tool.
- *Step 9:* Determine the client's comprehension and reinforce key information.
- *Step 10:* Make sure the client has made a definite decision: Give her/him the method chosen and/or a referral and back-up method, depending on the method selected.
- *Step 11:* Encourage the client to involve partner(s) in decisions about/practice of contraception through discussion or a visit to the clinic.
- *Step 12:* Give follow-up instructions, a condom brochure and the brochure of the method chosen.
- *Step 13:* Complete the counseling session. Invite the client to return at any time.

Thank her/him for the visit. End the session.

G. Summary and Evaluation (5 minutes)

♦ The Trainer summarizes the session by stating that:

- The Balanced Counseling Strategy (BCS) is a practical, interactive, and client-friendly tool for improving counseling within family planning consultations.
- The strategy improves the quality of the provider's counseling and allows the client to take ownership of the decision.
- The BCS has proved to be an effective tool that assists family planning providers to improve the quality of their care. The approach is practical, low cost, and easy to adapt to local contexts.

Evaluation

♦ The Trainer asks the participants to respond to the following questions:

- Mention the job aids of the BCS
- List the three counseling stages of the BCS
- Why is important to give the BCS Method Brochure to the client to take home?

Module Eight - Session 1: Asepsis, Hand Washing and Gloving

Time: 1 hour 30 Minutes

Learning Objectives:

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

- Discuss importance of Infection Prevention and the Disease Transmission Cycle
- Identify potential consequences of poor Infection Prevention practices
- Define Infection Prevention Terms
- Define Aseptic technique
- Explain the importance of hand washing in Infection Prevention
- Demonstrate the steps of surgical hand scrub
- Demonstrate the gloving process
- Describe ways to properly prepare a client for clinical procedures
- Describe the steps of establishing and maintaining a sterile field

Session Overview

- Importance of Infection Prevention and the Disease Transmission Cycle
- Potential consequences of poor Infection Prevention practices
- Definition of Infection Prevention terms
- Define Aseptic technique
- Importance of Hand washing in Infection Prevention
- Steps of surgical hand scrub
- The gloving process
- Preparing a client for clinical procedures
- Steps for establishing and maintaining a sterile field

Methods

- Discussion
- Demonstration and return demonstration
- Handout
- Case studies

Materials

- Video CDs
- Projector Screen
- LCD Projector
- Laptop
- Samples

Module Eight - Session 1: Asepsis, Hand Washing and Gloving

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Asepsis, Hand Washing and Gloving	1 hour 30 minutes	▪ Discuss importance of Infection Prevention and the Disease Transmission Cycle ▪ Identify potential consequences of poor Infection Prevention practices ▪ Define Infection Prevention Terms ▪ Define Aseptic technique ▪ Explain the importance of hand washing in Infection Prevention ▪ Demonstrate the steps of surgical hand scrub ▪ Demonstrate the gloving process ▪ Describe ways to properly prepare a client for clinical procedures ▪ Describe the steps of establishing and maintaining a sterile field	▪ Discussion ▪ Demonstration and return demonstration ▪ Handout ▪ Case studies	▪ Video CDs ▪ Projector Screen ▪ LCD Projector ▪ Laptop ▪ Samples

Module Eight - Session 1: Asepsis, Hand Washing and Gloving

SESSION PRESENTATION

A. Introduction (5)

- The Trainer displays and reviews the learning objectives for this session
- S/he asks participants for any clarification

B. Importance of Infection Prevention and the Disease Transmission Cycle (5)

C. The trainer asks participants why infection prevention is important in FP procedures.

- The Trainer explains to the participants that:
  - Proper infection prevention practices must be followed in order to minimize the risk of infection and serious disease for the client, the provider, and all facility staff members.
  - People with infections, both clients and staff members, may not have any sign or symptoms of the infections they carry.
  - This is particularly notable for HIV and hepatitis viruses, but is the case for other infections as well.
  - Therefore, it is important for all staff to practice proper infection prevention with all clients at all times.
  - All health providers are responsible for client and staff safety. This includes ensuring that appropriate infection prevention practices are followed at the facilities.

D. Potential consequences of poor Infection Prevention practices (10 minutes)

- The Trainer asks the participants to mention the potential consequences of poor Infection Prevention practices and notes their responses on the flip chart
- The Trainer provides clarification on the responses from the participants
- S/he states the potential consequences of poor Infection Prevention practices as:
  - Infection, such as HIV, hepatitis and others commonly found in clinic settings (e.g. *Staphylococcus* and *Streptococcus)* may be transmitted to clients, providers or clinic staff.
  - Many infections related to service use are consequences of inappropriate infection prevention (IP) procedure used during the service provision.
  - A provider-caused (iatrogenic) reproductive tract infection, such as endometritis or pelvic inflammatory disease (PID), may result from poor infection prevention practices.

- A client who acquires a post-procedure infection as a result of using a family planning method may never want to use the method again.

E. Definition of Infection Prevention terms (15 more minutes)

- The Trainer asks the participants to brainstorm on the definition of the following Infection Prevention terms:

  - Microorganisms
  - Antisepsis
  - Decontamination
  - Cleaning
  - Disinfection
  - High-level Disinfection (HLD)
  - Sterilization

- S/he notes their responses on the flip chart

- The Trainer clarifies the responses of the participants and provides the definitions of the terms as follows:

Definition of Infection Prevention Terms

- *Microorganisms* are the causative agents of infection. They include bacteria, viruses, fungi and parasites. For infection prevention purposes, bacteria can be further divided into three categories: vegetative (staphylococcus), mycobacteria (tuberculosis) and endospores (tetanus). Spores are the most difficult to kill.

- The terms asepsis, antisepsis, decontamination, cleaning, disinfection and sterilization often are confusing. For the purpose of this manual, the following definitions will be used:

- *Asepsis and Aseptic Technique* are general terms used to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of asepsis is to reduce to a safe level, or eliminate, the number of microorganism on both animate (living) surfaces such as skin and tissue, and inanimate objects such as surgical instruments and other items.
- *Antisepsis* is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues using a chemical agent (antiseptic).

- *Decontamination* is the process that makes objects safer to be handled by staff before cleaning (It reduces the number of, but does not eliminate, microorganisms on instruments and other items). Objects to be decontaminated include large surfaces (e.g. capsules or operating tables) and surgical instruments, gloves and other items contaminated with blood or body fluids.

- *Cleaning* is the process that physically removes all visible blood, body fluids or any other foreign material such as dust or dirt from skin or inanimate objects.

- *Disinfection* is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects.

- *High-Level Disinfection (HLD)* by boiling, steaming or the use of chemicals eliminates all microorganisms except some bacterial endospores from inanimate objects.

- *Sterilization* is the process that eliminates all microorganisms (bacteria, viruses, fungi and parasites) including bacteria endospores from inanimate objects.

F. Define Aseptic technique (15 minutes)

♦ The Trainer asks the participants to define Aseptic Technique and notes their responses on a flip chart

♦ S/he clarifies all the responses of the participants and inform them that:

- *Asepsis and Aseptic Technique* are general terms used to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection.

- The goal of asepsis is to reduce to a safe level, or eliminate, the number of microorganisms on both animate (living) surfaces such as skin and tissue, and inanimate objects such as surgical instruments and other items.

♦ The Trainer further informs the participants that:

- Aseptic techniques are routine practices before, during and after clinical procedures.

- Placing a physical, mechanical or chemical "barrier" between microorganisms and an individual, whether a client or health worker, is an effective means of preventing the spread of disease (i.e., the barrier serves to break the disease transmission cycle).

- The following aseptic techniques refer to infection prevention practices that create protective barriers for infection prevention:

  - Hand washing;
  - Wearing gloves (both hand) either for surgery or when handling contaminated waste materials or soiled instruments;
  - Wearing appropriate attire (e.g. protective goggles, face mask or apron) when contact with blood or body fluids is possible;
  - Using antiseptic solutions to prepare the skin prior to clinical procedure.
  - Using safe work practices such as **not** recapping or bending needles, safely handling surgical instruments, and properly disposing of waste materials; and
  - Maintaining a safer environment in the procedure area.

G. Importance of Hand washing in Infection Prevention (5 minutes)

♦ The Trainer asks the participants to list the importance of Hand Washing in Infection Prevention and notes their responses on the flip chart

♦ S/he clarifies their responses and informs the participants that:

- Hand washing may be the single most important procedure for preventing infection.

- It is indicated:

  - when examining a client (before and after each client)
  - when putting on sterile gloves for surgical procedure
  - after any situation that may make hands to be contaminated
  - after removing gloves

♦ The Trainer informs the participants about the types and steps of hand washing as follows:

Types of hand washing:

- Plain soap with running water – routine
- Antiseptic with running water
- Alcohol scrubs

Steps of hand washing:

- Wet the hands with running water
- Rub both hands together with soap and lather, making sure to rub all parts of your hands
- Vigorously weave fingers and thumbs together and slide them back and forth for 10–15 seconds or for longer if hands are visibly soiled
- Remember to wash around the nails
- Rinse hands under a stream of clean, running water until all soap is gone
- Dry hands with a clean towel or allow hands to air-dry

- The Trainer further informs the participants that hands should be washed first on arrival at work, in-between attending to clients, and as the last thing when leaving the health facility.

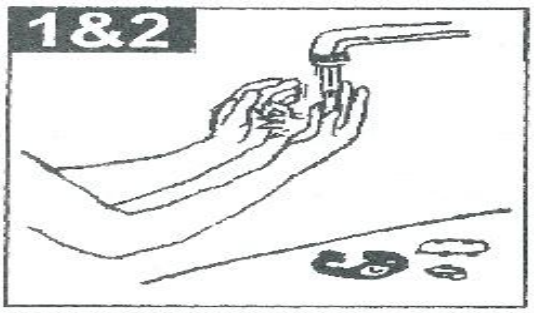
H. Steps of surgical hand scrub (10 minutes)

- The Trainer displays the slide on Steps of Surgical hand scrub and asks the participants to read out the steps one after the other

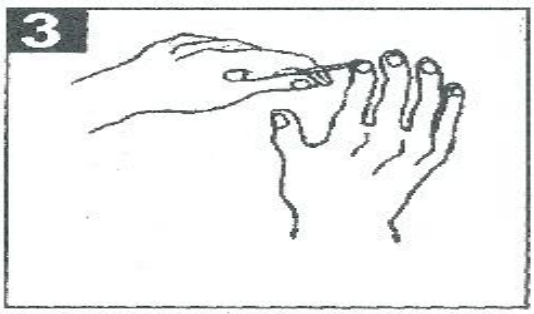
Steps of Surgical hand scrub

- Remove all jewellery
- Wet hands and forearms thoroughly
- Clean fingernails with a brush
- Hold your hands up above the level of your elbows
- Apply antiseptic
- Using a circular motion, begin at the fingertips of one hand, lather and wash between fingers, continuing from finger tips to elbows
- Repeat for the second hand and arm for 3–5 minutes
- Rinse each arm separately, finger tips first, holding your hand above the level of your elbow
- Using a sterile towel, wipe your arms dry from finger tips to elbow
- Use one side of the towel to dry the first hand and the other side to dry the second hand
- Keep your hands above the level of your elbows and do not touch anything

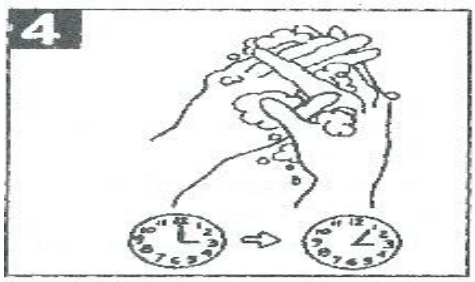
- The Trainer uses Figure 8.1.1- "Steps in performing a surgical hand scrub" to explain and demonstrate surgical hand scrub.
- Trainer request participants to do a return demonstration



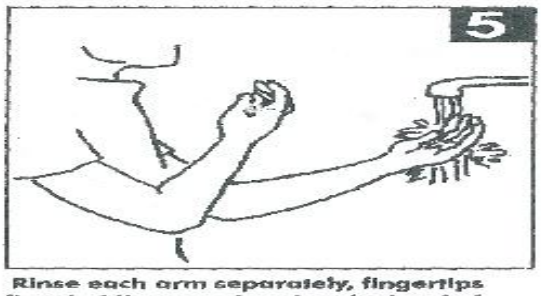
Remove all jewelary on your hands and wrists.
Adjust the water to a warm temperature and wet your hands and forearms thoroughly.



