How to use WHO's family planning guidelines and tools – 2

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World Health Organization

human reproduction programme hrp
research for impact
UNDP-UNFPA-UNICEF-WHO-THE WORLD BANK

Learning objectives

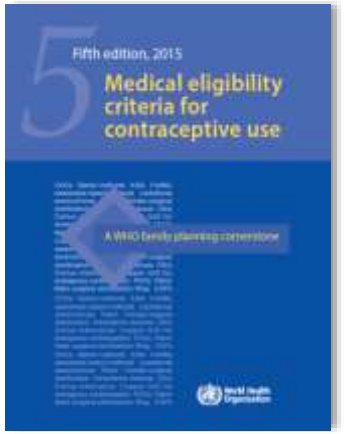
- To identify the purpose of WHO's family guidelines and tools.
- To identify and apply medical eligibility criteria and practice recommendations for family planning service delivery.
- To use these WHO family planning tools for service provision.
- To list other WHO reference materials on family planning.

The need for evidence-based guidance

- To base family planning practices on the best available published evidence
- To address misconceptions regarding who can safely use contraception
- To reduce medical barriers
- To improve access and quality of care in family planning

Family planning guidelines and tools

Medical Eligibility Criteria



5th edition

Selected Practice Recommendations

3rd edition in 2016

***The Medical Eligibility Criteria (MEC) Wheel* (new)**

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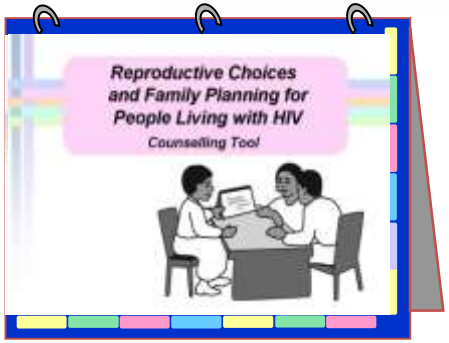
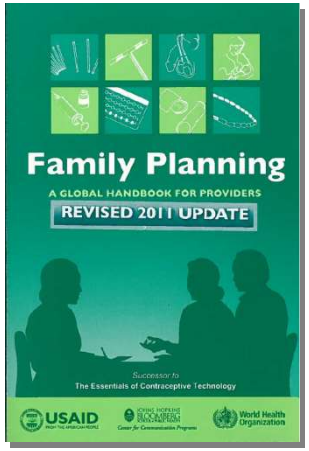


Reproductive Choices and Family Planning for People with HIV *(to be updated)*

Decision-Making Tool
(to be updated)



Global Handbook
To be updated in 2017

Guide to family planning for community health care providers and their clients (to be updated)

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Part 2

- Family Planning Global Handbook for Providers
- Family Planning Training Resource Package (TRP)

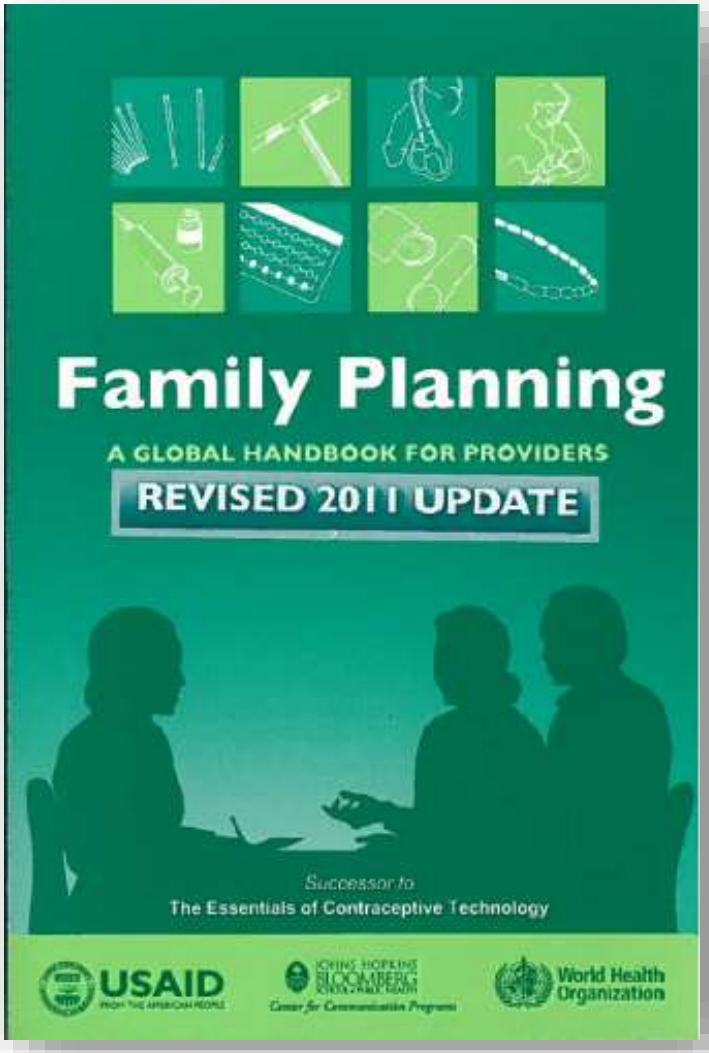
Others:

- Guideline documents on Human rights and contraception
- Task Sharing guidelines for contraception
- Essential medicines list (EML)
- Global strategy documents in Reproductive health
- Implementation and scaling up tools

- Website and social media links

Family Planning – A Global Handbook for Providers

- Manual that translates scientific evidence into practical guidance
  - Launched in 2007. new edition by late 2017
- Recommendations issued within the MEC 5th edition and SPR 3rd edition will be incorporated
- Chapters on all contraceptive methods, special diverse groups (adolescents, men, women near menopause), other issues (PPFP, Post abortion, VAW, infertility), and counselling, infection control
- Guidance from other relevant WHO documents to be included, such as (but not limited to):
  - task shifting
  - human rights
  - cervical cancer
  - gender-based violence
  - postnatal care
  - HIV counseling
- by the INFO Project at the Johns Hopkins Bloomberg School of Public Health. Endorsed by nearly 50 organizations



Contents: Method chapters

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Chapter Headings

- Key points
- Helping the Client Decide about Combined Oral Contraceptives (COCs)
- Side effects, health benefits, and risks
  - COCs and cancer
- Who can and cannot use combined oral contraceptives
  - Medical eligibility criteria
- Providing combined oral contraceptives
- Following up users of combined oral contraceptives
- Questions and Answers

Combined Oral Contraceptives

Key Points for Providers and Clients

- **Take one pill every day.** For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.
- **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.
- **Take any missed pill as soon as possible.** Missing pills risks pregnancy and may make some side effects worse.
- **Can be given to women at any time to start later.** If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.

What Are Combined Oral Contraceptives?

- Pills that contain low doses of 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body.
- Combined oral contraceptives (COCs) are also called "the Pill," low-dose combined pills, OCPs, and OCs.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.

Known Health Benefits

Help protect against:

- Risks of pregnancy
- Cancer of the lining of the uterus (endometrial cancer)
- Cancer of the ovary
- Symptomatic pelvic inflammatory disease

May help protect against:

- Ovarian cysts
- Iron-deficiency anemia

Reduce:

- Menstrual cramps
- Menstrual bleeding problems
- Ovulation pain
- Excess hair on face or body
- Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
- Symptoms of endometriosis (pelvic pain, irregular bleeding)

Known Health Risks

Very rare:

- Blood clot in deep veins of legs or lungs (deep vein thrombosis or pulmonary embolism)

Extremely rare:

- Stroke
- Heart attack

See also Facts About Combined Oral Contraceptives and Cancer, p. 4.

Correcting Misunderstandings (see also Questions and Answers, p. 22)

Combined oral contraceptives:

- Do not build up in a woman's body. Women do not need a "rest" from taking COCs.
- Must be taken every day, whether or not a woman has sex that day.
- Do not make women infertile.
- Do not cause birth defects or multiple births.
- Do not change women's sexual behavior.
- Do not collect in the stomach. Instead, the pill dissolves each day.
- Do not disrupt an existing pregnancy.

- Given by injection into the muscle (intramuscular injection). The hormone is then released slowly into the bloodstream. A different formulation of DMPA can be injected just under the skin (subcutaneous injection). See New Formulation of DMPA, p. 63.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective?

Effectiveness depends on getting injections regularly: Risk of pregnancy is greatest when a woman misses an injection.

- As commonly used, about 3 pregnancies per 100 women using progestin-only injectables over the first year. This means that 97 of every 100 women using injectables will not become pregnant.
- When women have injections on time, less than 1 pregnancy per 100 women using progestin-only injectables over the first year (3 per 1,000 women).

Return of fertility after injections are stopped: An average of about 4 months longer for DMPA and 1 month longer for NET-EN than with most other methods (see Question 7, p. 79).

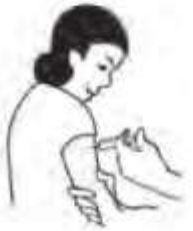
Protection against sexually transmitted infections (STIs): None

Side Effects, Health Benefits, and Health Risks

Side Effects (see Managing Any Problems, p. 75)

Some users report the following:

- Changes in bleeding patterns including, with DMPA:
  First 3 months:
  – Irregular bleeding
  – Prolonged bleeding
  At one year:
  – No monthly bleeding
  – Infrequent bleeding
  – Irregular bleeding
- NET-EN affects bleeding patterns less than DMPA. NET-EN users have fewer days of bleeding in the first 6 months and are less likely to have no monthly bleeding after one year than DMPA users.
- Weight gain (see Question 4, p. 78)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive



Other possible physical changes:

- Loss of bone density (see Question 10, p. 80)

Why Some Women Say They Like Progestin-Only Injectables

- Do not require daily action
- Do not interfere with sex
- Are private: No one else can tell that a woman is using contraception
- Cause no monthly bleeding (for many women)
- May help women to gain weight

Providing Vasectomy

When to Perform the Procedure

- Any time a man requests it (if there is no medical reason to delay).

