Focused Postpartum/Postnatal Care: Essentials of Maternal and Newborn Care Inclusive of Family Planning

Session 1

Jhpiego in partnership with Save the Children, Constella Futures, The Academy for Educational Development, The American College of Nurse-Midwives and IMA World Health
Rationale for Postpartum Care Inclusive of Family Planning

- High-risk time frame for maternal complication
- High-risk time for neonates
- Families are at risk for poor health outcome when another pregnancy occurs within 2 years after delivery
- Immediate and exclusive breastfeeding promotes child survival and LAM
- LAM is gateway method to other contraception that is compatible with breastfeeding
Objectives of Focused Postpartum Care

- Orient participants to postpartum care and review essential maternal and newborn care to provide quality care
- Orient participants to postpartum family planning
- Review opportunities to link family planning opportunities to other parts of the maternal-infant care continuum
- Understand link between essential postpartum/postnatal care and saving lives
Training Goal and Objectives

**Goal:**

- By the end of the training, participants will be able to provide high-quality postpartum care, including family planning

**Objectives:**

- Provide essentials of maternal and newborn care, achieving 90% of the tasks/steps on the checklist with prompting
- Understand that healthy timing and spacing of pregnancy saves lives
- Explain LAM and transition to postpartum family planning to clients
- Demonstrates competency in providing family planning to clients during the first postpartum year
- Develops an action plan
Why Postpartum/Postnatal Care Now?

- **Improve maternal health:**
  - 60% of maternal deaths occur during the first postpartum week

- **Improve neonatal and infant health:**
  - 75% of neonatal deaths occur during the first postpartum week

- **Prevention of unintended pregnancies:**
  - We cited four countries that show 60–70% of postpartum women report an unmet need for family planning during the 1st year postpartum
Cause of Maternal Death in Africa

Causes of Neonatal Mortality in SSA

- **Major causes of neonatal mortality:**
  - Infections: 39%
  - Preterm: 29%
  - Asphyxia: 24%

*Source: Opportunities for African Newborns, November 2006.*

**FIGURE 1.5 1.16 million newborn deaths in Africa – Why?**

Almost all newborn deaths are due to preventable conditions. Infections are the biggest cause of death and most feasible to prevent/treat.

*Source: Based on vital registration for one country and updated modeling for 45 African countries using 2004 birth cohort, deaths and other predictor variables. For more details see data notes on page 226 and for more details of estimation model see references 16, 17.*
4 Million Newborn Deaths - When?

- Up to 50% of neonatal deaths are in the first 24 hours.
- 75% of neonatal deaths are in the first week – 3 million deaths.

Postpartum Care

Session 2

Jhpiego in partnership with Save the Children, Constella Futures, The Academy for Educational Development, The American College of Nurse-Midwives and IMA World Health
Session Objectives

By the end of the session, participants will be able to:

- Describe essentials of maternal and newborn care during the postpartum period
- Describe symptoms and management of postnatal complications
Start Postpartum Family Planning during ANC

- Discuss benefits of immediate and exclusive breastfeeding…LAM
- Discuss possibilities for long-acting methods:
  - Postpartum IUD insertion, or
  - Limiting future pregnancies… postpartum tubal ligation of vasectomy
Overview of Postpartum/Postnatal Care: Four Focused Visits

- Mother and baby are assessed:
  - Within 24 to 48 hours after birth; the dyad should be assessed every 15 minutes during the first 2 hours, then per shift,
  - At 1–2 weeks,
  - At 6 weeks, and
  - At 4–6 months.
Elements of Postpartum Care

- Four focused visits of mother and baby
- Integrate at each visit:
  - Essential maternal and newborn care
  - Danger signs
  - Family planning
  - Immunization
  - HIV counseling and testing
Essentials of Maternal Postpartum Care (WHO 2007)

- **Assessment of maternal well-being:**
  - Prevention and detection of complications (e.g., infections, bleeding, anemia)
  - Anemia prevention and control (iron and folic acid supplementation)

- **Information and counseling on:**
  - Nutrition, safe sex, family planning and provision of some contraceptive methods
  - Advice on danger signs, emergency preparedness and follow-up
  - Provision of contraceptive methods
Basic Postpartum Care Provision

- During every visit:
  - Assess condition of mother and baby
  - Provide essential care
  - If abnormal symptoms and signs are present (based on assessment), provide additional care or refer
  - Integrate maternal and newborn care
Basic Postpartum Care Provision (cont.)

- Ongoing supportive care
- Basic care package:
  - Breastfeeding and breast care
  - LAM and transition to other FP
  - Nutritional support
  - Self-care and other healthy practices
  - Complication readiness plan
  - HIV counseling and testing (VCT)
  - Immunizations and other preventive measures
First Visit after Delivery:
*Quick check for danger signs to rule out emergency at beginning of visit*

- **History:**
  - Time of delivery, place and complications at delivery, HIV and syphilis screening done? TT?
- **Any pain or bleeding now?**
- **Physical exam:**
  - Vital signs
  - Check conjunctiva
  - Abdomen: palpate fundus: firm? tender?
  - Bladder: When did she void last?
  - Gently inspect labia and perineum
  - Evaluate vaginal bleeding, amount, origin
  - Evaluate lochia color, amount, odor

- **Care/Counseling:** Assist mother to nurse baby within 1st hour of care:
  - Observe infant feeding, assist with correct latching technique, if needed
  - Advise delayed return to fertility with exclusive breastfeeding…LAM

- **Advise about danger signs:**
  - Complication readiness
  - Check for continuation medications/immunizations

- **Discuss family planning**

- **Return to clinic per schedule or earlier if danger signs arise**
Essential Newborn Care Interventions

- **Initiation of breathing and resuscitation:**
  - Early asphyxia identification and management

- **Thermal protection:**
  - Prevent and manage newborn hypo/hyperthermia

- **Early and exclusive breastfeeding:**
  - Started within 1 hour after childbirth

- **Clean childbirth and cord care:**
  - Prevent newborn infection
Essential Newborn Care Interventions (cont.)

- **Eye care:**
  - Prevent and manage ophthalmia neonatorum

- **Immunization:**
  - At birth: bacilli Calmette-Guerin (BCG) vaccine, oral poliovirus vaccine (OPV) and hepatitis B virus (HBV) vaccine (WHO recommendation)

- **Identification and management of sick newborn**

- **Care of preterm and/or low birth weight newborn**
Support for Mother-Baby-Family Relationships

- **Bonding:**
  - Encourage touching, holding, exploring
  - Encourage rooming-in

- **Support:**
  - Encourage sharing in care of newborn
  - Assist in devising strategies for overcoming challenges

- **Information:**
  - Discuss key aspects of postpartum and newborn care
  - Encourage questions
Support for Mother-Baby-Family Relationships (cont.)

- Encouragement and praise:
  - Help build confidence
  - Provide reassurance that woman is capable of caring for newborn
Breastfeeding and Breast Care

- Feeding guidelines:
  - Breastfeed exclusively for first 6 months – no other food or fluids
  - Breastfeed on demand, day and night
Breastfeeding Best Practices

- **Best practices:**
  - Only COLOSTRUM, no pre-lacteal feeds
  - Giving first breastfeed within 1 hour of birth
  - Correct positioning to enable good attachment of the newborn
  - Breastfeeding on demand
  - Psycho-social support to breastfeeding mother

- **Additional advice:**
  - Use both breasts at each feed; do not limit time at either
  - Ensure adequate sleep/rest – take nap when baby sleeps
  - Ensure adequate food/fluid intake – glass of fluids per feed; extra meal per day
Return to Fertility

- **Return of fertility after birth:**
  - Not predictable
  - Can occur before menstruation resumes
  - On average, women who:
    - Do not breastfeed ovulate by 45 days or earlier
    - Exclusively breastfeed their babies will prevent ovulation because frequent suckling by the infant prevents ovulation
    - Breastfeed who also supplement will have a return to fertility sooner
Return to Sexual Activity

- Sexual relations and safer sex:
  - Avoidance of sex for at least 2 weeks and until it is comfortable
  - Increased susceptibility to STIs during postpartum period
  - Abstinence or mutually monogamous sex with uninfected partner – only sure protection
  - Consistent use of condoms
  - Avoidance of sexual practices that may further increase risk of infection
Return to Sexual Activity: Nigeria

![Graph showing % of postpartum women by postpartum months and categories of sexual activity and breastfeeding](graph.png)

ACCESS-FP 2006
Nutritional Support

- Eat balanced diet including variety of foods each day
- Breastfeeding women should have at least one or more extra serving(s) of staple food per day
- Eat a diverse diet with animal products, grains and vegetables:
  - No specific foods should be eaten or avoided
  - Drink in response to thirst – excessive fluids not needed
  - Give vitamin A supplement where deficiency is common
  - Use iodized salt
Nutritional Support (cont.)

- **Iron/folate supplementation:**
  - To prevent anemia, prescribe: iron 60 mg + folate 400 mcg orally once daily for 3 months
  - Dispense supply to last until next visit
  - Eat foods rich in vitamin C, which helps iron absorption
  - Avoid tea, coffee and colas, which inhibit iron absorption
  - Possible side effects of iron/folate – black stools, constipation and nausea
Self-Care and Other Healthy Practices

- Prevention of infection/hygiene:
  - Good general hygiene (handwashing, safe food and water preparation/handling, bathing and general cleanliness)
  - Good genital hygiene – especially important for postpartum women because more susceptible to infection
  - Increase rest time
Preventive Measures

- **In areas of endemic disease/deficiency:**
  - Insecticide-treated nets (ITNs) for malaria:
    - Both mother and baby should sleep under one net
  - Presumptive treatment for hookworm infection
## Tetanus Toxoid Immunization Schedule

<table>
<thead>
<tr>
<th>TT Injection</th>
<th>Due</th>
</tr>
</thead>
<tbody>
<tr>
<td>TT 1</td>
<td>At first contact with woman of childbearing age or as early as possible in pregnancy (at 1&lt;sup&gt;st&lt;/sup&gt; ANC visit)</td>
</tr>
<tr>
<td>TT 2</td>
<td>At least 4 weeks after TT 1</td>
</tr>
<tr>
<td>TT 3</td>
<td>At least 6 months after TT 2</td>
</tr>
<tr>
<td>TT 4</td>
<td>At least 1 year after TT 3</td>
</tr>
<tr>
<td>TT 5</td>
<td>At least 1 year after TT 4</td>
</tr>
</tbody>
</table>
Immunization Schedule Recommended by WHO

<table>
<thead>
<tr>
<th>Age</th>
<th>Vaccine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Birth</td>
<td>BCG, OPV-0, Hep B*</td>
</tr>
<tr>
<td>6 weeks</td>
<td>DTP-1, OPV-1, Hep B* Hip-1**</td>
</tr>
<tr>
<td>10 weeks</td>
<td>DTP-2, OPV-2, Hep B*, Hip-2**</td>
</tr>
<tr>
<td>14 weeks</td>
<td>DTP-3, OPV-3, Hep B*, Hip-3**</td>
</tr>
<tr>
<td>9 months</td>
<td>Measles, Hep B* Yellow Fever ***</td>
</tr>
</tbody>
</table>

* Only 3 doses of Hep B are needed for protection

** Hib stands for *Haemophilus influenzae* type b.

*** In countries where indicated
Complication Readiness Plan

- **At first visit after birth:**
  - Introduce concept and each element
  - Assist in developing plan

- **Return visits:**
  - Check arrangements made
  - Note changes and problems

- **Components:**
  - Appropriate health care facility for emergency care
  - Emergency transportation
  - Emergency funds
  - Decision-maker/decision-making process
  - Support person/companion
  - Blood donor
  - Danger signs for mother and newborn
Complication Readiness Plan for Clients

- **Danger signs:** ensure that woman and family know maternal and newborn danger signs

- What to do if danger signs present:
  - Where to go for help (facility)
  - Who will help her get there ($)
  - When to go (as soon as problem starts)
Maternal Danger Signs

- Vaginal bleeding (heavy or sudden increase)
- Fever
- Severe abdominal pain
- Breathing difficulty
- Severe headaches blurred vision
- Convulsions
- Foul-smelling discharge from vagina
- Strange behavior indicating woman may hurt self or baby
Postpartum Hemorrhage (PPH)

- Major cause of maternal mortality
- Occurs in 10% of all deliveries
- ANC risk assessment cannot predict PPH
- Bleeding may occur at a slow rate; PPH is not recognized until the woman is in shock
SBAs Provide AMTSL (Active Management of the Third Stage of Labor) for ALL Women

- Immediately give 10 units oxytocin IM after birth of baby
- Deliver the placenta by controlled cord traction
- Massage the uterus for 15 minutes after expulsion of placenta
Puerperal Pyrexia

When is puerperal pyrexia present?

