



Long-Acting Reversible Contraceptives Learning Package

Module 2: Family Planning Counseling

Facilitator Version

The Maternal and Child Survival Program (MCSP) is a global, United States Agency for International Development (USAID) Cooperative Agreement to introduce and support high-impact health interventions with a focus on 24 high-priority countries with the ultimate goal of ending preventable child and maternal deaths within a generation. The Program is focused on ensuring that all women, newborns and children most in need have equitable access to quality health care services to save lives. MCSP supports programming in maternal, newborn and child health, immunization, family planning and reproductive health, nutrition, health systems strengthening, water/sanitation/hygiene, malaria, prevention of mother-to-child transmission of HIV, and pediatric HIV care and treatment.

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Module 2: Family Planning Counseling

Module Overview

Module Overview for Facilitator

Assessments

Pre and Post Test Answer Key

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Activity 2-2: Lily's Story: Instructions

Activity 2-3: Lily's Story

Activity 2-4: Diverse Counseling Group Scenarios

Activity 2-5: Role Play Scenarios

BCS+

BCS+ 2-1: Algorithm

BCS+ 2-2: Methods Brochures

BCS+ 2-3: Counseling Cards

Checklists

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Handouts

Handout 2-1: Successful Counseling

Handout 2-2: Client Rights

Handout 2-3: Diverse Group Counseling

Handout 2-4: Rumors and Misconceptions about IUDs

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Job Aids

Job Aid 2-1: WHO MEC Quick Reference Chart

Job Aid 2-2: Method Effectiveness Chart

Job Aid 2-3: LARC Brochures for Adolescents

Facilitator Tools

Facilitator Tool 2-1: Video on Talking about LARCs with Young Clients

Facilitator Tool: 2-2: Key Point Video Discussion Guide

Module 2: Family Planning Counseling

Module Overview for Facilitator

Time: 8:10 hours

Module Objectives

By the end of the module, learners will be able to:

- Name at least three essentials of effective interpersonal communication skills
- Describe the four stages of the Balanced Counseling Strategy for FP
- Demonstrate how to use the Balanced Counseling-Plus algorithm and counseling cards to assist a client in making an informed decision about whether and which contraceptive method to choose
- Demonstrate at least two effective communication and counseling skills
- Counsel young clients for LARC methods uptake
- Identify at least two gender-related issues that influence family planning counseling, uptake and use
- Demonstrate competence in assisting clients to make an informed decision to use different LARC methods
- Correct at least three inaccurate rumors or misconceptions about different LARC methods

Session Plans

- Session One: Interpersonal Communication Skills and Gender-Related Issues
- Session Two: BCS+ Counseling and Rumors and Misconceptions
- Session Three: Counseling Clients Using the BCS+ Algorithm and Counseling Cards

Materials and Supplies

| Category | Name | Items to Print | |
|------------------|---|----------------|---------|
| | | Facilitator | Learner |
| Assessments | Pre/Post Test Questionnaire | | X |
| | Pre/Post Test Questionnaire Answer Sheet | | X |
| | Pre/Post Test Questionnaire Answer Key | X | |
| Activities | Activity 2-1: Reflection Exercise | X | |
| | Activity 2-2: Instructions: Lily's Story | X | |
| | Activity 2-3: Lily's Story | X | |
| | Activity 2-4: Diverse Counseling Group Scenarios | X | |
| | Activity 2-5: Role Play Scenarios | X | |
| BCS+ Tools | BCS+ 2-1: Algorithm | X | X |
| | BCS+ 2-2: Methods Brochures (if available OR any other method brochures available in the country) | X | X |
| | BCS+ 2-3: Counseling Cards | X | X |
| Checklists | Checklist 2-1: Pregnancy Checklist | X | X |
| Handouts | Handout 2-1: Successful Counseling | X | X |
| | Handout 2-2: Client Rights | X | X |
| | Handout 2-3: Diverse Group Counseling | X | X |
| | Handout 2-4: Rumors and Misconceptions about IUDs | X | X |
| | Handout 2-5: Rumors and Misconceptions about Implants | X | X |
| | Handout 2-6: Rumors and Misconceptions about LNG-IUS | X | X |
| Job Aids | Job Aid 2-1: WHO MEC Quick Reference Chart | X | X |
| | Job Aid 2-2: Method Effectiveness Chart | X | X |
| | Job Aid 2-3: LARC Brochures for Adolescents | X | X |
| Facilitator Tool | Facilitator Tool 2-1: Video on Talking about LARCs with Young Clients | X | |
| | Facilitator Tool: 2-2: Key Point Video Discussion Guide | X | |
| Supplies | Flip Chart | | |
| | Markers | | |
| | Contraceptive Samples Tray | | |
| | Laptop | | |

Session Plans

Module 2—Session I

| Date | Venue | Session number: I | Duration: 175 min |
|---|-------|-------------------|-------------------|
| Topic: Counseling: Interpersonal Communication Skills and Gender-Related Issues | | | |
| Session Objectives: By the end of this session, learners will be able to: <ul style="list-style-type: none"> • Name at least three essentials of effective interpersonal communication skills • Identify at least two gender-related issues that influence family planning counseling, uptake and use • Address the key barriers to LARC uptake among the youth | | | |

| Methods and Activities | Materials/Resources |
|--|---|
| Introduction (5 min) <ul style="list-style-type: none"> • Review session objectives with learners | <ul style="list-style-type: none"> • Objectives on Flip Chart |
| Pre Test (10 min) <ul style="list-style-type: none"> • Distribute copies of the Pre Test questionnaire and instruct learners about how to take the test. • Collect the answer sheets. | <ul style="list-style-type: none"> • Pre/Post Test Questionnaire and Answer Sheet (for learners) • Pre/Post Test Questionnaire Answer Key (for the facilitator) |
| Reflection Exercise (15 min) <ul style="list-style-type: none"> • Follow the instructions in Activity 2-1: Reflection Exercise to facilitate this activity. | <ul style="list-style-type: none"> • Activity 2-1: Reflection Exercise |
| Essentials of Successful Counseling (40 min) <ul style="list-style-type: none"> • Lead learners in brainstorming as many essentials of successful counseling that they can name. • Ask learners to open to Handout 2-1: Successful Counseling. <ul style="list-style-type: none"> • Ask learners to take turns reading “Tips for Successful Counseling” (at the bottom half of the page) • Lead them in comparing the list they have created with the list of “Tips” on the handout. • Review the chart on the top of page one • Ask learners to open Handout 2-2: Client Rights <ul style="list-style-type: none"> • Ask learners to take turns reading the handout out loud • Review the handout together, highlighting: Informed Choice and Informed Consent | <ul style="list-style-type: none"> • Flip Chart paper and Markers • Handout 2-1: Successful Counseling • Handout 2-2: Client Rights |
| Gender-Sensitive Approaches: Lily’s Story (15 min) <ul style="list-style-type: none"> • Follow the instructions provided in Activity 2-2: Instructions: Lily’s Story to facilitate this portion of the session. | <ul style="list-style-type: none"> • Activity 2-2: Instructions: Lily’s Story • Activity 2-3: Lily’s Story |

| Methods and Activities | Materials/Resources |
|--|---|
| <p>FP Needs for Diverse Groups (45 min)</p> <ul style="list-style-type: none"> • Ask learners to open “Handout 2-3: FP Needs for Diverse Groups” and “Activity 2-3: Diverse Counseling Group Scenarios” to all learners. • Review the handout, “FP Needs for Diverse Groups.” • Divide learners into 3 groups and assign a scenario to each group. • Tell the three groups that they have 15 minutes to read the scenario they have been assigned and answer the three questions that are listed below the scenarios. • Explain that you will invite each group to share their scenario and their answers with you and the other group at the end of 15 minutes. Tell them to begin. • Circulate and provide assistance, as needed. • Call the groups back together after 15 minutes and ask one group to present its scenario and their answers to the three questions. • Invite the other groups to comment. • Ask the second and third groups to present their scenario and their answers to the three questions. • Invite the other groups to comment. | <ul style="list-style-type: none"> • Handout 2-3: FP Needs for Diverse Groups • Activity 2-4: Diverse Counseling Group Scenarios • Flip Chart and Markers |
| <p>Counseling the youth for increasing LARC uptake (40 min)</p> <ul style="list-style-type: none"> • Ask learners to sit in a semi-circle or full circle so that everyone faces one another. • Ask the learners what is special about counseling youth for LARC methods? • How does providing LARCs to youth make you feel? Is this something you have done before? • Are you comfortable with it? Why or why not? • Show the video Talking about LARCs with Young Clients • Ask the following preliminary questions and allow time for learners to share and discuss their responses with one another: • What did you think of this video? What do you think of the information provided in the video? Was it new for you? Helpful? • How does providing LARCs to youth make you feel? Is this something you have done before? Are you comfortable with it? Why or why not? • Ask what are the benefits of LARCs for the providers? • Why is it important that providers counsel their clients about the different contraceptive methods available, including LARCs? • Allow time for multiple learners to share their responses to these questions. • Refer to the video discussion points for the facilitators and make sure that all key points are discussed. • Share and discuss Job Aid 2-3: LARC Brochures for Adolescents for distributing to clients (optional, if resources available for printing) | <ul style="list-style-type: none"> • Facilitator Tool 2-1: Video on Talking about LARCs with Young Clients • Facilitator Tool 2-2: Key Points Video Discussion Guide • Job Aid 2-3: LARC Brochures for Adolescents |

| Methods and Activities | Materials/Resources |
|---|---------------------|
| <p>Summary (5 min) Summarize the main points that have emerged about successful counseling, gender-sensitive approaches and youth counseling by asking the following questions:</p> <ul style="list-style-type: none"> • Name at least three essentials of effective interpersonal counseling • Identify at least two gender-related issues that influence family planning counseling, uptake and use • What are you planning to do now that you have seen the video on Talking about LARCs with Young Clients and taken part in this discussion? | |