Ensuring Informed Choice

IMPORTANT: A friendly counselor who listens to a man's concerns, answers his questions, and gives clear, practical information about the procedure—especially its permanence—will help a man make an informed choice and be a successful and satisfied user, without later regret (see Female Sterilization, Because Sterilization Is Permanent, p. 174). Involving his partner in counseling can be helpful but is not required.

The 6 Points of Informed Consent

Counseling must cover all 6 points of informed consent. In some programs the client and the counselor sign an informed consent form. To give informed consent to vasectomy, the client must understand the following points:

1. Temporary contraceptives also are available to the client.
2. Voluntary vasectomy is a surgical procedure.
3. There are certain risks of the procedure as well as benefits. (Both risks and benefits must be explained in a way that the client can understand.)
4. If successful, the procedure will prevent the client from ever having any more children.
5. The procedure is considered permanent and probably cannot be reversed.
6. The client can decide against the procedure at any time before it takes place (without losing rights to other medical, health, or other services or benefits).

Vasectomy Techniques

Reaching the Vas: No-Scalpel Vasectomy

No-scalpel vasectomy is the recommended technique for reaching each of the 2 tubes in the scrotum (vas deferens) that carries sperm to the penis. It is becoming the standard around the world.

Differences from conventional procedure using incisions:

- Uses one small puncture instead of 1 or 2 incisions in the scrotum.
- No stitches required to close the skin.
- Special anesthesia technique needs only one needle puncture instead of 2 or more.

Advantages:

- Less pain and bruising and quicker recovery.
- Fewer infections and less collection of blood in the tissue (hematoma).
- Total time for the vasectomy has been shorter when skilled providers use the no-scalpel approach.

Both no-scalpel and conventional incision procedures are quick, safe, and effective.

Blocking the Vas

For most vasectomies ligation and excision is used. This entails cutting and removing a short piece of each tube and then tying both remaining cut ends of the vas. This procedure has a low failure rate. Applying heat or electricity to the ends of each vas (cauterizing) has an even lower failure rate than ligation and excision. The chances that vasectomy will fail can be reduced further by enclosing a cut end of the vas, after the ends have been tied or cauterized, in the thin layer of tissue that surrounds the vas (fascial interposition). If training and equipment are available, cautery and/or fascial interposition are recommended. Blocking the vas with clips is not recommended because of higher pregnancy rates.

New Problems That May Require Switching Methods

May or may not be due to the method.

Migraine headaches (see Identifying Migraine Headaches and Auras, p. 368)

- If she has migraine headaches without aura, she can continue to use the method if she wishes.
- If she has migraine aura, do not give the injection. Help her choose a method without hormones.

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 progestin-only injectables to make diagnosis easier. Provide another method of her choice to use until the condition is evaluated and treated (not implants or a copper-bearing or hormonal IUD).
- If bleeding is caused by sexually transmitted infection or pelvic inflammatory disease, she can continue using progestin-only injectables during treatment.

Certain serious health conditions (suspected blocked or narrowed arteries, liver disease, severe high blood pressure, blood clots in deep veins of legs or lungs, stroke, breast cancer, or damage to arteries, vision, kidneys, or nervous system caused by diabetes). See Signs and Symptoms of Serious Health Conditions, p. 320.

- Do not give next injection.
- Give her a backup method to use until the condition is evaluated.
- Refer for diagnosis and care if not already under care.

Suspected pregnancy

- Assess for pregnancy.
- Stop injections if pregnancy is confirmed.
- There are no known risks to a fetus conceived while a woman is using injectables (see Question 11, p. 80).

Questions and Answers About Progestin-Only Injectables

1. Can women who could get sexually transmitted infections (STIs) use progestin-only injectables?

Yes. Women at risk for STIs can use progestin-only injectables. The few studies available have found that women using DMPA were more likely to acquire chlamydia than women not using hormonal contraception. The reason for this difference is not known. There are few studies available on use of NET-EN and STIs. Like anyone else at risk for STIs, a user of progestin-only injectables who may be at risk for STIs should be advised to use condoms correctly every time she has sex. Consistent and correct condom use will reduce her risk of becoming infected if she is exposed to an STI.

2. If a woman does not have monthly bleeding while using progestin-only injectables, does this mean that she is pregnant?

Probably not, especially if she is breastfeeding. Eventually most women using progestin-only injectables will not have monthly bleeding. If she has been getting her injections on time, she is probably not pregnant and can keep using injectables. If she is still worried after being reassured, she can be offered a pregnancy test, if available, or referred for one. If not having monthly bleeding bothers her, switching to another method may help.

3. Can a woman who is breastfeeding safely use progestin-only injectables?

Yes. This is a good choice for a breastfeeding mother who wants a hormonal method. Progestin-only injectables are safe for both the mother and the baby starting as early as 6 weeks after childbirth. They do not affect milk production.

4. How much weight do women gain when they use progestin-only injectables?

Women gain an average of 1–2 kg per year when using DMPA. Some of the weight increase may be the usual weight gain as people age. Some women, particularly overweight adolescents, have gained much more than 1–2 kg per year. At the same time, some users of progestin-only injectables lose weight or have no significant change in weight. Asian women in particular do not tend to gain weight when using DMPA.

5. Do DMPA and NET-EN cause abortion?

No. Research on progestin-only injectables finds that they do not disrupt an existing pregnancy. They should not be used to try to cause an abortion. They will not do so.

THE TRAINING RESOURCE PACKAGE FOR FAMILY PLANNING

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Featured Module: Benefits of Family Planning

This module is designed to provide a basic definition of family planning and discuss how it can help improve the lives of women, children, families, and communities. © 2012 Akintunde Akinleye/NURHI, Courtesy of Photoshare

Read More

Welcome to the TRP!

This website offers curriculum components and tools for trainers to design, implement, and evaluate family planning and reproductive health (FP/RH) training.

All materials can be downloaded for free, and you may adapt or translate them for your own work. If you do use or adapt these materials, please **let us know!**

Learn More

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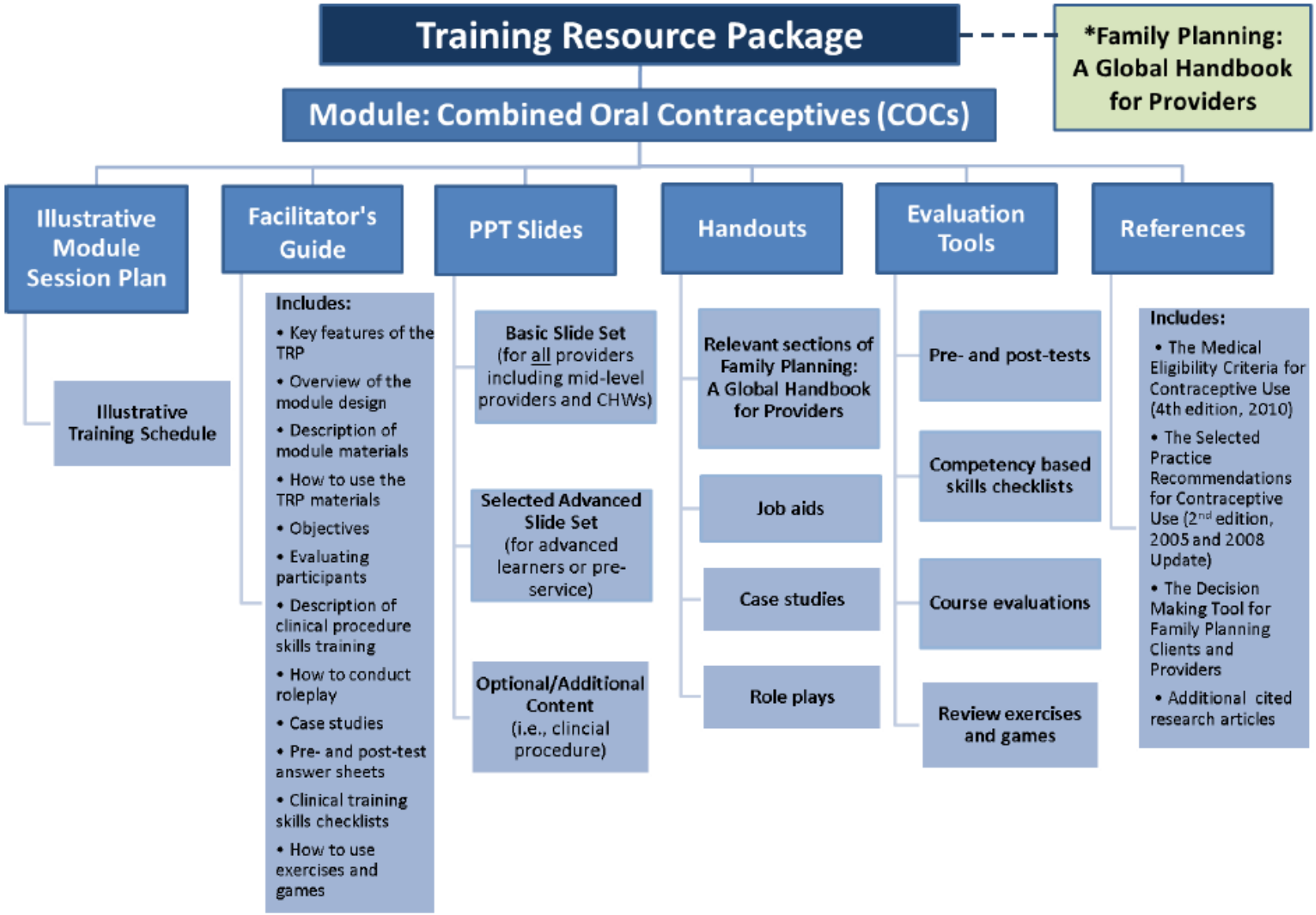
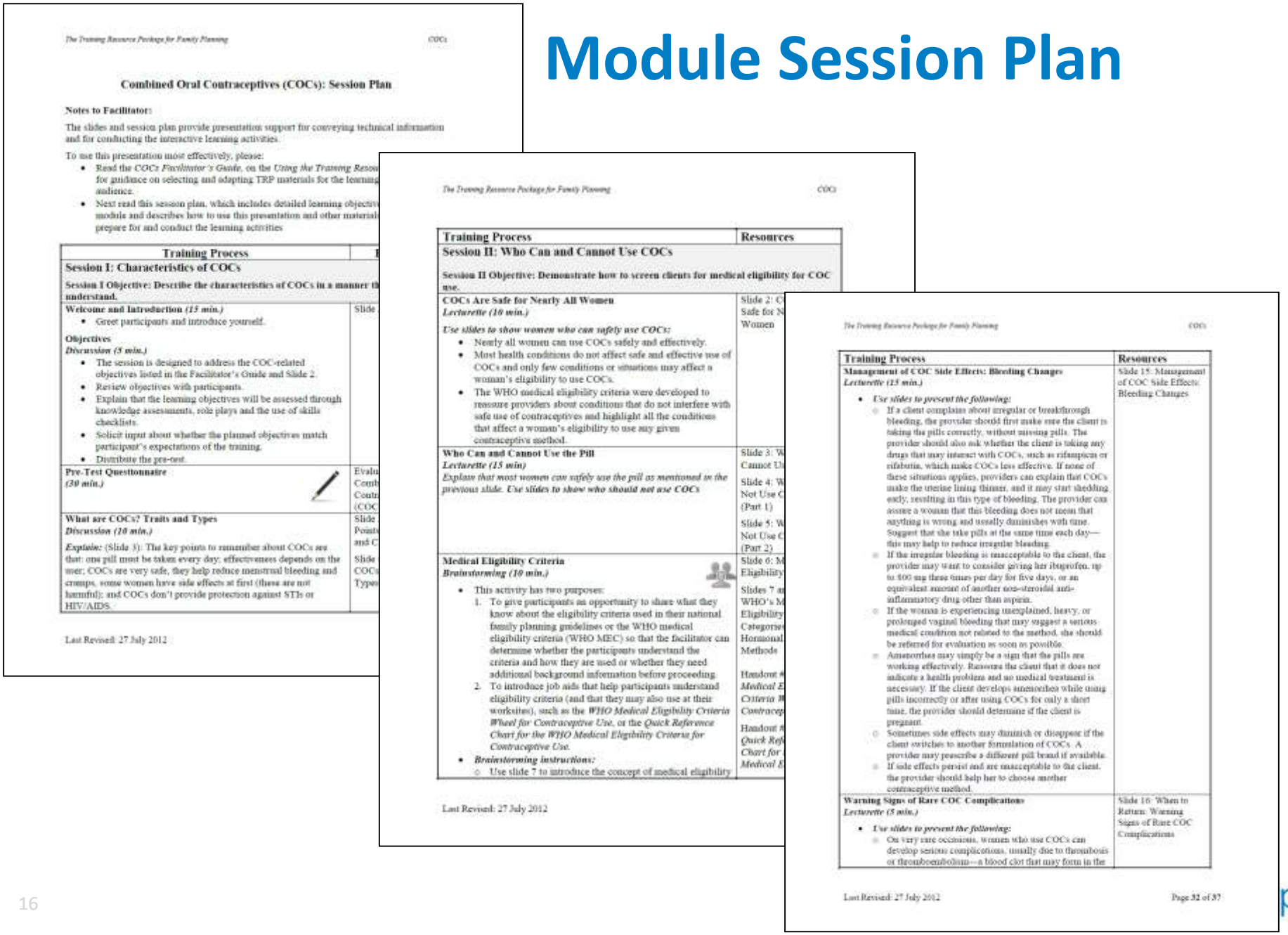
A Training Resource Package for Family Planning