- Oral temperature rises to 38°C or higher:
  - On two or more occasions
  - During the first 14 days postpartum
Causes of Puerperal Pyrexia

- Genital tract infection
- Urinary tract infection
- Mastitis or breast abscess
- Superficial leg vein thrombophlebitis
- Respiratory tract Infection
- Other infections
Management:
Perform Good History and Exam

- **History:**
  - Preterm or pre-labor rupture of membranes
  - A long labor
  - Operative delivery incomplete placenta or membranes
  - Patient feels generally unwell
  - Lower abdominal pain

- **Examination:**
  - Fever – usually develops in first 24 hours after delivery
  - Rigors may occur
  - Marked tachycardia
  - Lower abdominal tenderness
  - Offensive lochia
  - Episiotomy wound or perineal/vaginal tears
Management of Genital Tract Infection

Prevention:
- Strict asepsis during delivery
- Reduction in number of vaginal exams
- No routine AROM
- No routine episiotomy
- Give antibiotics if PROM >18 hours
- Advise client to abstain until lochia has no bloody or brown tinge 4–6 weeks

Signs and Symptoms:
- Lower abdominal pain
- Tender uterus
- Purulent, foul-smelling lochia
- Fever (> 38°), rapid pulse, confusion

Treatment:
- IV fluids, monitor intake and output
- Antibiotics: ampicillin, gentamicin and metronidazole
- Test hemoglobin levels
Detect for Newborn Abnormalities within 48 Hours after Delivery

- Assess breathing, warmth, colour, activity and tone:
  - Movements are normal and symmetrical
- Check fontanels are not bulging or sunken
- Check no discharge from eyes
- Ability to nurse (rooting, sucking palate intact)
- Bleeding from cord, area red
- Check for jaundice
- Congenital anomalies: spina bifida, hydrocephalus
- Check body for septic spots
- Check that meconium passed (patent anus):
  - Do not insert anything into anus
Recognizing Newborn Danger Signs

- Convulsions
- Fast breathing > 60/minute
- Severe chest in-drawing
- Nasal flaring
- Bulging fontanels
- Many skin pustules or big boil
- Axillary temp < 35.5 > 37.5
- Wet cord with blood, pus
- Jaundice
- Floppy
- Distended abdomen

Treatment:
- Give first dose IM ampicillin and gentamicin
- Treat to prevent low blood sugar
- Warm neonate skin to skin if temp <36.5 or feels cool
- Advise mother to keep baby warm and **continue breastfeeding**
- Refer URGENTLY to hospital
Local Bacterial Infection

- **Symptoms:**
  - Umbilicus red or draining pus
  - Pus or discharge from ear
  - Skin pustules

- **Treatment:**
  - Oral cotrimoxazole or amoxicillin for 5 days
  - Teach mother to give medication at home
  - Follow up in 2 days
Jaundice

- Severe Jaundice:
  - Yellow palms and soles
  - Neonate < 24 hours or older than 14 days

- Jaundice:
  - Palms and soles not yellow

Treatment:
- Treat to prevent low blood sugar
- Warm neonate skin to skin if temp < 36.5° or feels cool
- Advise mother to keep baby warm on way to hospital (referral)
- Follow up in 2 days
- Give home care
- Advise mother to return immediately if jaundice becomes severe
Low Birth Weight (LBW) Babies

- Nearly 30% of newborn deaths occur in LBW babies, many of whom are pre-term
- *Intensive care is not needed* to save the majority of these babies
- Identify the small baby (birth weight is < 2500 gm)
- Assess for danger signs and manage or refer as appropriate
- Provide extra support for breastfeeding, including expressing milk and cup feeding if necessary...teach mother
- Maintain infant body temperature:
  - Skin-to-skin care between mother’s breasts; keep baby’s head covered; refer to KMC if indicated...teach mother
- Ensure early identification and rapid referral of babies who are unable to breastfeed or accept expressed breast milk
Summary

Postpartum care provision includes:

- Assessing for maternal and newborn complications
- Providing basic care for mother and newborn:
  - Breastfeeding and breast care
  - Complication readiness plan
  - Support for mother-baby-family relationships
  - Newborn care
  - Family planning
  - Nutritional support
  - Self-care and other healthy practices
  - HIV voluntary counseling and testing
  - Immunizations and other preventive measures
Definition and Overview of Postpartum Family Planning

Session 3
Session Objectives

By the end of this session, participants will be able to:

- Define postpartum contraception
- Discuss the rationale for postpartum family planning
- Explain the benefits of birth spacing
- Describe postpartum return of fertility
Definitions

- **Postpartum contraception** is the initiation and use of family planning methods during the first year after delivery:
  - **Post-placental** – within 10 minutes after delivery of placenta
  - **Immediate postpartum** – within 48 hours after delivery (e.g., voluntary sterilization)
  - **Early postpartum** – 48 hours up to 6 weeks
  - **Extended postpartum** – 6 weeks up to 1 year after birth
Unmet Need: Fertility Preferences of Postpartum Women

- According to DHS surveys in 27 countries:
  - 92–97% of women do not want another child within 2 years after giving birth
  - But 35% of women had their children spaced at 2 years apart or less
  - 64.6% of women in the extended postpartum have an unmet need for family planning

Benefits of Eliminating Unmet Need for Family Planning

Number of maternal deaths with and without unmet need for FP (1996–2003)

<table>
<thead>
<tr>
<th>Country</th>
<th>Maternal deaths</th>
<th>No. of deaths with no unmet need</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malawi</td>
<td>5,857</td>
<td>3,811</td>
</tr>
<tr>
<td>Zambia</td>
<td>2,966</td>
<td>2,048</td>
</tr>
<tr>
<td>Uganda</td>
<td>6,024</td>
<td>3,781</td>
</tr>
<tr>
<td>Tanzania</td>
<td>7,501</td>
<td>5,668</td>
</tr>
</tbody>
</table>

Number of maternal deaths:
- Malawi: 5,857
- Zambia: 2,966
- Uganda: 6,024
- Tanzania: 7,501

Number of deaths with no unmet need:
- Malawi: 3,811
- Zambia: 2,048
- Uganda: 3,781
- Tanzania: 5,668

Malawi: 5,857 deaths, 3,811 no unmet need
Zambia: 2,966 deaths, 2,048 no unmet need
Uganda: 6,024 deaths, 3,781 no unmet need
Tanzania: 7,501 deaths, 5,668 no unmet need
Contraception after Childbirth: Basic Care and Services

- Promote healthy timing and spacing of pregnancy
- Encourage exclusive breastfeeding and LAM
- Counsel on return to fertility
- Increase contraception choices
- Integrate family planning into other MCH programs, immunization and PMTCT
Service Contacts Are Multiple, But Not Systematically Integrated

<table>
<thead>
<tr>
<th>Country</th>
<th>ANC</th>
<th>PPC*</th>
<th>BCG</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bangladesh</td>
<td>56%</td>
<td>27%</td>
<td>93%</td>
</tr>
<tr>
<td></td>
<td>2004 DHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Haiti</td>
<td>85%</td>
<td>45%</td>
<td>73%</td>
</tr>
<tr>
<td></td>
<td>2003 DHS</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Kenya</td>
<td>88%</td>
<td>55%</td>
<td>87%</td>
</tr>
<tr>
<td></td>
<td>2003 DHS</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Source: Fort A et al. Postpartum Care. DHS Comparative Reports 15.*
Miss No Opportunity!

At every immunization visit, ask about FP intentions and LAM transition plan!

THINK, and provide the LINK!
Extended Postpartum (6–9 Months)

- Link immunizations and infant care with family planning follow-up, for example, measles immunization or vitamin A
- Especially important visit for breastfeeding mothers who have been relying on LAM (6 months)
- Discuss and provide a transition plan from LAM to another modern method
Healthy Timing and Spacing of Pregnancy

- Girls should wait until they are at least 18 years old before they conceive for the first time

- Healthy timing and spacing of pregnancy decreases the risk of preterm, low birth weight and other adverse outcomes:
  - Couples should wait 2 years after the birth of their last baby before trying to conceive
  - Couples should wait 6 months after an abortion or miscarriage before they conceive

Healthy Timing and Spacing of Pregnancy

- **Pregnancy spacing:**
  - Birth to pregnancy intervals: couples should wait 2 years after the last birth before trying to conceive again
  - Reduces risks of having a pre-term infant or low birth weight infant
  - Allows mother to breastfeed her baby for up to 2 years
  - Reduces pregnancy risks to mother
Can you identify benefits of healthy birth spacing?
Birth Spacing Saves Mothers’ and Babies’ Lives

- Healthy timing and spacing of pregnancy have positive effects on maternal health and newborn outcomes
- Women who conceive at least 24 months after the birth of their last delivery are:
  - More likely to have term pregnancies
  - More likely to avoid low birth weight babies
  - More likely to provide a good nutritional start to her last baby
Healthy Timing and Spacing of Pregnancy Lowers Risks for:

- **For Children:**
  - Small for gestational age
  - Low birth weight
  - Preterm birth
  - Fetal death
  - Neonatal death
  - Infant death
  - Stunted and underweight child
  - Child death

- **For Mothers:**
  - Anemia
  - Puerperal endometritis
  - Premature rupture of membranes
  - Third trimester bleeding
  - Malnutrition
  - Maternal death
Other Benefits of Healthy Timing and Spacing of Pregnancy

- Contributes to preserving the health and fertility of women and their overall quality of life
- Contributes to improving children’s lives by increasing their access to adequate food, clothing, housing and educational opportunities
- Decreases a woman’s work burden
- Provides a cost-effective means of improving health and quality of life compared with other investments
Return to Fertility

- During pregnancy, the cyclic function of the ovaries is suspended due to presence of placental hormones
- During early postpartum:
  - Inhibiting effects of estrogen and progesterone are removed
  - Levels of Follicle Stimulating Hormone (FSH) and Luteinizing Hormone (LH) gradually rise
  - Ovarian function begins again
- Return to fertility occurs prior to return to menses in about 1/3 of women
Return to Fertility: Effect of Lactation

- **Breastfeeding women:**
  - Period of infertility longer for exclusive or nearly exclusive breastfeeding
  - After 6 months, the infant is taking complementary foods and breastfeeds less:
    - Return to fertility is not predictable and ovulation may occur prior to menses
Return to Fertility: Effect of Lactation (cont.)