Module 2—Session 2

| Date | Venue | Session number: 2 | Duration: 160 min |
|---|-------|-------------------|-------------------|
| Topic: Counseling: BCS+ Counseling, and Rumors and Misconceptions | | | |
| <p>Session Objectives: By the end of this session, learners will be able to:</p> <ul style="list-style-type: none"> • Describe the four stages of BCS+ counseling • Address rumors and misconceptions about different LARC methods | | | |

| Methods and Activities | Materials/Resources |
|---|---|
| <p>Introduction (5 min)</p> <ul style="list-style-type: none"> • Review session objectives with learners | <ul style="list-style-type: none"> • Flip Chart of Session Objectives |
| <p>Step-by-step review of BCS+ materials (60 min)</p> <p>Note : that some settings may subscribe to a different counseling approach than the BCS+, in which case you may opt to train learners on the locally-approved approach. For the purpose of these materials, the BCS+ approach is the one that is being trained.</p> <ul style="list-style-type: none"> • Ask learners what they know about the BCS+ approach to counseling • Ask learners to open BCS+ 2-1: Algorithm • Review the Algorithm with the learners and emphasize the four stages of BCS+ counseling. • Ask learners to take out BCS+ 2-3 Counseling Cards, keeping them on the ring. • Review the cards with learners, explaining how the Algorithm and the cards support and guide the counselor to help the client identify and choose the contraceptive method that she wishes to use. • Ask learners to take out the BCS+ 2-2: Methods Brochures, or country specific method information sheets. • Review the Brochures with the learners, explaining that they contain the same information (but more) that is on the cards; but once the client has chosen the method she wishes to use (and you have confirmed that the method will be safe and effective for her, which you will do shortly), you will give her a copy of the brochure for that method. • Review Job Aids 2-1: WHO MEC Quick Reference Chart and 2-2: Method Effectiveness Chart with the learners. <p>Note: If BCS counseling method brochure cards are not available, use the flip book and method brochure cards available in the country.</p> | <ul style="list-style-type: none"> • BCS+ 2-1: Algorithm • BCS+ 2-2: Methods Brochures (or country-specific method information sheets) • BCS+ 2-3: Counseling Cards • Job Aid 2-1: WHO MEC Quick Reference Chart • Job Aid 2-2: Method Effectiveness Chart |

| Methods and Activities | Materials/Resources |
|--|---|
| <p>Negative Perceptions about LARCs (10 min)</p> <ul style="list-style-type: none"> • Explain that there are many rumors and misconceptions about LARC methods (and family planning in general), as well as <i>real</i> negative experiences, which together can sometimes prevent clients from seeking or accepting these methods. • Ask learners to name some rumors, misconceptions, and other negative perceptions about LARCs that they have heard. • Ask the learners to categorize which ones are real (e.g. bleeding patterns may change while using implants) and which ones are not (e.g., IUDs can cause cancer). • Note that the side-effects women experience while using contraceptives are real and should be managed properly (more information on how to do so in each module). Explain that we will now focus on the rumors and misconceptions. | <ul style="list-style-type: none"> • Flip chart and Markers |
| <p>Addressing Rumors and Misconceptions (20 min)</p> <ul style="list-style-type: none"> • Ask learners to open Handouts 2-4: Rumors and Misconceptions about IUDs and 2-5: Rumors and Misconceptions about Implants. • Point to one rumor or misconception and ask learners to find it in one of the handouts. • Ask a learner to read out the facts related to addressing the rumor or misconception. • Repeat this process for a few other rumors or misconceptions. • Ask learners for examples of how they could use the information in the handouts to address rumors and misconceptions about IUDs and Implants with clients. | <ul style="list-style-type: none"> • Handout 2-4: Rumors and Misconceptions about IUDs • Handout 2-5: Rumors and Misconceptions about Implants • Handout 2-6: Rumors and Misconceptions about LNG-IUS |
| <p>Demonstration (15 min)</p> <ul style="list-style-type: none"> • Explain that facilitators will now do a role play on BCS+ counseling. • Introduce the Scenario and the Players (The Provider, The Client and The Observer). • Demonstrate how to follow BCS+ guidelines (step 1-12) using algorithm, BCS+ cards and brochures. • Demonstrate how the observer gives feedback about the counseling, using the observer information sheet. • Summarize the role play with the key messages. | <ul style="list-style-type: none"> • BCS+ 2-1: Algorithm • BCS+ 2-2: Brochures • BCS+ 2-3: Counseling Cards • Activity 2-5: Role Play Scenarios (with Role Play Observation Checklist) • Job Aid 2-1: WHO MEC Quick Reference Chart • Job Aid 2-2: Method Effectiveness Chart • Checklist 2-1: Pregnancy Checklist |
| <p>Practice in a classroom setting (45 min)</p> <ul style="list-style-type: none"> • Ask learners to open Activity 2-5: Role Play Scenarios and all counseling materials. • Divide learners into groups of three each. • Ask each group to prepare its counseling station with all the required materials. • Ask the members of each group to take turns practicing counseling a client using the role play scenarios and the counseling materials. • Tell each group to invite the provider to self-assess first then the observer to provide feedback based on the observer information sheet • Tell them they have 30 minutes to practice • Circulate and note where additional assistance/practice may be needed | <ul style="list-style-type: none"> • BCS+ 2-1: Algorithm • BCS+ 2-2: Methods Brochures • BCS+ 2-3: Counseling Cards • Activity 2-5: Role Play Scenarios • Job Aid 2-1: WHO MEC Quick Reference Chart • Job Aid 2-2: Method Effectiveness Chart • Checklist 2-1: Pregnancy Checklist • WHO MEC Wheel |

| Methods and Activities | Materials/Resources |
|---|---------------------|
| <p>Summary (5 min)</p> <ul style="list-style-type: none"> Summarize the main points of the session Tell learners that in the next session, they will practice counseling in a clinical setting | |

Module 2—Session 3

| Date | Venue | Session number: 3 | Duration: 155 min |
|--|-------|-------------------|-------------------|
| Topic: Counseling | | | |
| <p>Session Objectives: By the end of this session, learners will be able to:</p> <ul style="list-style-type: none"> Use the Balanced Counseling-Plus algorithm and counseling cards Demonstrate effective communication and counseling skills | | | |
| <p>Advanced Preparation</p> <ul style="list-style-type: none"> Inform the clinic about your visit. | | | |

| Methods and Activities | Materials/Resources |
|---|--|
| <p>Introduction (5 min)</p> <ul style="list-style-type: none"> Review session objectives with learners | <ul style="list-style-type: none"> Flip Chart of Session Objectives |
| <p>Pre-clinical instructions (10 min)</p> <ul style="list-style-type: none"> NOTE: Practice may occur in the FP unit, Antenatal or postnatal ward depending on the situation. Explain what learners will do, the role of the facilitator and their responsibility in the clinical area. Ensure availability of all counseling materials. Learners who are awaiting their turn to practice in the clinical setting will continue classroom practice in pairs using the BCS+ materials and observer information sheet. | <ul style="list-style-type: none"> BCS+ 2-1: Algorithm BCS+ 2-2: Methods Brochures BCS+ 2-3: Counseling Cards Effectiveness Chart WHO MEC Wheel |
| <p>Clinical Practice in Counseling (90 min)</p> <ul style="list-style-type: none"> Learners - practice counseling clients under supervision using the BCS+ tools. Facilitators - Supervise the counseling that each learner provides, ensuring that she or he uses the BCS+ tools and observers instruction sheet. | <ul style="list-style-type: none"> BCS+ 2-1: Algorithm BCS+ 2-2: Methods Brochures BCS+ 2-3: Counseling Cards Job Aid 2-1: WHO MEC Quick Reference Chart Job Aid 2-2: Method Effectiveness Chart Checklist 2-1: Pregnancy Checklist WHO MEC Wheel |
| <p>Post clinical Debriefing (15 min)</p> <ul style="list-style-type: none"> Identify 1-2 clinical counseling practices for discussion. Focus on what went well, learning moments, and areas for improvement. | <ul style="list-style-type: none"> Flip chart and Markers |
| <p>Summary (20 min)</p> <ul style="list-style-type: none"> Individual Practice Goals – each learner reflects on his or her practice and identifies and documents next steps to master counseling skills. Debriefing by learners | |

| Methods and Activities | Materials/Resources |
|---|---|
| <p>Post Test (10 min)</p> <ul style="list-style-type: none"> • Distribute copies of the Post Test questionnaire and instruct learners about how to take the test. • Collect the test sheets. | <ul style="list-style-type: none"> • Pre/Post Test Questionnaire and Answer Sheet (for learners) • Pre/Post Test Questionnaire Answer Key (for the facilitator) |
| <p>Closing (5 min)</p> <ul style="list-style-type: none"> • Thank the learners | |

Sample Schedule

Facility-based delivery: Three consecutive days

| Day 1 (PM 2 hrs 55 min) | | Day 2 (PM 2 hrs 40 min) | | Day 3 (PM 2 hrs 35 min) | |
|-------------------------|--|-------------------------|--|-------------------------|--|
| Time | Session: Activity | Time | Session: Activity | Time | Session: Activity |
| 5 min | One: Introduction | 5 min | Two: Introduction | 5 min | Introduction |
| 10 min | One: Pre Test | 60 min | Two: Review of BCS+ materials | 10 min | Preparations/Pre-clinical Instructions |
| 15 min | One: Reflection Exercise | 10 min | Two: Rumors and Misconceptions | 90 min | Clinical Practice in Counseling |
| 40 min | One: Essentials of Successful Counseling | 20 min | Two: Addressing Rumors and Misconceptions | 15 min | Post-clinical de-briefing |
| 15 min | One: Lily's Story | 15 min | Two: Counseling Demonstration | 20 min | Summary |
| 45 min | One: Gender Sensitive Approaches | 45 min | Two: Counseling Practice (classroom setting) | 10 min | Post Test |
| 40 min | One: Counseling the youth for increasing LARC uptake | | | | |
| 5 min | One: Summary | 5 min | Two: Summary | 5 min | Closing and thank you |

