

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

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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

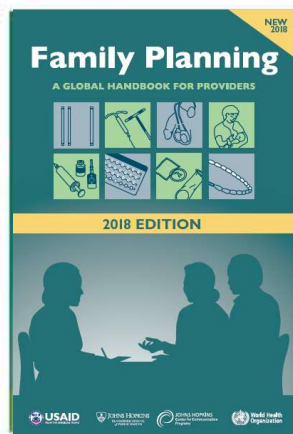


5th edition



Decision-Making Tool
(to be updated)

Selected Practice Recommendations



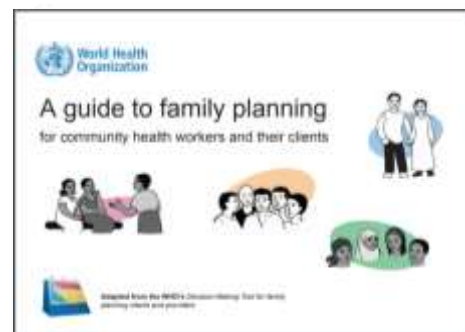
Global Handbook



The Medical Eligibility Criteria (MEC) Wheel



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



Guide to family planning for community health care providers and their clients

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 in 2018.

What's New in This Edition?

- ❑ **New family planning recommendations from WHO:**

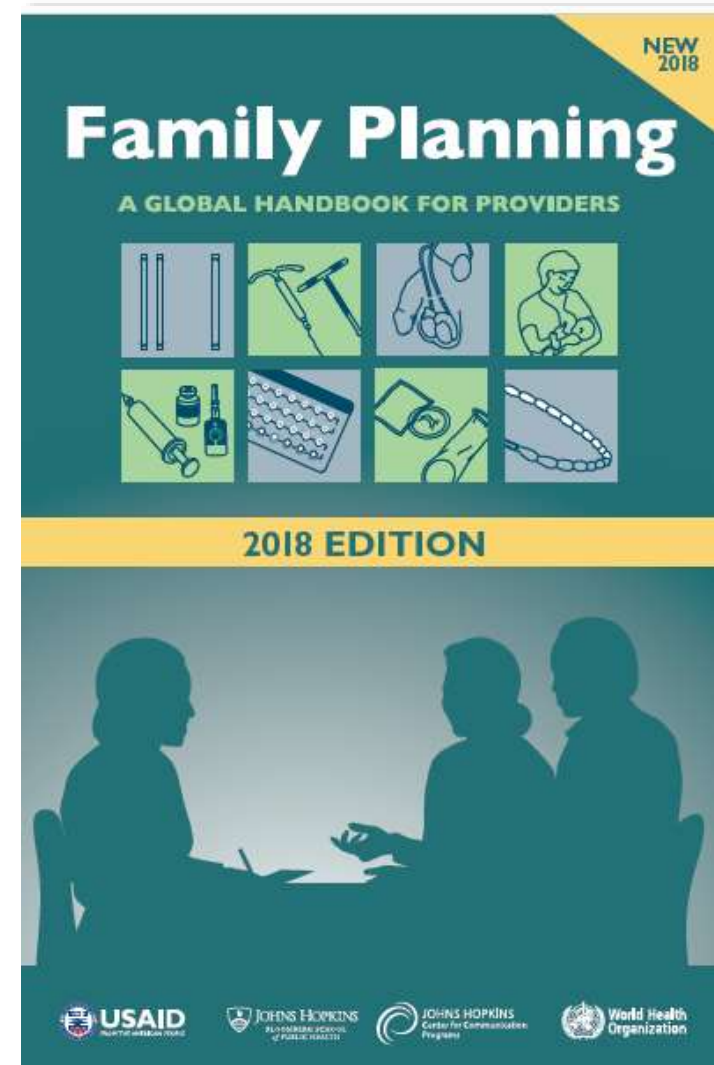
Women who are breastfeeding can start progestin only pills or implants at any time postpartum; New Selected Practice Recommendations on the levonorgestrel implant Levoplant (Sino-Implant (II)), subcutaneous DMPA, the combined patch, the combined vaginal ring, and ulipristal acetate for emergency contraception; When to start a family planning method after taking emergency contraceptive pills.

