Logo	Name of institution

Promote and Provide Family Planning Service

NTQF Level III

Learning Guide # 4

Unit of Competence	**Promote and Provide Family Planning Service**
Module Title:	**promoting and Providing Family Planning**
LG Code:	**HLT MDW3 M07 LO04-04**
TTLM Code:	**HLT MDW3 TTLM 0919v1**

LO 4: Provide long acting contraceptive method and manage side effects

Instruction Sheet	Learning Guide # 4

This learning guide is developed to provide you the necessary information regarding the following **content coverage** and topics:

Long acting contraceptive methods

Managing side-effects of long acting contraceptives

Managing complications of long acting contraceptive

Addressing needs of adolescents and youth.

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, **upon completion of this Learning Guide, you will be able to**:

- Provide long acting contraceptive method
- Manage side-effects of long acting contraceptives
- Manage complications of long acting contraceptive
- Demonstrate skills in addressing special needs of adolescentsand youth.
- Link long acting family planning service with other RH services

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below 3 to 6.
3. Read the information written in the information “Sheet 1, Sheet 2, Sheet 3 and Sheet 4 respectively.
4. Accomplish the “Self-check 1, Self-check 2, Self-check 3 and Self-check 4 in **page 14, 42, 47, and 53 respectively**.

5. If you earned a satisfactory evaluation from the “Self-check” proceed to “Operation Sheet 1, Operation Sheet 2 , Operation Sheet 3, Operation Sheet 4 and Operation Sheet 5” in page 16,19,22,24 and 31
6. Do the “LAP test” in page 33

Information sheet 1	**Long acting contraceptive methods**

1.1. Providing Implants

When to Start

IMPORTANT: A woman can start using implants any time she wants if it is reasonably certain she is not pregnant. No tests or examinations are necessary before starting implants, although blood pressure measurement is desirable.

Woman’s situation	When to start
Having menstrual cycles or switching from a nonhormonal method	**Any time of the month** • If she is starting within 7 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If she is switching from an IUD, immediately
Switching from another hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method.

	• If she is switching from a progestin-only or monthly injectable, she can have implants inserted when the repeat injection would have been given. No need for a backup method.
Fully or nearly fully breastfeeding Less than 6 months after giving birth	• If her monthly bleeding has not returned, she can have implants inserted any time between giving birth and 6 months. No need for a backup method. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding More than 6 months after giving birth	• If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Partially breastfeeding If her monthly bleeding has not returned	• She can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
Partially breastfeeding If her monthly bleeding has returned	• If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
Not breastfeeding Less than 4 weeks after giving birth	• She can have implants inserted at any time. No need for a backup method.
Not breastfeeding More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If her monthly bleeding has returned, she can have implants inserted as advised for women having menstrual cycles.
No monthly	• She can have implants inserted any time if it is reasonably certain she is not

bleeding (not related to childbirth or breastfeeding)	pregnant. She will need a backup method for the first 7 days after insertion.
After miscarriage or abortion	• Immediately. If implants are inserted within 7 days after first- or second-trimester miscarriage or abortion, no need for a backup method. • If it is more than 7 days after first- or second trimester miscarriage or abortion, she can have implants inserted any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
After taking emergency Contraceptive pills (ECPs)	• Implants can be inserted on the same day as she takes the ECPs. ✓ She will need to use a backup method for the first 7 days. • If she does not start immediately, but returns for an implant, she can start at any time if it is reasonably certain she is not pregnant.

Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes and other side effects must come before inserting implants. Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects

- Changes in her bleeding pattern:
  - ✓ Irregular bleeding that lasts more than 8 days at a time over the first year.
  - ✓ Later, regular, infrequent, or no bleeding at all.
- Headaches, abdominal pain, breast tenderness, and possibly other side effects.

Explain about these side effects

- Side effects are not signs of illness. Lack of bleeding does not mean pregnancy.
- Most side effects usually become less or stop within the first year.
- Common, but some women do not have them.
- Client can come back for help if side effects bother her or if she has other concerns.

Supporting the User

Giving Specific Instructions

Keep arm dry

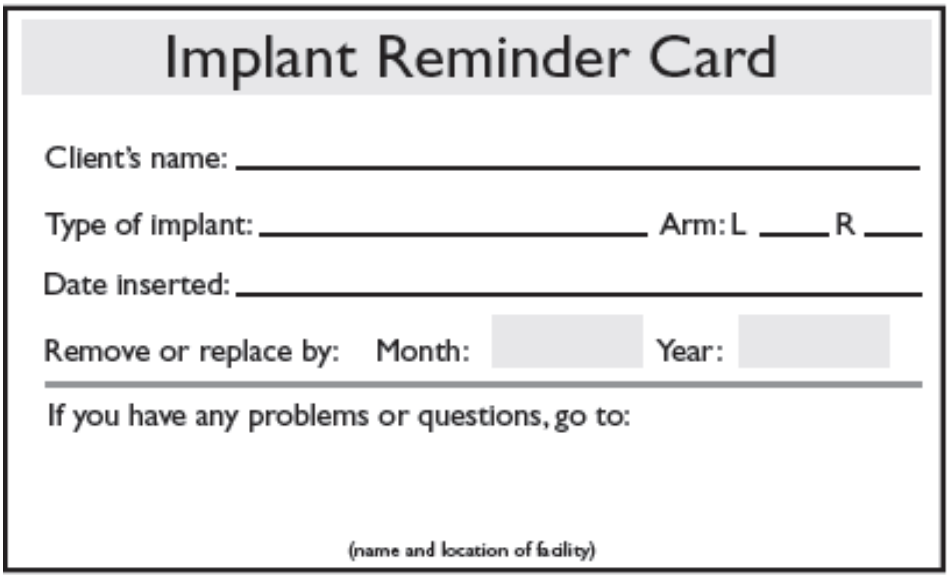
- The user should keep the insertion area dry for 4 days. She can take off the gauze after 2 days and the adhesive bandage and surgical tape when the incision heals, usually after 3 to 5 days.

Expect soreness, bruising

- After the anesthetic wears off, her arm may be sore for a few days. She also may have swelling and bruising at the insertion site. This is common and will go away without treatment.

Length of pregnancy protection

- Explain that it is important to have implants removed before they start to lose effectiveness. She can have a new set of implants inserted if she wants.
- Discuss how to remember the date to return for implant removal and possible replacement.
- Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain:
  - ✓ The type of implant she has and in which arm
  - ✓ Date of insertion
  - ✓ Month and year when implants will need to be removed or replaced
  - ✓ Where to go if she has problems or questions about her implants



Implant Reminder Card

Client's name: _____

Type of implant: _____ Arm: L ____ R ____

Date inserted: _____

Remove or replace by: Month: Year:

If you have any problems or questions, go to:

(name and location of facility)

"Come Back Any Time": Reasons to Return

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; she has a major change in health status; or she thinks she might be pregnant. Also if:

- She has pain, heat, pus, or redness at the insertion site that becomes worse or does not go away, or she sees a rod coming out.
- She wants the implants taken out, for whatever reason.
- It is time for the implants to be removed and, if she wishes, for new implants to be put in.

General health advice: Anyone who suddenly feels that something is seriously wrong with her health should immediately seek medical care from a midwife or doctor. Her contraceptive method is most likely not the cause of the condition, but she should tell the midwife or doctor what method she is using.

Removing Implants

IMPORTANT: Providers must not refuse or delay when a woman asks to have her implants removed, whatever her reason, whether it is personal or medical. All staff must understand and agree that she must not be pressured or forced to continue using

implants. If the implants may be difficult to remove, a provider with the necessary skills should be available. Removals should be provided free of charge if possible.

1.2. Providing the Intrauterine Device

When to Start

IMPORTANT: In many cases a woman can start the IUD any time if it is reasonably certain she is not pregnant. To be reasonably certain she is not pregnant, use the Pregnancy Checklist.

