



Long-Acting Reversible Contraceptives Learning Package

Module 2: Family Planning Counseling

Learner 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

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Module Overview for Learner

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Module 2: Family Planning Counseling

Module Overview for Learner

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

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 Questionnaire

Instructions: Write the letter of the single **BEST** answer to each question in the blank next to the corresponding number on the attached answer sheet.

Total time: 10 minutes

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

Pre and Post Test Answer Sheet

Q.1 _____

Q.2 _____

Q.3 _____

Q.4 _____

Q.5 _____

Q.6 _____

Q.7 _____

Q.8 _____

Q.9 _____

Q.10 _____

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.

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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.

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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>.

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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

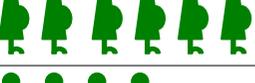
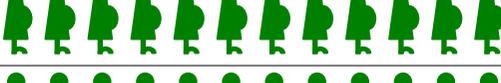
- Category 1** There are no restrictions for use.
- Category 2** Generally use; some follow-up may be needed.
- Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.
- Category 4** The method should not be used.

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.

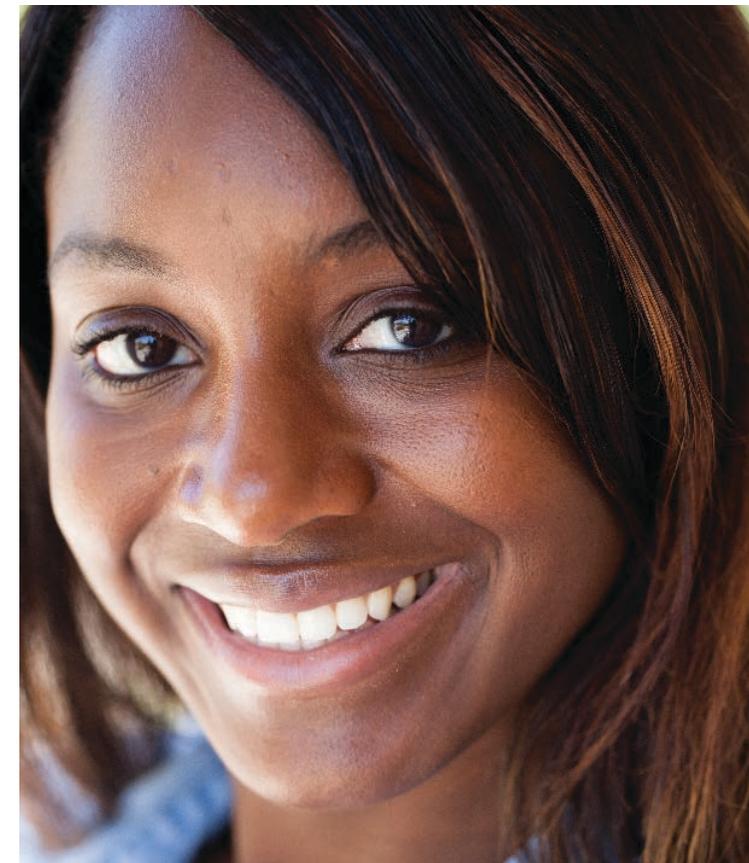
Think about an
IUD or Implant



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



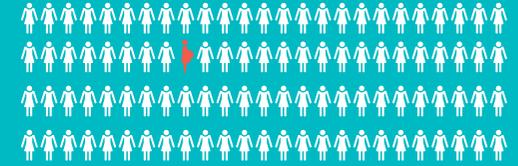
For more information, go to
www.healthcommcapacity.org/LARCS





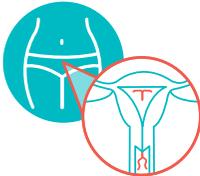
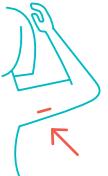
IUDs and implants are **the most effective** contraceptive methods.

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*