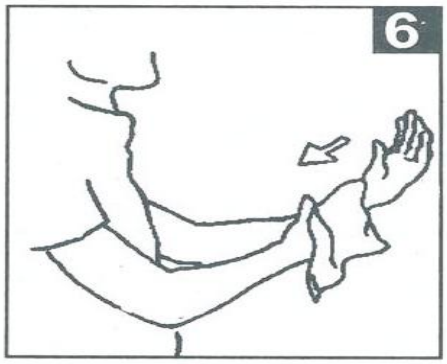
Clean under each fingernail with a stick or brush. (Note: Fingernails should be kept short.)



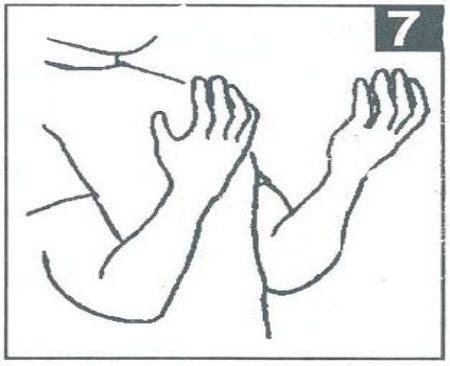
Holding your hands up above the level of your elbow, apply the antiseptic. Using a circular motion, begin at the fingertips of one hand and lather and wash between the fingers, continuing from fingertip to elbow. Repeat this for the second hand and arm. Continue washing for 3-5 minutes.



Rinse each arm separately, fingertips first, holding your hand at the level of your elbow.



Using a sterile towel, wipe your arm- from fingertips to elbow- dry. Use one side of the towel to dry the first hand and the other side of the towel to dry the second hand.



Keep your hands above the level of your elbow and do not touch any thing

- The Trainer informs the participants about the procedures to follow in cleaning hands when running water is not available

- S/he tells the participants that they can use either:

  - A bucket with a tap that can be turned off to lather hands and turned on again for rinsing

  - A bucket and pitcher, with one person pouring the water over the other's hands and allowing it to drain into the bucket

  - An alcohol hand rub, which does not require water

Steps of Alcohol Hand rub

- Apply 3-5 ml of alcohol or an alcohol handrub solution
- Rub hands together until they are dry
- Because using alcohol alone tends to dry the skin, it is best to use an alcohol handrub solution.

To prepare an alcohol handrub solution, add together:

- 2 ml of glycerine, propylene glycol, or sorbitol and
- 100 ml of 60-90% alcohol

Note: An alcohol handrub does not remove soil or organic material such as blood. Therefore, an alcohol handrub should not be used when hands are visibly soiled.

- The Trainer seeks for clarification and addresses all concerns from the participants.

I. The gloving process (20 minutes)

- The Trainer informs the participants about the use of gloves

When to wear gloves:

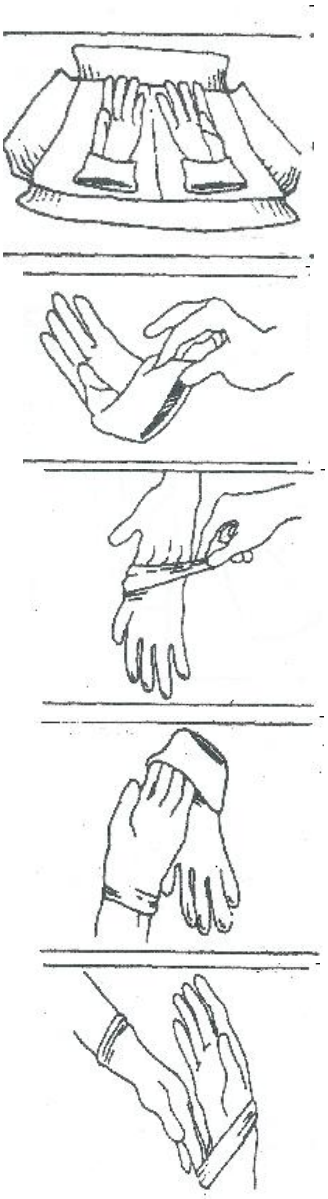
- When in contact with blood and body fluids from any client

- When performing a procedure
- When disposing of contaminated waste items (cotton, gauze or dressings)

Note: A separate pair of gloves must be used for each client to avoid cross-contamination

♦ The Trainer uses the Figure 8.1.2- "Steps for putting on sterile or high-level disinfected surgical gloves" to explain and demonstrate the steps for hand gloving:

Figure 8.1.2: Steps for putting on sterile or high-level disinfected surgical gloves



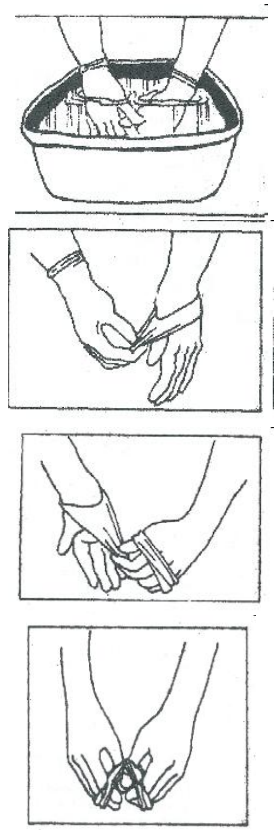
1. Prepare a large, clean, dry area for opening the package of gloves. (If the gloves have been processed and are not wrapped in a package, lay them on a sterile or high-level disinfected surface). Either (1) open the outer glove package and then perform a surgical hand scrub, or (2) perform a surgical hand scrub and then ask someone to open the package for you. Dry your hands completely.
2. Open the inner glove wrapper, exposing the cuffed gloves with the palms up.
3. Pick up the glove by the cuff, touching only the inside portion of the cuff (the side that will be touching your skin when the glove is on).
4. While holding the cuff, slip your other hand into the glove. (Pointing the fingers of the glove toward the floor will keep the fingers open). Be careful not to touch anything, and hold the gloves above waist level. (Note: if the first glove is not fitted correctly, wait to make any adjustment until the second glove is on. Then use the sterile or high-level disinfected fingers of one glove to adjust the sterile or high-level disinfected portion of the other glove).
5. Pick up the second glove by sliding the fingers of the gloved hand under the cuff of the second glove. Be careful not to contaminate the gloved hand with the ungloved hand as the second glove is being put on.
6. Put the second glove on the ungloved hand by maintaining a steady pull through the cuff.
7. Adjust the position of the gloved fingers until the gloves fit comfortably.

Adapted from: Intrah, 1996.Infection Prevention in FP/MCH Clinics. In: Guidelines for Clinical Procedures in Family Planning: A Reference for Trainers. Chapel Hill, NC, pp. A11-22, A11-23.

♦ The Trainer seeks for clarification and addresses all concerns from the participants.

♦ The Trainer uses the following Figure 8.1.3- "Steps for removing surgical gloves" to explain and demonstrate the steps for degloving:

Figure 8.1.3: Steps for removing surgical gloves



1. Rinse gloved hands in a basin of decontaminated solution to remove blood or other body fluids.
2. Grasp one of the gloves near the cuff and pull it part of the way off. Turn the glove partially on your hand before removing the second glove to protect you from touching the outside surface of either glove with your bare hands.
3. Leaving the first glove over your fingers, grasp the second glove near the cuff and pull it part of the way off. The glove will run inside out. It is important to keep the second glove partially on your hand to protect you from touching the outside surface of the first glove with your bare hand.
4. Pull off the two gloves at the same time, being careful to touch only the inside surfaces of the gloves with your bare hands.
5. If the gloves are disposable or are not intact, dispose of them properly (as stated under information on managing medical waste at the end of this chapter). Wash your hands immediately after removing the gloves, since the gloves may contain invisible holes or tears, leaving you at risk of exposure to contaminated blood and other body fluids.

- The Trainer seeks for clarification and address all concerns from the participants.

J. Preparing a client for clinical procedures (5 minutes)

- The Trainer asks the participants to describe ways to properly prepare a client for clinical procedures and notes their responses on the flip chart

- S/he clarifies their responses and tells the participants that:

  - Client preparation before a clinical procedure involves using an antiseptic solution on the client's skin, vagina, or cervix to destroy or prevent the growth of microorganisms.

  - Most surgical-site infections result from contamination during surgery – not, as many people believe, because clients do not keep the wound clean after surgery. Frequently, bacteria from the client's skin or tissues is the cause of infections.

  - Thus, it is critical to pay strict attention to proper preparation of the client before a procedure.

K. Steps for establishing and maintaining a sterile field (10 minutes)

- The Trainer displays the slides on **"**Steps for establishing a sterile field" and informs the participants about the steps as follows:

Steps for establishing a sterile field

  - Place only sterile items within the sterile field;

- Open, dispense, and transfer sterile items without contaminating them;
- Consider items located below the level of draped painted as unsterile;
- Do not allow *scrubbed personnel* to reach across unsterile areas or touch unsterile items;
- Do not allow *unscrubbed personnel* to reach across sterile field or touch sterile items;
- Recognize and maintain sterile field;
- Recognize that the edges of a package containing sterile items are unsterile;
- *Recognize that a sterile barrier that has been penetrated is considered contaminated.*
- Be conscious of where you are at all times and move within or around the sterile field.
- Do not place sterile items near open windows or doors.

♦ The Trainer displays the slides on "Steps for maintaining a sterile field" and explains to the participants the steps for maintaining a safer environment as follows:

Steps for maintaining a safer environment

- Limit entry of unauthorized individuals to surgical/procedure areas;
- Close doors and draw curtains during all procedures;
- Ensure that all personnel in the surgical area wear clean clothes, masks, caps and good footwear;
- Enclose the surgical procedure area to minimize dust and eliminate insects; air-condition the room;
- Decontaminate and clean examination/operating tables, counters, instrument trolleys, etc., before a new client is brought into the room;
- Remove used gloves before touching anything. Countertops, faucets, and pens and pencils are frequently contaminated because health care workers touch them while wearing used gloves;
- Processing gloves for reuse is **not** recommended, since gloves are difficult to properly process. Processing and reusing disposable gloves is especially not recommended.
- Studies have shown that invisible holes or tears are likely to occur when gloves are processed.
- Surgical gloves are the most expensive. Whenever possible, they should be used only for procedures in which there will be contact with the bloodstream or tissues under the skin.

Summary/Evaluation (5 minutes)

- The Trainer summarizes the session by stating that:
  - Adoption of Aseptic Techniques when conducting medical procedures remains one of the major strategies for preventing infection.
  - The understanding of the various procedures of proper hand washing, gloving and removal of used gloves and the wearing of proper attires is imperative for the maintenance of a sterile field.

Evaluation

- The Trainer asks the participants to respond to the following questions:
  - Why is infection prevention important in family planning services?
  - Define Asepsis, Antisepsis, Decontamination, High Level Disinfectant and Sterilization.
  - Describe proper hand-washing during IUD and implant services.
  - Describe the proper use of gloves.
  - Explain the steps of establishing and maintaining a sterile field.

Module Eight - Session 2: Disinfection and Sterilization

Time: 1 hour and 5 minutes

Learning Objectives:

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

- List the steps of processing instruments and other items
- Explain the steps of processing instruments and other items
- Discuss the correct way of preparing 0.5% chlorine solution
- Explain the types and steps of processing instruments and other items by sterilization
- Explain the types and steps of processing instruments and other items by High-level Disinfection (HLD)
- Discuss how to appropriately store processed instruments and other items

Session Overview

- Steps of processing instruments and other items
- Correct way of preparing 0.5% chlorine solution
- Types and steps of processing instruments and other items by sterilization
- Types and steps of processing instruments and other items by High-level Disinfection (HLD)
- Storage of processed instruments

Methods

- Lecture
- Discussion
- Demonstration and return demonstration
- Hand out
- Case studies

Materials

- Flip charts stand and paper
- Colored markers
- Masking tape
- Laptop
- LCD projector
- Projector Screen
- Video CDs

Module Eight - Session 2: Disinfection and Sterilization

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Disinfection and Sterilization	1 h our 5 minutes	▪ List the steps of processing instruments and other items ▪ Explain the steps of processing instruments and other items ▪ Discuss the correct way of preparing 0.5% chlorine solution ▪ Explain the types and steps of processing instruments and other items by sterilization ▪ Explain the types and steps of processing instruments and other item s by High - level Disinfection (HLD) ▪ Discuss how to appropriately store processed instruments and other items	▪ Lecture ▪ Discussion ▪ Demonstration and return demonstration ▪ Hand out ▪ Case studies	▪ Flip charts stand and paper ▪ Colored markers ▪ Masking tape ▪ Laptop ▪ LCD projector ▪ Projector Screen ▪ Video CDs

Module Eight - Session 2: Disinfection and Sterilization

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays the learning objectives for this session and asks the participants to read out the learning objectives
- S/he clarifies all issues

B. Steps of processing instruments and other items (15 minutes)

- Inform the participants that:
  - To prevent transmission of infections via medical instruments, the following steps of instrument processing i.e.,
    - decontamination,
    - cleaning, and
    - Sterilization or high level disinfection, must be done properly.
- The Trainer displays the slide on *"Step 1: Decontamination" and explains to the participants that:*
  - Decontamination kills many disease-causing microorganisms such as hepatitis virus and HIV, making instruments and other items safer for handling during cleaning.
  - Decontamination is performed by soaking used instruments and other items in 0.5% Chlorine solution for 10 minutes.