Module 2: Family Planning Counseling

Pre and Post Test Answer Key

1. Which of the following is the MOST important component of contraceptive counseling?
 - a. **Identifying and addressing the client's contraceptive concerns**
 - b. Obtaining formal consent for the procedure from the client
 - c. Describing adverse side-effects to the client
 - d. Telling the client about the effectiveness of the contraceptive method
2. Which of these are examples of positive, **nonverbal** behaviors?
 - a. Keeping your face down, looking at your papers
 - b. Using short prompting words to make sure the client understands
 - c. **Leaning forward, facing the client**
 - d. Using a warm and caring tone of voice
3. In a good counseling session, the provider:
 - a. Leads and keeps control of the discussion
 - b. **Encourages the client to explain needs, express concerns, and ask questions**
 - c. Only listens to the client's concerns, but does not offer advice or ask questions
 - d. Informs the client only about the benefits of the contraceptive method
4. Which of the following is true of informed choice?
 - a. It is only necessary if men and women are making a decision about sterilization.
 - b. It is provided only on a client's request.
 - c. **Clients need to be able to choose their method from an array of family planning options, with full knowledge of each method's benefits and risks.**
 - d. The provider can make the decision for the client after informing her about the method.
5. If a client is unsure about which method to use, the provider should:
 - a. Tell the client which method the provider thinks is best for her
 - b. **Explore with the client which method would fit best with her daily life, her present family life, and her goals about having more children**
 - c. Give her information about all the methods, and tell her to go home and think about it
 - d. Not mention any method the provider thinks the client might not be able to use correctly
6. Which is the best way to counteract a rumor about a family planning method?
 - a. Tell the client that the rumor is not true and brush off her comments lightly
 - b. Ignore it because it is just a rumor
 - c. Tell the client that people who believe such rumors are stupid
 - d. **Explain that the rumor is not true and why it is not true**

7. When using the BCS+ counseling strategy, detailed information about the selected contraceptive method is given during the:
 - a. Pre-choice stage
 - b. **Post-choice stage**
 - c. Method-choice stage
 - d. Systematic screening stage
8. The pre-choice stage of Basic Counseling Strategy Plus (BCS+) counseling includes:
 - a. **Asking the client about current family size, desire to have more children, and current contraceptive practices, and counseling the client on healthy timing and spacing of pregnancy using the counseling card**
 - b. Briefly reviewing the methods on the cards that are remaining and explaining their effectiveness
 - c. Making sure the client has made a definite decision
 - d. Explaining common side-effects, especially changes in the menstrual bleeding pattern, and being sure that the client fully understands the impact on changes in her daily routine
9. It is important to engage men as clients or as supportive companions because:
 - a. Men use major family planning methods—male condoms and vasectomy
 - b. Men have their own sexual needs and concerns
 - c. Men may have control over decisions about the couple's fertility, whether or not a woman is allowed to visit a health facility, and whether or not she has money to cover transport and fees
 - d. **All of the above**
10. To serve the family planning needs of adolescents:
 - a. Provide detailed information only on the contraceptive method selected
 - b. Advise unmarried adolescents to abstain from sex because health care providers are respected persons of authority in the community
 - c. **Take time to fully address questions, fears, and misinformation about sex, sexually transmitted infections (STIs), the full range of available contraceptive options, and condom negotiation skills**
 - d. Because fewer methods are available to adolescents, it is acceptable to offer them condoms; if they really insist, they might be given an injectable

Module 2: Family Planning Counseling

Activity 2-1: Reflection Exercise

Learning Exercise

Time: 15 minutes

The purpose of this activity is to list the components of good counseling and link these to the learning objectives so that learners can understand the training's relevance. During the activity, pay particular attention to what the learners know and don't know about counseling, and take note of learners who seem better informed so that you can call on them to help during other activities.

- Ask the learners to close their eyes. Ask them to think of a time they received good counseling that helped them make a decision or address a problem—it could have been with a friend, a family member, another health care worker, or a respected member of the community. The counseling could have concerned any situation—for example, choosing a family planning method, deciding to become a health care worker, or deciding on a plan to talk with their partners about whether to have another child. Ask them to think about what happened at the time and how they felt. Ask them to reflect upon what made that person such an effective counselor.
- Ask the learners to open their eyes. Ask them to share the things that made this counseling session effective or satisfying and the things the counselor said or did that made it good. You may also ask the learners about the qualities that made the person such an effective counselor. Write responses on a blank flip chart.
- Discuss.

Source: Adapted from *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Family Planning Counseling Module <https://www.fptraining.org>.

Module 2: Family Planning Counseling

Activity 2-2: Instructions for Discussions on Lily's Story

Instructions

- Ask participants to open the handout: *Lily's Story*, and ask a trainee to read it aloud.
 - Discuss the story, using the following questions.
1. In this story, what are the issues related to social and cultural beliefs and practices regarding girls and boys, women and men?

Possible responses:

- Lily was expected to stay at home and help her mother instead of going to school. It was not considered as important for her to attend as it was for her brothers.
- When the family didn't have enough money to send all the children to school, the boys were given preference over the girls.
- Lily had no choice but to marry at 18 because she was not educated and could not support herself.
- Lily's husband made the decisions about childbearing in the family. Lily did not feel she could challenge her husband's decisions.

2. What changes might have made Lily's life story different?

Possible responses:

- Lily could have been encouraged to finish school, which might have given her a means of economic support.
- Lily's husband was informed about the benefits of healthy timing and spacing of pregnancies, including a healthier wife and children and cost savings.

3. Ask the trainees to think about, and list, traditional beliefs and cultural practices regarding women's and men's roles that are related to family planning. (Alternatively, ask the trainees to form small groups to discuss.)

Possible responses:

- Women give birth and are primarily responsible for the rearing of the child, yet women traditionally have not had control over their fertility.
 - Men are traditionally the decision-makers regarding the number of children a woman will bear and whether or not she can use family planning.
 - Girls often do not have the same opportunities for education as boys. This has resulted in their economic dependence on men and their lack of power in decision-making, including making decisions about childbearing.
 - Women do not have the same opportunities as men in education and employment, partly because of their lack of control over their fertility.
 - Access to family planning can be difficult for women because of their restricted mobility.
 - Women often do not have control over their sexual relations.
 - Male children may be valued more than female children, especially in countries where females cannot inherit land, money, and titles.
 - Economic need sometimes forces women into situations in which their health might be compromised, such as exchanging sex for money.
 - Men may become violent if a woman does not want to have more children or suggests using family planning.
4. As service providers, it is important to help women control their own fertility. Discuss some strategies for empowering women to control some aspects of their lives and change some of the traditional roles and beliefs that make women less powerful or less important than men.

Possible responses:

- Promote the importance of education for girls within the community.
- Support women's organizations that promote opportunities for women.
- Practice gender equality with children at home and reject violence.
- Promote income-generating activities for women. If women have economic independence, they will have more options.
- Promote access to family planning to enable women to control their fertility.
- Practice male engagement and work with couples to help men understand the importance of family planning.

Source: Adapted from *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Family Planning Counseling Module <https://www.fptraining.org>.

Module 2: Family Planning Counseling

Activity 2-3: Lily's Story

Lily's Story

Lily was the oldest of six children. She had one sister and four brothers. Lily attended school regularly and was an enthusiastic and capable student. When she turned 13 years old and was ready to begin high school, her mother had her stay home to help take care of the younger children. After a year, her mother didn't need as much help at home, but Lily could not return to school because money was tight, and the family decided to send only Lily's brothers to school.

When she was 18, she received a marriage proposal, which she accepted because her family could not continue to support her. She became pregnant within the first month of her marriage and had two more babies over the next three years, all daughters.

Lily was always tired, and her children were not healthy. She had heard about family planning and wanted to take a rest before having the next child, but her husband was not interested. He wanted to have at least six children and was disappointed he didn't yet have a male heir; his decision was final. Lily believed she had no choice because she relied on her husband for food and income, and soon she was pregnant again. Lily had a difficult time with her fourth child. Again she brought up the topic of family planning, but her husband refused to consider it.

Lily knew that her husband had many girlfriends. He also drank heavily at times and had a violent temper. Lily became resigned to being tired and unhappy. She had four children to take care of. She felt trapped, but she assumed her situation was no different from that of many women.

Source: Adapted from *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Family Planning Counseling Module <https://www.fptraining.org>.

Module 2: Family Planning Counseling

Activity 2-4: Diverse Counseling Group Scenarios

Instructions

- Divide participants into three groups.
- Ask each group to read one of the scenarios and then work together to answer the following questions:
 1. What are the special points about this client in this scenario?
 2. What things should you especially consider while counseling this client?
 3. How would you make your center gender friendly?

Scenario 1

The client is a 22-year-old unmarried woman. Three days ago she took an herbal drink to induce abortion. She went to the health center when she started bleeding heavily and cramping. The doctor there gave her post abortion care. The nurse gave her some pamphlets about family planning and told her to return to the clinic or to see a community health worker for family planning when she felt better, but not to wait more than a few days because fertility returns quickly after abortion. The client does not want her family to know that she had an abortion.

Scenario 2

The client is a 15-year-old female. She attends secondary school in a neighboring town where she stays with her aunt and uncle. She has a sexual relationship with a young man, who is in his mid-20s. She insists that she wants this relationship. She does not know if he has sex with other women. She does not want to get pregnant.

Scenario 3

The client is a 35-year-old man. His wife is pregnant. He occasionally sleeps with other women, but does not say whether they are sex workers or not. He wants to know about family planning options for him to use with his other partners so that he does not pass an infection on to his wife. You know his wife.

Source: Adapted from *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Family Planning Counseling Module <https://www.fptraining.org>.