Woman's situation	**When to start**
Having menstrual cycles	**Any time of the month** • If she is starting within 12 days after the start of her monthly bleeding, no need for a backup method. • If it is more than 12 days after the start of her monthly bleeding, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method.
Switching from another method	• Immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from an injectable, she can have the IUD inserted when the next injection would have been given. No need for a backup method.
Soon after childbirth (regardless of breastfeeding status)	• Any time within 48 hours after giving birth, including by caesarean delivery. (Provider needs specific training in postpartum insertion by hand or using a ring forceps.) • If it is more than 48 hours after giving birth, delay until 4 weeks or more after giving birth.
Fully or nearly fully breastfeeding	• If the IUD is not inserted within the first 48 hours and her monthly bleeding has not returned, she can have the IUD inserted any time

Less than 6 months after giving birth	between 4 weeks and 6 months after giving birth. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
Fully or nearly fully breastfeeding More than 6 months after giving birth	• If her monthly bleeding has not returned, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
Partially breastfeeding or not breastfeeding More than 4 weeks after giving birth	• If her monthly bleeding has not returned, she can have the IUD inserted *if it can be determined that she is not pregnant.* No need for a backup method. • If her monthly bleeding has returned, she can have the IUD inserted as advised for women having menstrual cycles.
No monthly bleeding (not related to childbirth or breastfeeding)	• Any time *if it can be determined that she is not pregnant*. No need for a backup method.
After miscarriage or abortion	• Immediately, if the IUD is inserted within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. No need for a backup method. • If it is more than 12 days after first- or second trimester miscarriage or abortion and no infection is present, she can have the IUD inserted any time if it is reasonably certain she is not pregnant. No need for a backup method. • If infection is present, treat or refer, and help the client choose another method. If she still wants the IUD, it can be inserted after the infection has completely cleared. • IUD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least

	weeks after miscarriage or abortion.
For emergency contraception	• Within 5 days after unprotected sex. • When the time of ovulation can be estimated, she can have an IUD inserted up to 5 days after ovulation. Sometimes this may be more than 5 days after unprotected sex.
After taking emergency contraceptive pills (ECPs)	• The IUD can be inserted on the same day that she takes the ECPs (progestin-only, combined, or ulipristal acetate ECPs). No need for a backup method. • If she does not have it inserted immediately, but returns for an IUD, she can have it inserted any time *if it can be determined that she is not pregnant.*

Preventing Infection at IUD Insertion

Proper insertion technique can help prevent many problems, such as infection, expulsion, and perforation.

- Follow proper infection-prevention procedures.
- Use high-level disinfected or sterile instruments. High-level disinfect by boiling, steaming, or soaking them in disinfectant chemicals.
- Use a new, presterilized IUD that is packaged with its inserter.
- The “no-touch” insertion technique is safest. This includes not letting the loaded IUD or uterine sound touch any unsterile surfaces (for example, hands, speculum, vagina, table top). The no-touch technique involves:
  - ✓ Loading the IUD into the inserter while the IUD is still in the sterile package, to avoid touching the IUD directly
  - ✓ Cleaning the cervix thoroughly with antiseptic before IUD insertion
  - ✓ Being careful not to touch the vaginal wall or speculum blades with the uterine sound or loaded IUD inserter
  - ✓ Passing both the uterine sound and the loaded IUD inserter only once each through the cervical canal

- Giving antibiotics routinely is generally not recommended for women at low risk of STIs.

Giving Advice on Side Effects

IMPORTANT: Thorough counseling about bleeding changes must come before IUD insertion. Counseling about bleeding changes may be the most important help a woman needs to keep using the method without concern.

Describe the most common side effects

- Changes in her bleeding pattern:
  - ✓ Prolonged and heavy monthly bleeding
  - ✓ Irregular bleeding
  - ✓ More cramps and pain during monthly bleeding

Explain about these side effects

- Bleeding changes are not signs of illness.
- Usually become less after the first several months after insertion.
- Client can come back for help if problems bother her or if she has other concerns.

Inserting the IUD

Talk with the client before the procedure

- Explain the insertion procedure.
- Show her the speculum, tenaculum, and the IUD and inserter in the package.
- Tell her that she will experience some discomfort or cramping during the procedure, and that this is to be expected.
- Ask her to tell you any time that she feels discomfort or pain.
- Ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever may be given 30 minutes before insertion to help reduce cramping and pain. Do not give aspirin, which slows blood clotting.

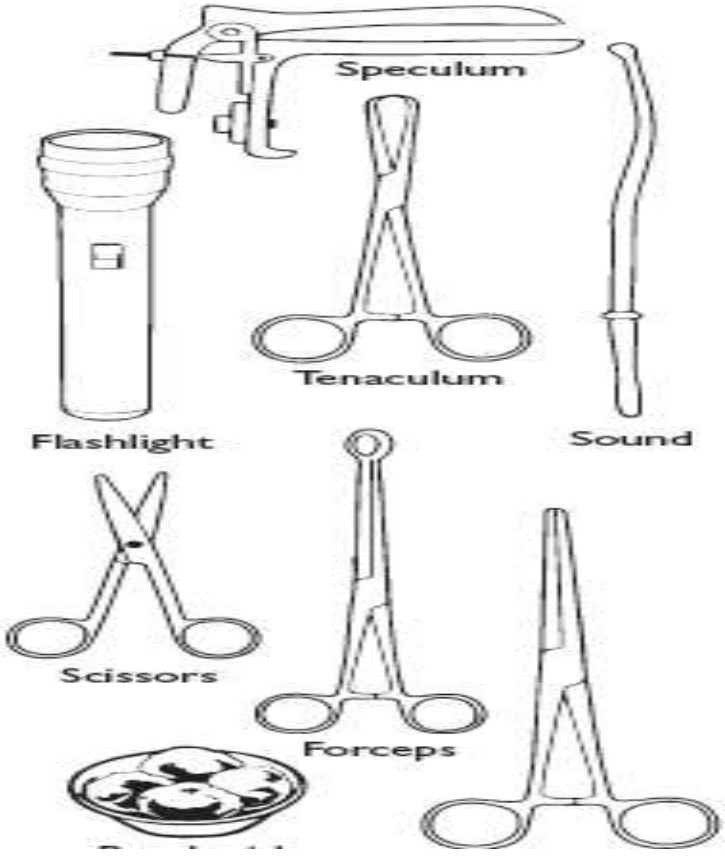
Talk with the client during the procedure

- Tell her what is happening, step by step, and reassure her.

- Alert her before a step that may cause pain or might startle her.
- Ask from time to time if she is feeling pain.

Talk with the client after the procedure

- Ask her how she is doing.
- Tell her that the procedure was successful and that the IUD is in place.
- Tell her that she can rest for a while and then slowly sit up before getting up and dressing.
- Remind her that the two of you will be discussing next steps and follow-up.



Supporting the User

Giving Specific Instructions

Expect cramping and pain

- She can expect some cramping and pain for a few days after insertion.

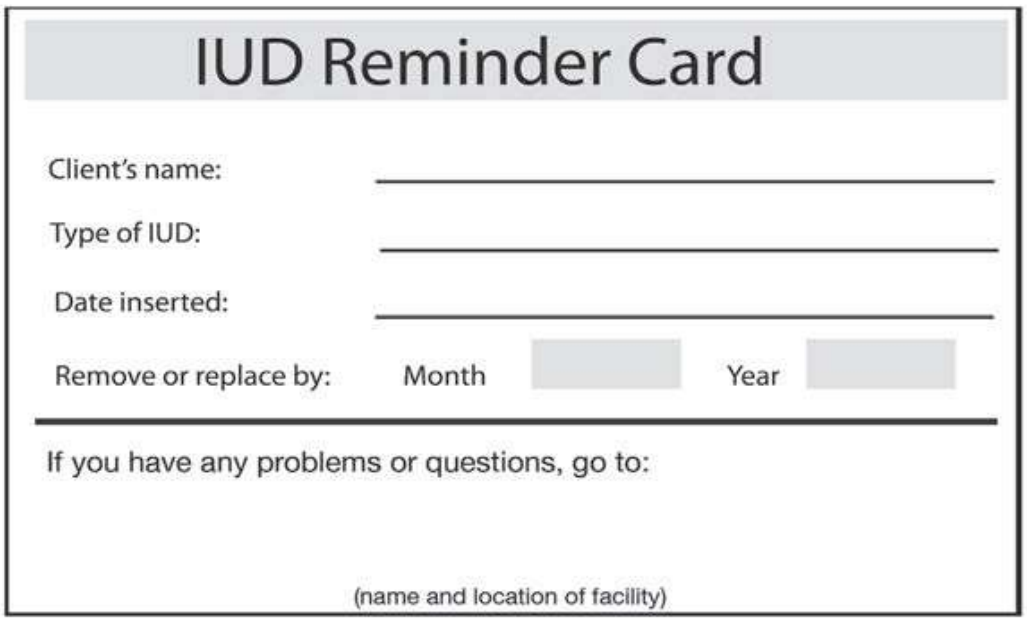
- Suggest ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever as needed.
- Also, she can expect some bleeding or spotting immediately after insertion. **Irregular spotting can continue during the first month after insertion.**

Length of pregnancy protection

- Discuss how to remember the date to return for removal or replacement.
- Give each woman the following information in writing on a reminder card, like the one shown below, if possible, and explain:
  - ✓ The type of IUD she has
  - ✓ Date of IUD insertion
  - ✓ Month and year when IUD will need to be removed or replaced
  - ✓ Where to go if she has problems or questions about her IUD

Follow-up visit

- A follow-up visit after her first monthly bleeding or 3 to 6 weeks after IUD insertion is recommended. No woman should be denied an IUD, however, because follow-up would be difficult or not possible.