Correct way of preparing 0.5% chlorine solution

- The Trainer displays the slide on "Making a Chlorine Solution" and explains the formula on how to prepare a dilute chlorine.

MAKING A CHLORINE SOLUTION

Use the following formula to prepare a dilute chlorine solution from liquid

$$\left[\frac{\%\ \text{Chlorine in solution}}{\%\ \text{Chlorine solution desired}}\right] - 1 = \text{number parts water needed per part chlorine}$$

Example: to make a 0.5% chlorine solution from bleach with 3.5% active chlorine

$$\left[\frac{3.5\%}{0.5}\right] - 1 = 7 - 1 = 6$$

Thus, add 6 parts water to 1 part liquid bleach

Note: Instruments should not be exposed to chlorine for prolonged periods. A 10-minute time period is sufficient for decontamination.

Large surfaces such as examination and operating tables, laboratory bench tops and other equipment that may have come in contact with blood or other body fluids also should be decontaminated. Wiping them down with a suitable disinfected towel or cloth (e.g. 0.5% chlorine or 1-2% phenol) is a practical, inexpensive way to decontaminate these items.

- A participant is asked to demonstrate the preparation of chlorine solution
- A participant is asked to demonstrate the cleaning of the instruments.

♦ The Trainer displays the slide on *"Step 2: Cleaning" and explain to the participants that:*

- Cleaning instruments with detergent and water removes blood and particulate matter and improves the quality of subsequent high-level disinfection or sterilization.

- A brush should be used for cleaning most instruments. Staff members must wear thick utility gloves while cleaning instruments.

♦ The Trainer displays the slide on *"Step 3: Sterilization or High-level Disinfection" and explains to the participants that:*

- To be effective, both sterilization and high-level disinfection (HLD) must be preceded by decontamination, careful cleaning, and thorough rinsing.

- When sterilization of instruments is not possible, HLD is the only acceptable alternative.

C. Types and steps of processing instruments and other items by sterilization (10 minutes)

♦ The trainer explains to the participants that:

- Sterilization using steam, dry heat, or chemical solution destroys all microorganisms (bacteria, viruses, fungi, and parasites) including bacterial endospores, from instruments and other items.

- Sterilization is the method recommended for items that come in contact with the blood stream or tissues beneath the skin (such as reusable needles, syringes, and surgical and many delivery instruments):

- Jointed instruments, such as ring forceps, should be open or unlocked for sterilization.

- Sterilization can be done using steam (autoclaving), dry heat (oven) or chemical solutions.

- Sterilization items should then be used immediately or stored in a sterile, covered container.

- The Trainer displays the slide on *"Steam Sterilization" and e*xplains to the participants that:
  - Instruments may be sterilized either wrapped or unwrapped;
  - If items are to be wrapped before steam sterilization, use two layers of paper wrap or two layers of cotton fabric (do not use canvas);
  - The unwrapped items or wrapped packs should be arranged to allow free circulation of steam.
  - Steam sterilization of items is done at 121 degrees C (250 degrees F) and 106 kPa pressure (15 ibs/in2). Steam 30 minutes for wrapped, 20 minutes for unwrapped items.
- S/he emphasizes to the participants that:
  - Timing should not begin until the steam sterilizer reaches the desired temperature and pressure.
  - Allow unwrapped items or wrapped packs to dry before removing them from the steam sterilizer.
  - Allow items to cool before storage or use.
- The Trainer displays the slide on *"Dry Heat Sterilization" a*nd explains to the participants that:
  - Items can be wrapped in foil or double-layered cotton fabric before dry heat sterilization.
  - Dry heat sterilization of items is done at 170 degrees C (340 degrees F) for 60 minutes, or 160 degrees C (320 degrees F) for 120 minutes.
  - Dry heat can dull sharp instruments and needles. These items should not be sterilized at temperatures higher than 160 degrees C.
  - Items should be allowed to cool before they are removed from the oven.
- S/he emphasizes to the participants that timing should not begin until the oven reaches the desired temperature.
- The Trainer displays the slide on *"Chemical Sterilization" a*nd explains the process to the participants as follows:
  - Cover all items with correct dilution of glutaraldehyde solution (Cidex) or an 8% formaldehyde solution (least desirable because it is dangerous to breathe). Do not use sporicidin for sterilization.
  - Jointed instruments such as ring forceps, should be opened or unlocked.
  - Soak items for 10 hours for Cidex, or 24 hours for formaldehyde, or as per manufacturer's instructions.

- Nothing should be added to or removed from the chemical solution once timing has begun.

- After soaking items, rinse them with sterile water air dry before use or storage.

D. Types and steps of processing instruments and other items by High-level Disinfection (HLD) (15 minutes)

♦ The Trainer informs the participants that:

- If sterilization is not available, high level disinfection is the only acceptable alternative for preparing instruments and other reusable items for use in Post-partum IUD (PPIUD) insertion.

- High-level disinfection (HLD) is effective in eliminating all microorganisms except some bacterial endospores.

- There are two methods of HLD: boiling and chemical HLD.

- After either boiling or chemical HLD procedure, items that are not used immediately should be air-dried and stored in a covered high-level disinfected container (for up to one week).

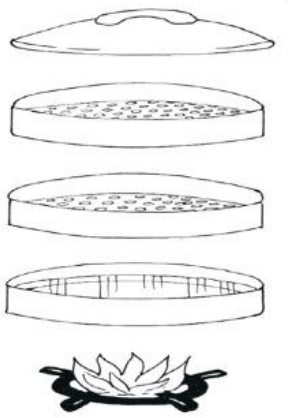
The Trainer displays the slide on *"High Level Disinfection by Steaming" and r*efers participants to the "Two-Tiered Steamer" in Figure 8.2.1 below *and e*xplains to them that:

- The best method of high-level disinfection of gloves and a useful method of high-level disinfection of cannulae used during manual vacuum aspiration (MVA) is to steam them in a steamer containing one to three tiers of gloves or cannulae.

- MVA cannulae may be high-level disinfected or sterilized by other methods. However, high-level disinfection of gloves by other methods is less appropriate and not recommended.

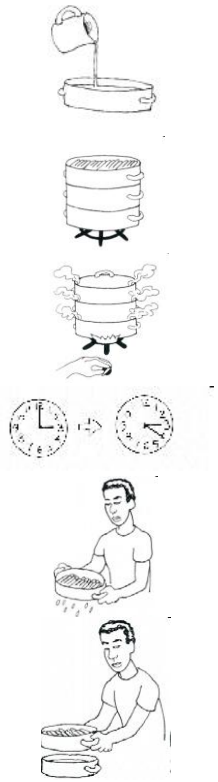
  Gloves should be used once and disposed.

Figure 8.2.1 - Two-Tiered Steamer



♦ S/he displays the slide showing *"Steps of HLD by Steaming"* and uses Figure 8.2.2 to explain the steps of HLD by steaming as follows.

Figure 8.2.2 – Steps of HLD by Steaming



STEPS OF HLD BY STEAMING

These steps should be followed for steaming MVA cannulae and other materials as shown in the diagram below:

1. Decontaminate the materials to be high-level disinfected.
2. Place water in the bottom tray (which has no holes).
3. Stack the tray(s) of materials on top of the bottom tray.
4. Place the lid on the top tray and bring the water to a boil. When steam comes out between the trays, the water is boiling. Reduce the heat, but maintain the water at a rolling boil (steam should continue to come out between the trays). High heat wastes fuel and causes the water to evaporate more quickly.
5. Steam the materials for 20 minutes. Use a timer or make sure to record the time.
6. Remove each tray, shake off the excess water, and place the tray(s) on a second tray that does not have holes or contain water (a second bottom tray). (Do not place the tray containing the materials directly on the countertop, since this may contaminate them; remember, there are holes in the bottom of the tray.)
7. Use the materials immediately or allow them to dry for 4–6 hours (drying may be difficult in areas of high humidity).
8. Storage: Store the materials in a covered tray or put them in a high-level disinfected container and use within one week.

♦ The Trainer displays the slide showing *"Steps of Chemical HLD" and e*xplains to the participants that:

- All items should be covered with the correct dilution of properly stored disinfectant:
  - Glutaraldehyde solution\
  - 0.5% or 0.1% chlorine solution
  - 8% formaldehyde solution
- Joined instruments, such as ring forceps, should be opened or unlocked;
- *Chemical HLD of i*tems should be for 20 minutes or as per manufacturer's instructions;
- Nothing should be added to or removed from the chemical solution once timing has begun. After soaking items, rinse them with boiled water.
- Items should be air-dried before use or storage.

E. Storage of processed instruments (10 minutes)

♦ The Trainer informs the participants that proper storage of HLD or sterilized items is as important as the HLD or sterilization process itself. Therefore:

- Items should be stored dry;
- If possible, store processed items in an enclosed cabinet.

- Do not store pick-up forceps in a bottle filled with antiseptic solution (microorganisms will multiply in the standing solution even if an antiseptic has been added);

- HLD or sterilize pick-up forceps each day and store them dry in a high-level disinfected or sterile bottle.

- Wrapped items must be considered contaminated when:

  - The package is torn or damaged
  - The wrapping is wet
  - The expiration date is exceeded.

- Wrapped items can be used for up to one week. Wrapped items sealed in plastic can be used for up to one month.

- Unwrapped items must be used immediately or stored in a covered sterile or HLD container (for up to one week)

Summary/Evaluation (10 minutes)

♦ The Trainer summarize the session by stating that:

- The session highlighted the importance of processing instruments and other medical items in stepwise manner to avoid contamination.

- Infections' prevention in medical settings relies on the effective decontamination and sterilization of instrument in use.

Evaluation

♦ The Trainer asks the participants to respond to the following questions:

- Describe steps for processing instruments and other medical items.

- Demonstrate appropriate order for processing instruments in the health facility

- Explain strategies for storing processed instruments.

Module Eight: Session 3: Disposal of Sharps and Waste

Time: 1 hour 30 minutes

Learning Objectives:

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

- List the ways by which health workers can be injured by sharps;
- Describe actions that surgical teams can take to prevent or minimize injuries by needles/sharps;
- Discuss the proper procedures for safe use and disposal of needles/sharps;
- Describe the proper procedures for giving injections
- State the proper procedures for the use of multi-dose vials;
- Discuss how to reduce the risk of transmitting infections between clients;
- Define Housekeeping and state its importance;
- State the importance of correct disposal of waste;
- Describe appropriate waste disposal.