- A comprehensive set of materials designed to support training in family planning and reproductive health.
- A web-based collection of the curricular components and tools needed to design, implement and evaluate training.
- Can be used by facilitators and curriculum developers to implement high quality training and education.
- The materials are appropriate for pre-service and in service training and applicable in both the public and private sectors.
- Incorporates up-to-date technical content and proven training methodologies.
- Content can be customized to meet needs of specific training audiences.
- Can be used by trainers with different levels of training experience – guidance is provided (facilitator's guide).



**The technical information for these materials is based on the Family Planning: A Global Handbook for Providers*

Module Session Plan



The Training Resource Package for Family Planning COCs

Combined Oral Contraceptives (COCs): Session Plan

Notes to Facilitator:

The slides and session plan provide presentation support for conveying technical information and for conducting the interactive learning activities.

To use this presentation most effectively, please:

- Read the *COCs Facilitator's Guide*, on the *Using the Training Resou* for guidance on selecting and adapting TRP materials for the learning audience.
- Next read this session plan, which includes detailed learning objectiv module and describes how to use this presentation and other material prepare for and conduct the learning activities.

Training Process	
Session I: Characteristics of COCs	
Session I Objective: Describe the characteristics of COCs in a manner th understand.	
Welcome and Introduction *(15 min.)* • Greet participants and introduce yourself. **Objectives** ***Discussion (5 min.)*** • The session is designed to address the COC-related objectives listed in the Facilitator's Guide and Slide 2. • Review objectives with participants. • Explain that the learning objectives will be assessed through knowledge assessments, role plays and the use of skills checklists. • Solicit input about whether the planned objectives match participant's expectations of the training. • Distribute the pre-test.	Slide
Pre-Test Questionnaire *(30 min.)*	Evalu Contr Contr (COC
What are COCs? Traits and Types ***Discussion (10 min.)*** ***Explain:*** (Slide 3): The key points to remember about COCs are that: one pill must be taken every day; effectiveness depends on the user; COCs are very safe, they help reduce menstrual bleeding and cramps, some women have side effects at first (these are not harmful); and COCs don't provide protection against STIs or HIV/AIDS.	Slide Points and C Slide COCs Types

Last Revised: 27 July 2012

The Training Resource Package for Family Planning COCs

Training Process	Resources
Session II: Who Can and Cannot Use COCs **Session II Objective: Demonstrate how to screen clients for medical eligibility for COC use.**	
COCs Are Safe for Nearly All Women ***Lecturette (10 min.)*** ***Use slides to show women who can safely use COCs:*** • Nearly all women can use COCs safely and effectively. • Most health conditions do not affect safe and effective use of COCs and only few conditions or situations may affect a woman's eligibility to use COCs. • The WHO medical eligibility criteria were developed to reassure providers about conditions that do not interfere with safe use of contraceptives and highlight all the conditions that affect a woman's eligibility to use any given contraceptive method.	Slide 2: C Safe for N Women
Who Can and Cannot Use the Pill ***Lecturette (15 min)*** ***Explain that most women can safely use the pill as mentioned in the previous slide. Use slides to show who should not use COCs***	Slide 3: W Cannot U Slide 4: W Not Use C (Part 1) Slide 5: W Not Use C (Part 2)
Medical Eligibility Criteria ***Brainstorming (10 min.)*** • This activity has two purposes: 1. To give participants an opportunity to share what they know about the eligibility criteria used in their national family planning guidelines or the WHO medical eligibility criteria (WHO MEC) so that the facilitator can determine whether the participants understand the criteria and how they are used or whether they need additional background information before proceeding. 2. To introduce job aids that help participants understand eligibility criteria (and that they may also use at their worksites), such as the *WHO Medical Eligibility Criteria Wheel for Contraceptive Use*, or the *Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use.* • ***Brainstorming instructions:*** ○ Use slide 7 to introduce the concept of medical eligibility	Slide 6: M Eligibility Slides 7 a WHO's M Eligibility Categorie Hormonal Methods Handout # *Medical E Criteria W Contracep Handout # *Quick Ref Chart for Medical E*

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The Training Resource Package for Family Planning COCs

Training Process	Resources
Management of COC Side Effects: Bleeding Changes ***Lecturette (15 min.)*** • ***Use slides to present the following:*** ○ If a client complains about irregular or breakthrough bleeding, the provider should first make sure the client is taking the pills correctly, without missing pills. The provider should also ask whether the client is taking any drugs that may interact with COCs, such as rifampicin or rifabutin, which make COCs less effective. If none of these situations applies, providers can explain that COCs make the uterine lining thinner, and it may start shedding early, resulting in this type of bleeding. The provider can assure a woman that this bleeding does not mean that anything is wrong and usually diminishes with time. Suggest that she take pills at the same time each day—this may help to reduce irregular bleeding. ○ If the irregular bleeding is unacceptable to the client, the provider may want to consider giving her ibuprofen, up to 800 mg three times per day for five days, or an equivalent amount of another non-steroidal anti-inflammatory drug other than aspirin. ○ If the woman is experiencing unexplained, heavy, or prolonged vaginal bleeding that may suggest a serious medical condition not related to the method, she should be referred for evaluation as soon as possible. ○ Amenorrhea may simply be a sign that the pills are working effectively. Reassure the client that it does not indicate a health problem and no medical treatment is necessary. If the client develops amenorrhea while using pills incorrectly or after using COCs for only a short time, the provider should determine if the client is pregnant. ○ Sometimes side effects may diminish or disappear if the client switches to another formulation of COCs. A provider may prescribe a different pill brand if available. ○ If side effects persist and are unacceptable to the client, the provider should help her to choose another contraceptive method.	Slide 15: Management of COC Side Effects: Bleeding Changes
Warning Signs of Rare COC Complications ***Lecturette (5 min.)*** • ***Use slides to present the following:*** ○ On very rare occasions, women who use COCs can develop serious complications, usually due to thrombosis or thromboembolism—a blood clot that may form in the	Slide 16: When to Return: Warning Signs of Rare COC Complications