- **Non-lactating women:**
  - Will menstruate within 12 weeks
  - On average, first ovulation occurs 45 days or earlier after delivery
  - **2 out of 3 women will ovulate before menstruation occurs**
  - Risk of pregnancy
Family Planning

- LAM is a temporary method
- Progestin-only methods can be safely given to breastfeeding women after 6 weeks if mother is not EBF
- Interval IUDs are safe at 4–6 weeks post-delivery
- Dual protection with condoms

*Ensure that she receives an appropriate method or has access to the service*
Summary

- Globally, almost 65% of women in the extended postpartum have an unmet need for family planning
- Healthy timing and spacing of pregnancies saves lives
- Infants are seen 5 times during the first year for immunizations; ask mothers about their need for contraception – THINK AND LINK
Preventing Mother-to-Child Transmission of HIV

Session 4
Estimated Risk and Timing of Mother-to-Child Transmission of HIV in the Absence of Interventions (WHO)

- During pregnancy 5–10%
- During labor and delivery 10–15%
- During breastfeeding 5–20%
- Overall without breastfeeding 15–25%
- Overall with breastfeeding to 6 months 20–35%
- Overall with breastfeeding to 18 to 24 months 30–45%
- Not every baby born to an HIV-infected mother will be infected: without intervention, about 1 out of 3 babies born to mothers with HIV will become HIV-positive
Risk Factors for MTCT

- **Viral Factors:**
  - Clinical stage of infection: New and advanced infections
  - Low maternal CD4 count (the lower the maternal CD4 count the more sick the mother is likely to be)
  - High viral load in blood and genital tract
MTCT Risk Factors

- Maternal:
  - Unprotected sex with an infected partner
  - Substance abuse
  - Smoking
  - STIs and other co-infections
  - Becomes FIRST infected while pregnant or while she is breastfeeding
  - Vitamin A deficiency
  - Mother not taking ARV agents
  - Malaria infection in pregnant women
MTCT Risk Factors (cont.)

Obstetric:

- Invasive fetal monitoring
- Prolonged rupture of membranes
- Routine episiotomy
- Placental disruption
- Vaginal delivery
MTCT Risk Factors: Infant

- Preterm delivery
- Neonatal birth injuries
- Vigorous naso-gastric tube suction
- Breastfeeding (WHO recommends counseling women on feeding options* and supporting her decision)

*AFFASS: Is replacement feeding Acceptable? Feasible? Affordable? Sustainable? Safe? If all of these answers are YES, HIV-infected mothers should avoid all breastfeeding. If any of the answers are NO, she should breastfeed exclusively during the first 6 months of life or until AFFASS is yes. After 6 months, the mother needs to introduce complementary foods. The mother should continue to breastfeed until replacement feeding is AFFASS.
Counseling and Testing for HIV

- Every woman and her partner should be offered HIV testing during their pregnancy and postpartum
- HIV testing should be voluntary
- Rapid HIV tests are available that can give results in less than an hour
- Preventing mother-to-child transmission depends on being able to identify women who can benefit from interventions
HIV Counseling and Testing

Provider-initiated HIV testing and counseling:
- Recommend HIV testing to all patients unless they opt out; be respectful of:
  - Confidentiality
  - Counseling
  - Consent (client given option to opt out)
- HIV testing is voluntary; client may not be ready to be tested today. Provider-initiated means just to ask, NOT a mandate.
- HIV testing is linked to appropriate HIV prevention, treatment, care and support.

Pre-test information and post-test counseling remain integral parts of the HIV testing process.
Integration of HIV with FP

- HIV prevention should be an integral part of FP services to help clients assess their risk and make necessary changes in behavior.
- FP providers should ask clients if they want VCT to prevent HIV transmission to partners, to improve quality of life if HIV-positive, and to prevent HIV transmission to future children.
Contraception and HIV Acquisition

- Male condoms proven effective; female condoms’ effectiveness may be similar to that of male condoms
- Spermicides (N-9) not effective against HIV:
  - N-9 in WHO MEC is category 4 for HIV-positive people
- IUDs and hormonals do not increase HIV acquisition according to findings of observational studies
Postpartum FP and HIV

- HIV-positive women who are not breastfeeding need a family planning method choice immediately.

- HIV-positive women who are breastfeeding may practice LAM, but will need to choose another method when LAM no longer applies.

- Counsel all women (even when status is unknown) about the importance of postpartum FP:
  - Benefits of exclusive breastfeeding and LAM
  - Significance of safer sex and dual protection
  - Available contraceptive choices
  - Healthy timing and spacing if future pregnancy desired
AFASS Counseling

- In the MASHI study (Botswana), breastfeeding improves survival of HIV-infected infants:
  - @ 6 months BF 8% IMR vs. FF 32% IMR (p=0.004)
  - @ 24 months BF IMR 30% vs. FF 45% IMR (p=0.14)

- Promoting EBF in the general population may reduce HIV transmission by HIV mothers who do not know their status via reductions of mixed breastfeeding.

These studies provide evidence-based medicine to carefully and realistically provide AFASS counseling to HIV+ women. At 6 months, if AFASS criteria are not met, it is recommended that HIV-infected women continue to breastfeed their infants and give complementary foods in addition, and continue to return for regular follow-up assessments. As soon as AFASS criteria are met, all breastfeeding should stop.
Postpartum Care for HIV+ Women and Their Babies

- Treat babies with nevirapine within 72 hours after birth
- Offer cotrimoxazole syrup daily to baby at 4–6 weeks
- Ensure that HIV+ mothers who meet eligibility criteria are taking ARV
- Offer HIV screening of infants born to HIV+ mothers at 6 weeks, 3 months and again at 18 months
- Offer family planning options to HIV+ women; counsel on healthy timing and spacing of pregnancies
- The contraceptive strategy averts 28.6% more HIV+ births than nevirapine for prevention of mother-to-child transmission of HIV

Risk of HIV Transmission from Breastfeeding Is Increased When...

- **The mother:**
  - Has cracked nipples, abscesses or other breast problems
  - Has symptoms for HIV-related disease

Or

- **The baby:**
  - Has sores in his/her mouth
  - Has an inflamed gut from mixed feeding
Babies of HIV+ Mothers

- Are more at risk of illness and malnutrition than those born to HIV- mothers, even though most of these babies are HIV- themselves
- Pay special attention to infant feeding and growth monitoring
- Provide routine immunizations
- All symptomatic HIV-infected infants with AIDS-related complex (ARC) or AIDS should receive inactivated vaccines
Condoms Should Be Used with ALL Methods

- To help to prevent re-infection
- To protect the woman from increasing her viral load; this is especially important if the woman is breastfeeding
Remaining Faithful Is More Important Now than Ever! Protect Your Family!

- A mother who first acquires HIV during breastfeeding is more likely to transmit the virus to the baby (the viral load is high when first infected)
- Fathers: Get tested, remain faithful and use condoms consistently and correctly, if indicated
- Protect your family!
Values Clarification Activity

Session 5
Session Objectives

By the end of this session, participants will be able to:

- Identify personal values that may act as barriers to quality service provision
- Recognize and accept differing opinions and attitudes regarding reproductive health issues
- Minimize the effect of personal values on service provision and counseling
Activity

- On the walls are statements: “strongly agree,” “agree,” “neutral,” “disagree,” and “strongly disagree”
- We will read out a statement on FP/RH and the participants are to stand at the sign that describes their opinions about the statement
- We will ask each group to state why they feel the way they do about this statement
- Repeat the exercise using different statements
Statement 1

Family planning should be made available to married people only
Statement 2

FP counseling and method provision should be available for unmarried secondary schoolgirls who are sexually active.
Statement 3

Married women requesting FP services must have their husband’s written consent
Statement 4

Women who have only one child don’t need information about postpartum family planning
Statement 5

Information about emergency contraception should not be available to unmarried women
Statement 6

The Lactational Amenorrhea Method (LAM) is not effective, so there is no need to counsel women about it.
Statement 7

Women who have never had children should not use long-acting methods such as DMPA, IUDs or implants
Key Points

- Everyone has his/her own values based on his/her sociocultural background
- Individual values may have positive or negative impacts on FP/RH service provision
- All service providers should keep their personal values separate from their professional activities
- All service providers should be open to different opinions and attitudes
Postpartum Family Planning Counseling

Session 6
Session Objectives

By the end of this module, participants will be able to:

- Define basic elements of PPFP counseling
- Understand benefits of counseling
- Describe effective counseling techniques
- Close the counseling session
Postpartum Family Planning Counseling: Purpose

- Helps mothers:
  - Take advantage of the natural infertility created by breastfeeding through LAM
  - Learn health benefits to their infants of waiting at least 2 years after the last birth before they get pregnant
  - Understand return to fertility
  - Learn about FP methods that are safe during breastfeeding:
    - Efficacy
    - Common side effects
    - When where and how to initiate method
Family Planning Counseling: Benefits

- Increases acceptance
- Promotes effective use
- Improves continuation
- Increases client satisfaction
- Dispels rumors and misconceptions
Quality Counseling and Care Increases Family Planning Use

Perception of Quality of Care Influences Contraceptive Continuation

- Low Perception of Care: 53%
- Medium Perception of Care: 59%
- High Perception of Care: 65%

Source: Contraception Online, Baylor University.
Family Planning Counseling: Rights of the Client

- In serving clients, it is important to remember that they have:
  - The right to decide whether or not to practice family planning,
  - The freedom to choose which method to use,
  - The right to privacy and confidentiality,
  - The right to complete and accurate information,
  - The right to form/express their own opinions, and
  - The right to refuse any type of examination.
Effective Communication

- Stay attentive – use active listening
- Use nonverbal cues to convey concern
- Ask open-ended questions
- Use encouraging words
- Pay close attention to the woman's spoken words
- Observe her nonverbal cues
- Help her explore her feelings
Communication is essential in counseling and includes:

- **Verbal communication:**
  - Open-ended questions
  - Reflecting feelings (paraphrasing)

- **Non-verbal communication:**
  - Body gestures
  - Facial expressions
Family Planning Education

- Provides information on all available contraceptive methods
- Provides up-to-date and unbiased information
- Uses one- or two-way communication
- Can be done through individual, group or mass communication
- Dispels rumors and misconceptions
Family Planning Counseling

- Encourages the client to ask questions
- Involves active listening
- Assures that the client is fully informed
- Helps the client make her/his own choice
Family Planning Counseling Process

- Counseling should include the following information:
  - Effectiveness of the method;
  - The benefits and limitations of the method;
  - Reversibility;
  - Short- and long-term side effects;
  - Warning signs and symptoms; and
  - The need for protection against STIs (e.g., chlamydia, HBV, HIV/AIDS).
The GATHER Approach

- Greet respectfully
- Ask/Assess needs
- Tell information
- Help choose
- Explain demonstrate
- Return reinforce/refer
Being a Good Counselor

An effective counselor:
- Understands and respects the client’s rights
- Earns the client’s trust
- Understands the benefits and limitations of all contraceptive methods
- Understands the cultural and emotional factors that affect a woman’s (or a couple’s) decision to use a particular contraceptive method
- Encourages the client to ask questions
Being a Good Counselor (cont.)

- Key points:
  - Be brief (most important information only)
  - First things first
  - Use simple words and short sentences
  - Repeat most important information
  - Organize information
  - Be specific

Key Points for PPFP Counseling

- **Promote exclusive breastfeeding and LAM:**
  - Four criteria of LAM: Exclusive, mother is amenorrheic, infant is 6 months or less, and transition to other modern method when one of the three criteria does not apply

- **Advise on return to fertility**

- **Counsel on healthy timing and spacing of pregnancy:**
  - Couples should wait 2 years after the birth before they try to get pregnant again

- **Ask about limiting versus spacing:**
  - Have the client and her partner finished their family size? Are they interested in permanent methods?
  - Has the mother expressed a request for BTL at time of delivery?