Session Overview

- Ways by which health workers can be injured by sharps
- Actions that surgical teams can take to prevent or minimize injuries by needles/sharps
- Proper procedures for safe use and disposal of needles/sharps
- Proper procedures for giving injections and use of multi-dose vials
- Proper procedures for the use of multi-dose vials
- Reducing the risk of transmitting infections between clients
- Definition of House-keeping and its importance
- Importance of correct disposal of waste
- Appropriate waste disposal

Methods

- Brainstorming
- Lecture
- Discussion
- Demonstration and return demonstration
- Role Play

Materials

- Flip charts stand and paper
- Colored markers
- Masking tape
- Laptop
- LCD projector
- Sharps disposal containers

Module Eight - Session 3: Disposal of Sharps and Waste

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Disposal of Sharps and Waste	1 hour 30 minutes	▪ List the ways by which health workers can be injured by sharps; ▪ Describe actions that surgical teams can take to prevent or minimize injuries by needles/sharps; ▪ Discuss the proper procedures for safe use and disposal of needles/sharps; ▪ Describe the proper procedures for giving injections ▪ State the proper procedures for the use of multi-dose vials; ▪ Discuss how to reduce the risk of transmitting infections between clients; ▪ Define Housekeeping and state its importance. ▪ State the importance of correct disposal of waste ▪ Describe appropriate waste disposal.	▪ Brainstorming ▪ Lecture ▪ Discussion ▪ Demonstration and return demonstration ▪ Role Play	▪ Flip charts stand and paper ▪ Colored markers ▪ Masking tape ▪ Laptop ▪ LCD projector ▪ Sharps disposal containers

Module Eight - Session 3: Disposal of Sharps and Waste

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays the learning objectives for this session and asks the participants to read out the objectives

- S/he clarifies all issues and informs the participants that:

  - All staff that come in contact with sharps – from doctors and nurse to those who dispose of the trash – are at risk of infections.

B. Ways by which health workers can be injured by sharps (5 minutes)

- The Trainer asks the participants to list the ways that health workers can be injured by sharps and notes their responses on the flip chart.

- S/he clarifies their responses and displays the slide on *"How Injuries commonly occur" to add to their responses.*

How injuries commonly occur:

  - Recapping hypodermic needles after use (this is one of the major causes of sharp-object injuries.
  - Any manipulation of used sharps before disposal (such as bending, breaking or cutting hypodermic needles, which can cause the blood inside to splatter or cause staff to accidentally injure themselves)
  - Accidentally sticking another staff member when there is sudden motion involving persons carrying unprotected sharps
  - Leaving sharp items in areas where they are unexpected, such as on surgical drapes or bed line
  - Accidentally sticking or cutting themselves during surgical procedures in which there is limited visibility of the hands, many sharp instruments are used, or sharp instruments/suture needles are used in confined spaces (such as many obstetric/gynecological and orthopedic procedures)
  - Handling or disposing of waste that contains used hypodermic needles or other sharps
  - Unexpected client motion at the time of injections. Always warn clients when you are about to give them an injection
  - During placement of needles or sharps into disposal container that are full or do not allow for easy insertion of the items
  - When the surgeon or assistant uses their fingers as a guide or when tissue is hand-held during suturing, during manual retraction of tissue/organs, or when tying suture material with the needle still attached
  - When needle holders with the needle are left exposed
  - Other devices that cause stick-injuries and perforation of gloves include the use of suture needle without a needle holder, wire sutures, trocars, stylets, sharp pointed scissors, sharp pointed retractors, skin hooks, penetrating towel clips, tenaculi.

- Scalpel injuries occur most frequently when instruments are handed from the user to an assistant (transferring between personnel).

♦ The Trainer addresses any concerns by the participants.

C. Actions that surgical teams can take to prevent or minimize injuries by needles/sharps (10 minutes)

♦ The Trainer asks the participants to list the ways that health workers can prevent injuries by needles/sharps and notes their responses on the flip chart

♦ S/he clarifies all their responses and displays the slides on *"How to prevent Injuries due to sharps"* and *"The Hand-free Technique for passing Sharps during Clinical Procedures".*

How to prevent injuries due to sharps:

- Handle hypodermic needles, syringes, and other sharps minimally after use, and use extreme care whenever sharps are handled.
- Avoid recapping needles and do not bend, break or cut them before disposal.
- Dispose of hypodermic needles, scalpel blades, and other sharps in puncture-resistant containers immediately (or as soon as practical) after use. (Disposal of sharps is described more fully in the next section of this module).
- Incinerate/burn or bury the container when three quarters full.
- Always wear utility gloves when disposing of sharps containers.
- Always wear utility gloves when washing sharps.
- Use the "hands-free technique" (described on the next page) to pass sharps during clinical procedures.
- Let clients know when you are going to give an injection to avoid startling client and causing an injury.
- Promote safety awareness during in-service session focused on supporting behaviour change to prevent or minimize needle stick and sharp instrument injuries.
- Manipulate or reposition scalpel blades using forceps to grasp the blade.
- Consider using staples in place of suture and suture needles, if it would be an appropriate option.
- Use curved needles with a needle holder as a safer option to straight, hand held needles.
- Blunt instruments can be an alternative for preventing injuries, such as rounded point scissors, non-penetrating towel clips, blunt retractors, and synthetic sutures instead of wire sutures.
- When transferring sharps between personnel, avoid hand-to-hand transfer. Create a safety zone using a flat tray, mat, part of the instrument stand, or designated area on the field where instruments can be placed by the user and safely picked up by the assistant. ***Do not use a kidney basin from which items are hard to pick-up.***

The Hands Free technique for passing Sharps during Clinical Procedures:

- Health care workers can accidentally stick each other if or when passing sharps during a procedure, there is sudden motion involving persons carrying unprotected sharps (such as on surgical drapes).
- Unprotected sharps should not be passed directly from one person to another.

- In the operating theatre or procedure room, pass sharp instruments and other items in such a way that the surgeon and assistant are never touching the instrument or other item at the same time (known as the hands-free technique).

♦ The Trainer addresses any concerns by the participants.

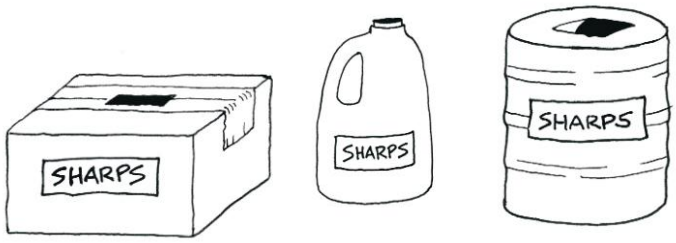
D. Proper procedures for safe use and disposal of needles/sharps (10 minutes)

♦ The Trainer informs the participants that:

- Improper disposal of contaminated sharp objects can cause infections in the health care facility and the community.
- Make hypodermic needles and other sharps unusable by incinerating them.
- If an industrial incinerator that will destroy hypodermic needles and other sharps is not available, reduce the risk of infections by decontaminating sharps before disposal, and bury them in a pit to make it difficult for others to scavenge them.

♦ The Trainer displays Figure 8.3.1 - *"Sharp-disposal container "* - a puncture-resistant container for disposal of used needles and other sharp objects

Figure 8.3.1 - "Sharp-disposal container



♦ S/he informs the participants that a sharp-disposal container may be made out of a heavy cardboard box, an empty plastic jug, or a metal container.

E. Proper procedures for giving injections and use of multi-dose vials (10 minutes)

♦ The Trainer asks the participants to brainstorm on the proper procedures for giving injections and use of multi-dose vials and notes their responses on the flip chart

♦ S/he clarifies their responses and informs the participants that:

When Giving Injections - To reduce the risk of transmitting infections between clients:

- Always use a new or correctly re-processed hypodermic needle and syringe every time an injection is given.
- Never change the needle without also changing the syringe between clients. Re-using the same syringe to give injections to multiple clients – even if the needle is changed – is not a safe practice.
- Before giving an injection if there is visible dirt, wash the injection site with soap and water.

- Wipe the client's skin at the injection site with an antiseptic solution to minimize the number of microorganisms and reduce the risk of infections. Using a fresh swab, wipe in a circular motion from the center outward.

- If alcohol is used, allow the alcohol to dry in order to provide maximum effectiveness in reducing microorganisms.

To avoid transmitting infections when giving IV fluids:

- Unhook the needle or catheter from the IV line, and dispose of it in a sharps-disposal container.

- Throw away the IV line and any remaining fluid. Microorganisms can survive and grow in IV fluids; if the IV line and bag/bottle of fluid are used again, infection can be transmitted to other clients.

- Never use the same IV line and fluid bag/bottle with multiple clients.

♦ The Trainer emphasizes to the participants that unexpected client motion at the time of injection can lead to accidents. Therefore, always warn clients when you are about to give an injection.

F. Proper procedures for the use of multi-dose vials (5 minutes)

♦ The Trainer informs the participants that:

- Before filling a syringe from a multi-dose vial, they should:

  - Check the vial to be sure there are no leaks or cracks;

  - Check the solution to be sure it is not cloudy and that there is no particulate matter in the vial. (Most solutions that come in vials are clear. One exception is the injectable contraceptive Depo-Provera, which is milky).

  - Wipe the top of the vial with a fresh cotton swab soaked with 60-70% alcohol; allow to dry.

G. Reducing the risk of transmitting infections between clients (20 minutes)

♦ The Trainer asks the participants to list the ways that health workers can reduce the risk of transmitting infections between clients and notes their responses on the flip chart.

♦ S/he clarifies their responses and displays the slides on *"How to reduce the risk of transmitting infections between clients"*

To reduce the risk of transmitting infections between clients:

- Always use a new hypodermic needle and syringe every time medication is withdrawn from a multidose vial. ***Reusing the same syringe to give injections to multiple clients – even if the needle is changed is not a safe practice. (DEMONSTRATE AND RETURN DEMONSTRATION BY PARTICIPANT)***

- **Never** leave one needle inserted in the vial cap for multiple uses. This provides a direct route for microorganisms to enter the vial and contaminate the fluid between each use. ***(DEMONSTRATE AND RETURN DEMONSTRATION BY PARTICIPANT)***
- Wash hands with soap and water ***(DEMONSTRATE AND RETURN DEMONSTRATION BY PARTICIPANT)***
- Where there is bleeding, allow the site to bleed briefly. (***There is no scientific evidence that cleaning the wound with an antiseptic or squeezing the wound decreases the risk of transmitting blood borne organisms)*.**
- If a mucous membrane has been injured or splashed, flush with a large amount of water.
- If the eyes have been splashed, irrigate with clean water, saline, or sterile irrigating solution.
- In the absence of water, an antiseptic solution can be used to flush the area but remember that antiseptic solutions have not been proven to be any more effective than soap and water
- Assess the injured health worker's risk for infection following exposure – depth of wound, type of instrument involved, amount and type of bodily fluid.
- If feasible, determine the HIV status of the source patient, with appropriate counseling and disclosure of serological status. This is a particularly important step in settings where resources are limited and recommended prophylactic drugs may not be readily available. Determining that the source patient is HIV negative will eliminate the need for drug therapy, its attendant side effects, costs and emotional stress of not knowing the risk following exposure or whether the drug therapy will work. Based on the assessment findings, determine the need for prophylaxis.
- Post exposure care includes voluntary Counseling, HIV testing, treatment, and follow-up care.
- If the health care worker will receive antiretroviral drugs, counsel the worker about the possible side effects associated with the prophylactic drugs (ZDV) and 3TC). Although these drugs are usually well tolerated, some of the more common side effects include:
  - Stomach upset (nausea, vomiting and diarrhea), tiredness, or headache (ZDV).
  - Stomach upset (rarely, pancreatitis with 3 TC)
  - Jaundice and kidney stones in people taking ZDV; this can be reduced by drinking 48 ounces of fluids during every 24-hour period.

- Counsel the injured health worker about behaviours to prevent transmission of HIV, such as not providing blood, organ, or semen donations; abstaining from sexual intercourse. If abstinence will be difficult or not possible for the health worker, counsel her/him to use latex condoms consistently and correctly to reduce the sexual transmission of HIV.
- Encourage the injured health care worker to include their partner in counseling. In settings where breast milk substitutes are affordable, accessible, and can be safely used, women may be advised to avoid breastfeeding during the PEP period to prevent exposing their infants to HIV in the breast milk. Post-exposure care should include the following, where feasible:
  - Screening / Testing for baseline and periodically up to 6 months after exposure (e.g. at 6 weeks HIV antibody testing of the health care worker, as soon as possible after, 12 weeks, and 6 months).

- When antiretroviral drugs are being taken for PEP, assessment of toxicity with complete blood count, kidney and liver function tests before starting treatment and at 2 weeks after starting treatment.
- Instruct the health care staff under treatment to report any sudden or severe flu-like illness that occurs during the follow-up period.
- Counsel the injured worker regarding her/his emotional response, fears, and/or concerns regarding the reaction of their partner or spouse.

♦ The Trainer notes and address any concerns by the participants.

H. Definition of House-keeping and its importance (10 minutes)

♦ The Trainer asks the participants to define Housekeeping and state its importance and notes their responses on the flip chart

♦ S/he clarifies their responses and defines "Housekeeping" as follows:

o The general cleaning and maintenance of cleanliness in a health care facility.

o In addition to cleanliness, the purpose of housekeeping is to reduce the number of microorganisms in the facility.