- ❑ **New coverage in this edition:**

Human rights: Family Planning Providers' Contribution; "How Can a Partner Help?"; Giving the Injection with Subcutaneous DMPA in Uniject (Sayana Press); Teaching Clients to Self-Inject; Progesterone-releasing vaginal ring; Clients with disabilities; Safer Conception for HIV Serodiscordant Couples; "LIVES"—5 steps for helping women subjected to violence; Counseling About Effectiveness; Task-Sharing: WHO Recommendations; Considering Progestin-Only Injectables Where HIV Risk Is High: Counseling Tips; Ruling Out Pregnancy.

- ❑ **Expanded or updated coverage:**

Instructions on implant insertion; Levonorgestrel IUD; Prenatal care; Infant feeding for women with HIV; Infertility; Effectiveness of family planning methods; Medical Eligibility Criteria for Contraceptive Use.



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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.
- Take any missed pill as soon as possible. Missing pills risks pregnancy and may make some side effects worse.
- Bleeding changes are common but not harmful. Typically, there is irregular bleeding for the first few months and then lighter and more regular bleeding.
- Can be given to a woman at any time to start now or later.

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)

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

Correcting Misunderstandings (see also Questions and Answers, p. 25)

Combined oral contraceptives:

- Do not build up hormones 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 after they stop taking COCs.
- 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.

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



- DMPA, the most widely used progestin-only injectable, is also known in its intramuscular form as "the shot," "the jab," the injection, Depo, Depo-Provera, and Petogen. The subcutaneous version in the Uniject injection system is currently marketed under the name Sayana Press and in prefilled single-dose disposable hypodermic syringes as depo-subQ provera 104.
- NET-EN is also known as norethindrone enanthate, Noristerat, Norigest, and Syngestal. (See *Comparing Injectables*, p. 427, for differences between DMPA and NET-EN.)
- 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 4 pregnancies per 100 women using progestin-only injectables over the first year. This means that 96 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 (2 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 8, p. 94).

Protection against sexually transmitted infections (STIs): None



Side Effects, Health Benefits, and Health Risks

Side Effects (see also *Managing Any Problems*, p. 89)

Most users report some changes in monthly bleeding.¹

- Typically, these include, 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 than DMPA users to have no monthly bleeding after one year.

Some users report the following:

- Weight gain (see Question 5, p. 93)
- Headaches
- Dizziness
- Abdominal bloating and discomfort
- Mood changes
- Less sex drive

Other possible physical changes:

- Loss of bone density (see Question 11, p. 95)

Bleeding changes are normal and not harmful. If a woman finds them bothersome, counseling and support can help.



Why Some Women Say They Like Progestin-Only Injectables

- Requires action only every 2 or 3 months. No daily pill-taking.
- Do not interfere with sex
- Are private: No one else can tell that a woman is using contraception
- Stop monthly bleeding (for many women)
- May help women to gain weight

¹ For definitions of bleeding patterns, see "vaginal bleeding," p. 407.

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 adequate, clear and 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. 220). Involving his partner in counseling can be helpful but is not necessary or required.



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Vasectomy

The 7 Points of Informed Consent

Counseling must cover all 7 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).
7. The procedure does not protect against sexually transmitted infections, including HIV.

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. 436)

- 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 LNG-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, serious 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. 384.

- 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 12, p. 95) or to a woman who receives an injection while pregnant.

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Progestin-Only Injectables

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 with an STI.

2. Can women at high risk for HIV use progestin-only injectables?

Yes. Women at high risk of HIV infection can use any contraceptive method, including progestin-only injectables, except spermicide or diaphragm with spermicide (see Spermicides and Diaphragms, p. 271).

In late 2016 a WHO assessment observed that some research finds that women who are at high risk of HIV infection and use a progestin-only injectable are slightly more likely to get HIV. It is not clear why studies find this. The injectable may or may not be responsible for increasing a woman's chances of becoming infected if exposed to HIV.

An expert group convened by WHO concluded, "Women should not be denied the use of progestogen-only injectables because of concerns about the possible increased risk" of HIV infection. WHO classified progestin-only injectables, such as DMPA (including Sayana Press) and NET-EN, as Medical Eligibility Criteria (MEC) category 2 for high risk of HIV. This classification means that women at high risk of HIV can generally use the method.

