Counseling for Postpartum Family Planning and Postpartum IUCD

Reference Manual

Family Planning Division
Ministry of Health and Family Welfare
Government of India

January 2012

सत्यमेव जयते

चिकित्सा एवम् स्वास्थ्य विभाग राजस्थान

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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Government of India, Nirman Bhawan, New Delhi-110011

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FOREWORD

Research and program experience worldwide indicate that the adoption of family planning to delay the first pregnancy and space subsequent pregnancies significantly contribute towards safe motherhood and child survival. The postpartum period is recognized as an important phase in the life cycle of women for adoption of family planning because it is during this period that the woman experiences return of fertility and has a high unmet need for contraception (which is 65% during the first year after birth). The Ministry of Health and Family Welfare (MoHFW), GoI as a part of its commitment towards provision of quality spacing services in family planning has been working towards strengthening of postpartum family planning services.

The overarching strategy of family planning program is to offer clients easy access to a wide range of affordable, reliable and good quality contraceptive services. It has been seen that the best decisions about family planning are those that people make for themselves, based on accurate information and a range of contraceptive options. Effective counselling is a tool which empowers people to seek what is best for them and to exercise their right to good quality family planning care. A need was therefore felt to reorient and refocus the family planning counselling to offer a tailored approach for meeting individual needs of the clients.

This reference manual 'Counselling for Postpartum Family Planning and Postpartum IUCD' has therefore been prepared to address the critical issue of counselling in the family planning program. The manual includes essential knowledge and tools to develop skills that are required to provide effective family planning counselling. At the same time it provides a special focus to newer and critical areas of family planning like postpartum family planning and IUCD counselling and responds to the needs expressed by those in the field.

The content of this reference manual can be used and adapted by trainers in the training for strengthening the counseling skills of family planning providers and counsellors.

The effort of the Family Planning Division in developing this manual, which gives an overview of counselling, is commendable. I hope the family planning service providers and health workers find this manual useful in the field.

6/1/2012

(Anuradha Gupta)

NATIONAL RURAL HEALTH MISSION
राष्ट्रीय ग्रामीण स्वास्थ्य मिशन

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ACKNOWLEDGEMENT

The reference manual 'Counselling for Postpartum Family Planning and Postpartum IUCD' has been developed based on the felt need among service providers for such a manual. The manual is a comprehensive book and details out various aspects of counselling during the postpartum period and highlights the critical issues to be considered while counselling for postpartum IUCD.

The endeavour has been made possible through contribution from the technical team of Jhpiego, comprising of Dr Saswati Das, Dr G. V. Rashmi, Dr Dinesh Singh, Dr Vivek Yadav and Dr Somesh Kumar under the leadership of Country Director Dr Bulbul Sood. The contribution of Dr Rashmi Asif, Ms Holly Blanchard and Dr Jeffrey Smith is acknowledged for reviewing the manual. The contribution of Dr Vineet Srivastava and Dr Kailash Saran, who have translated the manual in Hindi and Celine Gomes, who has designed and formatted the manual, is also acknowledged.

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Special appreciation goes to Dr Sushma Dureja, DC (FP-II) for reviewing the technical content of the manual.

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6/1/12

(Dr S K Sikdar)

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ACCRONYMS AND ABBREVIATIONS

AIDS	Acquired Immuno Deficiency Syndrome
ANC	Antenatal Care
ARV	Anti Retro Viral
COC	Combined Oral Contraceptive
CNS	Central Nervous System
DMPA	Depot Medroxy Progesterone Acetate
DVT	Deep Vein Thrombosis
EBF	Exclusive Breast feeding
EC	Emergency Contraception
ECP	Emergency Contraceptive Pill
FP	Family Planning
HIV	Human Immuno Deficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information, Education and Communication
IPPF	International Planned Parenthood Federation
IUCD	Intrauterine Contraceptive Device
JSY	Janani Suraksha Yojna
LAM	Lactational Amenorrhea Method
NSV	No Scalpel Vasectomy
OCP	Oral Contraceptive Pill
PID	Pelvic Inflammatory Disease
PNC	Postnatal Care
POP	Progestin Only Pill
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intrauterine Contraceptive Device
RH	Reproductive Health
SDM	Standard Days Method
STD	Sexually Transmitted Disease
STI	Sexually Transmitted Infection
TB	Tuberculosis
WHO	World Health Organization

Introduction

Family planning (FP) counseling is an interpersonal exchange in which a service provider and a client engage in a dialog about FP issues. Counseling is essential to ensure quality of care in FP services. The success of health and family welfare program heavily depends upon the counseling capabilities of the health professionals. As counseling is a face-to-face communication, the counselor must have the skills to understand his/ her clients, develop a friendly relationship and give complete, correct and clear information, using an easy language and rectify the myths and misconceptions about the family planning methods.