I. Importance of correct disposal of waste (5 minutes)

♦ The Trainer informs the participants that the purpose of proper waste disposal of clinic wastes is to:

o Prevent spread of infection to clinic personnel who handle the waste and to the local community;

o Protect those who handle wastes from accidental injury;

o Provide an aesthetically pleasing atmosphere.

J. Appropriate waste disposal (5minutes)

♦ The Trainer informs the participants that:

o Wastes from procedure rooms, delivery rooms, operating rooms and laboratories should be considered contaminated

o Contaminated wastes should be transported to disposal sites in covered containers where available. Persons handling wastes should wear heavy gloves.

o All sharp items should be disposed in puncture-resistant containers.

o Liquid waste should be carefully poured down a utility drain or flushable toilet or latrine.

o It is best to burn or bury contaminated waste rather than use community waste collection.

Summary/Evaluation (10 minutes)

- The Trainer summarizes the session by stating that:
  - All staff that come in contact with sharps – from doctors and nurse to those who dispose of the trash – are at risk of injury and infections.
  - Proper disposal of sharps, effective housekeeping within the health facility, and appropriate disposal of dry and wet wastes are essential for infection prevention.
  - Observing the general guidelines for housekeeping is the easiest way to keep the facility infection free.

Evaluation

- The Trainer asks the participants to respond to the following questions:
  - List ways by which health care workers can be injured by sharps.
  - Describe strategies for the prevention of injuries during surgery.
  - Describe the appropriate procedures for the disposal of needles and sharps.
  - Mention five Housekeeping guidelines.

MODULE NINE

PROBLEM MANAGEMENT/INFORMATION AND SUPPORT DURING IUD AND IMPLANT USE

Session 1: Problem Management during use of Copper bearing IUDs

Session 2: Problem Management during Implant Use

Module Nine - Session 1: Problem Management during use of Copper bearing IUDs

Time: 1 hour 30 minutes

Learning Objectives:

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

- List the common side effects, the occasional side effects and the warning signs requiring prompt medical attention in IUD users.
- Indicate what action should be taken medically for each side effect.
- Demonstrate through case studies and role plays ways of handling client concerns about side effects of IUDs.

Session Overview

- Common side effects, the occasional side effects and the warning signs requiring prompt medical attention in IUDs users
- Action to be taken medically for each side effect
- Demonstration of ways of handling client concerns about side effects of IUDs (through case studies and role plays)

Methods

- Brainstorming
- Discussion
- Illustrated Lecture
- Small group discussion
- Case Studies
- Role Play

Materials

- Flip chart and Stand
- Markers
- Lap top
- LCD Projector
- Handouts of Case studies

Module Nine - Session 1: Problem Management during use of Copper bearing IUDs

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Problem Management during use of Copper bearing IUDs	1 hour 30 minutes	▪ List the common side effects, the occasional side effects and the warning signs requiring prompt medical attention in IUD users. ▪ Indicate what action should be taken medically for each side effect. ▪ Demonstrate through case studies and role plays ways of handling client concerns about side effects of IUDs.	▪ Brainstorming ▪ Discussion ▪ Illustrated Lecture ▪ Small group discussion ▪ Case Studies ▪ Role Play	▪ Flip chart and Stand ▪ Markers ▪ Lap top ▪ LCD Projector

Module Nine - Session 1: Problem Management during use of Copper bearing IUDs

SESSION PRESENTATION

A. Introduction (10 minutes)

- The trainer displays and reviews the learning objectives for this session
- S/he asks participants for any clarification and informs the participants that:
  - Most side effects and other health problems associated with the use of IUDs are not life threatening
  - Changes in the menstrual bleeding, especially some increase in the amount and duration of the menstrual bleeding, are the most common adverse side effects.

B. Common side effects, the occasional side effects and the warning signs requiring prompt medical attention in IUDs users (10 minutes)

- The Trainer asks the participants to mention the common health problems and side effects associated with use of IUDs
- S/he notes their responses on the flip chart and clarifies the responses from the participants
- The Trainer classifies the common health problems and side effects associated with the use of IUDs as:
  - Suspected perforation
  - Bleeding changes
  - Severe pain and cramping in the lower abdomen
  - Missing strings
  - Uterine perforation
  - IUD expulsion

C. Actions to be taken medically for each side effect (45 minutes)

- The Trainer displays the slide on "Suspected perforation" and discusses the actions that should be taken medically in suspected perforation:
  - If perforation is suspected based on the signs such as fainting during or after insertion, pain, rapid pulse and respiration, fatigue

Actions to be taken in Suspected perforation

- Stop the insertion. If IUD was already inserted, remove it
- Place client in a horizontal position and observe for an hour
- Monitor vital signs (BP, pulse, respiration and temperature) every 5 to 10 minutes
- Check for signs of intra-abdominal bleeding (haematocrit, haemoglobin paper)

- If no signs of bleeding, observe for several more hours before sending home.
- Counsel to abstain from sex for 2 weeks
- Help her choose another method

If intra-abdominal bleeding is suspected

- If her vital signs are getting worse (rapid pulse, falling blood pressure, fainting) and or her haematocrit/haemoglobin are falling, refer to higher level of care without further delay.

♦ The Trainer displays the slide on *"Bleeding changes"* and discusses the actions that should be taken medically in bleeding changes such as:

If there is spotting or irregular bleeding

- Reassure that many IUD users experience irregular bleeding or spotting. This is not harmful and usually becomes less **after the first 3 months**
- Suggest a course of Paracetamol 2 tablets 3 times a day and Buscopan 1 tablet 3 times a day for 3 days.

If there is heavy or prolonged monthly bleeding

- Reassure that many women who use IUD experience heavy or prolonged menses. It is generally not harmful and becomes less or stops **after the first 3 months of use.**

- For moderate short-term relief, try (one at a time):

  - Tranexamic acid 1500 mg 3 times a day for 3 days, then 1000 mg once a day for 2 days, beginning when heavy bleeding starts
  - Paracetamol 2 tablets 3 times a day and Buscopan 1 tablet 3 times a day for 3 days. Provide iron tablets if possible and counsel about diet high in iron

If irregular, heavy or prolonged bleeding continues or starts after 3 months of normal bleeding or long after the IUD was inserted

- Rule out underlying condition (e.g. infection or genital malignancy) and treat accordingly or refer to the specialist
- She can continue using the IUD while condition is being evaluated
- If bleeding is caused by STI or PID, she can continue using the IUD during treatment

♦ The Trainer displays the slide on *"Severe pain in the lower abdomen"* and discusses the actions that should be taken medically in severe pain in the lower abdomen:

If there is suspicion of PID (foul-smelling vaginal discharge)

- Begin antibiotics immediately, e.g.
  Ciprofloxacin 500 mg bd x 5 days
  Doxycycline 100 mg tab orally twice daily x 7 days
  Metronidazole 400 mg tab orally twice daily x 14 days
- Follow-up in 48 hours

- There is no need to remove IUD unless client wants to discontinue. If she wants it removed, take it out after 2-3 days of antibiotic treatment
- Instruct client to take all medication until it is finished
- Tell patient to return to clinic 4–7 days after completing antibiotics
- Tetracycline/Doxycycline should be taken one hour before meals or two hours after meals. Avoid antacids, dairy products, e.g. milk, and mineral preparations, e.g. calcium, when taken tetracycline
- Counsel client to avoid sexual intercourse until client and partner(s) are cured; use condoms to prevent re-infections. If STI is suspected, treat partner(s)
- If IUD is removed, counsel client regarding choice of alternative family planning method until pregnancy is desired
- A client who desires another IUD can have it inserted after she and her partner were cured.

If there is suspicion of ectopic pregnancy (abdominal pain, absence of menstrual periods and vaginal bleeding)

- Refer to a higher level provider immediately for diagnosis and care

♦ The Trainer displays the slide on *"Pain or Cramping"* and discusses the actions that should be taken medically when there is Pain or Cramping:

If pain or cramps occurred since IUD insertion (first three months) and are linked to monthly bleeding

- Re-assure client that pain and cramps are not an unusual side effect of IUD use and usually decrease over time. They are not harmful.
  - Give simple analgesic tablets - Paracetamol 2 tablets 3 times a day and Buscopan 1 tablet 3 times a day for 3 days.
  - If the pain persists, refer to a higher level of care.

If cramping continues and occurs outside of monthly bleeding

- Evaluate for underlying health condition (infection, partial expulsion of the IUD) and treat or refer
- If no underlying condition is found and cramping is unacceptable to the client, help her choose another method

♦ The Trainer displays the slide on *"Missing Strings"* and discusses the actions that should be taken medically in missing strings:

If strings are neither visible nor felt and client is not pregnant

- Refer to higher level of care without delay

♦ The Trainer displays the slide on "Uterine pregnancy" and discusses the actions that should be taken medically in uterine pregnancy.

If strings are visible

- Inform client of your findings and explain that IUD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage (possibly septic) during the first or second trimester.
- Explain that if she is planning to continue the pregnancy, it is best to remove the IUD, although the removal procedure itself involves a small risk of miscarriage.
- If client consents, remove device by gently pulling the strings
- Refer for antenatal care, counsel client to return to clinic if abdominal pain and bleeding/spotting occurs.

If strings are not visible, refer to higher level of care

♦ The Trainer displays the slide on *"IUD expulsion"* and discusses the action that should be taken medically in IUD expulsion:

If strings are unusually long or stem of device is at cervical os and pregnancy is ruled out

- Remove the IUD
- If client wants to continue using IUD, re-insert another one and follow-up in six weeks. If not, help her choose another method

If strings are unusually long or stem of device is at cervical os, and unable to exclude pregnancy

- Remove the IUD
- Provide barrier contraceptive
- Ask client to return to the clinic in four weeks for re-evaluation

If client reports that IUD came out

- Discuss whether she wants another IUD or a different method
- If she wants another IUD, she can have one inserted at any time as long as provider is reasonably certain she is not pregnant

♦ The Trainer informs the participants to refer clients with acute low abdominal pain to a higher level of care if:

- diagnosis is uncertain
- surgical emergency (e.g. appendicitis, ectopic pregnancy) is suspected
- pelvic abscess is suspected
- client is pregnant
- client is unable to follow or tolerate outpatient therapy
- client fails to respond to outpatient therapy
- outpatient follow-up after 48–72 hours cannot be arranged.

D. Demonstration of ways of handling client concerns about side effects of IUDs (through case studies and role plays) (25 minutes)

- The Trainer distributes handouts of prepared case studies and asks the participants to either:
  - Discuss them, or
  - Act them as Role Plays

- S/he clarifies any issues raised by the participants during the discussion of the case studies or role plays.

Summary/Evaluation (5 minutes)

- The Trainer summarizes the session by stating that:
  - Long-term success, as defined by satisfied clients and high continuation rates, will occur only if clinic staff recognize the importance of providing follow-up care (including counseling) and prompt management of side effects as well as other problems should they occur.
  - Most side effects and other health problems associated with IUD are not serious.

Evaluation

- The Trainer asks participants to respond to the following questions:
  - List the common side effects of use of IUDs.
  - What are the warning signs requiring prompt medical attention?
  - Discuss the management of IUD-related pregnancy.
  - Discuss the management of missing string.

Module Nine - Session 2: Problem Management during use of Contraceptive Sub-dermal Implants

Time: 1 hour 30 minutes

Learning Objectives:

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

- List the common side effects, the occasional side effects and the warning signs requiring prompt medical attention in implant users.
- Indicate what actions should be taken medically for each side effect.
- Demonstrate through case studies and role plays ways of handling client concerns about side effects of Implants.
- Demonstrate counseling clients on side effects of Implants in clear everyday language.

Session Overview

- Common side effects, the occasional side effects and the warning signs requiring prompt medical attention in implant users.
- Actions to be taken medically for each side effect.
- Demonstration of ways of handling client concerns about side effects of Implants (through case studies and role plays).
- Demonstration of ways of counseling clients on side effects of Implants in clear everyday language.