WHO advises that, in countries and populations where HIV is common, providers should clearly inform women interested in progestin-only injectables about these research findings and their uncertainty, as well as how to protect themselves from HIV, so that each woman can make a fully informed choice (see Considering Progestin-Only Injectables Where HIV Risk Is High, p. 438, for counseling tips). In keeping with the MEC 2 classification, women

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](#)

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!

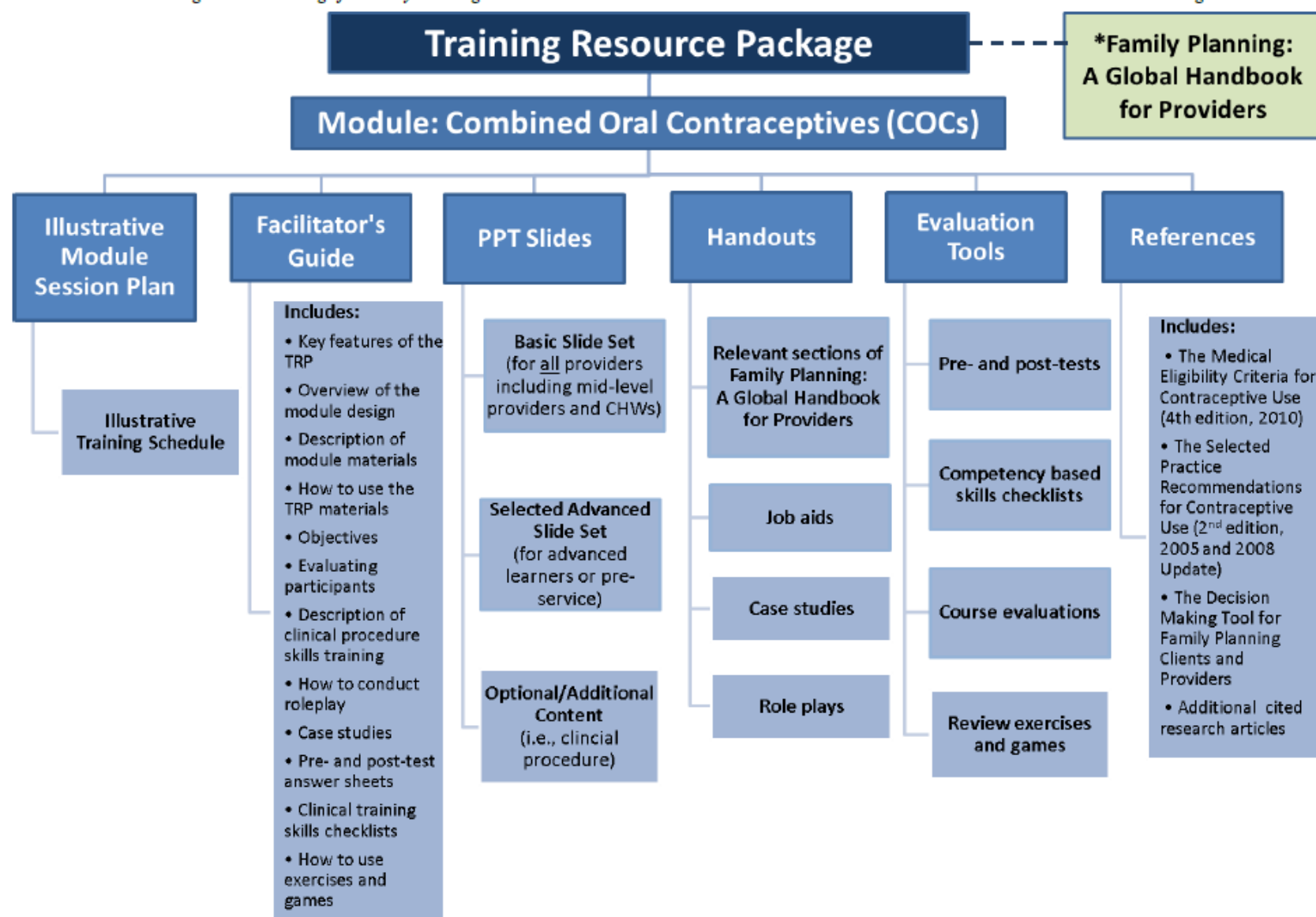
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A Training Resource Package for Family Planning