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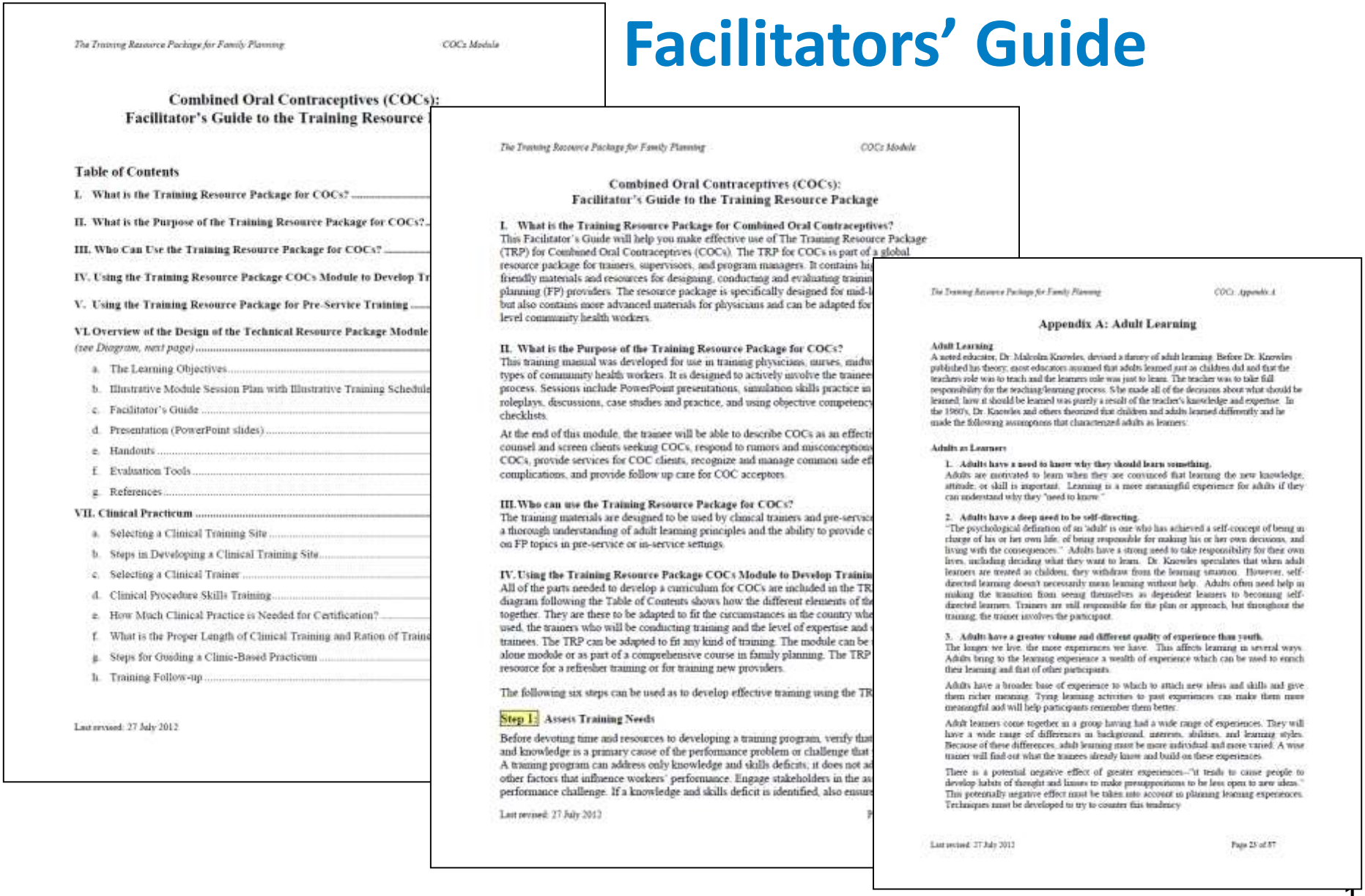
Facilitators' Guide



The Training Resource Package for Family Planning — *COCs Module*

Combined Oral Contraceptives (COCs):
Facilitator's Guide to the Training Resource Package

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The Training Resource Package for Family Planning — *COCs Module*

Combined Oral Contraceptives (COCs):
Facilitator's Guide to the Training Resource Package

I. What is the Training Resource Package for Combined Oral Contraceptives?
This Facilitator's Guide will help you make effective use of The Training Resource Package (TRP) for Combined Oral Contraceptives (COCs). The TRP for COCs is part of a global resource package for trainers, supervisors, and program managers. It contains hig friendly materials and resources for designing, conducting and evaluating trainin planning (FP) providers. The resource package is specifically designed for mid-l but also contains more advanced materials for physicians and can be adapted for level community health workers.

II. What is the Purpose of the Training Resource Package for COCs?
This training manual was developed for use in training physicians, nurses, midw types of community health workers. It is designed to actively involve the trainee process. Sessions include PowerPoint presentations, simulation skills practice an roleplays, discussions, case studies and practice, and using objective competency checklists.

At the end of this module, the trainee will be able to describe COCs as an effecti counsel and screen clients seeking COCs, respond to rumors and misconceptions COCs, provide services for COC clients, recognize and manage common side eff complications, and provide follow up care for COC acceptors.

III. Who can use the Training Resource Package for COCs?
The training materials are designed to be used by clinical trainers and pre-servic a thorough understanding of adult learning principles and the ability to provide c on FP topics in pre-service or in-service settings.

IV. Using the Training Resource Package COCs Module to Develop Trainin
All of the parts needed to develop a curriculum for COCs are included in the TR diagram following the Table of Contents shows how the different elements of th together. They are there to be adapted to fit the circumstances in the country wh used, the trainers who will be conducting training and the level of expertise and trainees. The TRP can be adapted to fit any kind of training. The module can be alone module or as part of a comprehensive course in family planning. The TRP resource for a refresher training or for training new providers.

The following six steps can be used as to develop effective training using the TR

Step 1: Assess Training Needs

Before devoting time and resources to developing a training program, verify that and knowledge is a primary cause of the performance problem or challenge that A training program can address only knowledge and skills deficits; it does not ad other factors that influence workers' performance. Engage stakeholders in the as performance challenge. If a knowledge and skills deficit is identified, also ensure

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The Training Resource Package for Family Planning — *COCs: Appendix A*

Appendix A: Adult Learning

Adult Learning
A noted educator, Dr. Malcolm Knowles, devised a theory of adult learning. Before Dr. Knowles published his theory, most educators assumed that adults learned just as children did and that the teachers role was to teach and the learners role was just to learn. The teacher was to take full responsibility for the teaching/learning process. S/he made all of the decisions about what should be learned, how it should be learned was purely a result of the teacher's knowledge and expertise. In the 1960's, Dr. Knowles and others theorized that children and adults learned differently and he made the following assumptions that characterized adults as learners:

Adults as Learners

1. **Adults have a need to know why they should learn something.**
Adults are motivated to learn when they are convinced that learning the new knowledge, attitude, or skill is important. Learning is a more meaningful experience for adults if they can understand why they "need to know."

2. **Adults have a deep need to be self-directing.**
"The psychological definition of an 'adult' is one who has achieved a self-concept of being in charge of his or her own life, of being responsible for making his or her own decisions, and living with the consequences." Adults have a strong need to take responsibility for their own lives, including deciding what they want to learn. Dr. Knowles speculates that when adult learners are treated as children, they withdraw from the learning situation. However, self-directed learning doesn't necessarily mean learning without help. Adults often need help in making the transition from seeing themselves as dependent learners to becoming self-directed learners. Trainers are still responsible for the plan or approach, but throughout the training, the trainer involves the participant.

3. **Adults have a greater volume and different quality of experience than youth.**
The longer we live, the more experiences we have. This affects learning in several ways. Adults bring to the learning experience a wealth of experience which can be used to enrich their learning and that of other participants.

Adults have a broader base of experience to which to attach new ideas and skills and give them richer meaning. Tying learning activities to past experiences can make them more meaningful and will help participants remember them better.

Adult learners come together in a group having had a wide range of experiences. They will have a wide range of differences in background, interests, abilities, and learning styles. Because of these differences, adult learning must be more individual and more varied. A wise trainer will find out what the trainees already know and build on these experiences.

There is a potential negative effect of greater experiences--"it tends to cause people to develop habits of thought and biases to make presuppositions to be less open to new ideas." This potentially negative effect must be taken into account in planning learning experiences. Techniques must be developed to try to counter this tendency.

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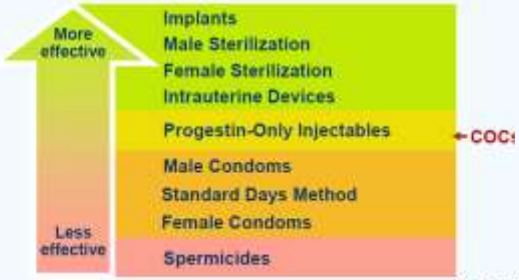
Combined Oral Contraceptive Pills (COCs)

Session I: Characteristics of COCs

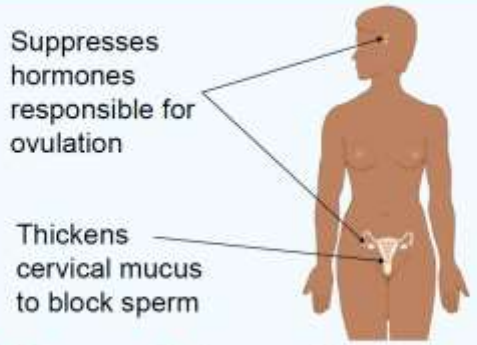
Effectiveness of COCs

In this progression of effectiveness, where would you place combined oral contraceptives (COCs)



Session I, Slide 5

COCs: Mechanism of Action



COCs have no effect on an existing pregnancy.