Methods

- Brainstorming
- Discussion
- Illustrated Lecture
- Small group discussion

Materials

- Flip chart and Stand
- Markers
- Lap top
- LCD Projector
- Handouts of Case studies

Module Nine - Session 2: Problem Management during use of Contraceptive Sub-dermal Implants

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Problem Management during use of Contraceptive Sub-dermal Implants	1 hour 30 minutes	▪ List the common side effects, the occasional side effects and the warning signs requiring prompt medical attention in implant users. ▪ Indicate what action should be taken medically for each side effect. ▪ Demonstrate through case studies and role plays ways of handling client concerns about side effects of Implant ▪ Demonstrate counseling clients on side effects of Implants in clear everyday language	▪ Brainstorming ▪ Discussion ▪ Illustrated Lecture ▪ Small group discussion	▪ Flip chart and Stand ▪ Markers ▪ Lap top ▪ LCD Projector ▪ Handouts of Case studies

Module Nine - Session 2: Problem Management during use of Contraceptive Sub-dermal Implants

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays the learning objectives for this session and asks the participants to read out the objectives

- S/he clarifies all issues and inform the participants that:

  - Most side effects and other health problems associated with the use of Implants are not life threatening.

  - Changes in menstrual bleeding patterns are by far the most common adverse effect.

  - In addition to menstrual bleeding changes, women using Jadelle^{R} implants occasionally develop enlarged ovarian follicles. Fortunately, they rarely cause symptoms and usually are discovered only incidentally at pelvic examinations. In addition, they generally shrink and disappear spontaneously and rarely require treatment.

  - Ectopic pregnancies also have occurred, although clinical studies have shown no increase in the rate of ectopic pregnancies per year among Implants users compared with women not using any contraceptive method.

B. Common side effects, the occasional side effects and the warning signs requiring prompt medical attention in Implant users (10 minutes)

- The Trainer asks the participants to mention the common health problems and side effects associated with the use of Implants and notes their responses on the flip chart

- S/he clarifies the responses from the participants and then classifies the common health problems and side effects associated with the use of Implant use as:

  - Pain after insertion or removal
  - Infection at the insertion site
  - Irregular or heavy bleeding
  - Severe pain in the lower abdomen
  - Headaches

- The trainer emphasizes to the participants that several other conditions that may or may not be associated with the use of Implants have been reported. They include:

  - breast tenderness and/or discharge,
  - weight gain,
  - increased body or facial hair (hirsutism) and
  - vaginal infection (vaginitis).

C. Action to be taken medically for each side effect (45 minutes)

♦ The Trainer displays the slide on *"Pain after insertion or removal"* and discusses the actions that should be taken medically if there is pain after insertion or removal:

If no signs of infection

- Advise her to avoid pressing on the Implants for a few days and never press on the Implants if tender
- Give Paracetamol 2 tablets 3 times a day and Buscopan 1 tablet 3 times a day for 3 days.
- If the pain persists, refer to a higher level of care.

♦ The Trainer displays the slide on *"Infection at the insertion site"* and discusses the actions that should be taken medically if there is Infection at the insertion site:

If there is redness, heat, pain, pus

- Do not remove the Implants
- Clean the infected area with soap and water or antiseptic
- Give an oral antibiotic, e.g. Amoxicillin 500 gm tds for 7 days and ask the client to return in one week
- Then if no improvement, remove the implants or refer for removal

If there is an abscess

- Clean the infected area with antiseptic, make an incision, and drain the pus
- Treat the wound and give oral antibiotic for seven days
- Ask client to return in 7 days if she still has symptoms (heat, pain, drainage, redness).If infection is still present, remove the Implants or refer for removal. Help to choose another method

♦ The Trainer displays the slide on *"Irregular or Heavy vaginal bleeding"* and discusses the actions that should be taken medically if there is irregular or heavy vaginal bleeding:

If no underlying condition is suspected (Implant is still in place and bleeding started after Implant initiation)

- Reassure the client that bleeding changes are common in women who are using Implants, they are not harmful and usually become less or stop altogether after the first year of use
- If the client finds the bleeding unacceptable and no estrogen contraindication, offer:

  a. Up to three cycles of low-dose combined oral contraceptive (pill containing the progestin levonorgestrel). The same progestin present in the Implants is best for controlling bleeding

  b. Paracetamol 2 tablets 3 times a day and Buscopan 1 tablet 3 times a day for 3 days.

  c. If the pain persists, refer to a higher level of care.

If bleeding is very heavy (twice as much as usual):

- check for anaemia. If present, treat and refer
- advise on food containing iron

If bleeding is unacceptable to the client, help her choose another method and remove Implant

Note: Uterine evacuation is not necessary and is contraindicated

If bleeding is due to gynaecological problems

Treat or refer for care as appropriate

Unexplained abnormal vaginal bleeding that suggests underlying medical condition unrelated to method use

- The client can continue using Implant while her condition is being evaluated
- If no cause of bleeding can be found, consider stopping Implants to make diagnosis easier. Provide another method until the condition is evaluated and treated (other than hormonal method or IUD)
- Treat any underlying medical problems or refer for care. If bleeding is caused by STI or PID, she can continue using Implants during treatment. If caused by cervical or endometrial cancer, she can continue using implants while awaiting treatment.

♦ The Trainer displays the slide on "Severe Pain in the lower abdomen" and discusses the actions that should be taken medically if there is severe pain in the lower abdomen:

If ectopic pregnancy or another serious condition is suspected

- Refer for immediate diagnosis and care
- Implants can remain in place

If pain is due to ovarian cyst (frequent urination, abdominal pain, menstrual period changes)

- Implants can remain in place.
- Re-assure the client that these cysts usually disappear on their own without surgery.
- To be sure there is no problem, see the client again in about three weeks if possible

♦ The Trainer displays the slide on *"Headaches"* and discusses the actions that should be taken medically if there is headache:

If it is mild headache

- Suggest pain killers such as Paracetamol 2 tablets 3 times a day
- Reassure

If migrainous headaches with aura (blurred vision, temporary loss of vision, seeing flashing lights or zigzag line);

- If migraines with aura started or became worse after she began using the method, remove implants.
- Help client to choose non-hormonal contraceptive method
- Refer for care as needed

If there is no pregnancy and amenorrhea is less than six weeks

- Re-assure the client that menstruation may resume within 4–6 weeks or onset of last menses
- Give follow-up appointment for 2–4 weeks

If the client is pregnant

- Remove the implant
- Refer immediately for antenatal care

♦ The Trainer emphasizes to the participants the Warning Signs/Special Concerns of Implant use.

- The client should report to the nearest family planning clinic if she notices any of the following:

  - Severe lower abdominal pain
  - Heavy vaginal bleeding
  - Arm pain
  - Pus or bleeding at the insertion site (this may indicate infection)
  - Expulsion of an implant (this rarely occurs with proper placement)
  - Episodes of migraine, repeated severe headaches, or blurred vision
  - Delayed menstrual cycles after along interval of regular cycles
  - Suspicion of pregnancy
  - Jaundice

D. Demonstration of ways of handling client concerns about side effects of Implants (through case studies and role plays) (25 minutes)

♦ The Trainer distributes handouts of prepared case studies and asks the participants to either:

- Discuss them, or
- Act them as Role Plays

♦ S/he clarifies any issues raised by the participants during the discussion of the case studies or role plays

Summary/Evaluation (5 minutes)

♦ The Trainer summarizes the session by stating that:

- Most of the health problems associated with implants' use are mild.

- Good counseling about these side effects enables the client to tolerate them while improving continuation rates.

- Changes in menstrual bleeding patterns are by far the most common side effect.
- Management of the side effects ranges from simple reassurance, medical treatment, to referral for further care.
- User concerns must be patiently listened to and addressed accordingly.

Evaluation

♦ The trainer asks the participants to respond to the following questions:

- List the common side effects of implants' use.
- What are the warning signs requiring prompt medical attention?

.

- What are the known medical treatments for vaginal bleeding in Implant users?
- Give five examples of user concerns.

MODULE TEN

RECORD KEEPING, HEALTH MANAGEMENT INFORMATION SYSTEM (HMIS) AND CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM (CLMS)

Session 1: Record Keeping and Health Management Information System (HMIS)

Session 2: Contraceptive Logistics Management System (CLMS)

Module Ten - Session 1: Record Keeping and Health Management Information System (HMIS)

Time: 2 Hours

Learning Objectives:

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

- Describe the HMIS
- Mention the importance of HMIS
- State the reasons for accurate record keeping and its implication for data quality
- List the advantages of Record Keeping
- Explain the disadvantages of NOT keeping records
- Explain the content of the various national record keeping forms

Session Overview

- Description of the HMIS
- The importance of HMIS
- Reasons for accurate record keeping and its implication for data quality
- Advantages of Record Keeping
- Disadvantages of NOT keeping records
- Content of the various national record keeping forms

Methods

- Brainstorming
- Discussion
- Lecture
- Group work

Materials

- Flip chart stand/paper
- Markers
- Laptop
- Multimedia Projector
- Various MIS tools

Module Ten - Session 1: Record Keeping and Health Management Information System (HMIS)

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Record Keeping and Management Information System (MIS)	2 hours	▪ Describe the MIS ▪ Mention the importance of MIS ▪ State the reasons for accurate record keeping and its implication for data quality ▪ List the advantages of Record Keeping ▪ Explain the disadvantages of NOT keeping records ▪ Explain the content of the various national record keeping forms	▪ Brainstorming ▪ Discussion ▪ Lecture ▪ Group work	▪ Flip chart stand/paper ▪ Markers ▪ Laptop ▪ Multimedia Projector ▪ Various MIS tools

Module Ten - Session 1: Record Keeping and Health Management Information System (HMIS)

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays and reviews the learning objectives for this session and asks the participants for any clarification

- S/he informs the participants that:

- This session discusses the importance of Record Keeping in FP Programme, information needed to measure programme success and informs programme or service delivery improvement.

B. Description of the HMIS (5 minutes)

- The Trainer asks the participants to define Health Management Information System (HMIS) and notes their responses on the flip chart

- Clarify the participants' responses and state that:

  - Health Management Information System (HMIS) is an organized way of recording, collating, and interpreting information for planning and decision-making

C. Importance of HMIS (10 minutes)

- The Trainer asks the participants to mention the importance of HMIS and notes their responses on the flip chart

- She clarifies the participants' responses and then displays the slides on *"Importance of HMIS."*

Importance of HMIS

  - The effective management of any programme depends on availability of information for optimal decision-making. In this regard, the setting up of HMIS will provide the programme management with necessary information for decision. The quality of management decision-making will be determined by the quality of HMIS; it is essential for effective programme management.

Reasons for accurate record keeping and its implication for data quality

  - Other uses of HMIS are:

    - It provides feedback on the performance of the critical functions of the programme. Such feedback allows managers to take corrective actions when problems arise.

- It provides stakeholders with regular assessments of programme performance.
- It is useful for measuring programme output i.e. products or services delivered to programme participants or other such activities viewed as part of programme's contribution to society. Examples are number of clients served, the nature and volume of advocacy or promotional effects, numbers and types of IEC materials produced and distributed etc.
- It is used in the assessment of programme impact.
- It provides answer to specific management and research questions.
- It is an important monitoring tool.
- It is critical for resource allocation and evaluation.

♦ S/he notes and addresses any concerns by the participants.

D. Advantages of Record Keeping (10 minutes)

♦ The Trainer asks the participants to state the advantages of Record Keeping and notes their responses on the flip chart

♦ S/he clarifies the participants' responses and informs them that Record Keeping allows the programme to:

- Know the total number of clients
- Know the number of new clients and old clients to determine the rate of new acceptors and revisits for each method.
- Know the number of female clients attending the family planning clinics at the various locations in the community for comparison.
- Use data for assessment, planning, implementation, evaluation e.g.
  - give an account of commodities and determine future needs
  - determine future needs regarding staffing and facilities
  - know the progress of family planning in the community and society
  - use data for future planning
  - use data for research purpose
  - use for referral purposes

E. Disadvantages of NOT keeping records (10 minutes)

♦ The Trainer asks the participants to state the disadvantages of NOT keeping records and notes their responses on the flip chart

♦ She clarifies the participants' responses and informs them that by not keeping records, the provider would not:

- Know the total number of clients served;
- Be able to determine the rate of acceptors for each method/procedure;
- Be able to compare number of clients with other Family Planning facilities in the community;

- Be able to assess or plan for future improvements and evaluate up-to-date progress;
- Be able to supply evidence of past work;
- Be able to conduct good research due to e.g. lack of statistics;
- Give good impression of clinic activities;
- Be able to help planners determine the general needs of the clinic;
- Be able to make planning and evaluation easy;
- Be able to obtain other adequate information in case a problem of a legal nature arises.