- 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*

Last revised: 27 July 2012

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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 Resource Package for guidance on selecting and adapting TRP materials for the learning audience.
- Next read this session plan, which includes detailed learning objectives, module and describes how to use this presentation and other materials to 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 that is understandable.	
Welcome and Introduction (15 min.)	Slide 1
<ul style="list-style-type: none"> • Greet participants and introduce yourself. 	
Objectives (5 min.)	
<ul style="list-style-type: none"> • 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. 	
Pre-Test Questionnaire (20 min.)	Evaluate Content (COC)
What are COCs? Traits and Types (10 min.)	Slide Points and COC Types
<p>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.</p>	

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Module Session Plan

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 (10 min.)	Slide 2: COCs Are Safe for Nearly All Women
<p>Use slides to show women who can safely use COCs:</p> <ul style="list-style-type: none"> • 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. 	
Who Can and Cannot Use the Pill (15 min.)	Slide 3: Who Can and Cannot Use the Pill
<p>Explain: that most women can safely use the pill as mentioned in the previous slide. Use slides to show who should not use COCs</p>	Slide 4: Who Cannot Use COCs (Part 1) Slide 5: Who Cannot Use COCs (Part 2)
Medical Eligibility Criteria Brainstorming (10 min.)	Slide 6: Medical Eligibility Criteria
<ul style="list-style-type: none"> • This activity has two purposes: <ol style="list-style-type: none"> 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 work sites), such as the <i>WHO Medical Eligibility Criteria Wheel for Contraceptive Use</i>, or the <i>Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use</i>. • Brainstorming instructions: <ul style="list-style-type: none"> ◦ Use slide 7 to introduce the concept of medical eligibility 	Slides 7 and 8: WHO's Medical Eligibility Categories: Hormonal Methods Handout #1: Medical Eligibility Criteria Wheel for Contraceptive Use Handout #2: Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use

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Training Process	Resources
Management of COC Side Effects: Bleeding Changes (15 min.)	
<p>Use slides to present the following:</p> <ul style="list-style-type: none"> • 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 400 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. 	
Warning Signs of Rare COC Complications (5 min.)	Slide 16: When to Return: Warning Signs of Rare COC Complications
<p>Use slides to present the following:</p> <ul style="list-style-type: none"> • 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 	

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Facilitators' Guide

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

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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 high-quality materials and resources for designing, conducting and evaluating training for family planning (FP) providers. The resource package is specifically designed for mid-level 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, midwives types of community health workers. It is designed to actively involve the trainee process. Sessions include PowerPoint presentations, simulation skills practice in 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 effective method of family planning, respond to rumors and misconceptions about COCs, provide services for COC clients, recognize and manage common side effects, 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-service providers. A thorough understanding of adult learning principles and the ability to provide on FP topics in pre-service or in-service settings.

IV. Using the Training Resource Package COCs Module to Develop Training Materials
All of the parts needed to develop a curriculum for COCs are included in the TRP. The diagram following the Table of Contents shows how the different elements of the TRP fit together. They are there to be adapted to fit the circumstances in the country where you are working. The trainers who will be conducting training and the level of expertise and experience of the trainees. The TRP can be adapted to fit any kind of training. The module can be used as a standalone 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 TRP:

Step 1: Assess Training Needs

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

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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. She 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 experience. In the 1960s, 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 attitudes 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.

Last revised: 27 July 2012

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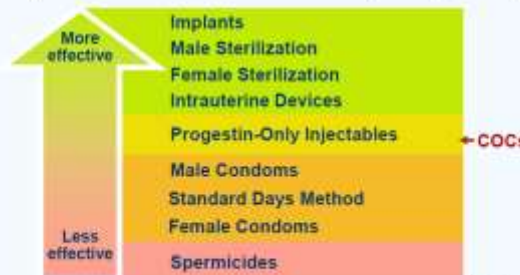
Combined Oral Contraceptive Pills (COCs)

Session I: Characteristics of COCs



Effectiveness of COCs

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

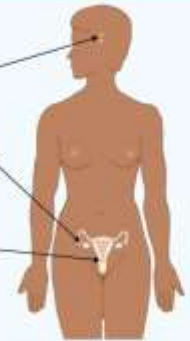


Session I, Slide 5

COCs: Mechanism of Action

Suppresses hormones responsible for ovulation

Thickens cervical mucus to block sperm



COCs have no effect on an existing pregnancy.