Module 2: Family Planning Counseling

Activity 2-5: Role Play Scenarios

Role Play Scenario 1: Postpartum client is interested in and is eligible for an IUD/intrauterine system (LNG-IUS)

| IUD Scenario 1—Client Information Sheet | IUD Scenario 1—Observer Information Sheet |
|--|---|
| <p>Client Description: You are a 23-year-old woman who gave birth to your second child 6 hours ago, and you are breastfeeding your baby. You and your husband are mutually monogamous. You are interested in IUDs.</p> <p>Offer this information <i>only</i> when the provider asks relevant questions:</p> <ul style="list-style-type: none"> You have been married for 2 years. You and your spouse are both HIV positive. You do not want to become pregnant for 2–3 years. You used condoms before, but worry about condom slippage and breakage. You feel healthy and have no other health problems. | <p>Make note of whether the provider performs these case-specific tasks:</p> <ul style="list-style-type: none"> Uses Balanced Counseling Strategy Plus (BCS+) counseling guidelines Assesses the client’s reproductive health goals, fertility intentions, and life plans Tells her about the benefits of healthy timing and spacing of pregnancy Asks her if she has plans to breastfeed her baby. Provides information on contraceptive methods available, including the lactational amenorrhea method (LAM), and ensures that the client understands their effectiveness, using Job Aid 2-3: If 100 Women Use a Method for One Year, How Many Will Become Pregnant?, as well as duration of protection Screens client for medical eligibility* using Job Aid 2-1: Quick Reference Chart for MEC Outlines insertion and follow-up procedures and side-effects Emphasizes the benefits of using condoms even though both partners are HIV positive Offers couples counseling <p>*Methods for which the client is eligible:</p> <ul style="list-style-type: none"> Implants IUD LNG-IUS (levonorgestrel intrauterine system) DMPA (depot medroxyprogesterone acetate or NET-EN (norethisterone enanthate) COCs (combined oral contraceptives) |

Role Play Scenario 2—Postpartum, breastfeeding client is interested in and is eligible for implants

| Implants Scenario—Client Information Sheet | Implants Scenario—Observer Information Sheet |
|---|---|
| <p>Client Description You are a 20-year-old woman who gave birth to your first child 6 months ago and are breastfeeding your baby. You are unmarried and are not in a serious relationship. You read about progestin-only implants in a family planning brochure, and you have come to the family planning site to learn more.</p> <p>Offer this information only when the provider asks relevant questions:</p> <ul style="list-style-type: none"> • You love your infant, but your pregnancy was unintentional. • You use condoms pretty consistently. • You are in school, want to finish, and cannot afford to have another child anytime soon. • You started having your first menstrual period after delivery, 2 days ago. • You are fully breastfeeding, but you intend to start weaning the baby soon because of the demands of school. • You feel healthy and have no health problems. • You have not had sex since the baby was born. | <p>Make note of whether the provider addresses these case-specific issues:</p> <ul style="list-style-type: none"> • Uses the BCS+ strategy for counseling • Assesses the client’s reproductive health goals, fertility intentions, and life plans • Tells her the health benefits of healthy timing and spacing of pregnancy • Ensures that she understand the effectiveness of different contraceptive methods, using Job Aid 2-3: If 100 Women Use a Method for One Year, How Many Will Become Pregnant? • Ensures that the client has made a fully informed decision to use implants and understands the possible side-effects, especially the likelihood of irregular bleeding • Describes implant insertion and follow-up procedures • Screens client for medical eligibility* using Job Aid 2-2: Quick Reference Chart for MEC <p>*Methods for which the client is eligible:</p> <ul style="list-style-type: none"> • Implant • IUD • LNG-IUS • Male or female condoms |

Role Play 3—Post abortion client is interested in and is eligible for the Pill (COCs)

| COCs Scenario 3—Client Information Sheet | COCs Scenario 3—Observer Information Sheet |
|---|---|
| <p>Client Description You are a 45-year-old woman who lives in the community. Your first husband died two years ago, and last year your brother-in-law took you as his second wife. He lives far away and visits only a few times a year. When he visits, you have sex. After his last visit you became pregnant and then miscarried, which was sad and scary for you. The doctor at the clinic told you it could be bad for your health if you became pregnant again.</p> <p>Offer this information only when the provider asks relevant questions:</p> <ul style="list-style-type: none"> • You have 5 children and your youngest child is 5 years old. • Your miscarriage was 6 days ago. • You do not want any more children. • You do not use condoms. • When you recently asked your new husband if he would use condoms, he refused, saying that you do not need protection from sexually transmitted infections (STIs) because you and his first wife are his only partners, and he is too old to have other women. • You think your husband would support you in using family planning if you told him it was needed to protect your health. • You do not want to use natural family planning because your periods are not very regular at present. • You do not want female sterilization or implants. • You are interested in the Pill, the IUD, and injectables. • After learning more about the IUD and injectables, you say you don't think you would be comfortable with irregular bleeding or heavy bleeding and cramps. • You choose the Pill because it is reliable and also because it allows you to have regular periods. | <p>Make note of whether the provider performs these case-specific tasks:</p> <ul style="list-style-type: none"> • Assesses the client's reproductive health goals, fertility intentions, life plans • Tells her the health benefits of healthy timing and spacing of pregnancy • Asks the method-selection questions • Provides information on methods that interest the client and ensures that the client understands her contraceptive options • Ensures that she understands the effectiveness of different methods, using Job Aid 2-3: If 100 Women Use a Method for One Year, How Many Will Become Pregnant? • After the client chooses the Pill, screen client for medical eligibility* using Job Aid 2-1 Quick Reference Chart for MEC • Gives the client information about the Pill using the BCS+ 2-3: Counseling Card: COCs (pp. 25–26) or other job aids • Explains how to use the Pill and gives instructions for what to do when pills are missed, or shows the client information about the Pill in the BCS+ 2-2: Counseling Brochure: COCs (pp. 37–40) or other job aids • Asks the client to repeat instructions to check for her understanding • Gives the client several pill packs, according to the recommended number; arranges for resupply • Tells the client when to return (or when to go to the clinic) <p>*Note to observer: If the provider has not learned to use the COCs screening checklist, tell her/him that the client has no conditions that would prevent safe use of the Pill and ask her/him to use Checklist 2-1: How to Be Reasonably Sure a Client is Not Pregnant. (The client is not pregnant because she would answer YES to question 5.)</p> <p>*Methods for which the client is eligible:</p> <ul style="list-style-type: none"> • Implants • Condoms • Female sterilization • IUD • Injectables • The Pill (COCs) |

Role Play Scenario 4—Male client is interested in and is eligible for male condoms

| Male Condoms Scenario 4—Client Information Sheet | Male Condoms Scenario 4—Observer Information Sheet |
|--|---|
| <p>Client Description You are a 17-year-old adolescent male. You have one girlfriend who became pregnant 6 months ago and miscarried 3 months later. You are interested in using condoms with your girlfriend until she decides to begin using a more reliable contraceptive method. You have tried condoms before, but had problems with them.</p> <p>Offer this information only when the provider asks relevant questions:</p> <ul style="list-style-type: none"> You have no serious health problems. You have not been tested for STIs or HIV, and you do not know if your partner has been tested. You wish to have children some day, but not for several years because you are still in school. Your girlfriend said she is going to start using a modern contraceptive method, but as far as you know she has not yet started using one. She is in agreement about using condoms. You have had experience with condoms on occasion, but felt that they dulled your sensitivity. Sometimes they would stay in your partner’s vagina after you had sex. | <p>Make note of whether the provider performs these case-specific tasks:</p> <ul style="list-style-type: none"> Asks about the client’s reproductive health goals, fertility intentions, partners, health, HIV status? Asks the client the following 2 method questions that apply to male clients: Do you wish to have children in the future? Do you have the cooperation of your partner in family planning? After the client reveals male condoms as his method of choice, discusses benefits: prevention of pregnancy and protection from STIs including HIV, or shows the client information about condoms, using the BCS+ Counseling Brochure: 2-2: Male Condoms (pp. 29–32)? Ensures that he understands male condoms’ effectiveness, using Job Aid 2-3: If 100 Women Use a Method for One Year, How Many Will Become Pregnant? Asks the client about problems using condoms? Counsels the client to remove the condom while the penis is still erect—to avoid the problem of having the condom come off in his partner’s vagina? Provides condoms and instructions on their correct use? Asks the client to demonstrate the correct use of condoms, using a condom and the penis model? Suggests that the client refer his girlfriend to the clinic (or invites him to bring his girlfriend with him on a return visit)? Suggests (or offers) testing for STIs and HIV for him and his girlfriend? <p>Methods for which the client is eligible:</p> <ul style="list-style-type: none"> Male or female condoms |

Role Play Scenario 5—Implant User Returns to Provider with Side-Effect Complaint

| Implant Client Revisit Scenario—Client Information Sheet | Implant Client Revisit Scenario—Observer Information Sheet |
|---|---|
| <p>Client Description You are a 30-year-old woman who has recently begun using Implanon. You have been experiencing irregular menstrual bleeding for the past few months and are considering changing methods because the bleeding is bothersome to you and your partner.</p> <p>Offer this information only when the provider asks relevant questions:</p> <ul style="list-style-type: none"> You have been using the implant for 5 months. The bleeding began a couple of weeks after the implant was inserted. You have never experienced this type of irregular bleeding before. The implant is still in your arm (you can feel it). You are not experiencing any breast tenderness or other signs of pregnancy. You are not postpartum. You do not smoke cigarettes or have any history of DVT (you are medically eligible for COCs if they are offered). You are unhappy and the reassurance the provider offers is not sufficient. You would like some type of medical intervention to stop/slow the bleeding so that you can continue using the implant. | <p>Make note of whether the provider performs these case-specific tasks:</p> <ul style="list-style-type: none"> Shows respect and avoids judging the client? Maintains a relaxed, friendly and attentive body posture and eye contact? Asks open-ended questions correctly and use simple, clear language? Asks client about her feelings and show empathy? Asks what side-effects the client has been experiencing? Asks about the bleeding pattern (frequency and amount)? Asks if the client had similar bleeding or any unexplained vaginal bleeding before using the implant? Confirms the presence of the implant(s) by palpating the woman’s arm? Asks questions to rule out pregnancy? Reassures the client that irregular bleeding is a common, but rarely dangerous side-effect of implant use? And that it will likely resolve in the near future? Assess whether or not the client will be satisfied without any additional medical intervention? Offers a low dose of COC (one daily for 21 days) or ibuprofen (800mg 3xday for 5 days)? Informs the client she can return for follow-up care at any time, especially if the use of COCs or Ibuprofen do not resolve her irregular bleeding? Asks the client if she is satisfied with the course of action they are taking? |