- **Increase FP method mix**
- **Integrate FP into MCH services**
When to Start Contraception

Timing depends on:

- Breastfeeding status
- Method of choice
- Reproductive goals

Photo: Catharine McKaig.
Breastfeeding Women

- Protected for at least 6 months if using LAM:
  - Fully or nearly fully breastfeeding
  - Less than 6 months postpartum
  - Menses has not returned

- Protected up to 6 weeks if not using LAM:
  - At 6 weeks can use progestin only methods safely

- IUD can be inserted 4 weeks or greater postpartum

- Condoms can be used at any time

- Perfect time for vasectomies for couples who want to limit
Non-Breastfeeding Women

- Contraception should be started at the time of or before first intercourse
- Progestin-only methods can be started right after delivery
- Combined hormonal methods can be used after 3 weeks postpartum
- For those opting limiting, tubal ligation or vasectomy can be done
Family Planning Counseling: Method Failure

- Although many contraceptive methods are highly effective, method failure can occur. In the case of method failure, the client should be counseled:
  - Informed about the available options, and
  - Referred for appropriate services.
Contraception after Childbirth: Basic Care and Services

- Assurance of contraceptive re-supply with access to follow-up care
- Integration with other maternal-infant child care:
  - ANC and postpartum visits
  - Newborn care
  - Immunizations
- HIV/STI prevention:
  - To help clients assess their risk and make necessary changes in behavior and choose appropriate FP method
Closing a Counseling Session

- Summarize key concepts
- Ensure that the woman understands:
  - Ask her to explain back to you how to use the method
- Provide written instructions or referrals
- Explain what to expect during clinic visits

Photo: Angela Nash-Mercado, Jhpiego.
Medical Eligibility Criteria for Contraceptive Methods

Session 7
Session Objectives

By the end of this session, participants will be able to:

- Describe who can use the various contraceptive methods based on medical criteria defined by WHO (Medical Eligibility Criteria)
- Use the resource tool from FHI
Medical Eligibility Criteria for Contraceptive Use (MEC)

- Covers 17 contraceptive methods, 120 medical conditions
- Addresses who can use contraceptive method based on medical methods
- Gives guidance to providers for clients with medical problems or other special conditions

Purpose of the Medical Eligibility Criteria (MEC)

- To guide family planning practices based on the **best available evidence**
- To **address and change misconceptions** about who can and cannot safely use contraceptive methods
- To **reduce medical policy and practice barriers** (i.e., not supported by evidence)
- To **improve quality, access and use of family planning services**
What is answered by the MEC?

The MEC identify which contraceptive or FP method can be safely used in the presence of a given individual characteristic or medical condition.
## WHO Medical Eligibility Criteria Classification Categories

<table>
<thead>
<tr>
<th>Classification</th>
<th>With clinical judgment</th>
<th>With limited clinical judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstances</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Generally use: advantages outweigh risks</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Use the method</td>
</tr>
<tr>
<td>3</td>
<td>Generally DO NOT use: risks outweigh advantages</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not use the method</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Do not use the method</td>
</tr>
</tbody>
</table>
## WHO Medical Eligibility Criteria: HIV/AIDS and Copper IUDs

<table>
<thead>
<tr>
<th>HIV/AIDS</th>
<th>2nd Ed. Category</th>
<th>3rd Ed 2004 Category</th>
</tr>
</thead>
<tbody>
<tr>
<td>High risk of HIV</td>
<td>3</td>
<td>I 2</td>
</tr>
<tr>
<td>HIV-infected</td>
<td>3</td>
<td>C 2</td>
</tr>
<tr>
<td>AIDS</td>
<td>3</td>
<td>I 3</td>
</tr>
<tr>
<td>Clinically well on ARV therapy</td>
<td></td>
<td>C 2</td>
</tr>
</tbody>
</table>
Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use – to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), norethisterone enantate (NET-EN), copper intrauterine device (Cu-IUD)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>COC</th>
<th>DMPA/NET-EN</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Age</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menarche to 39 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>40 years or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menarche to 17 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>18 years to 45 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>More than 45 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Menarche to 19 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>20 years or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Nulliparous</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Less than 6 weeks postpartum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 weeks to 6 months postpartum</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 months postpartum or more</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Smoking</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt; 35 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age ≥ 35 years, &lt; 15 cigarettes/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age ≥ 35 years, ≥ 15 cigarettes/day</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Hypertension</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of hypertension where blood pressure: CANNOT be evaluated</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic 140 – 159 or diastolic 90 – 99</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Systolic ≥ 160 or diastolic ≥ 100</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Headaches</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-migrainous (mild or severe)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine without aura (age &lt; 35 years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine without aura (age ≥ 35 years)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Migraine with aura</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>History of deep venous thrombosis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Superficial thrombophlebitis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Complicated valvular heart disease</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Ischemic heart disease/stroke</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Diabetes</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-vascular disease</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vascular disease or diabetes of ≥ 20 years</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Malaria</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Non-pelvic tuberculosis</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Thyroid disease</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Iron deficiency anemia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Sickle cell anemia</strong></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

---

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. For example, a woman with current PID who wants to initiate IUD use would be considered as Category 3, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the indicated category — whether or not she is initiating or continuing use of the method.

* Breastfeeding does not affect initiation and use of the IUD. Regardless of breastfeeding status, postpartum insertion of the IUD is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 4 four weeks and after.

** Evaluation should be pursued as soon as possible.
Case Studies

- Using the MEC Resource Tool, determine in the following cases which methods the clients can use
- Be ready to discuss your choices

Photo: Catharine McKaig.
Lactational Amenorrhea Method (LAM)

Session 8
LAM: Mechanism of Action

1. Nipple stimulation
2. Let-down reflex
3. Milk production
4. Suppression of ovulation
5. Amenorrhea
What is LAM versus breastfeeding?

- Lactational Amenorrhea Method (LAM) is a contraceptive method that uses a pattern of breastfeeding that can effectively suppress ovulation and prevent pregnancy.

- Breastfeeding is a method of infant feeding, not a contraceptive method.
Burkina Faso: Revitalize LAM and Transition Counseling and Service

- Advocacy on LAM and transition to other methods
- LAM training combined with CTU
- Messages simplified on exclusive breastfeeding
- Support supervision: note accomplishments for service providers
Is Bleeding Menstrual or a Postpartum Discharge?

- **Among breastfeeding women:**
  - **First 2 months postpartum:**
    - Bleeding throughout the first 2 months postpartum is lochia, not menses
  - **2–6 months postpartum:**
    - Menses is:
      - Any bleeding/spotting, or
      - When a woman perceives that menses has returned
LAM: Contraceptive Benefits – What are they?

- Effective (1–2 pregnancies per 100 women during first 6 months of use)
- Effective immediately
- Does not interfere with sexual intercourse
- No systemic side effects
- No medical supervision necessary
- No supplies required and no cost
- Allows time for decision/adoptions of another FP method during postpartum
LAM: Non-Contraceptive Benefits

- **For child:**
  - Passive immunization and protection from other infectious diseases
  - Best source of nutrition
  - Decreased exposure to contaminants in water, other milk or formulas, or on utensils

- **For mother:**
  - Lessens iron depletion by suppressing menses
  - Strengthens mother-baby bond
  - No cultural or religious conflict
LAM: Limitations

- User-dependent (requires following instructions regarding breastfeeding practices)
- May be difficult to practice due to social circumstances if separation of mother and baby
- Highly effective only until menses return or up to 6 months – short-term, postpartum period only
- Does not protect against STIs
LAM: Client Instructions

- Breastfeed from both breasts on demand
- Breastfeed at least once during night
- Do not substitute other food or liquids for breast milk meal
LAM: Client Instructions for Contraception

- Always keep a backup method of contraception, such as condoms, readily available. Use it if:
  - Your menses returns
  - You begin supplementing your baby’s diet
  - Your baby reaches 6 months of age

- Consult your health care provider or clinic before stopping LAM to transition to another FP method

- If you or your partner is at high risk for STIs, including the AIDS virus, you should use condoms as well as LAM
Breastfeeding and Breast Care

**Breast care:**
- To prevent engorgement, breastfeed frequently
- Wear supportive (but not tight) bra
- Ensure correct positioning
- Wash nipples with water only once per day – no soap
- After breastfeeding, leave milk on nipples and allow to air dry
Breastfeeding Problems

- **Flat nipples:**
  - Gently compress and roll the nipple between the thumb and index finger to try to make it more erect before feeding.
  - Inverted nipples are rare; treat as for flat nipples.

- **Sore nipples:**
  - Usually resulting from poor positioning or attachment; may result in cracked nipples.
  - Correct position and attachment; continue breastfeeding.

- **Cracked nipples:**
  - Correct position and attachment
  - Wash nipple once daily with water only; expose nipple to air and sun as much as possible. Apply a drop of milk on nipple after each feed. Continue breastfeeding. Avoid medicated creams as they may worsen soreness.
Breastfeeding Problems (cont.)

- Leakage of milk from the breast: normal oxytocin reflex, may be in response to emotional stimulus. Reassure.
- Blood in milk: not common, small amount of blood in milk. Usually occurs in absence of other symptoms, and is self-limiting. Reassure, continue breastfeeding.
- Working mothers: can continue breastfeeding by:
  - Taking baby to work if there is a crèche at the workplace
  - Having baby brought to work for feedings
  - Expressing breast milk for cup feeding at home
  - Taking breaks from work to breastfeed
Breastfeeding Problems (cont.)

- Blocked duct – due to baby not suckling well on a particular segment of the breast, resulting in the thick milk blocking the milk duct, leading to a painful hard swelling

Treatment:
- Improving suckling position – frequent feeding of the baby on the affected breast in different suckling positions to improve emptying
- Massaging the lump toward the nipple to promote emptying of the breast
- Resting and wearing loose clothes
Breastfeeding Problems (cont.)

- **Mastitis:** resulting from infection of a blocked duct or an engorged breast. May result in formation of an abscess.

- **Treatment:**
  - Express the milk frequently and continue breastfeeding
  - Analgesia and/or warm compress
  - Antibiotics may be necessary
  - Rarely incision and drainage of the abscess
  - Restart breastfeeding from the affected breast as soon as possible
Risk of HIV Transmission

Figure 2. Estimated Risk of HIV Infection in Infants and Young Children

Minimum and Maximum Estimated Percentage of Infants Who Will Become Infected with HIV During Pregnancy, Labor, and Delivery and During Breastfeeding, by Length of Breastfeeding

*Estimates are per 100 infants born to HIV-positive mothers who do not receive treatment.
Breastfeeding transmission estimate at six months includes early breastfeeding transmission (during the first two months), which is difficult to distinguish from transmission during labor and delivery in published studies but likely accounts for more than half of HIV transmission in the first six months postpartum.
Data are cumulative totals: that is, breastfeeding transmission estimates by 24 months include transmission occurring before 6 months.

Safer Practices on Breastfeeding for HIV-Infected Mothers

- When safe alternatives to breast milk are not available (not AFASS):
  - Mothers should breastfeed infants exclusively for the first 6 months of life before switching completely to replacement foods if possible
  - Otherwise, continue to assess that replacement milk source is AFASS
Key LAM Messages

- LAM is more than 98% effective
- LAM, readily accessible, is uncomplicated to use
- Women making informed choices about modern family planning methods should have LAM available to them
- Evidence suggests that LAM attracts women who have never used modern family planning methods
- Evidence also suggests that LAM users transition to become new users of modern family planning methods
Hormonal Contraceptive Methods

Session 9

Jhpiego in partnership with Save the Children, Constella Futures, The Academy for Educational Development, The American College of Nurse-Midwives and IMA World Health
Session Objectives

- By the end of this session, participants will be able to:
  - List the common hormonal contraceptive methods and their advantages and disadvantages
  - Describe the timing and initiation of key hormonal contraceptive methods
Hormonal Methods

- **Progestin-only contraceptives:**
  - Implants
  - Injectables
  - Progestin-only pills (POPs)

- **Combined estrogen-progestin methods:**
  - Combined oral contraceptives (COCs)
  - Monthly injectables (Mesigyna, Cyclofem)
When can a breastfeeding woman begin using a progestin-only contraceptive?
Progestin-Only Contraceptives: Breastfeeding Women

- May be oral, implants, injectables
- No effect on breastfeeding, breast milk production, or infant growth and development
- WHO recommends a delay of 6 weeks after childbirth before starting progestin-only methods, as neonates may be at risk of exposure to the progestin
Progestin-Only Contraception – POPs: Mechanisms of Action

- Suppress ovulation
- Reduce sperm transport in upper genital tract (fallopian tubes)
- Change endometrium making implantation less likely
- Thicken cervical mucus (preventing sperm penetration)
Progestin-Only Pills (POPs)

- 28-pill pack: 300 µg levonorgestrel or 350 µg norethindrone
- 28-pill pack: 75 µg norgestrel

<table>
<thead>
<tr>
<th>Progestin-only Pills</th>
<th>Progestin Content</th>
<th>Amount (µg)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Microlut⁷</td>
<td>Levonorgestrel</td>
<td>300</td>
</tr>
<tr>
<td>Micronor⁷</td>
<td>Norethindrone</td>
<td>350</td>
</tr>
<tr>
<td>Ovrette⁷</td>
<td>Norgestrel</td>
<td>75</td>
</tr>
</tbody>
</table>
POPs: Contraceptive Benefits

- Effective when taken at the same time every day (0.05–5 pregnancies per 100 women during the first year of use)
- Pelvic examination not required prior to use
- Do not interfere with intercourse
- Do not affect breastfeeding
- Immediate return of fertility when stopped
POPs: Contraceptive Benefits (cont.)