Postpartum period is a very important time to introduce contraceptive information because women are more ready to receive massages. In India 65% of postpartum women during their first year, want to space or limit their future pregnancies, but do not use any modern family planning method.[1] Additionally, 61% of Indian couples space their birth to next pregnancy 26 months or less, whereas research has shown that couples who space 24-30 months have the healthiest infant and child outcomes.[2]

Introducing some advices or methods is not sufficient; more qualified counseling techniques including proper communication skills is required in postpartum period. This manual will help counselors in providing quality counseling for postpartum family planning.

[1]Access FP 2009
[2]Rustein 2008

CHAPTER 1

BENEFITS OF FAMILY PLANNING AND IMPORTANCE OF POSTPARTUM FAMILY PLANNING

Research and program experience worldwide indicate that the use of family planning to time the first pregnancy to age 18, space subsequent pregnancies by at least 2 years (24 months) after a live birth and by at least 6 months after an abortion and limit high parity births, help women in avoiding unintended pregnancies. It significantly contributes to efforts to ensure safe motherhood and child survival by helping women and couples achieve healthy fertility and healthy pregnancy outcomes that in turn reduce maternal and infant illness and deaths.

The multiple benefits of family planning for women and their newborns are outlined in the Table 1 below:

Table 1: Benefits of Family Planning and Risks if family planning is not practiced

Benefits	Risks
For the Mother  ▪ Reduced risk of complications which are associated with closely spaced pregnancies ▪ She may have more time to take care of the baby if she does not have to deal with the demands of a new pregnancy ▪ She may breastfeed longer; longer duration of breastfeeding is linked to a reduced risk of breast and ovarian cancer ▪ She may be more rested and well-nourished so as to support the next healthy pregnancy ▪ She may have more time for herself, her children, and her partner, and to participate in educational, economic and social activities ▪ She may have more time to prepare physically, emotionally, and financially for her next pregnancy	**For the Mother** ▪ Women who experience closely spaced pregnancies, are: - at increased risk of miscarriage (abortion) - more likely to induce an abortion; and - at greater risk of maternal death
For the Baby  ▪ Babies are more likely to be born strong and healthy ▪ Babies can be breastfed for a longer period of time, which allows them to experience the health and nutritional benefits of breastfeeding ▪ Exclusive breast feeding during the first six months promotes good health among babies ▪ Mother-baby bonding is enhanced by breastfeeding, which facilitates the child's overall development ▪ Mothers who are not caring for another young child under the age of three may be better able to meet the needs of their newborns	**For the Baby** ▪ Risk of newborn and infant mortality is higher when pregnancies are closely spaced ▪ There is a greater chance of pre-term low birth weight baby, or small for its gestational age ▪ When breastfeeding stops before six months, the baby does not experience the health and nutritional benefits of breast milk, and is more at risk for diarrheal diseases, infections and mortality. The mother-baby bond may be diminished, which may affect the baby's intellectual development

1.1 Postpartum Family Planning

The postpartum period is a unique phase in the life of a woman and her baby. It is a time of transition, adjustment and adaptation along with significant biological, social and psychological changes.

According to the World Health Organization (WHO) the postpartum period starts after delivery of the placenta, and includes the first six weeks after delivery, when the body of the woman returns to its non-pregnant state. The extended postpartum period is considered up to one year after delivery.

Postpartum family planning is the initiation and use of family planning methods during the first year after delivery.