F. Content of the various national record keeping forms (1 hour 15 minutes)

♦ The Trainer informs the participants that:

- HMIS tools are used for keeping track of various services provided by the programme and activities performed
- S/he explains the use of the various *Types of National Family Planning MIS Tools:*

Client Record form/Instruction (Form A)

- This form is used to record client's history

Tally Sheets/daily activity summary Forms (Form B1.1 & B1.2)

- This is used to record services provided to client at the facility level. Information in this sheet is summed up at the end of every day and this summation should be transferred into the monthly summary sheets.

Monthly Summary Form (Form C1.1 & C1.2)

- This form is to be used for compilation of data in the Tally/daily Activity Summary Form, i.e. Forms B1.1 &B 1.2. It should be completed monthly by the responsible health worker in the facility.

Facility Based Referral Form (Form D)

- It is used by clinical service providers or outreach workers who provide clinical services to refer a client to a referral centre where further services can be obtained. This form is designed in a way that enables service providers to keep track of how many referrals they have made and how many of these referrals have gone to the points of referral and follow-up. It enables providers to keep track of clients for follow up purposes.

Quarterly Summary Form (Form E)

- This form is used for compilation of data in the Monthly Summary Form (C1.1 & C1.2). It should be completed monthly or at the end of the quarter by the responsible health worker in the facility.

Annual Summary forms (Form F)

- This is used for compilation of the data in the quarterly summary form. It should be a summary of all quarterly reports for the year in question.

Outreach activity Form (Form G)

- This is used for obtaining a record of reproductive health outreach activities undertaken by individual health workers (peer educator, community health extension worker etc.) during the month in question.

Monthly Outreach Summary Form (Form H.1)

- This is used for summarizing all reproductive health outreach activities undertaken by individual health workers (peer educator, community health extension worker etc.) during the month in question. This form is filled by the supervising officer, and submitted to the Project Coordinator, who would use the information generated for programme planning and report writing.

Quarterly/annual Outreach Summary form (Form H.2)

- This form summarizes all outreach reproductive health activities carried out by health workers during the quarter of year under reference.

Outreach Referral Forms (Form J)

- To be used by clinical service providers or outreach workers to refer a client to a referral centre, where further services can be obtained

Appointment Card (Form K)

- This card is used by the service provider to enter appointments for the client.

  A copy each of the forms discussed above is appended to this module will be available for practice during the module.

Summary/Evaluation (5 minutes)

♦ The Trainer summarizes the session by stating that:

- Record Keeping in FP Programme helps to generate information needed to measure programme success and inform programme or service delivery improvement.

- Effective management of FP programme depends on availability of information for optimal decision-making.

- The setting up of MIS will provide the programme management with necessary information for decision. The quality of management decision-making will be determined by the quality of MIS.

Evaluation

- The Trainer asks participants to respond to the following questions:
  - State the importance of record keeping in FP programme
  - List the advantages of record keeping
  - Describe the content of the national record keeping forms

Module Ten - Session 2: Contraceptive Logistics Management System (CLMS)

Time: 2 hours

Learning Objectives:
By the end of this session, participants should be able to:

- Explain logistics management
- State the objectives of the CLMS;
- Describe National Contraceptive Logistics Management system (CLMS)
- Demonstrate use of CLMS tools

Session Overview

- Introduction
- Logistics management
- Objectives of the CLMS;
- The National Contraceptive Logistics Management System (CLMS)
- Demonstration of use of CLMS tools

Methods

- Brainstorming
- Discussion
- Lecture

Materials

- Flip Chart/Markers
- Flip Chart Stand
- Laptop
- LCD Projector
- Screen
- Handout

Module Ten - Session 2: Contraceptive Logistics Management System (CLMS)

SESSION PLAN

SESSION	DURATION	OBJECTIVES	METHODS	MATERIALS
Contraceptive Logistics Management System (CLMS)	2 Hours	▪ Explain logistics management ▪ State the objectives of the CLMS; ▪ Describe National Contraceptive Logistics Management system (CLMS) ▪ Demonstrate use of CLMS tools	▪ Brainstorming ▪ Discussion ▪ Lecture	▪ Flip Chart/Markers ▪ Flip Chart Stand ▪ Laptop ▪ LCD Projector ▪ Screen ▪ Handout

Module Ten - Session 2: Contraceptive Logistics Management System (CLMS)

SESSION PRESENTATION

A. Introduction (5 minutes)

- The Trainer displays the learning objectives for this session and asks the participants to read out the objectives

- S/he clarifies all issues.

B. Logistics management (5 minutes)

- The Trainer informs the participants that:

  - A logistics management system is an organized system that uses data and information gathered from various communities and service sites to provide a steady supply of consumables that are required to maintain uninterrupted services in those communities.

  - The Contraceptive Logistics Management System (CLMS) provides commodities for effective contraceptive services at all service points, ensuring that all Nigerians are able to receive the contraceptives they need through their service delivery point or community based agents (CBA).

C. Objectives of the CLMS (10 minutes)

- The Trainer asks the participants to mention the objectives of the CLMS and notes their responses on the flip chart

- S/he clarifies the participants' responses and then displays the slides on *"Objectives of the CLMS."*

Objectives of CLMS system:

- Enhanced distribution of a complete range of family planning methods through the different levels of the supply system (federal central contraceptive warehouse, state stores, local government store (LGA) and service delivery point (SDP).
- Sustained availability of contraceptives with adequate stock levels to meet demand at all times.
- Expand access to a complete range of contraceptive methods with greater choice for clients.
- Improved ordering and stock management, ensuring that requests correspond to actual need.
- Increased capacity at all levels of the system to manage contraceptive supply.
- Adequate flow of essential information on the movement of contraceptives through the system.
- Improved contraceptive quality throughout the supply chain through procurement standards and proper storage.
- Reduced waste and increased efficiency throughout the supply chain.

- The Trainer notes and address any concerns by the participants.

D. The National Contraceptive Logistics Management System (CLMS) (1 hour 35 minutes)

♦ The Trainer explains the following terms to the participants:

Contraceptive Security

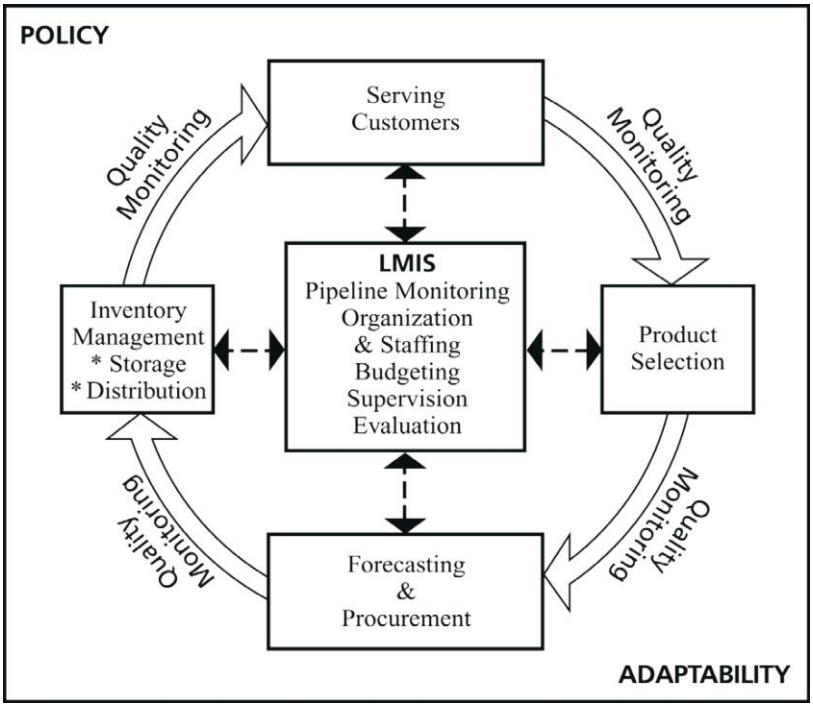
- This is guaranteed by a programme's ability to:

  - Accurately estimate requirements
  - Control financial resources
  - Technical capacity to procure products
  - Distribute products to the customer for the medium to long-term
  - Guarantee maximizing quality through good storage practices
  - Guarantee maximizing quality through Inventory control
  - Ensure maximizing quality through supervision of supplies

Flow of contraceptives through the public sector supply system

- The CLMS focuses on forecasting and procuring the right contraceptive quantities, storing and distributing them through all levels of the health system and delivering them to clients, as displayed in Figure 10.2.1.

Figure 10.2.1: The National Contraceptive Supply System



Source: FMOH

Contraceptive Commodities Selection

- Selection depends on factors such as the pattern of: clients' preferences, the capacity of service providers to offer wide range of FP methods and the quality of care.

Contraceptive Commodities Forecasting and Procurement

- Once the commodities to be procured are determined, the next step is to ascertain the quantities required for procurement.
- The process of determining those quantities to procure is what is called forecasting.
- Forecasting is usually done at LGA or state levels and covers a period of more than one year. The following data sources are used to forecast:
  - *Logistics data:* This is applied in availability of consumption and stock position.
  - *Demographic data:* this takes into account the population being served and the extent of unmet need for FP in the area.
  - *Service statistics:* This is very important in forecasting because it helps inform the project managers whether there is the need to recruit more staff to achieve the goals of the forecast or to reduce on expected consumption due to limited staff in the field.
  - *Targets:* Every service point should have annual targets in volume of services to be rendered, which will derive from LGA and State targets.
  - Once the forecast has been discussed and approved, then a procurement plan is developed.

Contraceptive Commodities Distribution and Storage

- The commodities distribution process begins when the commodities are sent from the manufacturers or suppliers and ends when the commodity consumption information is sent to the Central Medical store.
- An effective system should not only maintain a constant supply of the commodities but also keep the commodities in good condition throughout the distribution process, minimize loss due to spoilage and expiry, maintain accurate records, reduce theft and fraud and provide information for forecasting future commodity needs.

Contraceptive commodity consumption

- The CLMS delivers the correct commodities to the service delivery points.
- Rational use of the commodities requires that FP clients receive FP methods that are appropriate to their needs and choices, in adequate doses that meet their individual requirements, for the adequate period of time, at the lowest cost to them and their community.

Management Support

- The commodity logistics management cycle is driven by factors that must be in place for the system to operate smoothly.
- These factors include:

- competent human resources,
- sufficient finances to fund the activities and purchase the commodities,
- a functional logistics management information system that provides vital information for planning, and
- managerial support in form of supervision and evaluation.

Summary/Evaluation (5 minutes)

♦ The Trainer summarizes the session by stating that:

- Prompt and regular remittance of data compiled from good records kept on contraceptive services rendered at service points to the CBA Supervisor helps the CLMS to place orders for adequate quantity of contraceptive commodities from manufacturers, which are then distributed to the service sites to ensure uninterrupted availability of services to clients.

Evaluation

♦ The Trainer asks the participants to respond to the following questions:

- Explain CLMS;
- Mention 4 objectives of the CLMS;

Describe the flow of contraceptive through the public sector supply system.

TRAINING PROGRAMME IN INTRAUTERINE CONTRACEPTIVE DEVICE (IUD) AND IMPLANT INSERTION AND REMOVAL TECHNIQUES

Date:

END-OF-COURSE EVALUATION

Instruction: It will be very useful to us if you give us the information requested below.

SECTION A

Response Scale (For Questions 1 – 10 only)

1 = Very dissatisfied 2 = Dissatisfied, 3 = Indifferent

4 = Satisfied 5 = Very satisfied

Please circle the appropriate number for each question on the response scale:

1.	Overall, how satisfied are you with the training?	1 2 3 4 5
2.	Overall, how satisfied are you that the course achieved its stated objectives?	1 2 3 4 5
3.	Overall, how satisfied are you with the trainers' ability to explain the topics?	1 2 3 4 5
4.	Overall, how satisfied are you with the trainers' ability to clear up doubts expressed by the participants?	1 2 3 4 5
5.	Overall, how satisfied are you with the trainers' ability to respond to the training needs of the participants?	1 2 3 4 5
6.	Overall, how satisfied are you with the amount of time spent on this course?	1 2 3 4 5
7.	Overall, how satisfied are you with the organization of this training?	1 2 3 4 5
8.	How satisfied are you with the facility used for this training?	1 2 3 4 5
9.	How satisfied are you with the written materials supplied to you at this training?	1 2 3 4 5
10.	How satisfied are you with the training aids used?	1 2 3 4 5

SECTION B

11. Are there any topics discussed at this training that you believe are irrelevant and should be deleted?

    a.

    b.

    c.

    d.

    e.