Role Play Scenario 6—Implant Client returns to Provider with Side-Effect Complaints

| Implant Client Revisit Scenario—Client Information Sheet | Implant Client Revisit Scenario—Observer Information Sheet |
|--|---|
| <p>Client Description You are a 39-year-old woman with three adolescent children. You and your husband are relatively sure you do not want any more children, but your mother-in-law does not think that sterilization would be a good idea. Six weeks ago you had progestin-only implants inserted. Since then, you have experienced side-effects and are very concerned. You are returning to the family planning site because you think you would like to try another method.</p> <p>Offer this information only when the provider asks relevant questions:</p> <ul style="list-style-type: none"> • You have been experiencing heavy, irregular bleeding, whereas you had regular cycles with no heavy bleeding before the implant insertion. • The bleeding concerns you, and you will not be comfortable or satisfied if it continues. • Your mother-in-law heard from a friend that using implants could result in infertility. • You feel that your decision to use implants was made too quickly, and you are now having second thoughts. • You last had sex five days ago. • You are otherwise healthy. | <p>Make note of whether the provider performs these case-specific tasks:</p> <ul style="list-style-type: none"> • Shows respect and avoids judging the client? Maintains a relaxed, friendly and attentive body posture and eye contact? • Uses open-ended questions correctly and uses simple, clear language? • Asks client about her feelings and shows empathy? • Asks what side-effects the client has been experiencing? • Asks when the bleeding started? • Asks if the client had similar bleeding or any unexplained vaginal bleeding before using the implant? • Confirms the presence of the implant(s) by palpating the woman’s arm? • Reassesses the client’s reproductive health goals, fertility intentions, and life plans? • Attends to the mother-in-law’s concern about infertility and corrects misunderstandings about implants? • Reassures the client that heavy, irregular bleeding is frequently a side-effect among implant users and tends to go away after a few months? • Assesses whether or not the client will be satisfied without any additional medical intervention? • Reviews other contraceptive options for which the client may be eligible if she decides that implants are unacceptable? • Offers a low dose of COC (one daily for 21 days) or ibuprofen (800mg 3xday for 5 days)? • Informs the client she can return for follow-up care at any time, especially if the use of COCs or ibuprofen does not resolve her irregular bleeding? • Asks the client if she is satisfied with the course of action they are taking? |

Instructions for Learners

Provider Instructions for Role Plays

Pretend that you are meeting the client for the first time. Ask the client for his or her name, gender (male or female), and age. Pretend that there is a health center nearby to which you can refer the client, if needed.

Remember to:

- Assess the client's reproductive health (RH) goals, concerns, and fertility intentions.
- Address the primary and secondary reasons for the client's visit.
- Facilitate the client's decision-making process.
- Integrate information and services related to other RH issues as appropriate.
- Help the client act on her or his decision(s).

Apply your experience along with what you have learned from the training and use job aids and tools as appropriate to address the client's concerns.

Observer Instructions for Role Plays

Prior to the start of the interaction:

- Review the steps for good counseling
- Review the case-specific issues on the observer information sheet for the role play.

While observing the interaction between the provider and client, remember to:

- Take notes on what happens during the interaction.
- Record how well the provider addresses the case-specific issues in the space provided.
- Be prepared to give feedback to the provider regarding how well he or she addressed the client's needs and concerns about the side-effects.

Pay particular attention to whether the provider:

- Helped the client deal with anxiety.
- Facilitated communication with a partner.
- Allowed the client to make an informed decision.
- Ensured that the client met the medical eligibility criteria for the method she chose.
- Helped the client carry out her decision.
- Explained the side-effects specially related to bleeding problems. Ensured her that these side-effects are for short period and not a sign of disease.

Client Instructions for Role Plays

Prior to the start of the interaction:

- Read the client information sheet and make sure you understand your character's situation.
- Pick a name for your character. Tell the provider your name, age, and whether you are male or female.

During the interaction, offer information *only* when the provider asks relevant questions. Use the information given in your client information sheet to respond to the provider's questions. Feel free to ask questions of the provider.

Source: Adapted from *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Family Planning Contraceptive Implants Module <https://www.fptraining.org>.

Checklist 2-1: Pregnancy Checklist

How to Be Reasonably Sure a Client is Not Pregnant

Before initiating a medical regimen, health care providers often need to assess whether a woman is pregnant because some medications may have side effects that are potentially harmful to the fetus. According to the World Health Organization (WHO), there is no known harm to the woman, the course of her pregnancy, or fetus if hormonal contraceptive methods are accidentally used during pregnancy. However, it is recommended that family planning providers assess whether a woman seeking contraceptive services might already be pregnant, because women who are currently pregnant do not require contraception. In addition, methods such as IUDs should never be initiated in pregnant women because doing so might lead to septic miscarriage, a serious complication.

Providers often rely on the presence of menses as an indicator that a woman is not pregnant. However, providers often see women who want to start a contraceptive method when they are between menstrual periods. Since pregnancy cannot be confirmed or ruled out with a pregnancy test until a woman has missed her period, providers often require women to wait until they menstruate and then come back for method initiation. The pregnancy checklist helps providers rule out pregnancy with reasonable certainty when women are between menstrual periods, allowing women to initiate their method of choice without a delay.

FHI 360 (formerly Family Health International) developed the checklist with support from the U.S. Agency for International Development (USAID). The checklist is based on criteria endorsed by the WHO to determine with reasonable certainty that a woman is not pregnant. Evaluation of the checklist in family planning clinics has demonstrated that the tool is very effective in correctly identifying women who are not pregnant. Furthermore, studies in Guatemala, Mali, and Senegal have shown that use of these checklists by family planning providers significantly reduced the proportion of clients being turned away due to menstrual status, and improved women's access to contraceptive services.

Although the original checklist was developed for use by family planning providers, it can be used by both clinical and nonclinical health care providers to determine whether a client is pregnant. For example, pharmacists may use this checklist when selling medications that don't require a prescription, but should be avoided during pregnancy (e.g., certain antibiotics or certain common painkillers).

This checklist is part of a series of provider checklists for reproductive health services. The six questions that comprise the pregnancy checklist are integrated into these other checklists: the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)*, the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives (COCs)*, the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD*, and the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants*. For more information about the provider checklists, please visit www.fhi360.org.

Explanation of the Questions

The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers "yes" to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant.

Women who are in the first seven days of their menstrual cycle or who have had a miscarriage/abortion in the past seven days are protected from unplanned pregnancy because the possibility of ovulation in these situations is extremely low. With the IUD, this period is extended to day 12 of the menstrual cycle because of the additional contraceptive effectiveness of the copper IUD. The probability of ovulation is also very low for women who are in their first four weeks postpartum. Women who satisfy the lactational amenorrhea method criteria (e.g., women who are in their first six months postpartum, are fully or nearly-fully breastfeeding, and are amenorrheic) are protected from

unplanned pregnancy because of the effects of lactational amenorrhea on the reproductive cycle. Likewise, women who consistently and correctly use a reliable contraceptive method are effectively protected from pregnancy, as are those who have abstained from sexual intercourse since their last menstrual period.

Sources:

- ¹ Technical Guidance/Competence Working Group (TG/CWG). *Recommendations for Updating Selected Practices in Contraceptive Use: Volume II*. Washington: U.S. Agency for International Development, 1997.
- ² Stanback J, Qureshi Z, Nutley T, Sekadde-Kigondo C. Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet* 1999;354(August 14):566.
- ³ Stanback, John, Diabate Fatimata, Dieng Thierno, Duarter de Morales, Cummings Stirling, and Traore Mahamadou. Ruling Out Pregnancy Among Family Planning Clients: The Impact of a Checklist in Three Countries. *Studies in Family Planning* 2005;36[4]:311–315.

How to be Reasonably Sure a Client is Not Pregnant

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

| | | |
|-----------|--|------------|
| NO | 1. Did your last menstrual period start within the past 7 days?* | YES |
| NO | 2. Have you abstained from sexual intercourse since your last menstrual period or delivery? | YES |
| NO | 3. Have you been using a reliable contraceptive method consistently and correctly since your last menstrual period or delivery? | YES |
| NO | 4. Have you had a baby in the last 4 weeks? | YES |
| NO | 5. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then? | YES |
| NO | 6. Have you had a miscarriage or abortion in the past 7 days?* | YES |

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

If the client answered **NO** to *all of the questions*, pregnancy cannot be ruled out using the checklist.†
Rule out pregnancy by other means. Give her condoms to use until pregnancy can be ruled out.

If the client answered **YES** to *at least one of the questions* and she is free of signs or symptoms of pregnancy, you can be reasonably sure she is not pregnant.

† If the client is concerned about an unintended pregnancy, offer emergency contraception if every unprotected sex act since last menses occurred within the last 5 days.