Session I, Slide 7

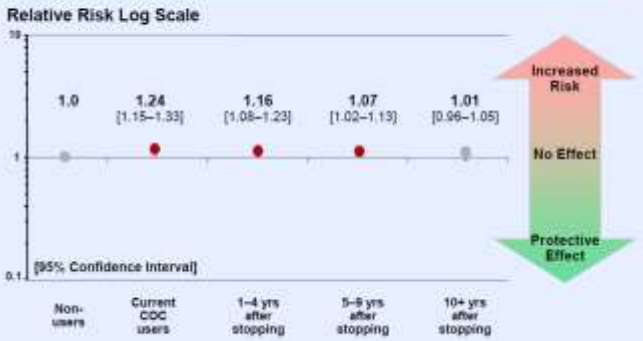
POWERPOINTS

Combined Oral Contraceptive Pills (COCs)

Advanced Slide Set

Advanced Slide Set, Slide #

Relative Risk for Breast Cancer among COC users and Non-users



Source: Collaborative Group on Hormonal Factors in Breast Cancer, 1996; Mikha, 2005; Silvera, 2005.

Advanced Slide Set, # 7

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HANDOUTS

How to Use the Pill

Take one pill each day

If you miss 1 or 2 active pills in a row or start a pack 1 or 2 days late:

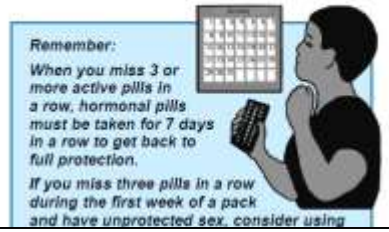
- Always take a pill as soon as you remember
- Continue to take one pill every day
- No need for additional protection

If you miss 3 or more active pills in a row or start a pack 3 or more days late:

- Take a pill as soon as possible, continue tak
  1 pill each day, and use condoms or avoid s
  for the next 7 days

- If you miss these pills in week 3, ALSO skip
  inactive pills and start a new pack.*

*With 21-pill packs, skip the pill-free interval and star



Remember:

When you miss 3 or more active pills in a row, hormonal pills must be taken for 7 days in a row to get back to full protection.

If you miss three pills in a row during the first week of a pack and have unprotected sex, consider using

Combined Oral Contraceptives (COCs)—Clinician

Role Play Scenario 1—Adolescent client is interested in and is eligible for COCs

COCs Scenario 1—Client Information Sheet	COCs Scenario 1—Observe
Client Description You are a 17-year-old female who has been counseled about the benefits of using family planning by a nurse at the antenatal clinic. You were pregnant but miscarried one month ago. You read the pamphlet on family planning method options that was given to you by the provider at the clinic and have made a decision about which method you believe best suits your needs. **Offer this information only when the provider asks relevant questions:** • You have had a steady boyfriend for about six months. • Your boyfriend was taking antibiotics recently after he went to see a doctor at the STI clinic. • You do not use condoms. • Your last period started five days ago and were very regular each month prior to the miscarriage. • You feel healthy and have no health problems. • You would like to have a child someday, but your boyfriend says he is not ready, so you have chosen to use COCs because you believe that COCs would best suit your needs.	**Make note of whether the provi** • Asks about the client's re intentions, and life plans • Ensures that the client und described in the pamphlet and has made an informed • Determines the client's m screening checklist • Provides COCs, instructio if pills are missed, and inf • Encourages her to be teste • Explains the benefit of us counseling to support con • Discusses benefits of heal noting it is best to wait six months after miscarriage **Methods for which the client is** • COCs • DMPA or NET-EN • Implants • Male or female condoms • Standard Days Method®

Training Resource Package for Family Planning, Combined Oral Contraceptives —Clinicians, Role Plays, 11/2011

CHAPTER 1

1

Combined Oral Contraceptives

Combined Oral Contraceptives

Key Points for Providers and Clients

- **Take one pill every day.** For greatest effectiveness a woman must take pills daily and start each new pack of pills on time.
- **Bleeding changes are common but not harmful.** Typically, irregular bleeding for the first few months and then lighter and more regular bleeding.
- **Take any missed pill as soon as possible.** Missing pills risks pregnancy and may make some side effects worse.
- **Can be given to women at any time to start later.** If pregnancy cannot be ruled out, a provider can give her pills to take later, when her monthly bleeding begins.

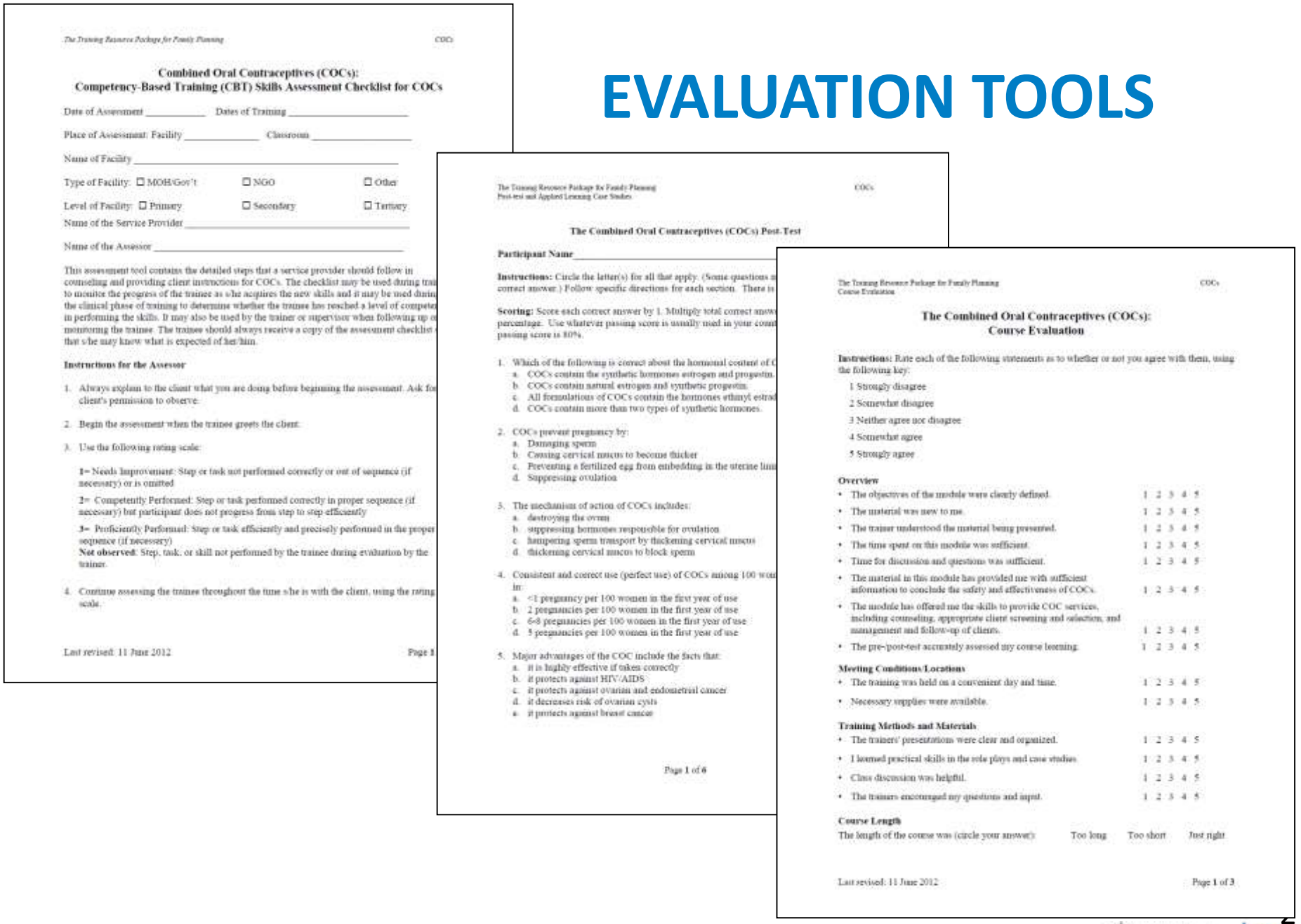
What Are Combined Oral Contraceptives?

- Pills that contain low doses of 2 hormones—a progestin and an estrogen—like the natural hormones progesterone and estrogen in a woman's body.
- Combined oral contraceptives (COCs) are also called "the Pill," low-dose combined pills, OCPs, and OCs.
- Work primarily by preventing the release of eggs from the ovaries (ovulation).

How Effective?

Effectiveness depends on the user: Risk of pregnancy is greatest when a woman starts a new pill pack 3 or more days late, or misses 3 or more pills near the beginning or end of a pill pack.

EVALUATION TOOLS



The Training Resource Package for Family Planning COCs

Combined Oral Contraceptives (COCs):
Competency-Based Training (CBT) Skills Assessment Checklist for COCs

Date of Assessment _____ Dates of Training _____

Place of Assessment: Facility _____ Classroom _____

Name of Facility _____

Type of Facility: ☐ MOH/Gov't ☐ NGO ☐ Other

Level of Facility: ☐ Primary ☐ Secondary ☐ Tertiary

Name of the Service Provider _____

Name of the Assessor _____

This assessment tool contains the detailed steps that a service provider should follow in counseling and providing client instructions for COCs. The checklist may be used during trai to monitor the progress of the trainee as s/he acquires the new skills and it may be used durin the clinical phase of training to determine whether the trainee has reached a level of competen in performing the skills. It may also be used by the trainer or supervisor when following up o monitoring the trainee. The trainee should always receive a copy of the assessment checklist that s/he may know what is expected of her/him.

Instructions for the Assessor

1. Always explain to the client what you are doing before beginning the assessment. Ask for client's permission to observe.
2. Begin the assessment when the trainee greets the client.
3. Use the following rating scale:

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

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

   3= Proficiently Performed: Step or task efficiently and precisely performed in the proper sequence (if necessary)
   Not observed: Step, task, or skill not performed by the trainee during evaluation by the trainer.