12. In general, what can the facilitators do to improve on future training programmes?

    a.

    b.

    c.

    d.

    e.

13. What other comments do you have with regards to this training?

TRAINING PROGRAMME IN INTRAUTERINE CONTRACEPTIVE DEVICE (IUD) AND IMPLANT INSERTION AND REMOVAL TECHNIQUES
Date:

DAILY PARTICIPANTS' EVALUATION

Day of Training Programme: ……

1. How would you describe today's activities, including the presentations?

(a) Very Useful (b) Useful (c) Indifferent (d) Not Useful

2. What sessions did you find very useful?

(a)

(b)

(c)

3. What sessions were not useful to you?

(a)

(b)

(c)

4. Is there any topic discussed today that you think should be deleted from this programme?

(a)

(b)

(c)

5. What suggestions do you have for the presenters and facilitators of today's activities?

FEDERAL MINISTRY OF HEALTH

TRAINING PROGRAMME IN INTRAUTERINE CONTRACEPTIVE DEVICE (IUD) AND IMPLANT INSERTION AND REMOVAL TECHNIQUES

PRE -TEST

Identification Number (Code) of Participant.....

Instructions: *Circle the letter of the* ***SINGLE BEST ANSWER*** *to each question.*

SECTION A: IUD COUNSELING SKILLS

1. The selection of a contraceptive method is done most appropriately by:

   a. The woman seeking a contraceptive method.
   b. The general practitioner providing health services to the woman
   c. The obstetrician providing health services to the woman
   d. The nurse practitioner providing health services to the woman.
   e. The woman's husband

2. The most important part of counseling is:

   a. Providing brochures about contraceptive methods to the woman for review with her partner.
   b. Identifying the woman's concerns about using contraceptives and answering her questions.
   c. Obtaining formal consent for the procedures from the client
   d. Describing adverse side effects
   e. Getting to know the client very well.

3. Allowing the client to handle a sample of Copper T 380A IUD should be:

   a. discouraged because it will only frighten her
   b. encouraged because it will reassure her and help her to know what the strings feel like.
   c. avoided because it is a waste of expensive material and she probably will not understand what she is looking for.
   d. avoided because it will neither reassure her or help her to know what the device feels like
   e. none of the above

4. Post – insertion counseling should inform the woman of the common side effects of IUD use such as:

   a. nausea (feeling sick) and headaches
   b. Amenorrhea
   c. mild cramping for days and possible intermenstrual spotting.
   d. increased risk of heart disease or stroke
   e. increased risk of ectopic pregnancy.

5. The Copper T 380A IUD should not be left in place for more than:

a. 2 years
b. 4 years
c. 6 years
d. 8 years
e. 12 years

SECTION B: IUD MEDICAL ELIGIBILITY CRITERIA

6. A good candidate for using IUD is a woman who:

a. has a purulent discharge from the cervix
b. has a past history of an ectopic pregnancy
c. has unexplained vaginal bleeding
d. is 6weeks or more post-partum
e. has multiple uterine fibroids with endometrial cavity distortion

7. A precaution of IUD use is a finding of:

a. Fe deficiency anaemia
b. Recent pelvic infection (PID)
c. Retroverted (posterior) uterus
d. severe dysmenorrhea
e. all of the above.

8. Women who can use IUDs without restriction are:

a. Women who are pregnant
b. Women who have purulent cervicitis
c. Women who have pelvic TB
d. Women with post abortal sepsis
e. Women who are within the 1st 48hrs post-partum

9. The use of IUD is recommended in this group of women:

a. Women who are at increased individual risk of STI.
b. Women between 48hrs and 6wks post-partum
c. Women who smoke irrespective of age.
d. Women with benign gestational trophoblastic disease
e. Women who have ovarian cancer

10. The use of IUDs is NOT recommended in these women (WHO Category 4)

a. Women who have current sexually transmitted diseases (STIs) such as gonorrhea or Chlamydia
b. Women who have cervical cancer (pre-treatment)
c. Women who have fibroids with cavity distortion
d. All of the above
e. None of the above

SECTION C: IUD CLINICAL SKILLS

11. Physical examination of a prospective IUD client must include at least:

    a. abdominal and bimanual pelvic examination
    b. abdominal, speculum and bimanual (pelvic) and breast examinations
    c. abdominal, speculum and bimanual (pelvic) and breast examinations
    d. general, breast, abdominal, speculum and bimanual (pelvic) examination
    e. breast and bimanual (pelvic) examinations.

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

    a. dried and stored in a sterile container
    b. high-level disinfected
    c. soaked in Savlon for 30 minutes
    d. used immediately
    e. all of the above.

13. To minimize the risk of transmitting hepatitis B or HIV viruses to staff during the cleaning process, all used (soiled) instruments and reusable gloves should first be:

    a. rinsed in water and scrubbed with a brush before disinfecting by boiling
    b. soaked in a fresh solution of 0.5% chlorine for 10 minutes before cleaning
    c. rinsed in water and scrubbed with a brush before sterilizing
    d. soaked overnight in 8% formaldehyde
    e. boiled immediately after use.

14. Correctly loading the Copper T 380A IUD in the sterile package:

    a. should be done only if sterile gloves are available
    b. assures that the IUD will remain sterile until it is removed from the package
    c. is difficult to learn to do.
    d. all of the above
    e. none of the above.

15. The purpose of sounding the uterus before an IUD insertion is:

    a. To check for obstruction in the cervical canal
    b. To measure the distance between the external Os and the uterine fundus
    c. To ensure correct positioning of the inserter
    d. All of the above
    e. None of the above

SECTION D: IMPLANT COUNSELING SKILLS

16. Which of the following clients could be a candidate for using Implant?

    a. a woman who has acute liver disease
    b. a woman who is considering sterilization, but is not ready to make a final decision.
    c. a woman who has undiagnosed abnormal genital bleeding
    d. all of the above
    e. none of the above
    f. a&b above

17. If inserted within the first seven days of the menses, the Jadelle[R] Implants become effective in preventing pregnancy within:

a. one (1) month
b. seven (7) days
c. 24 hours (1 day)
d. ten (10) days
e. none of the above

18. The Jadelle[R] implant can be left in place:

a. for 2 years
b. for 4 years
c. for 5 years
d. for 6 years
e. for 8 years

19. Removal of Implant capsules:

a. usually takes less time than insertion
b. usually causes less bleeding
c. requires gentleness and patience
d. is always very painful
e. all of the above

20. The Implant user should return to the clinic if she has any of the following problems:

a. pus or bleeding at the insertion site
b. delayed menstrual cycles after an interval of regular cycles
c. wants to have the implants removed for any reason
d. sudden increase in weight
e. all of the above

21. Post-insertion counseling should inform the woman of common side effects of Implant use, such as:

a. increased risk of gall bladder disease
b. heavy vaginal discharge requiring frequent personal hygiene (douching)
c. change in the menstrual bleeding pattern (e. g., prolonged bleeding during the first months of use, spotting, amenorrhoea)
d. change in bowel habits
e. none of the above

22. Jadelle implant contains:

a. 3-ketodesogestrel
b. Etonorgestrel
c. Levonorgestrel
d. Normogestrel
e. None of the above.

SECTION E: IMPLANT MEDICAL ELIGIBILITY CRITERIA

23. Women known to suffer from any of the following conditions should, if they use Implants have more frequent and supervised clinical follow-ups:

    a. the woman has diabetes
    b. the woman has breast nodules
    c. the woman is hypertensive
    d. all of the above
    e. none of the above

24. A woman who has a past history of acute pelvic inflammatory disease (PID):

    a. would not be considered a good candidate for Implant
    b. can use Implant only if she has at least three living children
    c. would be an appropriate candidate for Implant
    d. would definitely experience severe complications with the use of Implant
    e. Is more likely to discontinue the use of Implant within 3 months of insertion

25. Women who can use implants without restriction (WHO Category 1) include:

    a. women who are of any age and parity, including nulliparous
    b. women who have fibroids
    c. women who are breastfeeding within six weeks to six months
    d. All of the above
    e. None of the above

26. The following women can generally use implants although follow-up may be needed (WHO Category 2) include:

    a. hypertension higher than ^{140}/90 mmHg
    b. history of DVT or current DVT while established on anticoagulant therapy
    c. major surgery with prolonged hospitalization
    d. All of the above
    e. None of the above

SECTION F: CONTRACEPTIVE IMPLANT CLINICAL SKILLS

27. There is less risk the client may be pregnant if implant capsules are inserted:

    a. within seven days from the onset of menses
    b. within the first year post-partum in non-breastfeeding women
    c. within the first year post-partum in women who are breastfeeding
    d. all of the above
    e. none of the above

28. Implant capsules which have been inserted too deeply:

    a. are easier to remove
    b. may move (migrate) up the client's arm and into her body
    c. are less effective because the hormone is released more slowly from the `capsule
    d. all of the above
    e. none of the above

29. During client assessment, the history obtained from the client should include questions:

a. about menstruation, pregnancy and previous genital infection only
b. that elicit a detailed history of past contraceptive use
c. that are typically included in a general medical history, including current weight, and the client's reproductive history
d. the desired number of children (family size)
e. all of the above.

30. Handling the Jadelle[R] or Zarin[R] capsules with sterile gloves which are powdered:

a. may not be harmful to the client
b. may cause the silastic capsules to become more reactive (i.e., cause adhesions/fibrous reaction)
c. may cause severe infections at the insertion site
d. may result in expulsion of the capsules
e. may delay healing of the insertion site

KEY

1. A
2. B
3. B
4. C
5. E
6. D
7. B
8. E
9. C
10. D
11. D
12. B
13. B
14. B
15. D
16. F
17. C
18. C
19. C
20. E
21. C
22. C
23. D
24. C
25. D
26. B
27. E
28. E
29. E
30. B

DAILY CONSUMPTION RECORD															MONTH			YEAR		
STATE				LGA										SDP						
					Quantity sold on every working day									Quantity sold month						
N°	Product Name	Unit	Begin Bal	Qty Rec'd	1	2	3		19	20	21	22	23	To Client	To CBD	Total	Qty Lost	Close Balance	Comments	
			A	B	Q1+Q2+Q3+.....Q22+Q23= C									C	D	E C+D	F	G A+B-E-F		
1	Condom Female	Piece																		
2	Condom Male	Piece																		
3	Depo-Provera 150 mg inj+ syringe	Vial																		
4	Exluton	Cycle																		
5	IUCD	Piece																		
6	Lo-Femenal	Cycle																		
7	Microgynon	Cycle																		
8	Noristerat 200 mg inj + syringe	Ampoule																		
9	Implanon Implant	Piece																		
10	Jadelle Implant	Piece																		
11	Gloves disposable latex medium	Pair																		

REQUISITION, ISSUE AND REPORT FORM – SERVICE DELIVERY POINT

Reporting Period	Starting Month		Ending Month		Year	
SDP Name			LGA		State	

Columns		A	B	C	D	E	F	G	H	I	J	K	L	M	N
N°	Product Description	Stock balance at the beginning of the 2 months	Quantities received during the last 2 months	Cons over the past 2 Months	Losses	Stock on Hand	Physical Count	AMC	Max Qty	Order Quantity	Unit	Unit Price	Value item ordered	To Be completed by the supplier.	
														Qty Supplied	Value Supplied
						A+B-(C+D)		C × 2	G × 4	H - F			I x K		M x K
1	Condom Female										Piece	0.70			
2	Condom Male										Piece	0.70			
3	Depo-Provera 150 mg inj+ syringe										Vial	40			
4	Exluton										Cycle	11			
5	IUCD										Piece	70			
6	Lo-Femenal										Cycle	11			
7	Microgynon										Cycle	11			
8	Noristerat 200 mg inj + syringe										Amp.	40			
9	Implanon Implant										Piece	600			
10	Jadelle Implant										Piece	600			
11	Gloves disposable latex medium										Box of 100	400			
									TOTAL					TOTAL	

REQUISITION				ISSUE			
Prepared by		Date		Prepared by		Date	
				Supplied by		Date	
Authorized by		Date		Received by		Date	

Comments:

* When you start a new form, stock balance at the beginning of the 2 months (A) must always be equal to Physical Count (F) from the preceding reporting period's RIRF