Module 2: Family Planning Counseling

Handout 2-1: Successful Counseling

| Counseling Guidelines | Tips for Successful Counseling |
|--|---|
| The conversation is confidential | Clients may become embarrassed when discussing contraceptive methods. Try to set the tone of the visit in a low-key, non-pressured manner. Assure the client (or couple) that the conversation is confidential. |
| Listen attentively | Listen carefully. Listening is as important as giving correct information. Encourage the client to express her views by listening attentively and using nonverbal gestures, such as nodding, to encourage discussion. |
| Be patient | Never put pressure on the client to finish speaking. Let the client's wishes and needs guide the discussion. |
| Use open-ended questions | Encourage the client to explain needs, express concerns, and ask questions that require more than "yes" or "no" answers to increase the amount of information the woman gives you. |
| Use simple language | Give just key information and instructions. Use words the client knows. |
| Be respectful | Show every client respect, and help each client feel at ease. |
| Discuss side-effects openly and honestly | Bring up side-effects, if any, and take the client's concerns seriously. |
| Be alert to related needs if any | Be alert to related needs such as protection from sexually transmitted infections including HIV, and support for condom use. |
| Check the client's understanding | Ask the client to repeat back to you the key points to assure her understanding. |
| Give the client written information | Give the client written information (if available and appropriate) to remind her of instructions. |
| Invite her for return visit | Invite the client to come back at any time, for any reason, if needed. |

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

| Client Type | Usual Counseling Tasks |
|------------------------------------|---|
| New clients with no method in mind | Discuss the client's situation, plans, and what is important to her about a method (including the method's length of effectiveness, role of client administering method [e.g., daily pill vs. implant], types of side-effects that she can tolerate, etc.). Help the client consider methods that might suit her. If needed, help her reach a decision. Support the client's choice, give instructions on use, and discuss how to cope with any side-effects. |
| New clients with a method in mind | Check that the client's understanding is accurate, including her understanding of the side-effects she may experience. Support the client's choice, if the client is medically eligible. Discuss how to use the method and how to cope with any side-effects. |

| Client Type | Usual Counseling Tasks |
|------------------------------------|--|
| Returning clients with problems | Acknowledge the problem and help resolve it—whether the problem is side-effects, trouble using the method, an uncooperative partner, or another problem. Reassure the client that you will do your best to support her. If it is an issue that will likely resolve with time, encourage her to be patient and revisit the facility as needed. If the problem is too difficult to tolerate, provide symptomatic treatment or help her choose a different method that meets her needs. |
| Returning clients with no problems | Provide more supplies or routine follow-up. Ask a friendly question about how the client is doing with the method. |

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

Counseling has succeeded when clients

- Feel they got the help they wanted
- Know what to do, and feel confident that they can do it
- Feel respected and appreciated
- Come back when they need to
- And, most important, when clients use their methods effectively and with satisfaction.

Source: World Health Organization (WHO), United States Agency for International Development (USAID), Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs (JHSPH/CCP). Chapter 24: Family Planning Provision: Importance of Providing Family Planning Methods. In: *Family Planning: A Global Handbook for Providers*. Geneva, Switzerland; Washington, DC; and Baltimore, Maryland, 2007, pp. 307–317.

Module 2: Family Planning Counseling

Handout 2-2: Client Rights

All individuals of reproductive age have a right to information about family planning for themselves and their families, regardless of their ethnic origin, socioeconomic status, religion, marital status, or political beliefs.

There are various reasons individuals and couples decide to start, continue, or stop practicing family planning or contraception. Some may wish to delay the birth of their first child. Others may want to space the births of their children, and some may want to ensure that only a desired number of children are born. And some people may wish to use family planning services, not so much for protection from unplanned or unwanted pregnancy, but for other reasons, including achieving pregnancy or protecting their reproductive and sexual health.

- In helping couples achieve their ideal family size, the health care provider must be sensitive to the client's needs and must treat her/him with dignity and respect. Over the years, the following aspects of quality care have come to be known as client rights:
- All persons have a right to decide freely whether or not to practice family planning.
- Family planning programs should assist people in the practice of informed, free choice by providing unbiased information, education, and counseling, as well as an adequate range of contraceptive methods.
- Every person has the right to choose his/her contraceptive method.
- A client should be able to obtain the method s/he has decided to use, provided the method is available and there are no reasons why s/he should not use it.
- Because a client's concept of acceptability and appropriateness changes with circumstances, s/he has the right to decide when to start, stop, or switch methods.
- Clients have the right to discuss their concerns in an environment in which they feel confident. This includes being sure that conversations with counselors or service providers will not be listened to by other people.
- When a client is undergoing a physical examination, it should be carried out in an environment in which the right to bodily privacy is respected. The client's right to privacy also includes the following aspects related to quality of services:
 - When receiving counseling or undergoing a physical examination, the client should be informed about the role of each person in the room (e.g., service providers, individuals undergoing training, supervisors, instructors, researchers, etc.).
 - A client should know in advance the type of physical examination that is going to be done and has the right to refuse any particular type of examination if s/he does not feel comfortable with it.
- Clients should feel comfortable when receiving family planning services. To a certain extent this is related to the adequacy of service delivery facilities (e.g., proper ventilation, lighting, seating, and toilet facilities). In addition, the time clients spend receiving requested services should be reasonable.
- A client's access to other services should not depend on the continuation or refusal of contraceptive services.
- Finally, clients have the right to express their views about the services received. Opinions on the quality of services, either thanks or complaint, together with suggestions for changes in service provision, should be viewed positively in a program's ongoing effort to monitor, evaluate, and improve its services.

Source: Jhpiego. Providing Contraceptive Implants: Reference Manual. Baltimore, MD: Jhpiego, 2014.

Module 2: Family Planning Counseling

Handout 2-3: Diverse Group Counseling

Adolescents

Adolescents are young a very heterogeneous group—married, unmarried, parents, non-parents, in-school or out of school. Young people deserve nonjudgmental and respectful care no matter their age, marital status, school-status, parenting status, or otherwise. Criticism or unwelcoming attitudes will keep young people away from the care they need. Research has shown that family planning counseling and services do not encourage young people to have sex. Instead, they help young people make better decisions and protect their health.

To serve the needs of adolescents, you can:

- Show young people that you enjoy working with them.
- Use terms that suit young people. Avoid such terms as “family planning,” which may not make sense to unmarried adolescents. Use terms like contraception or “future planning” as an alternate.
- Try to make sure that a young woman’s choices are her own and are not pressured by her partner or her family. In particular, if she is being pressured to have sex, help a young woman think about what she can say and do to resist and reduce that pressure.
- Practice skills to negotiate condom use.
- Speak without expressing judgment (for example, say “You can” rather than “You should”). Do not criticize even if you do not approve of what the young person is saying or doing. Help young clients make decisions that are in their best interest.
- Reassure her/him that anything she/he shares with you is confidential, and you will not share her/his information with anyone.
- Take time to fully address questions, fears, and misinformation about sex, sexually transmitted infections (STIs), and contraceptives. Many young people want reassurance that the changes in their bodies and their feelings are normal.
- Reassure her/him that the contraceptive methods used are reversible and will not affect their future fertility

Men

For family planning counselors, men are important for two reasons. The first reason is the influence that men have on women. Some men care about their partner’s reproductive health and support them. Others stand in their way or make decisions for them. Thus, men’s attitudes can determine whether women can practice healthy behaviors. In some situations, such as needing to avoid HIV infection or getting help quickly in a medical emergency, a man’s actions can determine whether a woman lives or dies.

Men are also important as clients. Men use major family planning methods—male condoms and vasectomy. Men also have their own sexual and reproductive health needs and concerns—such as concerns about sexually transmitted infections (STIs)—that deserve the attention of health care providers.

Meeting the needs of male clients

- Coach men and women on how to talk with their partners about family planning and STIs.
- Encourage men to make decisions about sexual and reproductive health jointly with their partners.

- Encourage women to bring their partners to see clinical providers for joint counseling, decision-making, and care.
- Suggest to female clients that they tell their partners about health services for men. Give female clients informational materials to take home, if available.

Correct men’s misperceptions and give them information to inform their decisions and opinions. Topics important to men include:

- Family planning methods for men and for women, including safety and effectiveness
- STIs including HIV/AIDS—how they are and are not transmitted and where to go for testing and treatment
- The benefits of waiting until the youngest child is two years old before a woman becomes pregnant again
- Male and female sexual and reproductive anatomy and function
- Where to learn about safe pregnancy and childbirth

Young Women living with HIV

Women living with HIV can safely use many contraceptive methods while on ART, including COCs, injectables, and implants. Some additional considerations include:

- Contraceptive Implants: some medications used for HIV/AIDS, most likely protease inhibitors, the non-nucleoside reverse transcriptase inhibitors efavirenz and nevirapine, and cobicistat-boosted elvitegravir, may also affect the effectiveness of contraceptive implants. Therefore a barrier method, for dual protection, should be recommended for use by those who use these medications.
- Copper IUDs : If a woman is already using the IUD at the time of ART initiation, the IUD is generally safe for her to use. However, for women looking to initiate a contraceptive method while already on ART, it is not recommended that they use the IUD.
- LNG-IUS : If a woman is already using the LNG-IUS at the time of ART initiation, the LNG-IUS is generally safe for her to use. However, for women looking to initiate a contraceptive method while already on ART, it is not recommended that they use the LNG-IUS.

See Job Aid 2-1: WHO MEC Quick Reference Chart for more information on method eligibility among women with HIV.

Postpartum and post abortion women

Young women can safely use many contraceptive methods after abortion or childbirth, including among breastfeeding women. Important considerations for **postpartum** women include:

- During antenatal care, a woman can be counseled on immediate postpartum family planning (PPFP) methods available at her expected place of delivery. Uptake of PPFP will likely be higher when counseling is initiated antenatally.
- For clients who have not been counseled on PPFP during antenatal care or who didn’t select a method at that time, they can be counseling during early labor (but NOT during active labor).
- As stipulated by the WHO’s medical eligibility criteria, breastfeeding women in the immediate postpartum period can safely use contraceptive implants, IUDs, and a number of short-acting methods including POPs and condoms.

See Job Aid 2-1: WHO MEC Quick Reference Chart for more information on method eligibility among postpartum and post abortion women.

Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Family Planning Counseling Needs of Diverse Groups, 2012, <https://www.fptraining.org>.