4. Continue assessing the trainee throughout the time s/he is with the client, using the rating scale.

Last revised: 11 June 2012 Page 1

The Training Resource Package for Family Planning COCs
Post-test and Applied Learning Case Studies

The Combined Oral Contraceptives (COCs) Post-Test

Participant Name _____

Instructions: Circle the letter(s) for all that apply. (Some questions h correct answer.) Follow specific directions for each section. There is

Scoring: Score each correct answer by 1. Multiply total correct answ percentage. Use whatever passing score is usually used in your count passing score is 80%.

1. Which of the following is correct about the hormonal content of C
   a. COCs contain the synthetic hormones estrogen and progestin.
   b. COCs contain natural estrogen and synthetic progestin.
   c. All formulations of COCs contain the hormones ethinyl estrad
   d. COCs contain more than two types of synthetic hormones.
2. COCs prevent pregnancy by:
   a. Damaging sperm
   b. Causing cervical mucus to become thicker
   c. Preventing a fertilized egg from embedding in the uterine lini
   d. Suppressing ovulation
3. The mechanism of action of COCs includes:
   a. destroying the ovum
   b. suppressing hormones responsible for ovulation
   c. hampering sperm transport by thickening cervical mucus
   d. thickening cervical mucus to block sperm
4. Consistent and correct use (perfect use) of COCs among 100 wom in:
   a. <1 pregnancy per 100 women in the first year of use
   b. 2 pregnancies per 100 women in the first year of use
   c. 6-8 pregnancies per 100 women in the first year of use
   d. 5 pregnancies per 100 women in the first year of use
5. Major advantages of the COC include the facts that:
   a. it is highly effective if taken correctly
   b. it protects against HIV/AIDS
   c. it protects against ovarian and endometrial cancer
   d. it decreases risk of ovarian cysts
   e. it protects against breast cancer

Page 1 of 6

The Training Resource Package for Family Planning COCs
Course Evaluation

The Combined Oral Contraceptives (COCs):
Course Evaluation

Instructions: Rate each of the following statements as to whether or not you agree with them, using the following key:

1 Strongly disagree
2 Somewhat disagree
3 Neither agree nor disagree
4 Somewhat agree
5 Strongly agree

Overview

- The objectives of the module were clearly defined. 1 2 3 4 5
- The material was new to me. 1 2 3 4 5
- The trainer understood the material being presented. 1 2 3 4 5
- The time spent on this module was sufficient. 1 2 3 4 5
- Time for discussion and questions was sufficient. 1 2 3 4 5
- The material in this module has provided me with sufficient information to conclude the safety and effectiveness of COCs. 1 2 3 4 5
- The module has offered me the skills to provide COC services, including counseling, appropriate client screening and selection, and management and follow-up of clients. 1 2 3 4 5
- The pre-/post-test accurately assessed my course learning. 1 2 3 4 5

Meeting Conditions/Locations

- The training was held on a convenient day and time. 1 2 3 4 5
- Necessary supplies were available. 1 2 3 4 5

Training Methods and Materials

- The trainers' presentations were clear and organized. 1 2 3 4 5
- I learned practical skills in the role plays and case studies. 1 2 3 4 5
- Class discussion was helpful. 1 2 3 4 5
- The trainers encouraged my questions and input. 1 2 3 4 5

Course Length

The length of the course was (circle your answer): Too long Too short Just right

Last revised: 11 June 2012 Page 1 of 3

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REFERENCES

Combined Oral Contraceptives (COCs): References

The main references for the COC module as well as for other TRPs are the World Health Organization's four cornerstones of family planning guidance:

1. *Family Planning: A Global Handbook for Providers (2011 update).* This book serves as a quick-reference resource for all level of health care workers. It provides practical guidance on delivering family planning methods appropriately and effectively.
2. *The Medical Eligibility Criteria for Contraceptive Use (4th edition 2010.* This resource provides guidance on whether people with certain medical conditions can safely and effectively use specific contraceptive methods.
3. *Decision Making Tools for Family Planning Clients and Providers*
4. The *Selected Practice Recommendations for Contraceptive Use* (2nd Edition 2005) and the *Selected Practice Recommendations for Contraceptive* Use: 2008 Update.

Other resources related to COCs:

- *Fact Sheet: Combined Oral Contraceptives (COCs)*
  FactSheet_COCs_Generic (.doc or .pdf)
- *Comparing Effectiveness of Family Planning Methods*
  EffectivenessChart_GlobalHB_2007.pdf
- *If 100 Women Use a Method for One Year, How Many Will Become Pregnant?*
  EffectivenessChart_AllVersion (.doc or .pdf)
- *Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use*
  QuickRefChartMEC_2011.pdf
- The *WHO Medical Eligibility Criteria Wheel for Contraceptive Use*
  MECwheel_WHO_2008.pdf
- *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives*
  MECchecklist_COCs_2011.pdf
- National FP guidelines on managing COCs' side effects or *COCs—Managing Any Problems, Global Handbook*
  ManagingProblems_COCs_GlobalHandbook_2011.pdf
- *A Guide to Effective and Efficient Provision of Combined Oral Contraceptives (COCs)*
  JobAid_ProvidingCOCs_Clin.pdf
- *How to Use the Pill*
  JobAid_HowToUseCOCs_Generic.ppt

Modules presently available

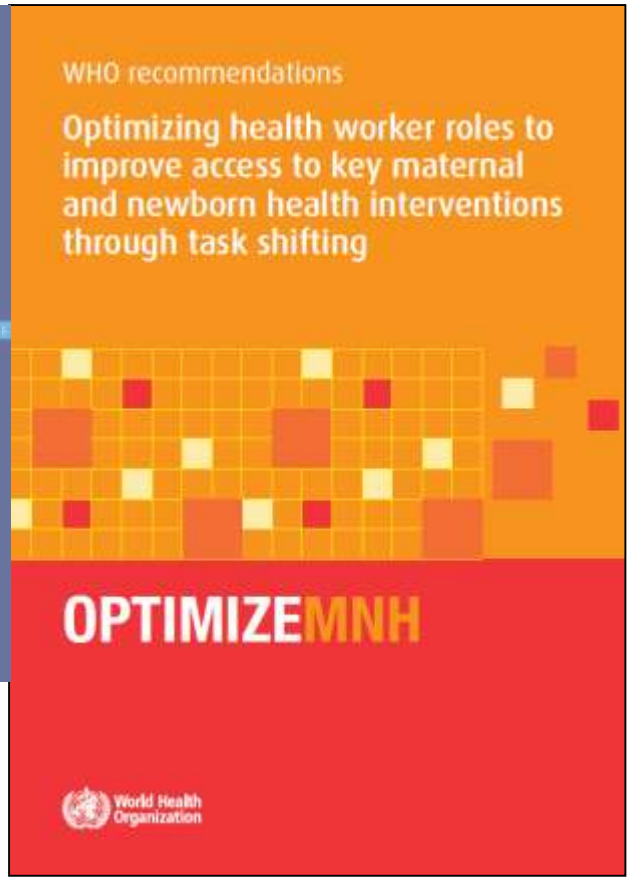
- Benefits of Family Planning (VF)
- Combined Oral Contraceptives (VF)
- Condoms- Male (VF)
- Condoms- Female (VF)
- Contraceptive Implants (VF)
- Emergency Contraceptive Pills (ECP)
- Emergency Contraceptive Pills (ECP) for Pharmacists
- Family Planning Counseling (VF)
- Intrauterine Devices (IUDs) (VF)
- Lactational Amenorrhea (VF)
- Progestin-only Injectable Contraception (Injectables) (VF)
- Standard Days Method
- WHO's FP Guidance documents and Job Aids (VF)

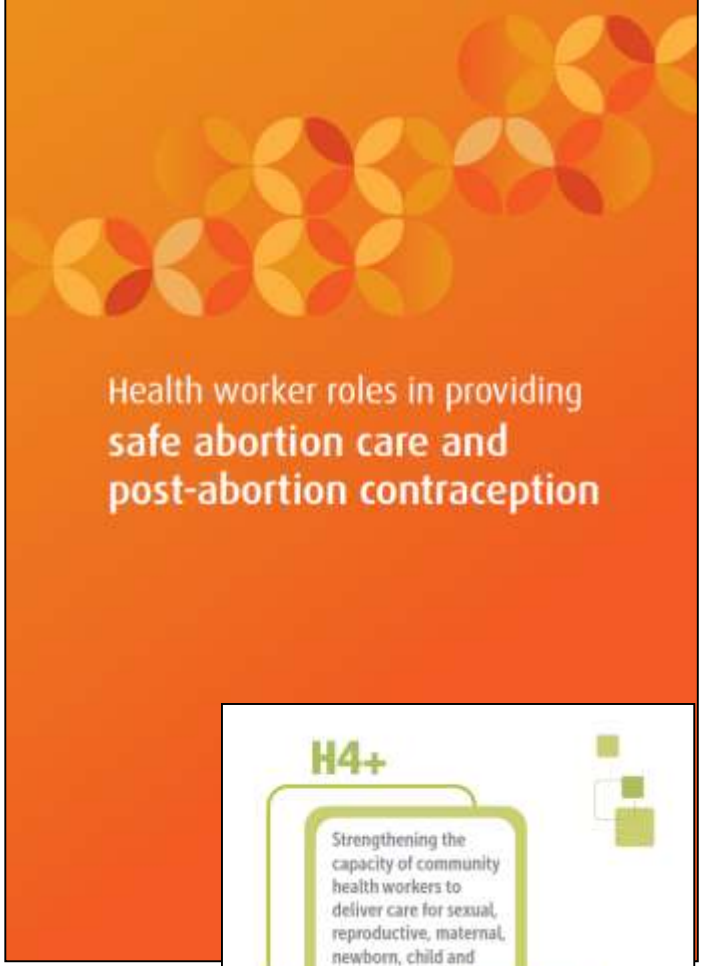
- Coming very soon - Permanent Methods
- Plans for wider dissemination and technical support
- Presently being updated, with inputs from new MEC and SPR
- New French versions of other modules coming soon, Spanish coming soon.