- Few side effects
- Convenient and easy-to-use
- Client can stop use
- Can be provided by trained non-medical staff
- Contain no estrogen
POPs: Non-Contraceptive Benefits

- May decrease menstrual cramps
- May decrease menstrual bleeding
- May improve anemia
- Protect against endometrial cancer
- Decrease benign breast disease
- Decrease ectopic pregnancy
- Protect against some causes of PID
POPs: Limitations

- Cause changes in menstrual bleeding pattern
- Some weight gain or loss may occur
- User-dependent (require continued motivation and daily use)
- Must be taken at the same time every day
- Forgetfulness increases method failure
- Re-supply must be available
- Effectiveness may be lowered when certain drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampin) are taken
- Do not protect against STIs
Progestin-Only Injectable Contraceptives (PICs)

- Safe to use immediately postpartum if not breastfeeding
- Safe to use after 6th week postpartum if breastfeeding
- Injection of:
  - 150 mg DMPA (Depo-Provera) IM every 3 months
  - 104 mg DMPA subcutaneously every 3 months
  - NET-EN (Noristerat) 200mg every 2 months
- Women of any age and parity can use it
- Safe to use immediately after an abortion
PICs: Contraceptive Benefits

- Highly effective (0.3* pregnancies per 100 women during first year of use)
- Rapidly effective (< 24 hours) if started by day 7 of menstrual cycle
- Intermediate-term method (2 or 3 months protection per injection)
- Pelvic examination not required to begin use
- Do not interfere with intercourse

* Source: Trussell et al. 1998. Note: This efficacy rate refers only to DMPA.
PICs: Contraceptive Benefits (cont.)

- Do not affect breastfeeding
- Few side effects
- No supplies needed by the client
- Can be provided by trained non-medical staff
- Contain no estrogen
PICs: Noncontraceptive Benefits

- Decrease ectopic pregnancy
- May decrease menstrual cramps
- May decrease menstrual bleeding
- May improve anemia
- Protect against endometrial cancer
- Decrease benign breast disease
- Decrease sickle cell crises
- Protect against some causes of PID
PICs: Limitations

- Changes in menstrual bleeding pattern:
  - Irregular bleeding/spotting initially in most women
- Weight gain (> 2 kg) is common
- Although pregnancy is unlikely, if pregnancy occurs, it is more likely to be ectopic than in a nonuser
- Resupply must be available
- Must return for injections every 3 months (DMPA) or 2 months (NET-EN):
  - Managing late injections: Acceptable to give DMPA 4 weeks late and NET-EN 2 weeks late
- Return to fertility may be delayed for 7–9 months (on average) after discontinuation
Combined Estrogen-Progestin Methods: Breastfeeding Women

- DO NOT use within the first 6 weeks postpartum
- NOT recommended during first 6 months postpartum due to diminished quantity of breast milk, decreased duration of lactation and possible adverse affects on infant growth
- Combined oral contraceptives are more common although combined injectable contraceptives also exist

Combined Oral Contraception – COCs: Mechanisms of Action

- Suppress ovulation
- Reduce sperm transport in upper genital tract (fallopian tubes)
- Change endometrium making implantation less likely
- Thicken cervical mucus (preventing sperm penetration)
Combined Estrogen-Progestin Methods

- **Breastfeeding:**
  - DO NOT use combined estrogen-progestin methods within the first 6 weeks postpartum
  - NOT recommended during the first 6 months postpartum

- **Non-Breastfeeding:**
  - NOT recommended to use combined estrogen-progestin methods during the first 3 weeks postpartum
  - Safe to start after 3 weeks post-delivery
COCs: Contraceptive Benefits

- Highly effective when taken daily (0.1 to 0.5 pregnancies per 100 women during the first year of use)
- Effective immediately if started by day 7 of menstrual cycle
- Pelvic examination not required to initiate use
- Do not interfere with intercourse
- Few side effects
- Convenient and easy to use
- Client can stop use
- Can be provided by trained non-medical staff

Source: Hatcher et al. 1998.
COCs: Non-Contraceptive Benefits

- Decrease menstrual flow (lighter, shorter periods)
- Decrease menstrual cramps
- May improve anemia
- Protect against ovarian and endometrial cancer
- Decrease benign breast disease and ovarian cysts
- Prevent ectopic pregnancy
- May protect against some causes of PID
COCs: Limitations

- User-dependent (require continued motivation and daily use)
- Some nausea, dizziness, mild breast tenderness, headaches or spotting may occur
- Effectiveness may be lowered when certain drugs are taken
- Forgetfulness increases method failure
- Can delay return to fertility
- Rare serious side effects possible
- Resupply must be readily and easily available
- Do not protect against STIs
QUESTIONS ???

- When can a breastfeeding woman begin using a combined (estrogen-progestin) contraceptive?
- When can a non-breastfeeding woman begin using a combined (estrogen-progestin) contraceptive?
Summary

- Hormonal contraceptives may contain only progestins or a combination of progestins and estrogens
- Progestin-only methods do not interfere with breastfeeding and can start 6 weeks after delivery
- Non-breastfeeding postpartum women can start progestin-only methods immediately
- Hormonal contraceptives may be taken in form of pills, injections or implants
Emergency Contraception (EC)

- Methods of preventing pregnancy after unprotected sexual intercourse
- Regular contraceptive pills used in a special, higher dosage:
  - ECPs are a higher dosage of the same hormones found in daily birth control pills
  - Within 120 hours (5 days) of unprotected sex (but as soon as possible after unprotected sex)
- EC does not stop a pregnancy that has started
- Millions of unintended pregnancies and abortions could be averted with EC
Emergency Contraception (cont.)

- Emergency contraception has enormous potential for use as safe and effective post-coital contraceptives.
- If integrated with ongoing family planning information and services, may encourage new clients to come to clinic.
- Emergency contraception should be promoted to reduce unintended pregnancies.
Should there be “limits” on EC use?

- The only disadvantage of repeated EC use is that clients have more effective contraception available.

- No need to limit:
  - Discuss better contraception options, and
  - Provide EC
Emergency Contraception: Counseling

- Ensure that client does not want to become pregnant
- Explain:
  - Correct way to use
  - Emergency contraception (EC) is not suitable for regular use because not as effective as other methods
  - Nausea and vomiting are common with COCs, less with POPs, and cramping is common with IUDs
  - EC pills do not provide protection following treatment
  - EC pills will not cause menses to come immediately
  - EC pills do not provide protection against STIs or HIV/AIDS
- Offer client regular contraceptive methods
Emergency Contraception: Benefits

- Effective (1–2 women out of 100 will conceive, as compared to 8 in 100 after one act of unprotected intercourse)
- Opportunity to initiate more effective contraception
- IUDs also provide long-term contraception
Emergency Contraception: Limitations

- COCs and POPs are more effective if used within 72 hours of unprotected intercourse, but still effective up to 120 hours.
- COCs cause nausea and vomiting; POPs cause less nausea.
- IUDs are effective only if inserted by a trained provider within 5 days of unprotected intercourse.
- IUDs are not best choice for women at risk for STDs (e.g., chlamydia, gonorrhea).
Women Who May Need Emergency Contraception

- Women who:
  - Have unplanned, unprotected intercourse
  - Used a condom that may have leaked or broken
  - Missed multiple OC pills
  - Waited > 16 weeks beyond last injection (DMPA)
  - Failed in using withdrawal method of contraception (ejaculation in vagina or external genitalia)
  - Failed to abstain when needed while using fertility awareness methods
  - Are rape victims
Think to Offer Emergency Contraception to Women Who:

- Are currently not using a contraceptive
- Have intercourse infrequently
- Are postpartum (before menses returns)
- Are over age 35 (presumed decreased fertility)
- Are sexually active adolescents in need of contraception
- Are postabortion (before menses returns)
Who Should Not Use Emergency Contraception

- **Women with a known pregnancy:**
  - *Because emergency contraception will not stop a pregnancy after it is started*
Types of EC Pills (ECPs)

- Progestin-only OCs: **levonorgestrel-only, in preferred regimen**, one dose of 1.5 mg
  
  (or can be in 2 doses of 0.75 mg, 12 hrs apart)

  → 88% reduction in risk (1/100 will get pregnant)

- Combined OCs: 2 doses of pills **containing ethinyl estradiol (0.01 mg)** and levonorgestrel (0.5 mg) taken 12 hrs apart

  → 75% reduction in risk (2/100 will get pregnant)
QUESTION ????

- Within what timeframe after unprotected sexual intercourse will emergency contraceptive pills be effective?
ECP Effectiveness and Time

- ECPs are effective up to 120 hours (5 days), and thought to be more effective during first 72 hours
- Offer providers and women more flexibility of use:
  - Particularly when ECPs are not given in advance of need
  - Consider providing ECPs to women who are not using a reliable method so that women have them on hand before they need them
Possible Mechanisms of Action of ECPs

Depending on when used during cycle, may:

- Inhibit or delay ovulation
- Affect sperm and ovum function

EC pills do not interrupt an established pregnancy
POPs: Instructions for Use as Emergency Contraception (High-Dose)

Preferred:

- **Step 1:** Take 2 tablets (1.5 mg of LNG) orally within 120 hours of unprotected intercourse:
  
  Total = 2 tablets

- **Step 2:** If no menses (vaginal bleeding) within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy

- Effectiveness: 2% failure rate when used correctly

- Safety:
  - No long-term problems in nearly all women
  - Less nausea (and vomiting) than with COCs
COCs: Instructions for Use as Emergency Contraception (Low-Dose)

Preferred:

- **Step 1:** Take 4 tablets of a low-dose COC (30–35 µg EE) orally within 120 hours of unprotected intercourse.

- **Step 2:** Take 4 more tablets in 12 hours after first dose:
  
  Total = 8 tablets

- **Step 3:** If no menses (vaginal bleeding) within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy.
COCs: Instructions for Use (High-Dose)

Alternative:

- **Step 1:** Take 2 tablets of a high-dose COC (50 µg EE) orally within 120 hours of unprotected intercourse.
- **Step 2:** Take 2 more tablets in 12 hours:
  Total = 4 tablets¹
- **Step 3:** If no menses (vaginal bleeding) within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy.

Summary

- Emergency contraception can be used to prevent pregnancy after unprotected sexual intercourse.
- Combined oral contraceptives or progestin-only contraceptives can be used for emergency contraception within 120 hours of unprotected sexual intercourse.
By the end of this session, participants will be able to:

- List the common non-hormonal contraceptive methods and their advantages and disadvantages
- Describe the timing and initiation of key non-hormonal contraceptive methods
Non-Hormonal Methods

- Non-hormonal methods:
  - Lactational Amenorrhea Method (LAM)
  - Barrier methods
  - Periodic abstinence (fertility awareness, SDM)
  - Coitus interruptus (withdrawal method)
  - Male and female sterilization
  - IUDs (Copper)
Barrier Methods: Condoms

- When used consistently and correctly, male and female condoms are highly effective against pregnancy and STIs/HIV
- Male condom: Latex sheath or covering made to fit over erect penis
- Female condom: Thin sheath of polyurethane plastic with polyurethane rings at either end, inserted into the vagina before intercourse
- Male condom: Typical use 85%
- Female condom: Typical use 79%

*Source: Trussell et al. 1998.*
Advantages of Condoms

- Prevent STIs, including HIV/AIDS as well as pregnancy when used correctly and with each act of intercourse
- May help prevent cervical cancer
- Can be used soon after childbirth, do not interfere with breastfeeding
- No systemic side effects
- Can be stopped any time
- No need for health provider or clinic visit
- Usually easy to obtain and sold in many places
Disadvantages of Condoms

- Person must be motivated to use condoms
- May decrease sensation
- Poor reputation
- May be embarrassing to purchase, ask partner to use or dispose of
- Can be weakened if used with oil-based lubricants—may break during use
- Some men or women may be allergic to latex
- Supplies must be readily available before intercourse begins
IUDs are among the most reliable and cost-effective long-acting method of contraception available to women today.