"Come Back Any Time": Reasons to Return

Assure every client that she is welcome to come back any time—for example, if she has problems, questions, or wants another method; or she has a major change in health status. Also if:

- The IUD was expelled or she thinks it may have been expelled from her uterus.
- She has symptoms of pelvic inflammatory disease (increasing or severe pain in the lower abdomen, pain during sex, unusual vaginal discharge, fever, chills, nausea, and/or vomiting), especially in the first 20 days after insertion.
- She thinks she might be pregnant.
- She wants the IUD removed, for whatever reason.

General health advice: Anyone who suddenly feels that something is seriously wrong with her health should immediately seek medical care from a nurse or doctor. Her contraceptive method is most likely not the cause of the condition, but she should tell the nurse or doctor what method she is using.

Helping Continuing Users

Post-Insertion Follow-Up Visit (3 to 6 Weeks)

1. Ask how the client is doing with the method and whether she is satisfied. Ask if she has any questions or anything to discuss.
2. Ask especially if she is concerned about bleeding changes. Give her any information or help that she needs.
3. Ask her if she has:

- Increasing or severe abdominal pain or pain during sex or urination
- Unusual vaginal discharge
- ever or chills
- Signs or symptoms of pregnancy
- Felt the hard plastic of an IUD that has partially come out
- A routine pelvic examination at the follow-up visit is not required. It may be appropriate in some settings or for some clients, however. Conduct a pelvic examination particularly if the client's answers lead you to suspect infection or that the IUD has partially or completely come out.

Any Visit

1. Ask how the client is doing with the method and about bleeding changes.
2. Ask a long-term client if she has had any new health problems. Address problems as appropriate.
3. Ask a long-term client about major life changes that may affect her needs—particularly plans for having children and STI/HIV risk. Follow up as needed.
4. Remind her how much longer the IUD will protect her from pregnancy and when she will need to have the IUD removed or replaced.

Removing the Intrauterine Device

IMPORTANT: Providers must not refuse or delay when a woman asks to have her IUD removed, whatever her reason, whether it is personal or medical. All staff must understand and agree that she must not be pressured or forced to continue using the IUD.

If a woman is finding side effects difficult to tolerate, first discuss the problems she is having. Ask if she would rather try to manage the problem or to have the IUD removed immediately. Removing an IUD is usually simple. It can be done any time of the month. Removal may be easier during monthly bleeding, when the cervix is naturally softened. In cases of uterine perforation or if removal is not easy (for example, when IUD strings are missing), refer the woman to an experienced clinician who can use an appropriate removal technique.

Self-check 1	**Written test**

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 4x2= 8%).

1. If a woman starts implant within 7 days after the start of her monthly bleeding, she need for a backup method for seven days.

2. After insertion of Implant the client should take off the gauze after 2 days and the adhesive bandage and surgical tape when the incision heals, usually after 3 to 5 days.
3. During insertion of IUD if the client feels pain and discomfort Aspirin should not be given because it slows blood clotting.
4. A routine pelvic examination at the follow-up visit is not required.

Part II. Choose the correct answer for the following alternatives (each 2 point 4x2=8%)

1. A women who is fully or nearly fully breastfeeding less than 6 months and her monthly has not returned, when should start Implant?
   A. At six week needs a backup method
   B. Any time between giving birth and 6 months
   C. After six months of child birth and needs a backup method
   D. Wait until she sees her monthly bleeding
2. For a women having monthly bleeding she can start IUD within _____ days after the start of her monthly bleeding
   A. 5 B. 7 C. 10 D. 12
3. When a follow-up visit should is recommended after IUD insertion?
   A. 3 to 6 days
   B. 3 to 6 weeks
   C. 3 to 6 months
   D. 3 to 6 years
4. Which is INCORRECT statement regarding IUD removal
   A. Providers must delay when a woman asks to have her IUD removed
   B. A women must be pressured or forced to continue using the IUD.
   C. Removing an IUD is usually difficult
   D. Removal may be easier during monthly bleeding

Note: **Satisfactory rating - 8 points** **Unsatisfactory - below 8 points**

Answer sheet for True or False

1. _____ 2. _____

3. _____ 4. _____

Answer Sheet for Multiple choose Questions

1. _____ 3. _____
2. _____ 4. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Operation sheet 1	**Insertion of Implanon NXT (Nexplanon):**

Techniques for insertion of Implanon NXT (Nexplanon)

1. Greet client, introduce one-self, offer a seat and ensure privacy.
2. Ask client if she still wants the Implanon NXT to be inserted.
3. Review client information in her record and ensure that she has been appropriately counseled; ask client what questions she has.
4. Review reproductive goal and medical history. Confirm that Implanon NXT is an appropriate choice; Use checklist to rule out pregnancy and identify conditions requiring special precautions.
5. Perform (or refer for) further evaluation, if indicated
6. Provide more detailed information about Implanon NXT
   - How it works,
   - Its effectiveness,
   - How it is inserted,
   - Its characteristics,
   - Common side effects,
   - When to return.
   - Inform her the need the need to remove at the end of 3 years or anytime she decides not to use it anymore.

7. Show the client the package of Implanon NXT, and using a training model, show her how the rods are inserted.
8. Ask the client to repeat information to ensure that she understands.
9. Describe the insertion procedure and what to expect.
10. Ensure needed supplies and equipment are available and ready: The implant, iodine solution, sterile gloves, local anesthesia (1% lidocaine), and syringe with needle, sterile gauze and plaster.
11. Check to be sure that the client has thoroughly washed and rinsed her entire non-dominant arm.
12. Help the client onto the examination table.
13. Explaining what you are doing at each step; remind her to tell you if she experiences discomfort and to take deep breaths and relax.
14. Allow the client to lie on her back with her non dominant arm turned outwards and bent at the elbow.
15. Mark the insertion site, 8 to 10 cm above the medial epicondyle. Make another mark a few centimeters proximal to the first mark.
16. Wash hands thoroughly and dry them.
17. Put on sterile gloves.
18. Clean the insertion site two times with iodine solution.
19. Drape with a small fenestrated drape, if available.
20. Anaesthetize with 2ml of 1% lidocaine applied just under the skin along the insertion area:
    - Raise a wheal in skin entry and advance needle to its full length (about 5 cm) directly under the skin and inject 2 ml.
21. Remove the sterile preloaded disposable applicator for IMPLANON NXT carrying the implant from its blister.
22. Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap. You may see the white- colored implant by looking into the tip of the needle. (Do not touch the purple slider.

23. With your free hand, stretch the skin around the insertion site with thumb and index finger.
24. Puncture the kin with the tip of the needle angled about 30°.
25. Lower the applicator to a horizontal position
26. While lifting the skin with the tip of the needle, slide the needle to its full length. Keep the applicator parallel to the surface of the skin. You may feel slight resistance but do not exert excessive force.
27. 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. Move the slider fully back until it stops, leaving the implant now in its final sub dermal position and locking the needle inside the body of the applicator.
28. Remove the applicator.
29. Apply pressure to the opening site to stop any bleeding.
30. Always verify the presence of the implant by palpation. If partial protrusion occurs, discard the implant and reinsert a new sterile implant. If the implant is not palpable, the woman must use a non-hormonal contraceptive as a backup until the presence of the implant has been confirmed.
31. Apply a small adhesive plaster over the insertion site then apply sterile gauze with a pressure bandage. (The woman may remove the pressure bandage after 24 hours and the plaster after 3-5 days).
32. The applicator must be disposed in safety box.
33. Dispose of waste materials, decontaminate and clean the table.
34. Wash hands with soap and water and dry with clean towel /air dry.
35. Provide post insertion instructions:
    - Inform the client effectiveness is for three years and it is effective immediately.
    - Explain when to return, have client repeat instructions.
    - Remind client of condoms use for STI protection
    - Explain that it can be removed whenever the client wants.
    - Ask client if she has any question.