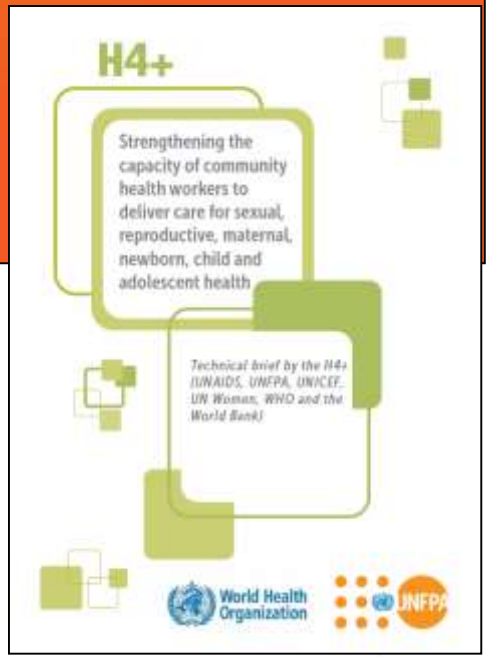
Human Rights and Contraception

- WHO guidelines provide recommendations how to ensure that **human rights are respected, protected and fulfilled**, while **quality services are scaled up** to reduce unmet need for contraception.
- Guidance included both health data and international human rights laws and treaties.
- This guidance is complementary to existing WHO recommendations for SRH programmes.
- Related documents:
  - Framework document
  - Quantitative indicators
  - Implementation guide

WHO GUIDELINES AND DOCUMENTS







Task sharing – usual providers retain task but involve or expand to other cadres,
Task shifting – delegate the task to other cadres, especially if there are not usually found there.
Either with confidentiality and privacy

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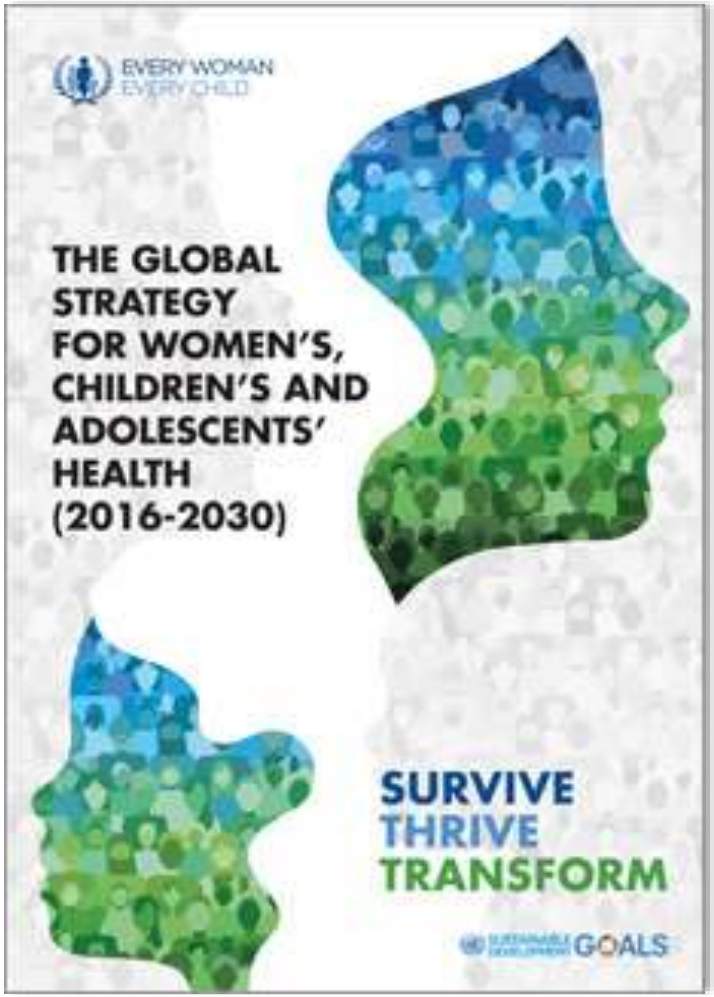
Essential Medicines List

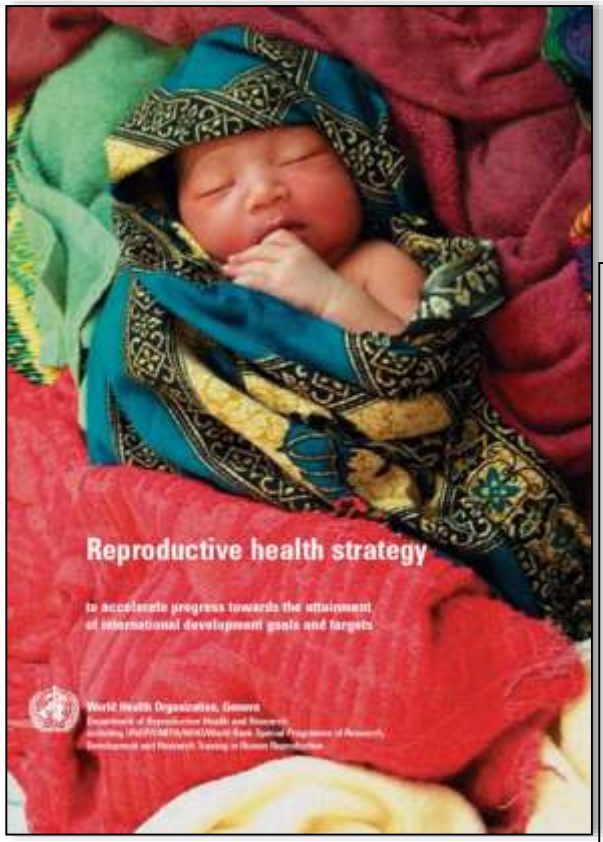
- Satisfy the priority health care needs of the population. They are selected with due regard to **public health relevance, evidence on efficacy and safety, and comparative cost-effectiveness**.
- Intended to be available within the context of functioning health systems at all times in adequate amounts, in the appropriate dosage forms, with assured quality and adequate information, and at a price the individual and community can afford.
- Updated in 2017, 20th ed.

WHO Model List of Essential Medicines 20th edition

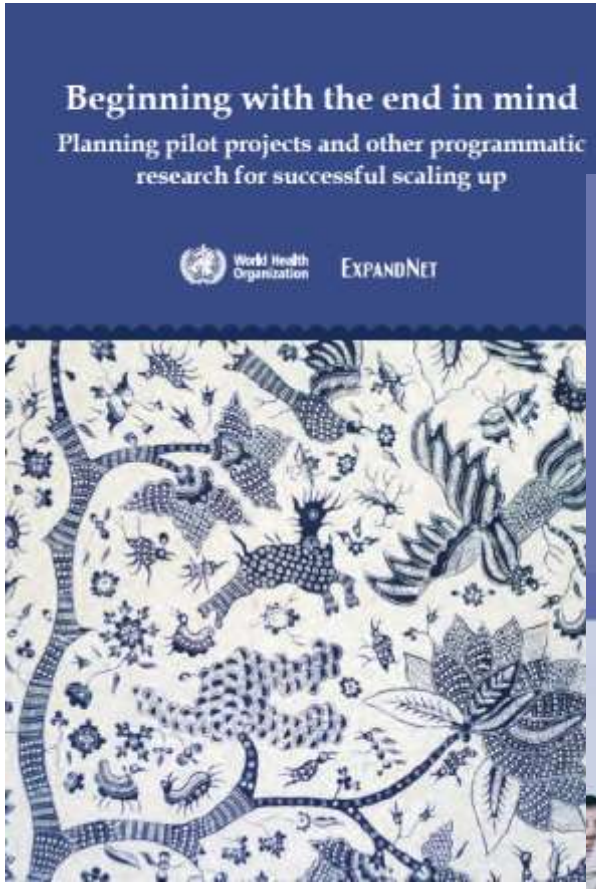
18.3.2 Injectable hormonal contraceptives	
estradiol cypionate + medroxyprogesterone acetate	**Injection:** 5 mg + 25 mg.
medroxyprogesterone acetate	**Injection (intramuscular):** 150 mg/ mL in 1- mL vial. **Injection (subcutaneous):** 104 mg/0.65 mL in pre-filled syringe or single-dose injection delivery system.
norethisterone enantate	**Oily solution:** 200 mg/ mL in 1- mL ampoule.
18.3.3 Intrauterine devices	
copper-containing device	
levonorgestrel-releasing intrauterine system	Intrauterine system with reservoir containing 52 mg of levonorestrel
18.3.4 Barrier methods	
condoms	
diaphragms	
18.3.5 Implantable contraceptives	
etonogestrel-releasing implant	Single-rod etonogestrel-releasing implant, containing 68 mg of etonogestrel.
levonorgestrel-releasing implant	Two-rod levonorgestrel-releasing implant, each rod containing 75 mg of levonorgestrel (150 mg total).
18.3.6 Intravaginal contraceptives	
progesterone vaginal ring*	Progesterone-releasing vaginal ring containing 2.074 g of micronized progesterone. *For use in women actively breastfeeding at least 4 times per day