IUD offers a level of protection comparable to female sterilization, with the added advantage of easy and rapid reversibility.

IUD prevents pregnancy by preventing fertilization; the copper in the IUDs is spermicidal. Copper causes a sterile body inflammatory reaction that is toxic to sperm in the uterine cavity, making them incapable of fertilization.
IUDs (Cu-T)

- IUDs can be inserted:
  - Post-placental within 10 minutes after expulsion
  - During C/Section
  - Within 48 hours of childbirth

- If not inserted within 48 hours of delivery, insertions should be delayed for 4–6 weeks

- Expulsion rates can be higher with postpartum IUD insertion (PPIUD) than with interval insertions:
  - Some studies show that insertion within 10 minutes of delivery of placenta is better than other times before hospital discharge
  - High fundal placement has lower expulsion rates
Important Programmatic Characteristics of IUDs

- Effectiveness is comparable to female sterilization:
  - 12–13 yrs with Cu-T (approved)
  - Cheaper to provide than other methods
  - Quickly and completely reversible

- Very safe for most women (including immediately postpartum, postabortion or interval; breastfeeding; young; nulliparas; and HIV-positive women)
IUDs: Programmatic Considerations

- More service cadres can provide (because it is non-surgical)
- Choice: Long-acting methods that can be used long-term, non-permanent. Providing a woman with a PPIUD prior to discharge is less than half as expensive as providing it in outpatient settings
- Good option for HIV+ women
- Most cost-effective method of all reversible methods if used for 2 or more years
Dispelling Myths about IUDs

IUDs...

- Do not cause abortion
- Do not cause infertility
- Are unlikely to cause discomfort for male partner
- Do not travel to distant parts of the body
- Are not too large for small women
- May offer protection against endometrial and cervical cancer
Common Concerns about IUDs: New Information

- Pelvic inflammatory disease (PID)
- Infertility
- HIV/AIDS
Medical Evidence: Low PID Rates and Infertility among IUD Users

- **First 20 days: highest risk for PID due to insertion:**
  - Woman already has chlamydia that was undetected

- **Beyond 20 days: PID risk is same as if no IUD:**
  - 99.8% of women with IUDs have no problems with PID

- **IUD use NOT associated with infertility:**
  - The real culprit is chlamydia trachomatis (and GC), not the IUD!
IUD Use and HIV: Three Main Questions

- Does IUD increase risk of HIV acquisition by the woman using it?
  - NO

- Does use of IUD by HIV-infected women increase their other health risks?
  - NO

- Does the HIV-infected IUD user increase risk to HIV-negative male partner?
  - NO
Postpartum Female Sterilization

- **Permanent** contraception
- Ideally done within 48 hours after delivery
- May be performed immediately following delivery or during C/section
- If not performed within 1 week of delivery, delay for 4–6 weeks
- Follow local protocols for counseling clients and obtaining informed consent in advance:
  - Discuss during ANC
Female Sterilization: Effectiveness

- Highly effective, 99.5% comparable to vasectomy, implants, IUDs
- Risk of failure (pregnancy), while low:
  - Continues for years after the procedure
  - Does not diminish with time
  - Is higher in younger women
- No medical condition absolutely restricts a person’s eligibility for female sterilization
Male Sterilization: Vasectomy

- A safe, convenient, highly effective and simple form of permanent contraception for men that is provided under local anesthesia in an outpatient setting.
- Vasectomy is safer, simpler, less expensive and equally effective as female sterilization (tubal ligation).
- Vasectomy is popular in the US and UK.
Male Sterilization: Vasectomy

- Highly effective in preventing pregnancy (99.6–99.8% effective):
  - Comparable to female sterilization, implants, IUDs in preventing pregnancy

- Not effective immediately:
  - WHO recommends use of backup contraception for 3 months after the procedure

- Counseling prior to procedure to confirm client’s desire of permanent method
Vasectomy: Safety

- Very safe, with few medical restrictions
- Adverse long-term effects have not been found
- Minor complications 5–10% (e.g., infection, bleeding, postoperative and/or chronic pain)
- No-scalpel (NSV) technique has lower incidence of bleeding and pain than incisional technique
- Morbidity and mortality rare
Vasectomy: Crucial Programmatic Facts

- Men in every region and cultural, religious and socio-economic setting show interest in vasectomy, despite common assumptions about negative male attitudes or societal prohibitions.

- However, men often lack full access to information and services, especially male-centered programming, which has been shown to result in greater uptake of vasectomy.
Fertility Awareness Methods

- Based on awareness of or ability to determine fertile time of menstrual cycle
- **Very difficult to initiate while breastfeeding:**
  - Symptoms of fertility are not evident
- **Include:**
  - Basal body temperature/cervical secretions
  - Calendar calculations
  - Standard Days Method:
    - Cycle beads
  - Periodic abstinence during fertile period
Fertility Awareness Methods

- **Advantages:**
  - Inexpensive
  - Not necessary to acquire supplies at clinic/dispensary

- **Disadvantages:**
  - Most methods unreliable in postpartum women
  - Postpartum women, especially when breastfeeding, need to have 4 menstrual cycles, the most recent cycle is 26 to 32 days long
  - Partner’s cooperation needed in periodic abstinence or using condoms during fertile period
Coitus Interruptus (CI)/Withdrawal

- A traditional family planning method in which the man completely removes his penis from the vagina, and away from the external genitalia of the female partner, before he ejaculates.
- CI prevents sperm from entering the woman’s vagina, thereby preventing contact between spermatozoa and the ovum.
CI: Effectiveness

- When used perfectly, effectiveness can be as high as 95%
- With typical usage, effectiveness about 75–81%
Advantages and Disadvantages?
Managing Side Effects of Family Planning Methods

Session 12
Session Objectives

By the end of this session, participants will be able to:

- Describe common side effects of various FP methods
- Discuss management of side effects of FP methods
Combined Oral Contraceptives: Common Side Effects

- Change in menses (frequently resolved in first 3 months):
  - Spotting
  - Break-through bleeding

- Nausea

- Acne (improvement usually)

- Breast fullness or tenderness (mastalgia)

- Mood changes may cause loss of libido
COCs: Managing Common Side Effects

- **Change in menses (spotting and breakthrough bleeding):**
  - Check to see if client is taking COCs correctly
  - Reassure that will resolve
  - Check to see if on rifampicin; change to DMPA
  - If not resolved after 3 months, advise different COCs

- **Nausea:**
  - Advise to take pill with evening meal or at bedtime with a snack
COCs: Managing Common Side Effects (cont.)

- Acne: usually improves
- Breast fullness or tenderness, usually subsides after a few months:
  - If breastfeeding, check for infection; if no infection, counsel on use of firm bra and continued breastfeeding. If infection present, give appropriate antibiotics.
  - Check for pregnancy; if not pregnant, and no lumps or cysts, reassure and counsel to avoid caffeine, chocolate, etc.
  - Switch to a lower estrogen pill offer progestin-only method.
- Mood changes are multifactorial. They may be related to the progestin in COCs. If depression has worsened using COCs, consider another method.
COCs: Evaluate for Potential Problems

- **Chest pain (especially with exercise):**
  - Assess for possible cardiovascular disease:
    - Check blood pressure and heart for irregular beats (arrhythmias)
    - If evidence of CVD, refer for further evaluation
    - Consider stopping COCs and help client choose another method
COCs: Evaluate for Potential Problems (cont.)

- **High blood pressure:**
  - Confirm blood pressure by checking again after 15 minutes of rest; monitor closely if first episode of increased BP.
  - Discontinue COCs if BP >140/90, or warning signs (e.g., severe headache, blurred vision, chest pain) occur.
  - Choose a method that does not contain estrogen.
  - Monitor monthly and refer for further evaluation if BP does not return to normal after 3 months.
COCs: Warning Signs

- Contact health care provider or clinic if you develop any of the following problems:
  - Severe chest pain or shortness of breath
  - Severe headaches or blurred vision
  - Severe leg pain
  - Absence of any bleeding or spotting during pill-free week (21-day pack) or while taking 7 inactive pills (28-day pack) may be a sign of pregnancy
Progestin-Only Methods (POPs, PICs and Implants): Side Effects

- Amenorrhea (absence of vaginal bleeding or spotting)
- Bleeding or spotting
- Heavy or prolonged bleeding
- Weight gain or loss (change in appetite)
- Headache
- Nausea (less frequent than with COC users)
Progestin-Only Methods: Management of Amenorrhea

- Rarely due to pregnancy, especially among PIC users; more often natural response to lack of estrogen
- Evaluate for pregnancy, especially if amenorrhea occurs after period of regular menstrual cycles
- Do not attempt to induce bleeding with COCs
Progestin-Only Methods: Management of Bleeding or Spotting

- Prolonged spotting (> 8 days) or moderate bleeding:
  - Reassure that it is common among POP non-lactating users
  - Check for gynecologic problem (e.g., cervicitis)

- Short-term treatment:
  - COCs (30–50 µg EE) for 1 cycle,¹ or
  - Ibuprofen (up to 800 mg 3 times daily x 5 days)

¹ Remind client to expect bleeding after completing COCs.
Progestin-Only Methods: Warning Signs

- Return to clinic if any of the following occur:
  - Delayed menstrual period after several months of regular cycles (may be sign of pregnancy)
  - Severe lower abdominal pain
  - Heavy or prolonged bleeding
### Progestin-Only Methods: Treatment of Common Side Effects

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular or heavy bleeding</td>
<td>Check for gynecologic problem</td>
</tr>
<tr>
<td></td>
<td>Counseling and reassurance COCs, NSAIDs or oral estrogens</td>
</tr>
<tr>
<td>Headache</td>
<td>Nonnarcotic analgesics</td>
</tr>
<tr>
<td>Weight change</td>
<td>Diet history, advice and exercise</td>
</tr>
<tr>
<td>Breast tenderness</td>
<td>Support bra</td>
</tr>
<tr>
<td>Breast discharge</td>
<td>Decreased nipple stimulation</td>
</tr>
<tr>
<td>Acne</td>
<td>Diet, cleansers and topical antibiotics</td>
</tr>
</tbody>
</table>
IUDs: Common Side Effects

- **Copper-releasing:**
  - Heavier menstrual bleeding
  - Irregular or heavy vaginal bleeding
  - Intermenstrual cramps
  - Increased menstrual cramping or pain
  - Vaginal discharge

- **Progestin-releasing:**
  - Amenorrhea or very light menstrual bleeding/spotting
IUDs: Possible Other Problems

- Missing strings
- Slight increased risk of pelvic infection (up to 20 days after insertion)
- Perforation of the uterus (rare)
- Spontaneous expulsion
- Ectopic pregnancy (rare)
- Spontaneous abortion (rare)
- Partner complains about feeling strings
IUDs: Management of Vaginal Bleeding Problems

- Reassure client that menses generally are heavier with an IUD, and bleeding/spotting may occur between periods, especially in first few months.
- Evaluate for other cause(s) and treat if necessary.
- If no other cause(s) found, treat with non-steroidal anti-inflammatory agent (NSAID, such as ibuprofen) for 5–7 days.
- Counsel on options and consider IUD removal if client requests.
IUDs: Management of Cramping and Pain

- Reassure client that cramping and menstrual pain occur with an IUD, usually resolve within first few months.
- Evaluate for other cause(s) and treat if necessary.
- If no other cause(s) found, consider treating with ibuprofen daily with onset of menses.
- Counsel on options and consider IUD removal if client requests.
Management of Partner Complaints about Feeling IUD String