Operation sheet 2	Jadelle®® Insertion Clinical Skills

Techniques for Jadelle®® Insertion Clinical Skills

PRE-INSERTION CLIENT ASSESSMENT AND COUNSELLING

1. Greet client politely, introduce one-self, offer a seat and ensure privacy.
2. Ask the woman about her reproductive goals and need for protection against STIs.
3. Make sure that the woman's contraceptive choice is Jadelle®.
4. Review client screening checklist to determine if Jadelle® is an appropriate choice for the client.
   - To ensure that the client is not pregnant:
   - Check for conditions requiring special precautions
5. Perform (or refer for) further evaluation, if indicated.
6. Provide more detailed information about Jadelle®-
   - How it works
   - Its effectiveness
   - How it is inserted

- Its characteristics
- Common side effects
- When to return.
- Inform the client that it will need to be removed at the end of 5 years or anytime she decides she wants to stop using Jadelle®

7. Show the client the package of Jadelle®, and using a training model, show her how the rods are inserted.
8. Ask the client to repeat information to ensure that she understands
9. Respond to client's needs and concerns about Jadelle®.
10. Describe insertion procedure and what to expect.

PRE-INSERTION TASK

1. Ensure that needed supplies and equipment are available and made ready for use: The complete set of sterile or HD instruments for insertion, Jadelle® implants package, disposable trocar (or reusable trocar and scalpel blade), iodine solution, sterile gloves, local anesthesia (1% lidocaine), and syringe with needle, sterile gauze and wound plaster.
2. Tell the client what is going to be done and encourage her to ask questions.
3. Check to be sure that client has thoroughly washed her entire arm with soap and water.
4. Help the client onto the examination table
5. Position the woman's arm and place clean, dry cloth under her arm.
6. Using template, mark position on arm for insertion of capsules i.e. 8 cm above the elbow fold, open your sterile instrument and supply package to make ready for use
7. Wash hands thoroughly and dry them.
8. Put sterile gloves on both hands
9. Prepare insertion site with iodine solution two times then put fenestrated drape over the arm
10. Inject local anesthetic about 2ml (1% lidocaine without epinephrine) just under skin
    - Raise a small wheal.

- Advance needle about 5 cm, inject 1 ml of local anesthetic where each of the two rods will be inserted

11. Check for anesthetic effect before making skin incision.

INSERTION TASK

1. Holding the disposable trocar at about a 45° angle, insert directly through the skin. **Note:** Alternatively, if using re-usable trocar, hold the scalpel at about a 45° angle and make a small (2 mm), shallow incision which just penetrates the skin.
2. Lift the skin with the tip of the trocar and while tenting the skin, advance trocar and plunger to mark (1) nearest hub of trocar.
3. Remove plunger and load capsule into trocar with gloved hand or forceps.
4. Reinsert plunger and advance it until resistance is felt.
5. Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.
6. Withdraw trocar and plunger together until mark (2) nearest trocar tip just clears incision (do not remove trocar from skin).
7. Move tip of trocar away from end of capsule and hold capsule out of the path of the trocar.
8. Redirect trocar about 15° and advance trocar and plunger to mark (1).
9. Insert remaining capsule using the same technique.
10. Palpate capsules to check that two capsules have been inserted in V shape distribution.
11. Palpate incision to check that the ends of the two capsules are 5 mm away from incision site.
12. Remove trocar only after insertion of last capsule.

POSTINSERTION TASKS

1. Remove drape and wipe client's skin with alcohol.
2. Bring edges of incision together and closes it with cotton or gauze swab.
3. Apply pressure dressing snugly.

4. Before removing gloves, place all instruments into a container filled with 0.5% chlorine solution for decontamination. Dispose of the trocar, scalpel and needle and syringe by placing in a puncture-proof container.
5. Dispose waste materials by placing in leak proof container or plastic bag.
6. Remove gloves by turning inside out.

Operation sheet 3	**Removal of Implant (jadelle or Implanon NXT (Nexplanon):**

Techniques for Removal of Implant (jadelle or Implanon NXT (Nexplanon)

CLIENT ASSESSMENT

1. Greet client politely, introduce one-self, offer a seat and ensure privacy.
2. Ask the client her reason for removal and answer any questions.
3. Review client's present reproductive goals and ask if she wants another method or a new implant
4. Describe the removal procedure and what to expect.

PRE-REMOVAL TASKS

1. Ensure that needed supplies and equipment are available and made ready for use: iodine solution, sterile gloves, local anesthesia (1% lidocaine), and syringe with needle, scalpel blade, sterile gauze and wound plaster.
2. Check to be sure client has thoroughly washed and rinsed her entire arm
3. Help the client onto the examination table
4. Explaining to client what you are doing at each step; ask her to tell you if she experiences discomfort; remind her to take deep breaths and relax
5. Allow the client to lie on her back with her non dominant arm turned outwards and bent at the elbow
6. Locate the rods first with ungloved fingers.

REMOVAL TASKS

1. Wash hands thoroughly and dry them
2. Put on sterile gloves.
3. Clean the area two times with the iodine solution, using folded gauze.
4. Localize the implant.
5. Drape with a small fenestrated drape.
6. Anaesthetize with 2 ml of 1%lidocaine for jadelle applied just under the lower tip of the implant: NB: for **Implanon NXT (Nexplanon)** removal use anaestthetize with 1 ml of 1% lidocaine

- Raise a small wheal in skin entry
- Advance the needle about 5 cm, inject 1 ml of local anesthetic below each road.

7. Check for anesthetic effect before making skin incision.
8. Make a small (4 mm) transverse incision on the lower tip of the implants. NB: For Implanon Classic and Implanon NXT removal, make 2mm longitudinal incision at the distal end of the implant.
9. Push the end of capsule easiest to remove towards the incision. When the tip is visible in the incision, grasp it with the Mosquito forceps.
10. Clean off and open fibrous sheath with sterile gauze (or scalpel if necessary).
11. Grasp exposed end of capsule with curved forceps and remove capsule completely.

- For Jadelle®, repeat the same technique to remove remaining capsules.

- Inject more anesthetic only if required

12. After removal of the capsule(s), show to the client.

POST- REMOVAL TASKS

1. Remove drape and wipe client's skin with alcohol.
2. Bring edges of incision together and close it with Band-Aid or surgical tape with sterile cotton.
3. Apply pressure dressing snugly.
4. Before removing gloves, place instruments into a container filled with 0.5% chlorine solution for decontamination. Dispose of scalpel and needle and syringe by placing in a puncture- proof container.
5. Dispose of waste materials such as gloves, cotton balls or gauze by placing them in a leak proof container or plastic bag, decontaminate and clean the work tops.
6. Remove gloves by turning inside out.
7. Wash hands thoroughly with soap and water and dry with clean towel or air dry.
8. Complete client record

POST- REMOVAL COUNSELING

1. Instruct client regarding wound care and make return visit appointment, if necessary.
2. Discuss what to do if any problems occur and answer any questions.
3. Counsel client regarding new contraceptive method, if desired.
4. Help client obtain new contraceptive method or provide temporary (barrier) method until method of choice can be started.
5. Observe client for at least 15 to 20 minutes before sending home.

Operation sheet 4	**IUCD Insertion Clinical Skills**

Techniques Insertion of IUCD

PRE-INSERTION MEDICAL ASSESSMENT

1. Greet client politely, introduce one self, offer a seat and ensure privacy for IUCD insertion.

2. Ask client if she still wants the IUCD (CU-T 380A) inserted

3. Review with client information in her record and ensure that she has been appropriately counseled for IUCD (CU-T 380A) insertion; ask client what questions she has about the IUCD (CU-T 380A) or the insertion
4. Review reproductive goal and pertinent general medical history with client. To confirm that the IUCD (CU-T 380A) is an appropriate choice for the client:
    - Review Client Screening Checklist to ensure that the client is not pregnant:
    - Check for conditions requiring special precautions.
    - Ensure that the client is not at high individual risk for sexually transmitted infections (STIs):
    - Date of last menstrual period, number of days between periods, bleeding pattern
    - Any current unusual or purulent vaginal discharge, pain with sex, or lower abdominal pain
    - HIV status, if known, to provide appropriate counseling/referral if indicated. If diagnosed with AIDS, ensure that she is doing well on ARV therapy before proceeding with insertion.
    - Known or suspected cancer of genital tract or pelvic tuberculosis
    - If delivered recently, ensure that she is not between 48 hours and 4 weeks after childbirth
5. If the client is an appropriate user based on the assessment above:
    - Explain to client that you will do a pelvic exam and insert the IUCD if all is normal during the pelvic exam, and also that you will explain each step throughout in order to avoid surprising her.
    - Provide more detailed information about IUCD (Cu-T 380A)
    - Show the client the package of IUCD (Cu-T 380A)
    - How it works
    - Its effectiveness
    - Its characteristics
    - How it is inserted and what to expect

- Common side effects
- When to return.
- Inform the client that it will need to be removed at the end of 12 years or anytime she decides to stop using the IUCD.