Session I, Slide 7

POWERPOINTS

Combined Oral Contraceptive Pills (COCs)

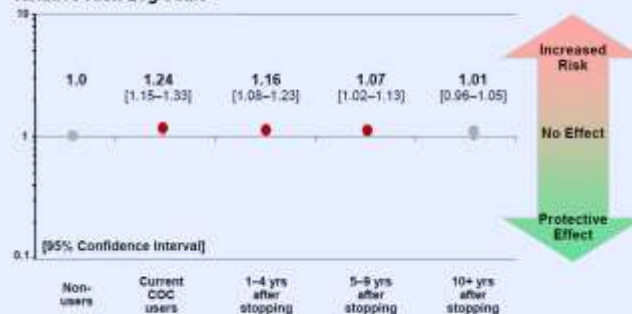
Advanced Slide Set



Advanced Slide Set, Slide #

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

Relative Risk Log Scale



Source: Collaborative Group on Hormonal Factors in Breast Cancer; 1996; Akh, 2005; Silver, 2005.

Advanced Slide Set, # 7

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 take 1 pill each day, and use condoms or avoid sex 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 start a new pack.

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

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.

COCs Scenario 1—Observe

Make note of whether the provider:

- Asks about the client's regular menstruation, and life plans.
- Ensures that the client understands the pill and has made an informed decision about which method you believe best suits your needs.
- Determines the client's need for screening checklist.
- Provides COCs, instructions if pills are missed, and information.
- Encourages her to be tested.
- Explains the benefit of using counseling to support her.
- Discusses benefits of breastfeeding if 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—Clinician, Role Plays, 11/2011

CHAPTER 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.

Combined Oral Contraceptives

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 training to monitor the progress of the trainee as she acquires the new skills and it may be used during the clinical phase of training to determine whether the trainee has reached a level of competence in performing the skills. It may also be used by the trainer or supervisor when following up on 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

EVALUATION TOOLS

The Combined Oral Contraceptives (COCs) Post-Test

Participant Name _____

Instructions: Circle the letter(s) for all that apply. (Some questions may have more than one correct answer.) Follow specific directions for each section. There is no time limit.

Scoring: Score each correct answer by 1. Multiply total correct answers by 10 to get percentage. Use whatever passing score is usually used in your country. A passing score is 80%.

1. Which of the following is correct about the hormonal content of COCs?
 - 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 estradiol and norgestrel.
 - 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 lining
 - 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 women 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 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

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:

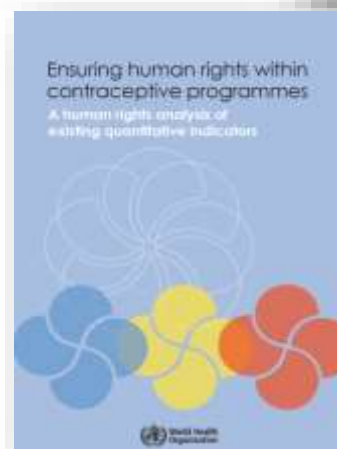
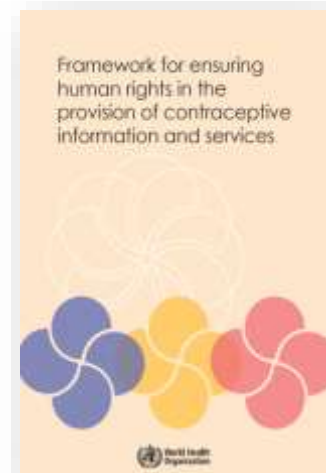
- *Fact Sheet: Combined Oral Contraceptives (COCs)*
[FactSheet_COCs_Generic \(.doc or .pdf\)](#)
- *Comparing Effectiveness of Family Planning Methods*
[EffectivenessChart_GlobalHB_2007.pdf](#)
- *If 100 Women Use a Method for One Year, How Many Will Become Pregnant?*
[EffectivenessChart_AltVersion \(.doc or .pdf\)](#)
- *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