- Discuss client/couple’s concerns, reassure it is not a serious problem and requires treatment only if really bothersome
- Check to be sure IUD is not partially expelled
- If IUD is in place, treatment options are:
  - With long strings, client can sweep them behind cervix
  - Remove IUD if client desires
IUDs: Indications for Removal

- If the client desires
- At the end of effective life of the IUD:
  - TCu 380A = 12 years
- If change in sexual practices (high-risk behavior), consider adding barrier method (condoms) or removing
- Menopause
Warning Signs for IUD Users

- Clients should contact health care provider or clinic if any of the following problems occur:
  - Delayed menses with pregnancy symptoms
  - Persistent lower abdominal pain, accompanied by fever or chills
  - Strings missing or the plastic tip of IUD can be felt when checking for strings
  - Symptoms of STI
Condoms: Management of Common Side Effects

- Allergic reactions, although uncommon, can be uncomfortable:
  - Allergic reaction to condom or local irritation to penis:
    - Ensure that condom is not medicated
    - If reaction persists, consider polyurethane condom
    - Help client choose another method
  - Allergic reaction to spermicide:
    - If symptoms persist after intercourse and no evidence of STI, provide another spermicide or a non-medicated condom or help client choose another method

* Better to use condoms without nonoxynol-9.
Condoms: Management of Other Problems

- Diminished sexual pleasure:
  - If decreased sensitivity is not acceptable, help client choose another method

- Condom breaks or breakage suspected (before intercourse):
  - Discard and use new condom
  - Do not use petroleum or vegetable based oils or lubricants

- Condom breaks or slips off during intercourse:
  - Consider using emergency contraception
Infection Prevention (IP)

Session 13

Jhpiego in partnership with Save the Children, Constella Futures, The Academy for Educational Development, The American College of Nurse-Midwives and IMA World Health
IP: Objectives

- To prevent major postoperative infections when providing surgical contraceptive methods
- To minimize the risk of transmitting serious infections (e.g., HBV, HIV/AIDS) from or to:
  - Clients
  - Service providers
  - Other staff, including cleaning and housekeeping personnel
IP: Universal Precautions

- Consider every person (client or staff) infectious

- Wash hands:
  - Every time you put on and take off gloves
  - The most practical procedure for preventing cross-contamination (person to person)

- Wear gloves before touching anything:
  - Mucous membranes, blood or other body fluids, or soiled instruments/ items

- Use physical barriers:
  - Protective goggles, face masks and aprons if splashes and spills of any body fluids are anticipated
IP: Principles

- **Use safe work practices:**
  - Not recappping or bending needles
  - Safely passing sharp instruments
  - Properly disposing of medical waste

- **Isolate patients only if secretions (airborne) or excretions (urine or feces) cannot be contained**

- **Process instruments and other items (decontaminate, clean, high-level disinfect or sterilize) using recommended infection prevention (IP) practices**
## IP: Risk of Disease Transmission

<table>
<thead>
<tr>
<th>Source of exposure</th>
<th>HBV (%)</th>
<th>HIV (%)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin puncture (broken skin)</td>
<td>27-37</td>
<td>0.3-0.4</td>
</tr>
<tr>
<td>Mucocutaneous</td>
<td>&lt; 0.1</td>
<td>&lt; 0.1</td>
</tr>
</tbody>
</table>

*Sources: Gerberding 1995; Seelf 1978.*
IP: Accidental Exposure to HBV-Infected Blood

- As little as 10-8 ml (.00000001 ml) of HBV-infected blood can transmit HBV to a susceptible host

IP: Practices for Reducing the Risk of Disease Transmission

- Between clients and staff:
  - Handwashing
  - Use of gloves (service provider and cleaning staff)
IP: Practices for Reducing the Risk of Disease Transmission (cont.)

- **From contaminated objects:**
  - Processing instruments and other items:
    - Decontamination (staff)
    - Cleaning (clients and staff)
    - Sterilization (clients and staff)
    - High-level disinfection (clients and staff)
  - Proper waste disposal (staff and community)
IP: Handwashing Practices

- **Steps:**
  - Use a plain or antiseptic soap
  - Vigorously rub lathered hands together for 10–15 seconds
  - Rinse with clean running water from a tap or bucket
  - Dry hands with a clean towel or air dry them

*Source: Larsen 1995.*
Handwashing may be the single most important procedure in preventing infection.

**Wash hands:**
- Before and after examining any client (direct contact)
- After removing gloves because gloves may have holes in them
- After exposure to blood or any body fluids (secretions and excretions), even if gloves were worn
**IP: Alcohol Solution for Surgical Handscrub**

**Formula**

- Add 2 ml glycerin to 100 ml 60–90% alcohol solution.
- Use 3 to 5 ml for each application and continue rubbing the solution over the hands for about 2–5 minutes, using a total of 6 to 10 ml per scrub.
IP: Skin and Mucous Membrane Preparation

- Do not shave hair at the operative site (if necessary, trim hair close to skin surface immediately before surgery)
- Ask the client about allergic reactions before selecting an antiseptic solution
- Wash first with soap and water if visibly soiled
- Apply antiseptic starting from the operative site and working outward in a circular motion for several inches
- Ask the client about allergic reaction to antiseptic
- Apply antiseptic solution liberally to the cervix (2 or 3 times) and then to vagina:
  - It is not necessary to prep the external genital area if it appears clean
  - If area is heavily soiled, it is better to have the client wash her genital area thoroughly with soap and water before starting the procedure
IP: Protective Barriers

- **Wear gloves:**
  - When performing a procedure in the clinic or operating room
  - When handling soiled instruments, gloves and other items
  - When disposing of contaminated waste items (cotton, gauze or dressings)

- **Wear protective goggles, face masks and aprons:**
  - If splashes and spills of any body fluids are likely
# IP: Effectiveness of Methods for Processing Instruments

<table>
<thead>
<tr>
<th>Method</th>
<th>Effectiveness (removal or inactivation of microbes)</th>
<th>End point</th>
</tr>
</thead>
<tbody>
<tr>
<td>Decontamination</td>
<td>Kills HBV and HIV</td>
<td>10 minute soak</td>
</tr>
<tr>
<td>Cleaning (water only)</td>
<td>Up to 50%</td>
<td>Until visibly clean</td>
</tr>
<tr>
<td>Cleaning (detergent with rinsing water)</td>
<td>Up to 80%</td>
<td>Until visibly clean</td>
</tr>
<tr>
<td>Sterilization&lt;sup&gt;1&lt;/sup&gt;</td>
<td>100%</td>
<td>Autoclave, dry heat or chemical for recommended time</td>
</tr>
<tr>
<td>High-level disinfection&lt;sup&gt;1&lt;/sup&gt;</td>
<td>95% (does not inactivate some endospores)</td>
<td>Boiling, steaming or chemical for 20 minutes</td>
</tr>
</tbody>
</table>

<sup>1</sup> Prior decontamination and thorough cleaning required.
IP: Processing Soiled Instruments and Other Items

Decontamination

Thoroughly wash and rinse

Preferred Methods
Sterilization

Chemical
Autoclave
Dry Heat

Acceptable Methods
High-Level Disinfection

Boil
Steam
Chemical

Cool
IP: Decontamination

- **Principles:**
  - Inactivates HBV and HIV
  - Makes items safer to handle
  - Must be done before cleaning

- **Practices:**
  - Place instruments and reusable gloves in 0.5% chlorine solution after use
  - Soak for 10 minutes and rinse immediately
  - Wipe surfaces (exam tables) with chlorine solution
IP: Instructions for Preparing Dilute Chlorine Solutions

Total parts (TP) (H₂O) = \[ \frac{\% \text{ Concentrate}}{\% \text{ Dilute}} \] - 1

To make a 0.5% chlorine solution from 5% bleach, mix 1 part bleach to 9 parts water:

Total parts (TP) (H₂O) = \[ \frac{5\% \text{ Concentrate}}{.5\% \text{ Dilute}} \] - 1 = 9 Total parts (TP) (H₂O)
IP: Instructions for Preparing a Chlorine Solution from a Powder

To make a 0.5% chlorine solution from a 35% chlorine powder, mix 14.2 grams of powder to 1 liter of water.

\[
\text{Gram/Liter} = \left( \frac{\text{% Dilute}}{\text{% Concentrate}} \right) \times 1000
\]

To calculate:

\[
\text{Gram/Liter} = \left( \frac{0.5}{35} \right) \times 1000 = 14.2 \text{ Gram/Liter}
\]
IP: Cleaning

- **Principles:**
  - Removes organic material that:
    - Protects microorganisms against sterilization and HLD
    - Can inactivate disinfectants
  - Must be done for sterilization and HLD to be effective
  - Method of mechanically reducing the number of endospores

- **Practices:**
  - Wash with detergent and water
  - Scrub instruments until visibly clean
  - Thoroughly rinse with clean water
**IP: Sterilization**

- **Principles:**
  - Destroys all microorganisms, including endospores
  - Used for instruments, gloves and other items that come in direct contact with blood stream or tissue under the skin
IP: Sterilization (cont.)

- **Practices:**
  - Steam sterilization (autoclave):
    - 121°C (250°F); 106 kPa (15 lbs/in²) pressure: 20 minutes for unwrapped items, 30 minutes for wrapped items
    - Allow all items to dry before removing
  - Dry-heat (oven):
    - 170°C (340°F) for 1 hour, or 160°C (320°F) for 2 hours
  - Chemical sterilization:
    - Soak items in glutaraldehyde for 8–10 hours or formaldehyde for 24 hours
    - Rinse with sterile water
IP: High-Level Disinfection

- **Principles:**
  - Destroys all microorganisms including HBV and HIV; does not reliably kill all bacterial endospores
  - Only acceptable alternative when sterilization equipment is not available

*Source: Favero 1985; McIntosh et al. 1994.*
IP: High-Level Disinfection—Boiling

- Practices:
  - Boil instruments and other items for 20 minutes (sufficient up to 5,500 meters/18,000 ft.)
  - Always boil for 20 minutes in pot with lid
  - Start timing when water begins to boil
  - Do not add anything to pot after timing begins
  - Air dry before use or storage
IP: High-Level Disinfection—Steaming

- Practices:
  - Steam instruments, gloves and other items for 20 minutes
  - Be sure there is enough water in bottom pan for entire steam cycle
  - Bring water to rolling boil
  - Start timing when steam begins to come out from under lid
  - Do not add anything to pan after timing starts
  - Air dry and store in covered steamer pans

*Source: McIntosh 1994.*
IP: Steamer Used for High-Level Disinfection
IP: Chemical High-Level Disinfection

**Practices:**
- Cover all items completely with disinfectant
- Soak for 20 minutes
- Rinse with boiled water
- Air dry before use and storage
IP: Preparing a High-Level Disinfected Container

- Boil (if small), or
- Fill a clean container with 0.5% chlorine solution:
  - Soak for 20 minutes.
  - Pour out solution. (The chlorine solution can then be transferred to a plastic container and reused.)
  - Rinse thoroughly with boiled water.
- Air dry and use for storage of HLD items.
IP: Waste Disposal

- **Principles:**
  - Prevents spread of infection to clinic personnel who handle waste
  - Prevents spread of infection to local community
  - Protects those who handle wastes from accidental injury

- **Practices:**
  - Wearing utility gloves, place contaminated items (gauze or cotton) in leak-proof container (with a lid) or plastic bag
  - Dispose by incineration or burial
IP: Traffic Flow and Activity Patterns

- **Goal:** To eliminate level of microbial contamination in areas where “clean activities” take place:
  - Procedure rooms
  - Surgical areas
  - Areas for final processing and instrument storage

- **Number of microorganisms in area is related to number of people present and their activity**
Overview of Family Planning and Statutory and Policy Requirements

Session 14
Session Objectives

- Describe key components of FP requirements
- Give examples of compliance monitoring activities
- Describe how to access resources for additional help
- Describe key components of HIV/AIDS requirements
FP Legislative and Policy Requirements