6. Ask the client to repeat information to ensure that she understands
7. If client is nervous and tense, explain that analgesics are available, provide if requested, and wait 20 minutes to insert the IUCD

PRE-INSERTION TASKS

1. Ensure that needed supplies and equipment are available in the procedure room
2. Confirm the client has recently emptied her bladder
3. Help the client onto the examination table
4. Explaining to client what you are doing at each step; ask her to tell you if she experiences discomfort; remind her to take deep breaths and relax
5. Palpate abdomen and check for lower abdominal, especially suprapubic, tenderness and masses or other abnormalities
6. Drape the client appropriately for pelvic exam
7. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry
8. Open high-level disinfected instrument pan or sterile pack/container without touching instruments, pour iodine solution in a cup, open gauze package
9. Put new examination gloves on both hands
10. Arrange instruments and supplies on a high-level disinfected or sterile tray or draped area without touching the parts of the instruments that will go into the uterus or pierce the mucosa

PELVIC EXAMINATION

1. Inspect external genitalia and urethral opening
2. Perform speculum exam by gently spreading the labia with two fingers and then inserting a bivalve speculum, starting obliquely and then rotating it clockwise to the horizontal position:

- Gently open and maneuver the speculum to be able to inspect the cervix and check for vaginal lesions or discharge
- If purulent cervical or abnormal discharge is present, the IUCD insertion should be delayed until treatment is provided, according to the STI syndromic management protocol
- Also look for any abnormality on the cervix which may warrant not to proceed the procedure

3. If there are no conditions not to insert the IUD, gently remove the speculum and put on the side of the instruments prepared
4. Perform bimanual exam:
    - Palpate Skene's and Bartholin's glands for tenderness or discharge
    - Gently introduce the index and middle fingers into the vagina
    - Follow the anterior vagina wall until you feel the cervix, and identify position, consistency, shape
    - Carefully determine size, shape, consistency, position and mobility of uterus
    - Determine if there is cervical motion tenderness to rule out PID
    - Rule out pregnancy or any uterine abnormality
    - Check for enlargement or tenderness of adnexa
    - (Only perform rectovaginal examination if the position or size of the uterus is questionable, or there is a possible mass behind the uterus.)
5. Insert the same speculum used for the examination for the insertion of the IUDBy gently spreading the labia with two fingers and then inserting a bivalve speculum, starting obliquely and then rotating it clockwise to the horizontal position. Place screw and lock the speculum on the first notch

INSERTION TASKS

1. If both bimanual and speculum exams are normal, tell the client that she is ready for the IUCD insertion; ask her if she has any questions
2. Clean the cervix and the vagina with antiseptic solution 2 times using 2 gauzes, and wait 2 minutes for the solution to act

3. While holding the speculum with one hand, the tenaculum with the other hand, and palms turned upwards, gently grasp the cervix with the tenaculum horizontally at the 2 and 10 o'clock positions. (Note: Do not lock the tenaculum beyond the first notch)
4. While gently pulling on the tenaculum, pass the sound through the cervix to the top of the uterus without touching the sidewalls of the vagina or the speculum blades.

- To easily identify the mark for the uterine depth on the uterine sound, grasp the sound with a sponge forceps close to the

5. Remove the sound along with the sponge forceps and determine the depth of the uterine cavity by reading from the sound
6. Place the sound in 0.5% chlorine decontamination solution
7. Load the Copper T 380A while it remains inside the sterile package:

- Partially open package (up to one third) and bend back the package flaps
- Put the white rod inside the inserter tube
- Place the package on a flat surface
- Slide the white measurement card (that is in the package)
- underneath the arms of the IUCD (CU-T 380A)
- Hold the tips of the IUCD (CU-T 380A) arms and push on the inserter tube to assist in bending the arms
- When the arms touch the sides of the inserter tube, pull the inserter tube away from the folded arms of the IUCD (CU-T 380A)
- Elevate the inserter tube and push and rotate it to catch the tips of the arms in the tube

8. With the loaded IUCD (CU-T 380A) still in the partially openedsterile package, move the flange (blue depth gauge) to the corresponding measurement obtained from sounding the uterus. Press down on the flange with one finger to keep it stable, and with the other hand slide the loaded inserter so that the tip of the IUCD (CU-T 380A) aligns with the tip in the diagram on the white measurement

card. Make sure the white rod is against the tip of the vertical arm of the IUCD (CU-T 380A).

- The movable blue flange and the folded wings of the IUCD (CU- T 380A) should be aligned in a horizontal position.
- Do not bend the arms of the T into the inserter tube more than 5 minutes before it is introduced into the uterus.

9. Complete opening the plastic cover of the package in one continuous movement with one hand, while holding the tube and rod down against the table (at the open end of the package) with the other hand.
10. Remove the loaded inserter tube without touching anything that is not sterile.
11. Hold the inserter tube with your palms turned upwards and the flange in the horizontal position. While gently pulling on the tenaculum, pass the loaded inserter tube through the cervix until the flange touches the cervix or slight resistance is felt (without touching the vagina and blades of the speculum)
12. Hold the tenaculum and the white rod stationary in one hand (Suggestion: Hold one loop of the tenaculum with your index and thumb while holding the loop of the white rod at the top with the index and the middle fingers)
13. Release the arms of the IUCD (CU-T 380A) using withdrawal technique: Pull the inserter tube toward you while holding the white rod stable. This will release the IUCD (CU-T 380A) arms.
14. Remove the white rod
15. Carefully move the inserter tube upward toward the top of the uterus until slight resistance is felt. (This helps ensure that the IUCD (CU- T 380A) is inserted high in the fundus)
16. Partially remove the inserter tube from the cervical canal until IUCD strings can be seen protruding from cervical os.
17. With the strings stabilized inside by the partially removed inserter tube cut the IUCD (CU-T 380A) strings to 3 cm length and remove the inserter.

18. Gently remove the tenaculum and place it in 0.5% chlorine decontamination solution
19. Examine the cervix. If there is bleeding at the tenaculum puncture site(s), place a cotton swab or gauze over the bleeding site and apply gentle pressure for 30–60 seconds
20. Gently remove the speculum, pull it out while gently closing the blades and rotating it counterclockwise to the vertical position and place it in 0.5% chlorine decontamination solution
21. Allow the client to rest until she feels ready to get dressed; help her off the table when she feels ready (HINT: The post insertion tasks can be performed while she is resting)

POSTINSERTION TASKS

1. Dispose of waste materials such as cotton balls or gauze by placing them in a leak proof container or plastic bag
2. Remove gloves by turning them inside out.
3. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry.
4. Provide post insertion instructions:

- Inform the client how many years the IUCD (CU-T 380A) is effective (give in writing), and that the IUCD (CU-T 380A) is effective immediately with no need for backup contraception
- Explain that some women like to check the IUCD (CU-T 380A) strings after their period to assure themselves that the IUCD (CU-T 380A) is in place and to see what it feels like, but that this is not required; briefly explain how to check the strings
- Explain when to return, have client repeat instructions and correct/clarify as needed:
- Follow-up visit (after her first period or within 3 to 6 week whichever comes first); give appointment if possible

- Any time she has any concerns or problems, including side- effects (Emphasize that many women do not experience side effects and, when they occur, they tend to decrease after the first 3 months)
- If she experiences warning signs such as late or unusually heavy period, abdominal pain, signs of infection such as fever, tenderness and abnormal discharge (emphasize that complications are rare)
- Remind client of condom use for STI protection
- Explain that the IUCD (CU-T 380A) can be removed whenever client wants, but that it needs to be done by a provider; the client must not attempt to remove the IUCD herself
- Ask client what questions she has; praise her for choosing an effective contraceptive method