Module 2: Family Planning Counseling

Handout 2-4: Rumors and Misconceptions about IUDs

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

In general, rumors arise when:

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

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

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

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

Methods for Counteracting Rumors and Misinformation

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

Rumors or Misinformation and Facts and Realities

| Rumor or Misinformation | Facts and Realities: Information to Combat Rumors |
|---|---|
| The IUD strings can trap the penis during intercourse. | The IUD strings are soft and flexible, cling to the walls of the vagina, and are rarely felt during intercourse. If the string is felt, it can be cut very short (leaving just enough string to be able to grasp it with a forceps). The IUD cannot trap the penis because the IUD is located within the uterine cavity and the penis is positioned in the vagina during intercourse. The string is too short to wrap around the penis and cannot injure it. (For greater reassurance, use a pelvic model to show how an IUD is inserted or demonstrate with your fingers how it would be impossible for the IUD to trap the penis.) |
| A woman who has an IUD cannot do heavy work. | Using an IUD should not stop a woman from carrying out her regular activities in any way. There is no correlation between the performance of chores or tasks and the use of an IUD. |
| The IUD might travel inside a woman's body to her heart or her brain. | There is no passage from the uterus to the other organs of the body. The IUD is placed inside the uterus and, unless it is accidentally expelled, stays there until it is removed by a trained health care provider. If the IUD is accidentally expelled, it comes out of the vagina, which is the only passage to the uterus. The provider can teach the client how to feel for the string, if the client is comfortable doing so. |
| A woman can't get pregnant after using an IUD. | A woman's fertility returns to normal very soon after the IUD is removed. Studies have shown that most women who discontinue the IUD become pregnant as rapidly as those who have never used contraception. |
| If a woman with an IUD becomes pregnant, the IUD gets embedded in the baby's forehead. | The baby is very well protected by the sac filled with amniotic fluid inside the mother's womb. If a woman gets pregnant with an IUD in place, the health care provider will remove the IUD immediately due to the risk of infection. If for some reason the IUD is left in place during a pregnancy, it is usually expelled with the placenta or with the baby at birth. |
| The IUD deteriorates in the uterus after prolonged use. | Once in place, if there are no problems, the IUD can remain in place up to 12 years. The IUD is made up of materials that cannot deteriorate. The client can keep it longer, if she desires, and there is no risk of deterioration. |
| Note: The information and misconceptions below apply more directly to health care workers. | |
| An IUD can't be inserted until 6 weeks postpartum. | The IUD can be inserted by a trained provider immediately after delivery (within 10 minutes of delivery of the placenta), or during a cesarean section, or up to 48 hours following delivery. Postpartum insertion of an IUD has been shown to be safe, effective, and convenient for women like the regular or interval IUD. Postpartum insertion appears to have a lower chance of perforation as instrument used is blunt and uterine wall is thick just after the pregnancy. After the 48-hour postpartum period, a Copper T380A may be safely inserted at four or more weeks postpartum. It has been shown that IUDs do not affect breast milk and can be safely used by breastfeeding women postpartum. |

| Rumor or Misinformation | Facts and Realities: Information to Combat Rumors |
|---|--|
| The IUD causes ectopic pregnancy. | There is no evidence that the use of an IUD increases the risk of an ectopic pregnancy. Studies have shown the risk of ectopic pregnancy to be the same for all women (with or without an IUD). However, if client becomes pregnant with IUD, ectopic pregnancy must be excluded. |
| An IUD that is discolored in the package is dangerous and can't be used. | The copper on IUDs sometimes changes color in the package as it oxidizes (reacts to air). The IUD can still be used and is safe as long as the package is not torn or broken open and as long as it is not past the expiration date printed on the packaging. |
| Women who have never given birth cannot use an IUD. | Women using the IUD who have never been pregnant may have an increased rate of expulsion and may experience more pain during insertion, however the IUD is still safe for them to use. WHO carefully reviewed all of the literature before listing nulliparity as Category 2 (generally use; some follow-up may be needed). |
| Women infected with HIV cannot use an IUD. | IUD use appears to be safe for HIV-infected women who are well and for women with AIDS who remain well on antiretroviral treatment. As per WHO Medical Eligibility Guidelines 2015, if the woman having Cu-IUD/LNG-IUS develop HIV, they can continue using it during treatment (Category 3A). |
| IUDs increase the risk of pelvic inflammatory disease (PID) and must be removed when it occurs. | Many studies have confirmed that the risk of infection and infertility among IUD users is very low (Hatcher 2004). However, studies also indicate that the insertion process, and not the IUD or its strings, poses the temporary risk of infection. Good infection prevention procedures should be practiced. Antibiotic prophylaxis should not be used routinely prior to insertion. The risk of infection following IUD insertion returns to a very low or normal level after 20 days (Farley et al. 1992). As per WHO Medical Eligibility Guide lines, if condition develops while using method, can continue using it during treatment (Category 4A). |

Source: Adapted from Solter C. *Intrauterine Devices (IUDs)*. Second Edition. Watertown, Massachusetts: Pathfinder International, 2008.

Module 2: Family Planning Counseling

Handout 2-5: Rumors and Misconceptions about Implants

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

In general, rumors arise when:

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

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

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

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

Methods for Counteracting Rumors and Misinformation

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

Rumors or Misinformation and Facts and Realities

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

Source: *Training Resource Package for Family Planning* (USAID, WHO, UNFPA). Contraceptive Implants Module <https://www.fptraining.org>.

Module 2: Family Planning Counseling

Handout 2-6: Rumors and Misconceptions about LNG-IUS

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

In general, rumors arise when:

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

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

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

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

Methods for Counteracting Rumors and Misinformation

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

Rumors or Misinformation and Facts and Realities

| Rumor or Misinformation | Facts and Realities: Information to Combat Rumors |
|---|---|
| The LNG-IUS might travel through the woman's body. | Show the client a picture or a model of a uterus, and explain that the LNG-IUS usually stays in the uterus until it is removed. If it comes out by itself, it comes out through the vagina. It is very rare that LNG-IUS perforates the wall of the uterus and remains in the abdomen |
| The LNG-IUS prevents pregnancy by causing an abortion. | Explain that the mechanism of action of the LNG-IUS is the inhibition of sperm motility and transfer through the cervix, thereby preventing the sperm from fertilizing the egg and inhibiting pregnancy. |
| Absence of bleeding with the LNG-IUS means that her ovaries stopped functioning and the woman is no longer fertile. | Absence of bleeding that occurs in some women with the LNG-IUS is caused by the local action of LNG at the level of the uterus. The functioning of the ovaries is not affected. When the system is removed, menstrual bleeding will reappear and fertility is restored. |
| Absence of bleeding is unhealthy, because it means that the dirty blood remains in the body. | Normally, menstrual bleeding consists of the inner lining of the uterus, the endometrium, and its vessels, that bleed away once a month as the hormones from the ovary regulate the cycle. Explain to the woman that with the LNG-IUS bleeding is scant or remains totally absent, because the local levonorgestrel in the uterus keeps the inner lining of the uterus in the resting phase, very thin. There simply is nothing to bleed away, and no dirty blood remains in the uterus. Instead, this may be beneficial as anemia is prevented and the iron stores are restored. |
| The LNG-IUS causes discomfort in coitus | The LNG-IUS is inside the uterus and it does not interfere with coitus. It is not possible for the partner to feel the LNG-IUS itself. However, sometimes the partner may feel the strings during intercourse. This is harmless, but if it causes discomfort for the partner, the strings can be cut shorter. |
| Note: The information and misconceptions below apply more directly to health workers. | |
| An LNG-IUS can't be inserted until 6 weeks postpartum. | The LNG-IUS can be inserted by a trained provider immediately after delivery (within 10 minutes of delivery of the placenta), or during a cesarean section, or up to 48 hours following delivery. Postpartum insertion of an LNG-IUS has been shown to be safe, effective, and convenient for women like the regular or interval IUS. Postpartum insertion appears to have a lower chance of perforation as the instrument used is blunt and uterine wall is thick just after the pregnancy. After the 48-hour postpartum period, a LNG-IUS may be safely inserted at four or more weeks postpartum. It has been shown that the LNG-IUS does not affect breast milk and can be safely used by breastfeeding women postpartum. |
| The LNG-IUS causes ectopic pregnancy. | There is no evidence that the use of an LNG-IUS increases the risk of an ectopic pregnancy. Clinical studies have shown that the LNG-IUS is extremely protective against ectopic pregnancies, ranking with the most effective contraceptive methods in its protection. However, if client becomes pregnant with LNG-IUS, ectopic pregnancy must be excluded. |
| Women who have never given birth and adolescents cannot use an LNG-IUS. | WHO carefully reviewed all of the literature before listing nulliparity and adolescent as Category 2 (generally use; some follow-up may be needed). However, women who have never been pregnant have an increased rate of expulsion. |
| Women infected with HIV cannot use an LNG-IUS. | IUS use appears to be safe for HIV-infected women who are well and for women with AIDS who remain well on antiretroviral treatment (ART). |
| LNG-IUS increases the risk of pelvic inflammatory disease (PID) and must be removed when it occurs. | Good infection prevention procedures should be practiced. Antibiotic prophylaxis should not be used routinely prior to insertion. If condition develops while using LNG-IUS, a woman can continue using it during treatment (WHO MEC). |

Source: Solter C. *Intrauterine Devices (IUDs)*. Second Edition. Watertown, MA: Pathfinder International, 2008. LNG-IUS Training Manual for Family Planning (ICA Foundation), WHO MEC Wheel 2015.

Job Aid 2-I: WHO MEC Quick Reference Chart

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

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

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

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

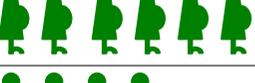
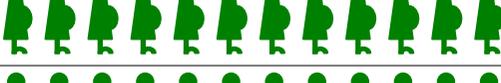
- Category 1** There are no restrictions for use.
- Category 2** Generally use; some follow-up may be needed.
- Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.
- Category 4** The method should not be used.

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

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

- I/C** Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where I/C is not marked, the category is the same for initiation and continuation.
- NA** Not Applicable: Women who are pregnant do not require contraception. If these methods are accidentally initiated, no harm will result.
- i** The condition, characteristic and/or timing is not applicable for determining eligibility for the method.
- ii** Women who use methods other than IUDs can use them regardless of HIV/AIDS-related illness or use of ART.
- *** Other risk factors for VTE include: previous VTE, thrombophilia, immobility, transfusion at delivery, BMI > 30 kg/m², postpartum hemorrhage, immediately post-caesarean delivery, pre-eclampsia, and smoking.
- **** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

Job Aid 2-2: Method Effectiveness Chart

| Method | If method is used consistently and correctly (<i>perfect use</i>): | If method is occasionally used incorrectly or not used (<i>typical use</i>): |
|-------------------------------|---|--|
| Implants | less than  | less than  |
| IUD | less than  | less than  |
| Male and Female Sterilization | less than  | less than  |
| Injectables | less than  |  |
| Pills | less than  |  |
| Male condoms |  |  |
| Standard Days Method |  |  |
| Female condoms |  |  |
| Diaphragm |  |  |
| Withdrawal |  |  |
| Spermicides |  |  |

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

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

Job Aid 2-3
LARC Brochures for Adolescents

Today there are many
contraceptive methods
to choose from.