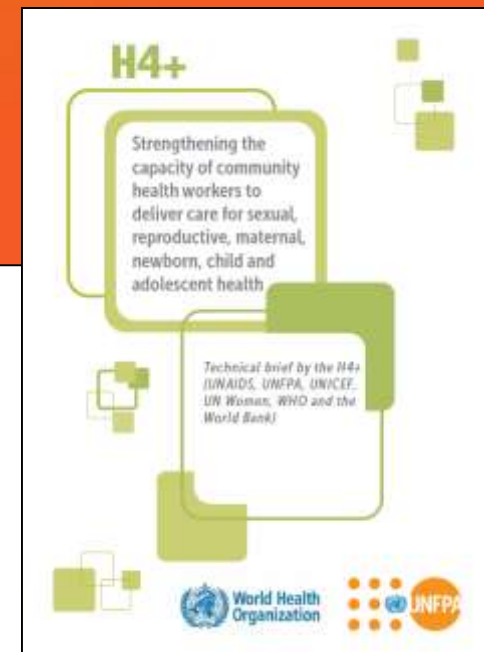
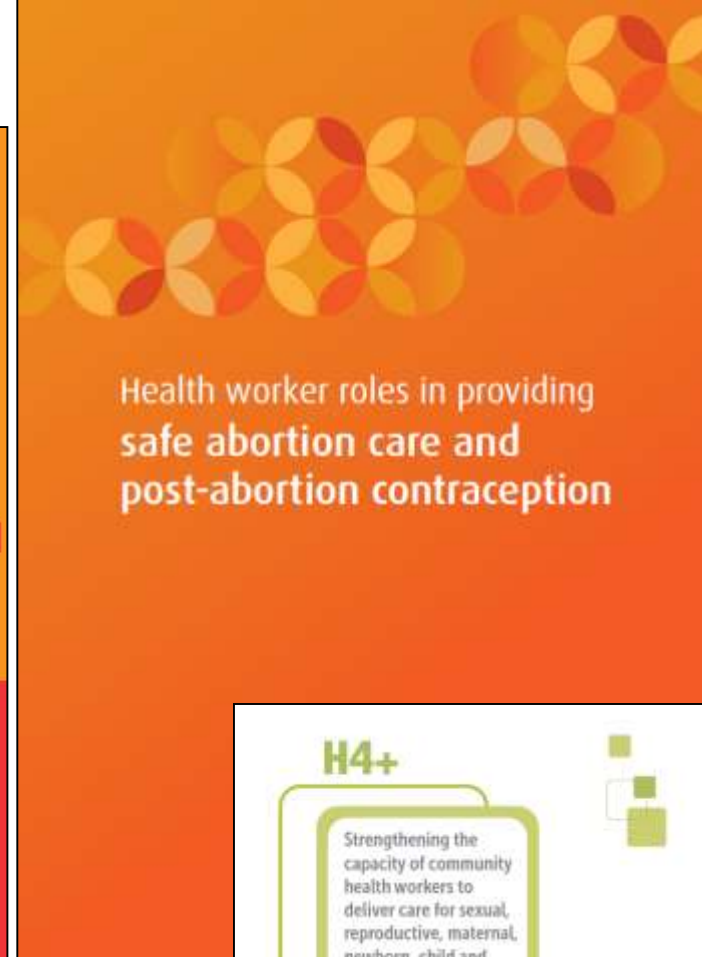
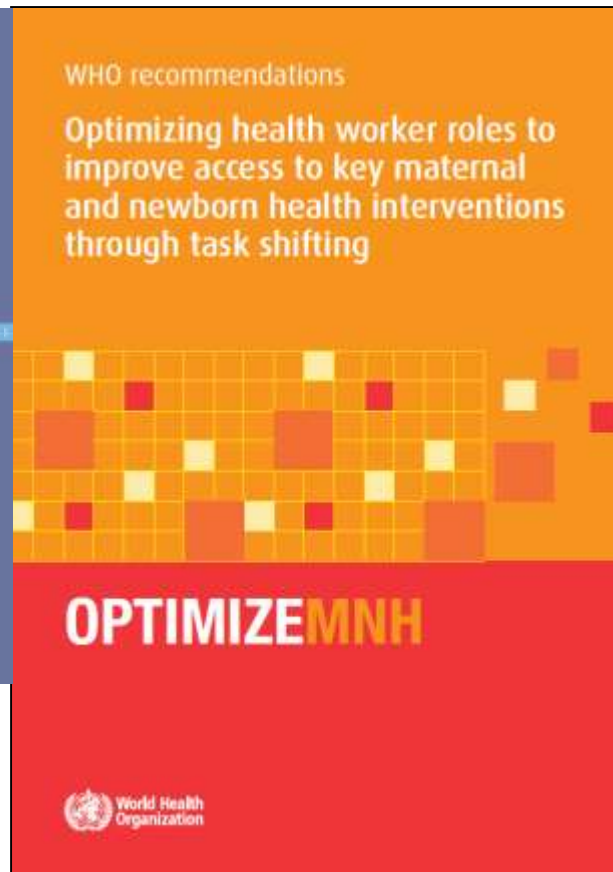
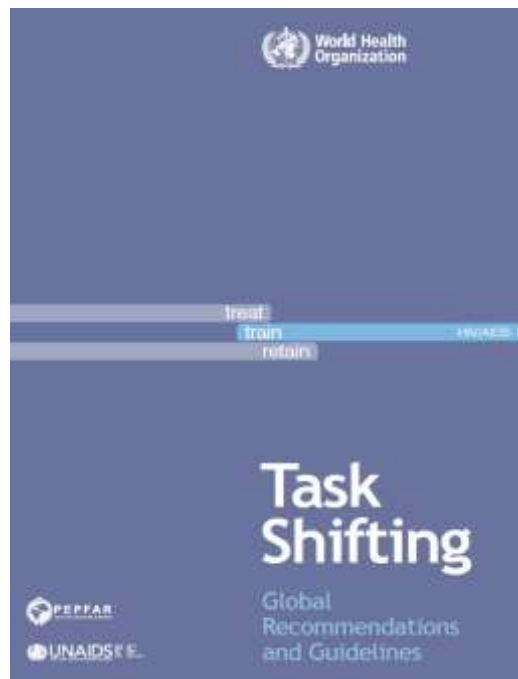
- Benefits of Family Planning (VF)
- Combined Oral Contraceptives (VF)
- Condoms- Male (VF)
- Condoms- Female (VF)
- Contraceptive Implants (VF)
- Emergency Contraceptive Pills (ECP)
- Emergency Contraceptive Pills (ECP) for Pharmacists
- Family Planning Counseling (VF)
- Intrauterine Devices (IUDs) (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