5. Complete the IUCD card, client record and IUCD register/log (as applicable)
6. After the client has left, wear utility gloves and clean the examination table with the 0.5% chlorine decontamination solution

Operation sheet 5	Removal of Copper-T 380A IUCD

Techniques of Removal of IUCD

CLIENT ASSESSMENT

1. Greet client politely and introduce oneself; offer a seat, ensure privacy; assure client of confidentiality
2. Ask the client her reason (s) for removing the IUCD
3. Verify that the client has received counseling and has made an informed decision about removing the IUCD
4. Explain to the client what will be done and ask her what questions she has
5. Check that the client has emptied her bladder

PRE-REMOVAL TASKS

1. Ensure that needed supplies and equipment are available in the procedure room
2. Help the client onto the examination table and start explaining the procedure as you perform it in order to avoid surprising her; explain to client importance of being relaxed, and taking deep breaths
3. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry
4. Put new examination gloves on both hands
5. Arrange the instruments and supplies on high-level disinfected or sterile tray or drape

REMOVAL OF THE COPPER T 380A IUCD

1. Insert the bivalve speculum to:

- check for vaginal lesions or discharge
- see the cervix and the IUCD strings

- clean the cervix and vagina with the antiseptic solution 2 times with 2 gauzes
- wait for 2 minutes for the antiseptic solution to act

2. Grasp the strings close to the cervix with hemostat or other narrow forceps
3. Pull on the strings slowly but firmly to remove the IUCD
4. Show the IUCD to the client
5. Immerse the IUCD in 0.5% chlorine solution and dispose it in a leak proof container or plastic bag. If the woman wants a new IUCD inserted follow the steps in the insertion guide from this point.
6. Gently remove the speculum and place in 0.5% chlorine decontamination solution

POSTREMOVAL TASKS

1. Before removing gloves, place all instruments in 0.5% chlorine solution for 10 minutes for decontamination
2. Dispose of waste materials by placing in a leak proof container or plastic bag
3. place them in a leak proof container or plastic bag
4. Wash hands thoroughly with soap and water and dry with clean, dry cloth or air dry
5. Encourage client to rest as needed, help her from the examination table, ensure she has received needed services and referral; encourage questions
6. Record the IUCD removal in the client record and register (if and when applicable)
7. After the client has left, wearing utility gloves clean the examination table with the 0.5% chlorine solution

Lap Test	Practical Demonstration

Name: _____ Date: _____

Time started: _____ Time finished: _____

Instructions: Given necessary templates, tools and materials you are required to perform the following tasks within 4 hour

Task 1. Insertion of Implanon NXT (Nexplanon):

Task 2. Jadelle®® Insertion Clinical Skills

Task 3. Removal of Implant (jadelle or Implanon NXT (Nexplanon)

Task 4. IUCD Insertion Clinical Skills

Task 5. Removal of Copper-T 380A IUCD

Information sheet 2	Managing side-effects of long acting contraceptives

2.1. Managing side-effects Implants

May or may not be due to the method.

- Problems with side effects and complications affect women's satisfaction and use of implants. They deserve the provider's attention. If the client reports any side effects or complications, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
- Offer to help the client choose another method—now, if she wishes, or if problems cannot be overcome.

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using implants experience irregular bleeding. It is not harmful and usually becomes less or stops after the first year of use.
- For modest short-term relief, she can take 800 mg ibuprofen or 500 mg mefenamic acid 3 times daily after meals for 5 days, beginning when irregular bleeding starts.
- If these drugs do not help her, she can try one of the following, beginning when irregular bleeding starts:
  - ✓ Combined oral contraceptives that contain the progestin levonorgestrel. Ask her to take one pill daily for 21 days.
  - ✓ 50 µg ethinyl estradiol daily for 21 days.
- If irregular bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

No monthly bleeding

- If she has no monthly bleeding soon after implant insertion, rule out pregnancy. She might have been pregnant at the time of insertion. If she is pregnant, remove the implant.

- Reassure her that some women stop having monthly bleeding when using implants, and this is not harmful. It is similar to not having monthly bleeding during pregnancy because of the effect of the hormones. She is not pregnant or infertile. Blood is not building up inside her. (Some women are happy to be free from monthly bleeding.) Also, not bleeding can have health benefits, for example, reducing the risk of anemia.

Heavy or prolonged bleeding (twice as much as usual as or longer than 8 days)

- Reassure her that some women using implants experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after a few months.
- For modest short-term relief, she can try any of the treatments for irregular bleeding, above, beginning when heavy bleeding starts. Combined oral contraceptives with 50 µg of ethinyl estradiol may work better than lower-dose combined pills.
- To help prevent anemia, suggest she take iron tablets and tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).
- If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Ordinary headaches (nonmigrainous)

- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.
- Any headaches that get worse or occur more often during use of implants should be evaluated.

Mild abdominal pain

- Suggest paracetamol (325–1000 mg), aspirin (325–650 mg), ibuprofen (200–400 mg), or other pain reliever.

- Consider locally available remedies.

Acne

- Consider locally available remedies.
- If client wants to stop using implants because of acne, she can consider switching to COCs. Many women's acne improves with COC use.

Weight change

- Review diet and counsel as needed.

Breast tenderness

- Recommend that she wear a supportive bra (including during strenuous activity and sleep).
- Try hot or cold compresses.
- Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. Consider locally available remedies.

Mood changes or changes in sex drive

- Ask about changes in her life that could affect her mood or sex drive, including changes in her relationship with her partner. Give her support as appropriate.
- Clients who have serious mood changes such as major depression should be referred for care.
- Consider locally available remedies.

Nausea or dizziness

- Consider locally available remedies.

Pain after insertion or removal

- For pain after insertion, check that the bandage or gauze on her arm is not too tight.
- Put a new bandage on the arm and advise her to avoid pressing on the site for a few days.

- Give her aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever.

Infection at the insertion site (redness, heat, pain, pus)

- Do not remove the implants.
- Clean the infected area with soap and water or antiseptic.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if the infection does not clear. If infection has not cleared, remove the implants or refer for removal.
- Expulsion or partial expulsion often follows infection. Ask the client to return if she notices an implant coming out.

Abscess (pocket of pus under the skin due to infection)

- Do not remove the implants.
- Clean the area with antiseptic.
- Cut open (incise) and drain the abscess.
- Treat the wound.
- Give oral antibiotics for 7 to 10 days.
- Ask the client to return after taking all antibiotics if she has heat, redness, pain, or drainage of the wound. If infection is present when she returns, remove the implants or refer for removal.

Expulsion (when one or more implants begin to come out of the arm)

- Rare. Usually occurs within a few months of insertion or with infection.
- If no infection is present, after explanation and counseling replace the expelled rod or capsule through a new incision near the other rods or capsules, or refer for replacement.

2.2. Managing side effects of IUD

May or may not be due to the method.

- Problems with side effects or complications affect women's satisfaction and use of IUDs. They deserve the provider's attention. If the client reports any side effects or complications, listen to her concerns, give her advice and support, and, if appropriate, treat. Make sure she understands the advice and agrees.
- Offer to help her choose another method—now, if she wishes, or if problems cannot be overcome.

Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)

- Reassure her that many women using IUDs experience heavy or prolonged bleeding. It is generally not harmful and usually becomes less or stops after the first several months of use.
- For modest short-term relief she can try (one at a time):
  - ✓ Tranexamic acid (1500 mg) 3 times daily for 3 days, then 1000 mg once daily for 2 days, beginning when heavy bleeding starts.
  - ✓ Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when heavy bleeding starts. Other NSAIDs— except aspirin—also may provide some relief of heavy or prolonged bleeding. Aspirin could increase bleeding.
- Provide iron tablets if possible and tell her it is important for her to eat foods containing iron.
- If heavy or prolonged bleeding continues or starts after several months of normal bleeding or long after the IUD was inserted, or if you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure her that many women using IUDs experience irregular bleeding. It is not harmful and usually becomes less or stops after the first several months of use.
- For modest short-term relief she can try NSAIDs such as ibuprofen (400 mg) or indomethacin (25 mg) 2 times daily after meals for 5 days, beginning when irregular bleeding starts.

- If irregular bleeding continues or starts after several months of normal bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

Cramping and pain

- She can expect some cramping and pain for the first day or two after IUD insertion.
- Explain that some cramping also is common in the first 3 to 6 months of IUD use, particularly during monthly bleeding. Generally, this is not harmful and usually decreases over time.
  - ✓ Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1000 mg), or other pain reliever. If she also has heavy or prolonged bleeding, aspirin should not be used because it may increase bleeding.
- If severe cramping continues beyond the first 2 days after insertion, evaluate for partial expulsion or perforation.