Long-acting reversible contraceptives
(LARCs), like the IUD or implant, are the
most effective methods. They can help
you live your dreams and wait until you
are ready to start a family.



Not ready to get
pregnant?

**Talk with a
healthcare
provider today**
about choosing the
right contraceptive
method for you.

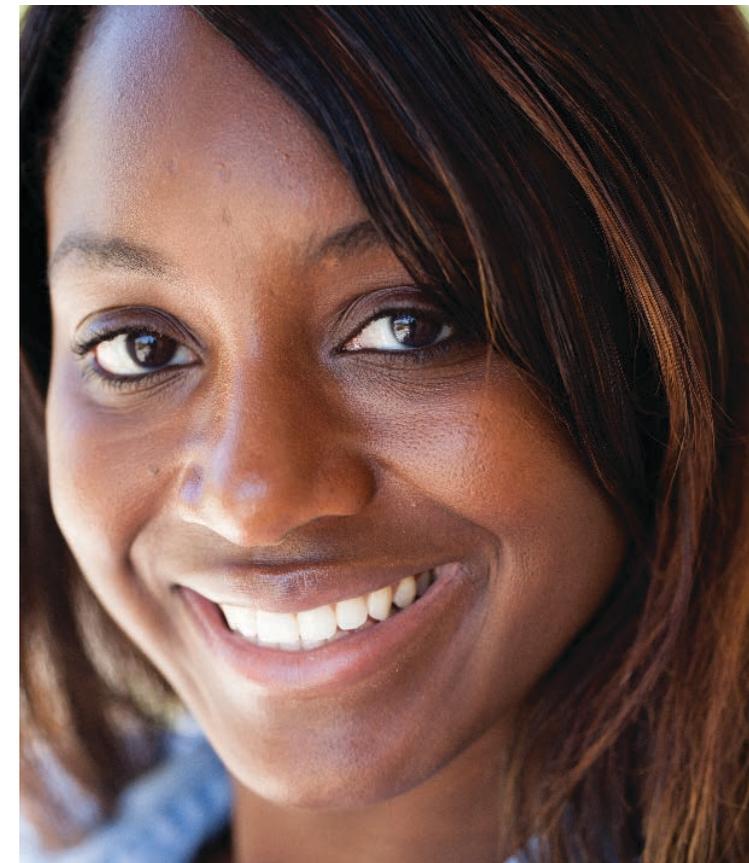
Think about an
IUD or Implant



IUD
(INTRAUTERINE
DEVICE)



IMPLANT



“My best friend
has an implant
and is happy
and worry-free.
That’s why I
want to find
out more.”

Irene, 19 years old



For more information, go to
www.healthcommcapacity.org/LARCS



USAID
FROM THE AMERICAN PEOPLE

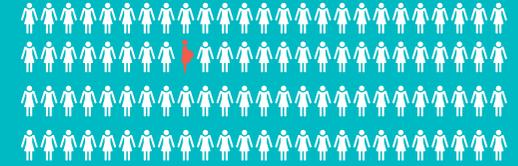


**HEALTH
COMMUNICATION
CAPACITY
COLLABORATIVE**



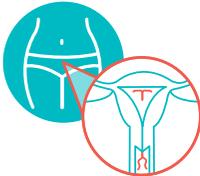
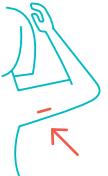
IUDs and implants are **the most effective** contraceptive methods.

If using an IUD or implant, **99 women in 100** will be protected from unintended pregnancy.



6 Reasons to Think About an IUD or Implant

- 1 **Safe for young women**, even those who have not had a child or are not married
- 2 **Effective** at preventing pregnancy
- 3 **Private** — not visible to others
- 4 **Convenient** — no daily pills to take or injections to schedule
- 5 **Removable** when you're ready to get pregnant
- 6 **Long-acting** protection against pregnancy

| | What is it? | What does it do? | Where does it go? | Can it be removed? | Are there side effects? |
|--|---|--|--|--|---|
|  <p>IUD (intrauterine device) Such as "Copper-T"</p> | A small, T-shaped piece of soft plastic . | Provides protection against pregnancy,* and stays where placed for up to 12 years , depending on IUD type |  <p>Carefully inserted into the uterus by a trained health provider</p> | Yes. When the IUD or implant is removed by a trained health provider, a woman can become pregnant right away. | Side effects are common, but some women do not experience them. They are not a sign of illness and are often manageable. Talk with a healthcare provider to learn more. |
|  <p>Implant Such as "NXT"</p> | One or two small, flexible rods , about the size of a matchstick | Provides protection against pregnancy,* and stays where placed for 3 to 5 years , depending on implant type |  <p>Carefully inserted into the inner side of either upper arm by a trained health provider</p> | | |

*IUDs and implants protect against pregnancy, but they do not protect against STIs or HIV. A condom should be used with an IUD or implant to prevent these infections.



"When we first got together, I wanted something easy to use, so I got an IUD. When we were ready, I had the IUD removed, and now we have our beautiful baby." *Fatima, 23 years old*

Module 2: Family Planning Counseling

Facilitator Tool 2-2: Key Points Video Discussion Guide

Facilitators should watch the video two to three times and review the guide carefully before they begin.

Ask participants to sit in a semi-circle or full circle so everyone faces one another. If you have a large group, you may want to divide into smaller groups to allow more participants to discuss with their colleagues. Show the video: Talking about LARCs with Young Clients

Ask the following preliminary questions and allow time for participants to share and discuss their responses with one another:

- What did you think of this video?
- What do you think of the information provided in the video?
- Was it new for you? Helpful?

Discuss: When the video begins, Maria, the health provider and narrator, asks you to remember when you were younger and had dreams. When you were young, say 15 or 18 years old, what did you think about? What did you plan for your future?

- Allow time for discussion.
- Probe if needed about whether or not they were starting to think about relationships, even if they were still not ready for marriage or pregnancy, and even if they had young friends that had unintended pregnancies.

Discuss: In the video, Maria says that an unintended pregnancy can cut a young woman's dreams short. What does she mean by this?

- Allow time for multiple participants to share their responses to this question. Make sure that you discuss each of the following:
- It can mean she has to drop out of school meaning less education, less job potential, less likely to earn or control her own money, all of which can keep her trapped in poverty.
- It can mean she is less able to make her own life choices.
- It can mean she is stigmatized by her community and family, especially if she is unmarried.
- It can mean she has to marry the father of her child even if that is not the person that she wants to marry, or even if she is not ready to get married.
- It can put her health and the health of her baby at risk if she is too young (under age 18) to safely carry a pregnancy, give birth or have a child.

Discuss: In the video, Maria says LARCs have benefits for the young client. What are some of the benefits of LARCs for the young client? Allow time for multiple participants to share their responses to this question. Make sure you discuss the following:

- LARCs are convenient and low maintenance. Users do not have to remember to take a pill every day or go for an injection every month, which can often be extra hard for young people. Once the IUD or implant is inserted, it stays there until the user is ready to have it taken out. This is important for young women because they may have less control over their schedule than older women, so remembering to take a pill or visit a clinic might be more difficult for them. Scheduling a follow-up visit with your client three to six weeks after IUD insertion or after her first monthly bleeding is, however, recommended. As with any other method, encourage your client to return to you or another trained provider if they have any questions or concerns about their LARC.
- They last a long time. If a girl or young woman is not planning a pregnancy for another one, two, three, or even 10 years, she can use a LARC and not have to worry about it. This is important for young women because during adolescence, whether we like thinking about it or not, young men and women begin to experiment with relationships and independence—and this may result in unplanned or unwanted sex. LARCs help provide a consistent, reliable safety net and protection against unintended pregnancy so they can continue to lead their lives as they and their families wish.
- They are reversible. Not only do the IUD and implant last a long time, but they are each reversible. This means that once an IUD or implant is removed, a woman can become pregnant. In some communities, there are myths that LARCs can cause infertility, but this is not true and this is important information to review with your clients.

Discuss: Maria also says that LARCs have benefits for the provider. What are some of the benefits of LARCs for the provider? Allow time for multiple participants to share their responses to this question. Make sure you discuss the following:

- Reduces client load. Because LARCs last longer, this reduces the number of required repeat visits compared with clients using shorter acting methods (e.g., pill, injection).
- More time with each client. Fewer repeat visits means fewer clients waiting in line, which means less stress for you, more time to see other clients, and more time to spend with each client.

Discuss: Why is it important that providers counsel their clients about the different contraceptive methods available, including LARCs? Allow time for multiple participants to share their responses to this question. Make sure you discuss the following:

- It is important to always give clients informed choice – including young clients. This means explaining all of the contraceptive options available, the benefits and drawbacks of those options, and then giving the client the choice to make a decision about which contraceptive method is right for her.
- This is part of being client-centered and ensuring that you are not making the decision for the client.
- Your job as the provider is to give accurate information in a way the client can understand, and to guide the client through making her own decision. It is not your job to persuade her to take one method over another, or any method at all.

Discuss: In the video, Maria provides four tips for counseling young people about LARCs. What are those four tips?

- Gently asking the client questions to understand why she's come to you and the goal of her visit. She might be shy, so do your best to make her feel comfortable speaking with you.
- Listening to the client and responding to what she wants and desires, rather than what you want and desire for her.
- Providing a safe, confidential and judgment-free environment for the counseling to take place.

- Being “judgment-free” means providing your client with factual information and guidance, regardless of her age, relationship status or parity. Remember, you are her trusted source of information; honoring all of her questions with a clear and polite response is crucial. Though it is tempting to advise young clients on their romantic or sexual behavior when discussing contraception, it is best to respect your client-provider relationship and focus on client care.
- Guiding the client through a decision process so she can make a choice that is right for her and her lifestyle. For instance, if she says she wants to have a method that she does not need to remember to take every day or that is discreet, a LARC might be a good option. If she says she does not want anything inserted into her body, then the LARC method would not be a good option.

Source: Adapted from Health Communication Capacity Collaborative. (2016). Talking about LARCs with Young Clients: Video Discussion Guide.