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.

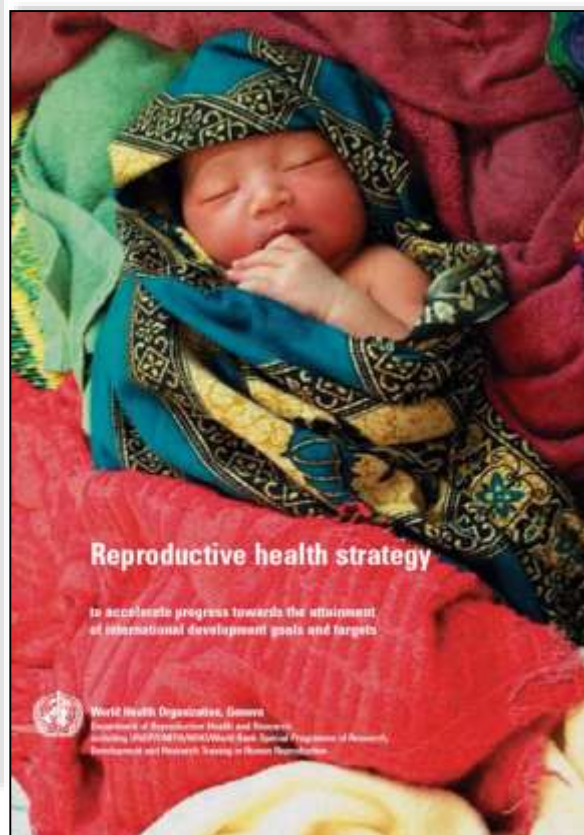
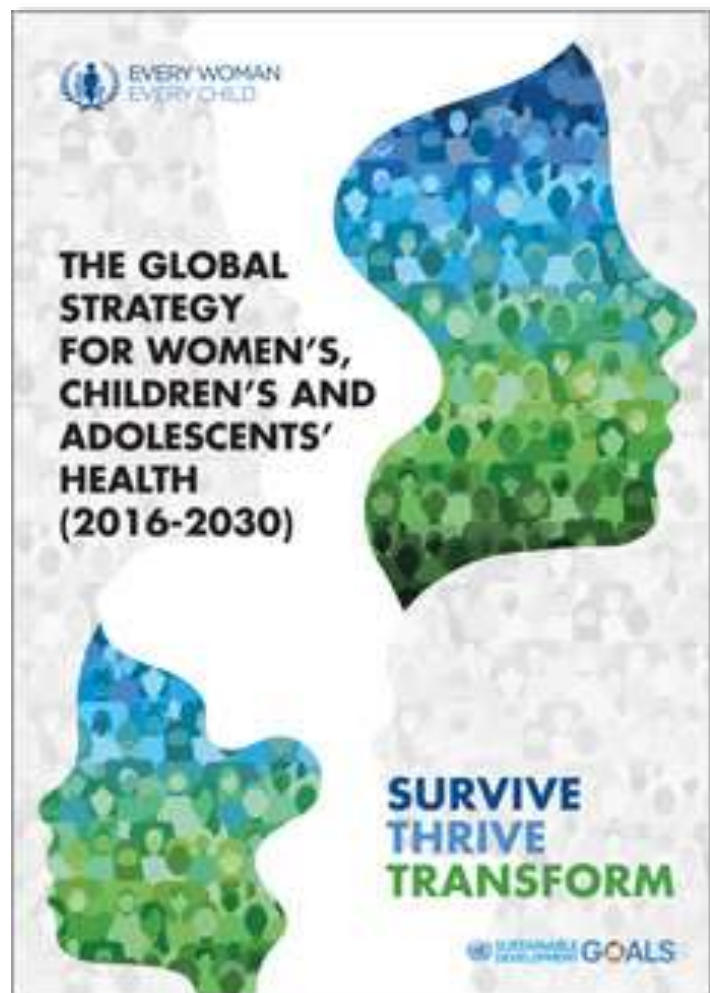
WHO Model List of Essential Medicines

20th edition

<i>18.3.2 Injectable hormonal contraceptives</i>	
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.
<i>18.3.3 Intrauterine devices</i>	
copper-containing device	
levonorgestrel-releasing intrauterine system	Intrauterine system with reservoir containing 52 mg of levonorelrel
<i>18.3.4 Barrier methods</i>	
condoms	
diaphragms	
<i>18.3.5 Implantable contraceptives</i>	
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).
<i>18.3.6 Intravaginal contraceptives</i>	
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

Beginning with the end in mind
Planning pilot projects and other programmatic
research for successful scaling up



EXPANDNET

Guide to fostering change to
scale up effective health services

Nine steps for developing a
scaling-up strategy



World Health
Organization

EXPANDNET



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

http://srhr.org



World Health Organization

human reproduction programme **hrp**
research for impact

Sexual and Reproductive Health and Rights (SRHR)

Our vision is the attainment by all people of the highest possible level of sexual and reproductive health

Interactive tools

These are interactive tools developed by WHO's Department of Reproductive Health and Research (including HRP).
For further information and resources access the [full site](#).

Search WHO guidelines in sexual and reproductive health and rights

This tool enables users to search WHO guidelines for individual recommendations across multiple guidelines with additional links to evidence and full texts.

World Health Organization **hrp**

Useful website links:

- ❑ WHO RHR – Family planning
 - <http://www.who.int/en/news-room/fact-sheets/detail/family-planning-contraception>
- ❑ 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>

Leading rigorous
and independent
research around
the world in sexual
and reproductive
health and rights



www.who.int/reproductivehealth

Thank you

For more information,

Follow us on Twitter [@HRPresearch](https://twitter.com/HRPresearch)

Website who.int/reproductivehealth/en