Possible anemia

- The copper-bearing IUD may contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
- Pay special attention to IUD users with any of the following signs and symptoms:
  - ✓ Inside of eyelids or underneath fingernails looks pale, pale skin, fatigue or weakness, dizziness, irritability, headache, ringing in the ears, sore tongue, and brittle nails.
  - ✓ If blood testing is available, hemoglobin less than 9 g/dl or hematocrit less than 30.
- Provide iron tablets if possible.
- Tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).

Partner can feel IUD strings during sex

- Explain that this happens sometimes when strings are cut too short.

- If her partner finds the strings bothersome, describe and discuss this option:
  - ✓ Strings can be cut even shorter so they are not coming out of the cervical canal. Her partner will not feel the strings, but it will make the removal procedure somewhat more difficult (may require a specially trained provider).

Severe pain in lower abdomen (suspected pelvic inflammatory disease [PID])

- Some common signs and symptoms of PID often also occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID.
- If possible, do abdominal and pelvic examinations.
- If a pelvic examination is not possible, and she has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID:
  - ✓ Unusual vaginal discharge
  - ✓ Fever or chills
  - ✓ Pain during sex or urination
  - ✓ Bleeding after sex or between monthly bleeding
  - ✓ Nausea and vomiting
  - ✓ A tender pelvic mass
  - ✓ Pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness)
- Treat PID or immediately refer for treatment:
  - ✓ Because of the serious consequences of PID, health care providers should treat all suspected cases, based on the signs and symptoms above. Treatment should be started as soon as possible. Treatment is more effective at preventing long-term complications when appropriate antibiotics are given immediately.
  - ✓ Treat for gonorrhea, chlamydia, and anaerobic bacterial infections. Counsel the client about prevention and treatment of STIs and about condom use. If possible, give her condoms.
  - ✓ There is no need to remove the IUD if she wants to continue using it. If she wants it removed, take it out after starting antibiotic treatment.

- ✓ If the infection does not improve, consider removing the IUD while continuing antibiotics. If the IUD is not removed, antibiotics should still be continued. In both cases the woman's health should be closely monitored.

Severe pain in lower abdomen (suspected ectopic pregnancy)

- Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening. While the IUD reduces risk of ectopic pregnancy, it does not eliminate it.
- In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:
  - ✓ Unusual abdominal pain or tenderness
  - ✓ Abnormal vaginal bleeding or no monthly bleeding—especially if this is
- a change from her usual bleeding pattern
  - ✓ Light-headedness or dizziness
  - ✓ Fainting
- If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.
- If the client does not have these additional symptoms or signs, assess for pelvic inflammatory disease.

Suspected uterine puncturing (perforation)

- If puncturing is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately (and remove the IUD if inserted).
- Observe the client in the clinic carefully:
  - ✓ For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10 minutes.
  - ✓ If the woman remains stable after one hour, check for signs of intra-abdominal bleeding, such as low hematocrit or hemoglobin or rebound on abdominal examination, if possible, and her vital signs. Observe for several more hours. If

she has no signs or symptoms, she can be sent home, but she should avoid sex for 2 weeks. Help her choose another method.

- ✓ If she has a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, refer her to a higher level of care.
- ✓ If uterine perforation is suspected within 6 weeks or more after insertion based on clinical symptoms, refer the client for evaluation to a clinician experienced at removing such IUDs.

IUD partially comes out (partial expulsion)

- If the IUD partially comes out, remove the IUD. Discuss with the client whether she wants another IUD or a different method. If she wants another IUD, she can have one inserted right away if it is reasonably certain she is not pregnant. If the client does not want to continue using an IUD, help her choose another method.

IUD completely comes out (complete expulsion)

- If the client reports that the IUD came out, discuss with her whether she wants another IUD or a different method. If she wants another IUD, she can have one inserted at any time it is reasonably certain she is not pregnant.
- If complete expulsion is suspected (for example, strings cannot be found on pelvic exam) and the client does not know whether the IUD came out, refer for ultrasound (or x-ray, if pregnancy can be ruled out) to assess whether the IUD might have moved to the abdominal cavity. Give her a backup method to use in the meantime.

Missing strings (suggesting possible pregnancy, uterine perforation, or expulsion)

- Ask the client:
  - ✓ Whether and when she saw the IUD come out
  - ✓ When she had her last monthly bleeding
  - ✓ If she has any symptoms of pregnancy
  - ✓ If she has used a backup method since she noticed that the IUD came out

- Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half of missing IUD strings can be found in the cervical canal.
- If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUD has been expelled unnoticed. Refer for ultrasound (or x-ray, if pregnancy can be ruled out). Give her a backup method to use in the meantime, in case the IUD came out.

Self-check 2	Written test

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 3x2= 6%).

1. A women using implant if develops Infection at the insertion site (redness, heat, pain, pus) the implants should not be removed.
2. The copper-bearing IUD may not contribute to anemia if a woman already has low iron blood stores before insertion.
3. If the IUD partially comes out, the IUD should be removed.

Part II. Choose the correct answer for the following alternatives (each 2 point 3x2=6%)

1. If a client using implants complains that no monthly bleeding which is the best management option?
   A. Suggest Paracetamol, Aspirin, Ibuprofen, or other pain reliever.
   B. Suspect that something may be wrong for other reasons.
   C. Give COCs that contain the progestin levonorgestrel one pill a day for 21 days
   D. Reassure that some women stop having monthly bleeding when using implants.
2. A women using IUD for contraception develops Heavy or prolonged bleeding (twice as much as usual or longer than 8 days), for modest short-term relief which drug is not recommended?
   A. Tranexamic Acid
   B. Ibuprofen
   C. Indomethacin
   D. Aspirin

3. A women using IUD develops a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus. What is the possible cause of the above sign and symptom?
   A. IUD completely comes out (complete expulsion)
   B. Uterine puncturing (perforation
   C. Severe pain in lower abdomen
   D. Heavy or prolonged bleeding

Note: **Satisfactory rating - 6 points** **Unsatisfactory - below 6 points**

Answer sheet for True or False

1. _____ 3. _____
2. _____

Answer Sheet for Multiple choose Questions

1. _____ 3. _____
2. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 3	**Managing complications of long acting contraceptive**

3.1. Managing Complications of Implants

New Problems That May Require Switching Methods

May or may not be due to method.

Unexplained vaginal bleeding (that suggests a medical condition not related to the method)

- Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.

- If no cause of bleeding can be found, consider stopping implants to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not progestin-only injectable or a copper-bearing or hormonal IUD).
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using implants during treatment.

Migraine headaches

- If she has migraine headaches without aura, she can continue to use implants if she wishes.
- If she has migraine aura, remove the implants. Help her choose a method without hormones.

Certain serious health conditions (suspected blood clots in deep veins of legs or lungs, serious liver disease, or breast cancer).

- Remove the implants or refer for removal.
- Give her a backup method to use until her condition is evaluated.
- Refer for diagnosis and care if not already under care.

Heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke

- A woman who has one of these conditions can safely start implants. If, however, the condition develops while she is using implants:
  - ✓ Remove the implants or refer for removal.
  - ✓ Help her choose a method without hormones.
  - ✓ Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy, including ectopic pregnancy (see severe pain in lower abdomen, previous page).
- Remove the implants or refer for removal if she will carry the pregnancy to term.
- There are no known risks to a fetus conceived while a woman has implants in place.

3.2. Managing complications of IUD

New Problems That May Require Switching Methods

May or may not be due to the method.

Unexplained vaginal bleeding (that suggests a medical condition not related to the method)

- Refer or evaluate by history or pelvic examination. Diagnose and treat as appropriate.
- She can continue using the IUD while her condition is being evaluated.
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using the IUD during treatment.

Suspected Pregnancy

- Assess for pregnancy, including ectopic pregnancy.
- Explain that an IUD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or second trimester, which can be life-threatening.
- If the woman does not want to continue the pregnancy, counsel her according to program guidelines.
- If she continues the pregnancy:
  - ✓ Advise her that it is best to remove the IUD.
  - ✓ Explain the risks of pregnancy with an IUD in place. Early removal of the IUD reduces these risks, although the removal procedure itself involves a small risk of miscarriage.
  - ✓ If she agrees to removal, gently remove the IUD or refer for removal.
  - ✓ Explain that she should return at once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).