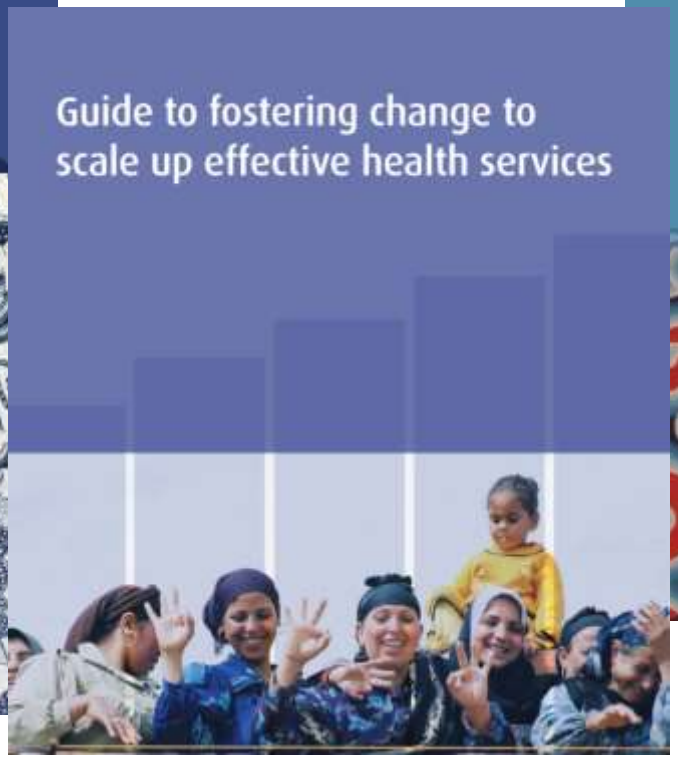
Global Strategies for RMNCAH

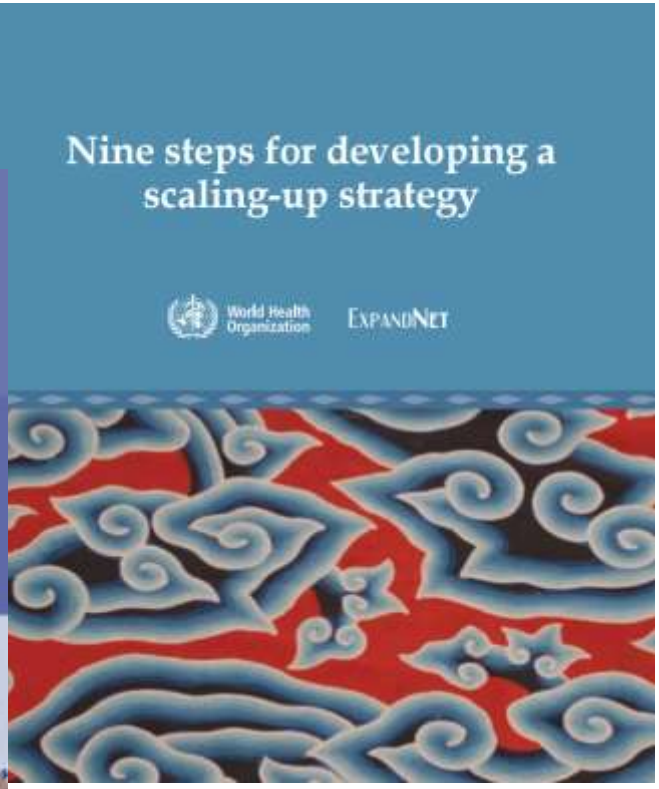




Useful resources on how to implement and scale up FP programs







http://www.who.int/reproductivehealth/topics/countries/strategic_approach/en/

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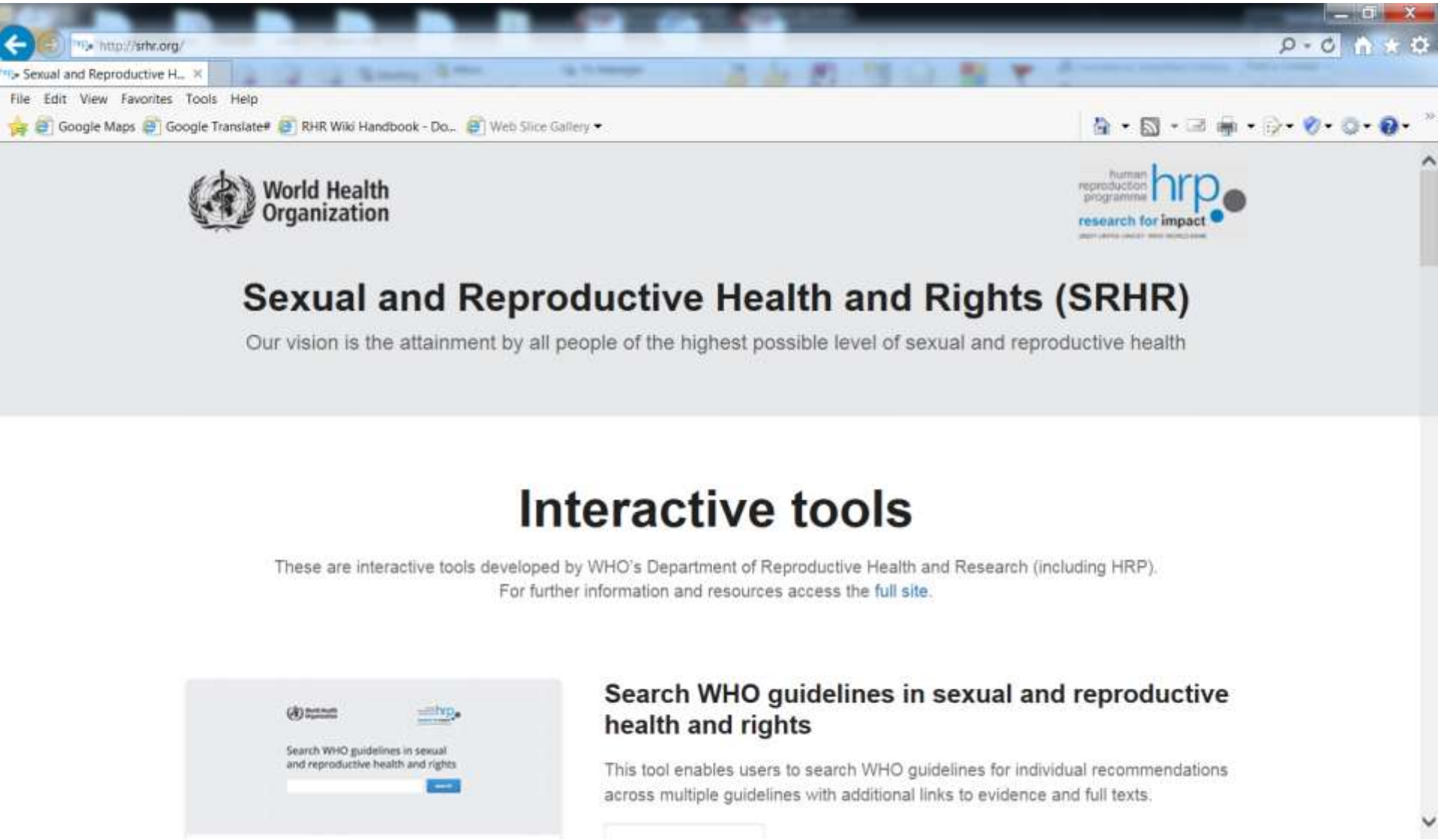
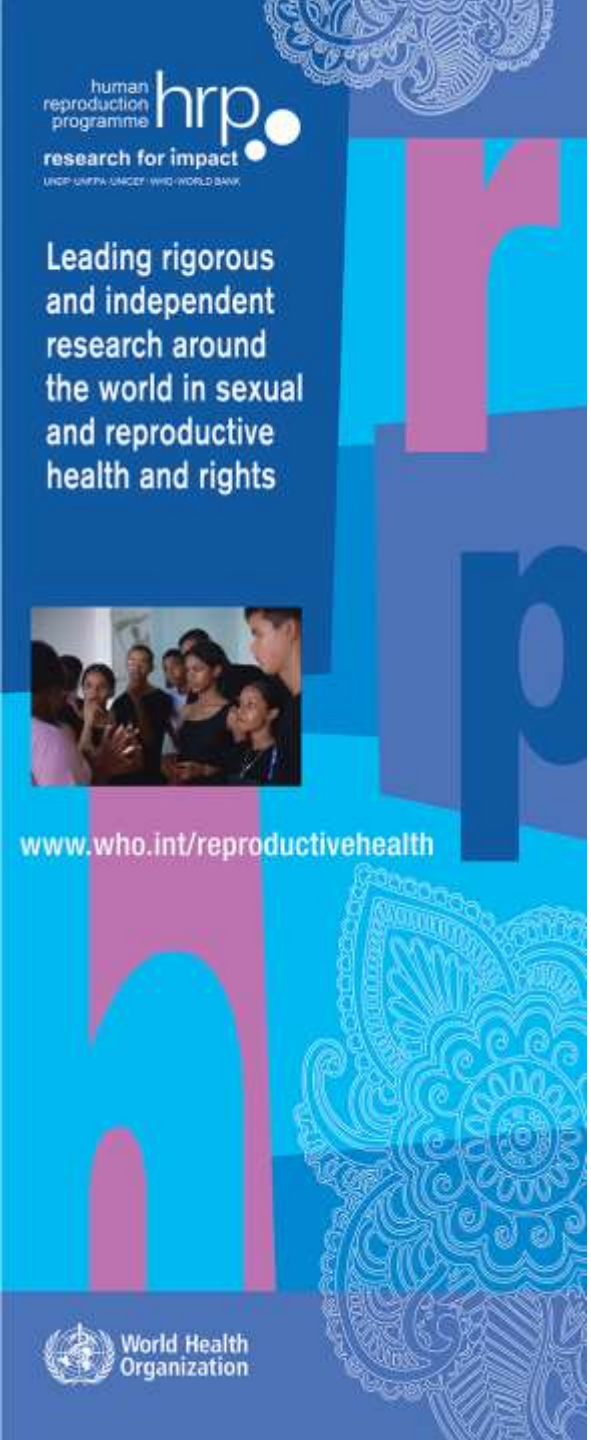
http://srhr.org



Useful website links:

- WHO RHR – Family planning
  - http://www.who.int/mediacentre/factsheets/fs351/en/
- Family planning Training Resource Package
  - https://www.fptraining.org/
- WHO Family planning guidelines
  - http://www.who.int/reproductivehealth/topics/family_planning/en/
- Implementing Best Practices (IBP) Initiative and Knowledge Gateway
  - http://www.ibpinitiative.org/index.php



Thank you

For more information,

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Website **who.int/reproductivehealth/en**

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