- Voluntarism and informed choice
- USAID supports the freedom of individuals to choose voluntarily the number and spacing of their children:
  - Voluntary – decisions based on free choice and not obtained by any special inducements or forms of coercion
  - Informed choice – effective access to information on family planning
Tiahrt Amendment (1999): Overview

- **Five components:**
  - No targets/quotas
  - No incentives
  - No denial of benefits
  - Comprehensible information required
  - Experimental methods
Tiahrt Amendment: Applicability

- **Which kinds of assistance does Tiahrt apply?**
  - Applies to family planning activities funded from any account (not just CSH)
  - Applies to FP service delivery projects to which USAID provides FP assistance
  - Applies to funds, technical assistance, commodities and training

- **To which entities does Tiahrt apply?**
  - Applies to US NGOs, foreign NGOs, public international organizations and foreign governments
Tiahrt Amendment: Applicability

- **To which kinds of assistance does Tiahrt apply?**
  - Applies to family planning activities funded from any account (not just CSH funds)
  - Applies to FP service delivery projects to which USAID provides FP assistance
  - Applies to funds, technical assistance, commodities and training

- **To which entities does Tiahrt apply?**
  - Applies to US NGOs, non-US NGOs, PIOs and foreign governments
Tiarht Amendment Requirements: Requirement (1) — Targets and Quotas

- Service providers or referral agents shall not implement or be subject to quotas/targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning.
- Quantitative estimates or indicators for budgeting and planning purposes are permitted.
Tiahrt Amendment Requirements: Requirement (2) — No Incentives/Financial Rewards

- No payments of incentives, bribes, gratuities or financial reward to:
  - (A) An individual in exchange for becoming a family planning acceptor
  - (B) Program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors or acceptors of a particular method of family planning
Tiahrt Amendment Requirements:  
Requirement (3) — No Denial of Rights or Benefits

- No denial of rights or benefits as a consequence of an individual’s decision not to accept family planning

- Rights or benefits include access to participate in any program of general welfare or right of access to health care
Tiahrt Amendment Requirements: Requirement (4) — Comprehensible Information Required

- Family planning acceptors must receive comprehensible information on the health benefits and risks of the method chosen.
- Comprehensible information can be provided in many forms such as counseling, posters, brochures and package inserts.
Tiahrt Amendment Requirements:
Requirement (5) — Experimental FP Methods

- Experimental contraceptive drugs, devices and medical procedures may be provided only in the context of a scientific study in which participants are advised of potential risks and benefits.

- USAID has regulations regarding human subjects; support for any such research must be carried out in accordance with these regulations.
Tiahrt Amendment Guidance

- Cases in which Tiahrt must be considered carefully:
  - Mass media campaigns
  - Performance-based financing
  - Social marketing
  - Contraceptive commodities
Tiahrt Amendment

- Three violations to date:
  - Peru: Controversial sterilization campaigns in which incentives were offered to women if they chose to be sterilized, and health benefits were denied if they did not.
  - Guatemala: Targets and cash incentives that were set for an NGO:
    - NGO violated the Tiahrt Amendment by establishing quotas for referral agents for numbers of sterilizations and paying promoters in its marketing department bonuses based on the number of sterilizations referred
  - Philippines:
    - Midwives were assigned targets for number of acceptors and acceptors of particular methods
The Tiahrt Amendment specifically requires that violations be reported to Congress:

- A single violation of requirements (1),(2), (3) or (5) must be reported
- A pattern or practice of violations of requirement (4) must be reported
- USAID Administrator makes determination of violation
- USAID must notify Congress within 60 days of the Administrator’s determination that a violation occurred
Policy Determination 3: Overview

- PD-3 is USAID policy and is complementary to Tiahrt
- Permanent nature of sterilization has required safeguards to protect against potential abuse
- PD-3 key requirements:
  - Informed consent—prior to procedure and documented
  - Ready access to other methods
  - No incentive payments
Policy Determination 3 — Applicability

- **To which kind of assistance does PD-3 apply?**
  - Applies to family assistance from any account (not just CSH)
  - Applies where USAID funds are used for whole or partial direct support of the performance of voluntary sterilization activities

- **To which entities does PD-3 apply?**
  - Applies to US NGOs FNGOs, public international organizations and governments
Other Voluntarism Requirements

- De Concini Amendment: Projects must offer, directly or indirectly, a broad range of methods
- Livingston Amendment: In awarding grants for NFP, no discrimination against applicants because of religious or conscientious commitment to offer only natural family planning, and all such applicants must comply with previous proviso
- Kemp-Kasten Amendment: No funds to organizations that participate in management of programs of coercive abortion or involuntary sterilization
Policies Related to Abortion Services

- Helms Amendment
- Mexico City Policy
- Other:
  - Siljander amendment
  - Biden Amendment
Helms Amendment

- No foreign assistance funds may be used to perform or motivate/coerce people to practice abortions

- To what kind of assistance does Helms apply?
  - To all foreign assistance funds
  - To USAID-funded activities only

- To which kind of entities does Helms apply?
  - Applies to US NGOs, foreign NGOs, PIOs and governments
Mexico City Policy

Foreign (non-US) NGOs must certify that they will not perform or actively promote abortion as a method of family planning as a condition for receiving USAID assistance for family planning.
Mexico City Policy Exclusions

- **Exclusions:**
  - If the life of the mother would be endangered if the fetus were carried to term
  - Following rape or incest
  - Treatment of injuries or illness caused by legal, spontaneous or illegal abortions (postabortion care [PAC] is permitted under Mexico City Policy)
  - Passive referral if abortions are legally available in that country
Family Planning Requirements Review

- **Requirements are either statutory or policy:**
  - Statutory: Tiahrt, Deconcini, Livingston, Kemp-Kasten, Helms, Bidan, Siljander
  - Policy: PD-3 (agency), Mexico City Policy (Executive)

- **Requirements generally relate to voluntarism/informed choice or abortion:**
  - Voluntarism/informed choice: Tiarht, PD-3, DeConcini, Livingston, Kemp-Kasten
  - Abortion: Mexico City Policy Helms, Bidan, Siljander

- **Requirements apply to particular kinds of assistance:**
  - Apply to all foreign assistance—Kemp-Kasten, Helms, Bidan, Siljander
  - Apply to FP assistance—Tiarht, PD-3, Deconcini, Livingston, Mexico City Policy

- **Requirements apply to particular types of entities:**
  - Apply to US NGO foreign NGO, PIOs, governments—all statutes, PD-3
  - Apply ONLY to foreign NGOs—Mexico City Policy

- **Requirements apply to particular types of agreements:**
  - Apply to all foreign agreements—all statutes, PD-3
  - Apply to all grants/CA only—Mexico City Policy
Ensuring Compliance

- Preventive activities (training)
- Monitoring
- Responding and taking corrective actions if breeches found
Monitoring

- Develop tools: Field visit checklists, discussion guides, monitoring schedule
- Ask questions about staff motivation: Look for patient information, wall charts, flipcharts for comprehensible information; ask patients if given info about method
- Monitor documents
- Contact USAID if non-compliance issues or possible non-compliance
HIV/AIDS Requirements: Overview

- Statutory and policy requirements:
- The U.S. Leadership Against HIV/AIDS, TB and Malaria Act of 2003
- AAPD 05-04 issued June 9, 2005:
  - Replaced AAPD 04-04 (Rev. 2)
HIV/AIDS Requirements: Medically Accurate Information Requirement

- Information provided about condoms must be medically accurate:
  - Such information must be consistent with USAID’s fact sheet entitled, “USAID: HIV/STI Prevention and Condoms”
  - This provision applies to all recipients, including PIOs
  - This provision must be included in all subawards
HIV/AIDS Requirements: Leadership Act
Requirement — Implementation of Section 301(d)

- Conscience clause:
  - A recipient is not required to use a multisectoral (ABC) approach or to participate in a prevention method to which it has a religious or moral objection
  - This provision applies to all recipients, including PIOs
  - This provision must be included in all subawards
HIV/AIDS Requirements: Leadership Act
Requirement — Implementation of Section 301(e)

- No USG funds for HIV/AIDS activities may be used to promote or advocate the legalization or practice of prostitution or sex trafficking:
  - This does not restrict the provision of HIV/AIDS prevention, care and treatment to individuals

- This provision applies to all recipients, including PIOs

- This provision must be included in all subawards
HIV/AIDS Requirements: Leadership Act
Requirement — Implementation of Section 301(f)

- Organizations receiving USG funds for HIV/AIDS activities must have a policy explicitly opposing prostitution and sex trafficking:
  - Applies to both US and foreign NGOs and non-exempt PIOs.
  - The clause must be included in all subawards.
  - The following organizations are exempt from this provision: the Global Fund to Fight AIDS, Tuberculosis and Malaria; the World Health Organization; the International AIDS Vaccine Initiative; and United Nations agencies. These organizations are not required to include the Section 301(f) clause in their subawards.
HIV/AIDS Requirements: Section 301(f) Policy Requirement

- USAID will not review organizations’ policies prior to award. The organizations will have to determine whether they can comply with the provisions of the AAPD.
HIV/AIDS Requirements: Certification Requirement

- Prime recipients of an HIV/AIDS grant or cooperative agreement must provide a certification that they are in compliance with the AAPD 05-04 clauses prior to receipt of award.
- At this time, the certification is not required of contractors.
- Do not confuse the certification requirement with the 301(f) policy requirement.
- This certification requirement is different from MCP certification requirement. Leadership Act certification is a separate document from the grant or cooperative agreement. MCP certification is accomplished by the recipient signing the grant or cooperative agreement.
HIV/AIDS Requirements: Applicability — Which Funds Are Affected?

- All funds (regardless of account) used for HIV/AIDS activities: GHAI, CSH, ESF, FSA, SEED
Different organizations may be responsible for different types of activities, and therefore be subject to different requirements:

- Both activities → both requirements (FP and AAPD 05-04)
- HIV/AIDS activities only → AAPD 05-04 only
- FP activities only → FP requirements only
  - Including MCP for foreign NGOs
Material Resources

- Summary of USAID Family Planning Requirements
- Contract information bulletins/AAPDs
- Tiahrt guidance documents
- All available at:
How to Implement Your Family Planning Skills in Your Facility: Transfer of Learning

Session 15
Why do we do training?

- To ensure that workers have the skills and knowledge to do the job
Transfer of Learning

- Transfer of learning is defined as ensuring that the knowledge and skills acquired during a learning intervention are applied on the job.
- The goal is to have 100% of the knowledge and skills acquired during a learning intervention be applied on the job, resulting in improved performance and quality health services.
Why focus on transfer of learning?

- Improves quality of client services
- Encourages and empowers learners
- Improves accountability for implementation
- Helps supervisors keep current to evidence based medical practices and standards
What are the barriers?

- Lack of reinforcement on the job
- Difficulties in the work environment
- Non-supportive organizational cultural
- Learners’ perceptions that the new skills are impractical
- Learners’ discomfort with change
- Separation from the instructional source
- Poor instructional design and delivery
- Negative peer pressure
What performance factors affect transfer of learning?

- Job expectation
- Feedback
- Physical environment and tools
- Motivation
- Skills and knowledge
- Organizational support
Action Plan

- Describes steps to maximize transfer of learning
- Used by learner, supervisor, trainer and co-workers
- Helps track expectations, commitments and resources
- Initiated before, refined during and implemented after training
Develop Action Plan

- Identify co-workers and supervisor
- Identify area to improve:
  - Improve postpartum care
  - Improve postpartum family planning
- Detailed specific actions:
  - Determine the steps and the sequence of these steps to reach the desired improvement, the staff involved, and dates to achieve each step
Support and Supervision Monitoring

- Trainers will support learners by monitoring and evaluating learners’ progress
- Support successes in activities on action plan
- Make adjustments involving all of the staff identified in the action plan
Resources for Transfer of Learning

- **Web:**
  - ReproLine Web site:
    - http://www.reproline/jhu.edu/english/6read6pi/tol/index.htm
  - Intra/Prime Web site:
    - http://www.intrah.org/tol/index.html