- ✓ If she chooses to keep the IUD, a midwife or doctor should follow her pregnancy closely. She should see a midwife or doctor at once if she develops any signs of septic miscarriage.

- If the IUD strings are not visible and cannot be found in the cervical canal, the IUD cannot be safely retrieved. Refer for ultrasound, if possible, to determine whether the IUD is still in the uterus. If it is, or if ultrasound is not available, her pregnancy should be followed closely. She should seek care at once if she develops any signs of septic miscarriage.

Self-check 3	**Written test**

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 2x2= 4%).

1. A woman using implant if develops heart disease due to blocked or narrowed arteries (ischemic heart disease) or stroke should be removed the implant.
2. IUD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage during the first or second trimester.

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2 points**

Answer sheet for True or False

1. _____
2. _____

Score= _____

Rating = _____

Name: _____ Date: _____

Information sheet 4	**Addressing needs of adolescents and youth.**

4.1.Definition:

World health organization defines adolescents as individuals between 10 and 19 years of age. The broader terms "youth" and “young” encompass the 15 to 24 year-old and 10

to 24 year-old age groups, respectively. Certain health problems (like STIs and HIV) are more prevalent in this age group**.** Adolescent reproductive health is affected by pregnancy, abortion, STIs, sexual violence, and by the systems that limit access to information and clinical services. The most common reproductive health risks and consequences for adolescents

1. Unwanted pregnancy:
2. Unsafe abortion:
3. STIs, including HIV/AIDs
4. Sexual violence

The above reproductive health risks of adolescents and youth are highly related to nonuse of contraception particularly the method which provides dual protection against Pregnancy and STIs including HIV which is condom. Few married adolescents use contraception before first pregnancy. Two common reasons for non-use of contraceptives among youth are: did not expect to have sex and lacked knowledge about contraception

4.2. Barrier to contraceptive use among adolescents

Adolescents' contraceptive use is limited due to: do not plan ahead or anticipate consequences, think they are not at risk, lack of confidence or motive to use, embarrassed or not assertive, lack power and skill to negotiate use, clinics not friendly to adolescent's use, providers reluctance to serve unmarried adolescents, prohibition by law/policy to serve adolescents, adolescent's reluctance to use service for fear of judgment or concerned about having pelvic examination

1.3. Needs of Adolescents

Young people may come to a family planning provider not only for contraception but also for advice about physical changes, sex, relationships, family, and problems of growing up. Their needs depend on their particular situations. Some are unmarried and sexually active, others are not sexually active, while still others are already married.

Some already have children. Age itself makes a great difference, since young people mature quickly during the adolescent years. These differences make it important to learn about each client first, to understand why that client has come, and to tailor counseling and the offer of services accordingly.

1.4. Provide Services with Care and Respect

Young people deserve reproductive health services that meet their needs and are nonjudgmental and respectful, no matter how young the person is. Criticism or unwelcoming attitudes will keep young people away from the care they need. Counseling and services do not encourage young people to have sex. Instead, they help young people protect their health.

Appropriate sexual and reproductive health services, including contraception, should be available and accessible to all adolescents without requiring authorization from a parent or guardian by law, policy, or practice. As much as possible, programs should avoid discouraging adolescents from seeking services and avoid limiting their choice of contraceptives because of cost.

To make services friendly to youth, you can:

- Show young people that you enjoy working with them.
- Offer services that are free or as low cost as possible.
- Offer a wide range of contraceptive methods, including long-acting reversible methods.
- Counsel in private areas where you and the client cannot be seen or overheard. Ensure confidentiality and assure the client of confidentiality.
- Listen carefully and ask open-ended questions such as “How can I help you?” and “What questions do you have?”
- Use simple language and avoid medical terms.
- Use terms that suit young people. Avoid such terms as “family planning,” which may seem irrelevant to those who are not married.
- Welcome partners and include them in counseling, if the client desires.

- Try to make sure that a young woman's choices are her own and are not pressured by her partner or her family. In particular, if she is being pressured to have sex, help a young woman think about what she can say and do to resist and reduce that pressure. Practice with her the skills to negotiate condom use.
- Speak without expressing judgment (for example, say "You can" rather than "You should"). Do not criticize even if you do not approve of what the young person is saying or doing. Help young clients make decisions that are in their best interest.
- Take time to fully address questions, fears, and misinformation about sex, sexually transmitted infections (STIs), and contraceptives. Many young people want reassurance that the changes in their bodies and their feelings are normal. Be prepared to answer common questions about puberty, monthly bleeding, masturbation, night-time ejaculation, and genital hygiene.
- Be aware of young people's norms about gender and gently encourage positive, healthful norms. In particular you can help young women feel that they have the right and the power to make their own decisions about sex and contraception. You can help young men to understand the consequences of their sexual behavior for themselves and for their partners.

1.5. Contraceptive methods for Adolescents

All Contraceptives Are Safe for Young People

Young people can safely use any contraceptive method. Age is not a medical reason for denying any method to adolescents.

- Young women are often less tolerant of side effects than older women. With counseling, however, they will know what to expect and may be less likely to stop using their methods.
- Unmarried young people may have more sex partners than older people and so may face a greater risk of STIs. It is important when counseling young people to consider STI risk and how to reduce it.

For some contraceptive methods there are specific considerations for young people (see contraceptive method chapters for complete guidance):

Long-acting reversible contraceptives—implants and IUDs

- Implants, copper-bearing IUDs, and LNG-IUDs may be good choices for many young women because:
  - ✓ These methods are very effective—less than 1 pregnancy per 100 women in the first year of use.
  - ✓ Once in place, these methods do not require any action by the user. She does not have to plan in advance for sex.
  - ✓ They work for a number of years.
  - ✓ They are quickly reversible. Once the implant or IUD is removed, a woman can again become pregnant.
  - ✓ It is not obvious that the woman is using a contraceptive method.
- IUDs are more likely to come out among women who have not given birth because their uteruses are small.

Injectable contraceptives

- Injectables can be used without others knowing.

Oral contraceptives

- Some young women find taking a pill every day particularly difficult.

Emergency contraceptive pills (ECPs)

- Young women may have less control than older women over having sex and using contraception. They may need ECPs more often. It is safe to use ECPs multiple times between monthly bleedings. Using combined oral contraceptives or a long-acting reversible method would be more effective in the long run.
- Provide young women with ECPs in advance, for use when needed. ECPs can be used whenever she has any unprotected sex, including sex against her will, or a mistake has occurred when using contraception.

Female sterilization and vasectomy

- Provide with great caution. Young people and people with few or no children are among those most likely to regret sterilization.

Male and female condoms

- Protect against STIs as well as pregnancy. Many young people need protection against both.
- Readily available, and they are affordable and convenient for occasional sex.
- Young men may be less successful than older men at using condoms correctly. They may need practice putting condoms on.

Diaphragms, spermicides, and cervical caps

- Although among the least effective methods, young women can control use of these methods, and they can be used as needed.

Fertility awareness methods

- Until a young woman has regular menstrual cycles, fertility awareness methods should be used with caution.
- Need a backup method or ECPs on hand in case abstinence fails.

Withdrawal

- Requires the man to know when he is about to ejaculate so he can withdraw in time. This may be difficult for some young men.
- One of the least effective methods of pregnancy prevention, but it may be the only method available—and always available—for some young people

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (2 point each 2x2= 2%).

1. Appropriate sexual and reproductive health services, including contraception, should be available and accessible to all adolescents with requiring authorization from a parent or guardian by law, policy, or practice.

2. Since age is not a medical reason for denying any method to adolescents, all Contraceptives Are Safe for Young People

Part II. Choose the correct answer for the following alternatives (each 2 point 2x2=2%)

1. Which practice do not make services friendly to youth?
   A. Show young people that you enjoy working with them.
   B. Ensure confidentiality and assure the client of confidentiality.
   C. Welcome partners and include them in counseling, if the client desires.
   D. Speak with expressing judgment
2. The contraception method that should be provided with great caution for young people is _____
   A. Withdrawal
   B. Female sterilization and vasectomy
   C. Male and female condom
   D. Fertility awareness method

Note: **Satisfactory rating - 4 points** **Unsatisfactory - below 4 points**

Answer sheet for True or False

1. **_____**
2. **_____**

Answer Sheet for Multiple choose Questions

1. **_____**
2. **_____**

Score= _____

Rating = _____

Name: _____ Date: _____

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