- **Post-placental –** within 10 minutes after placenta delivery
- **Immediate postpartum –** delivery to 48 hours
- **Postpartum** – initial 6 weeks post delivery
- **Extended postpartum** – 6 weeks to one year after delivery

Family planning (FP) programs recognize the importance of providing FP to postpartum women, because it is during the extended postpartum period when a woman's fertility returns, and where unmet need for FP is high. In India the unmet need for family planning among postpartum women during the first year is 65%.[3] Additionally, 61% of Indian couples space their birth to next pregnancy 36 months or less, whereas couples who space 24-30 months have the healthiest infant and child outcomes.[4]

The postpartum period is also a period of risk for women and babies. WHO reports that over 60% of maternal deaths in developing countries occur during the postpartum period. There are more than 3.3 million stillbirths each year, and more than 4 million neonatal deaths. About half of the neonatal deaths take place within 72 hours of delivery.[5]

1.2 Rationale for Postpartum Family Planning (PPFP)

Provision of family planning services during the first year postpartum is a critical component of maternal and child health (MCH) and reproductive health (RH) services.

Rationale for emphasizing Postpartum Family Planning is given below:

1. **The most receptive period to accept contraception:** Just after delivery, women are more receptive to accept a contraceptive method. With increased institutional deliveries influenced by the Janani Suraksha Yojna (JSY), the contact of women after childbirth in the first 48 hours,

[3]Access FP 2009
[4]Rustein 2008
[5]The World Health Report, 2005

with the health care providers is an opportunity to counsel and provide them with safe and appropriate contraceptive method(s) of their choice before they leave for home.

2. **Risk of pregnancy after childbirth:**
   - For women who are not breastfeeding, pregnancy may occur as soon as four weeks after childbirth
   - Breastfeeding women who are not practicing lactational amenorrhea method (LAM) are likely to become fertile before return of menses. They may become pregnant as soon as six weeks after childbirth
   - Women who are practicing LAM, which means 3 conditions: (i) The mother's monthly bleeding has not returned, (ii) The baby is fully breastfed, (iii) The baby is less than 6 months old, can become pregnant after 6 months of childbirth
   - Fertility may return prior to menstruation in 1/3 of women

3. **Unmet need** - Among women during their first year postpartum in India, 91% of women want to avoid another pregnancy but only 26% are using any method of family planning. As mentioned above, 65% have an unmet need for family planning.

4. **Ensuring healthy timing and spacing of pregnancy:**

   Birth to pregnancy intervals of less than 24 months are associated with the highest risk of poor maternal, perinatal, neonatal and infant health outcomes. Providing FP counseling and services following delivery can ensure healthy timing and spacing of pregnancy.

5. **Ensuring safe timing of pregnancy after abortion:**

   The intervals of less than 6 months between abortion and next pregnancy are associated with the higher risk of poor maternal, perinatal, neonatal and infant health outcomes. Providing FP counseling following abortion can ensure an interval of at least 6 months for the next pregnancy.

   Return of fertility is unpredictable and ovulation may occur prior to return of menses.

   In India, approximately 27% of births occur within 24 months after the last birth and next 34% of births occur between 24 and 35 months of last childbirth. These closely spaced pregnancies are dangerous both for mother and baby.

1.3 Importance of Postpartum Family Planning

Improved use of family planning services in the postpartum period can help reduce maternal and infant illness and death. Improved access to contraceptive services will help women delay, space and/or limit their pregnancies.

Use of family planning among postpartum women can significantly:

- Reduce maternal mortality and morbidity
- Reduce infant mortality and morbidity
- Prevent risky or unwanted pregnancies
- Prevent unintended pregnancies among younger and older women, when the risk of maternal and infant death is greatest
- Reduce the incidence of abortion, especially unsafe abortion, which causes 8-9 % of maternal mortality in India
- Allow women to space their pregnancies

1.4 Contraception for Postpartum Women

A woman who chooses to begin a contraceptive method after giving birth must consider several factors, including her breastfeeding status and the type of method she wants to use. Education and counseling should be provided by a counselor/health care provider so that she can select and use the method that is best for her.

When Postpartum Women Can Initiate Contraceptive Use

Table 2 (below) shows the methods that are most appropriate for postpartum women in the immediate and extended postpartum periods, depending on whether or not women are breastfeeding

Table 2: Timing of Method Use in the Postpartum Period

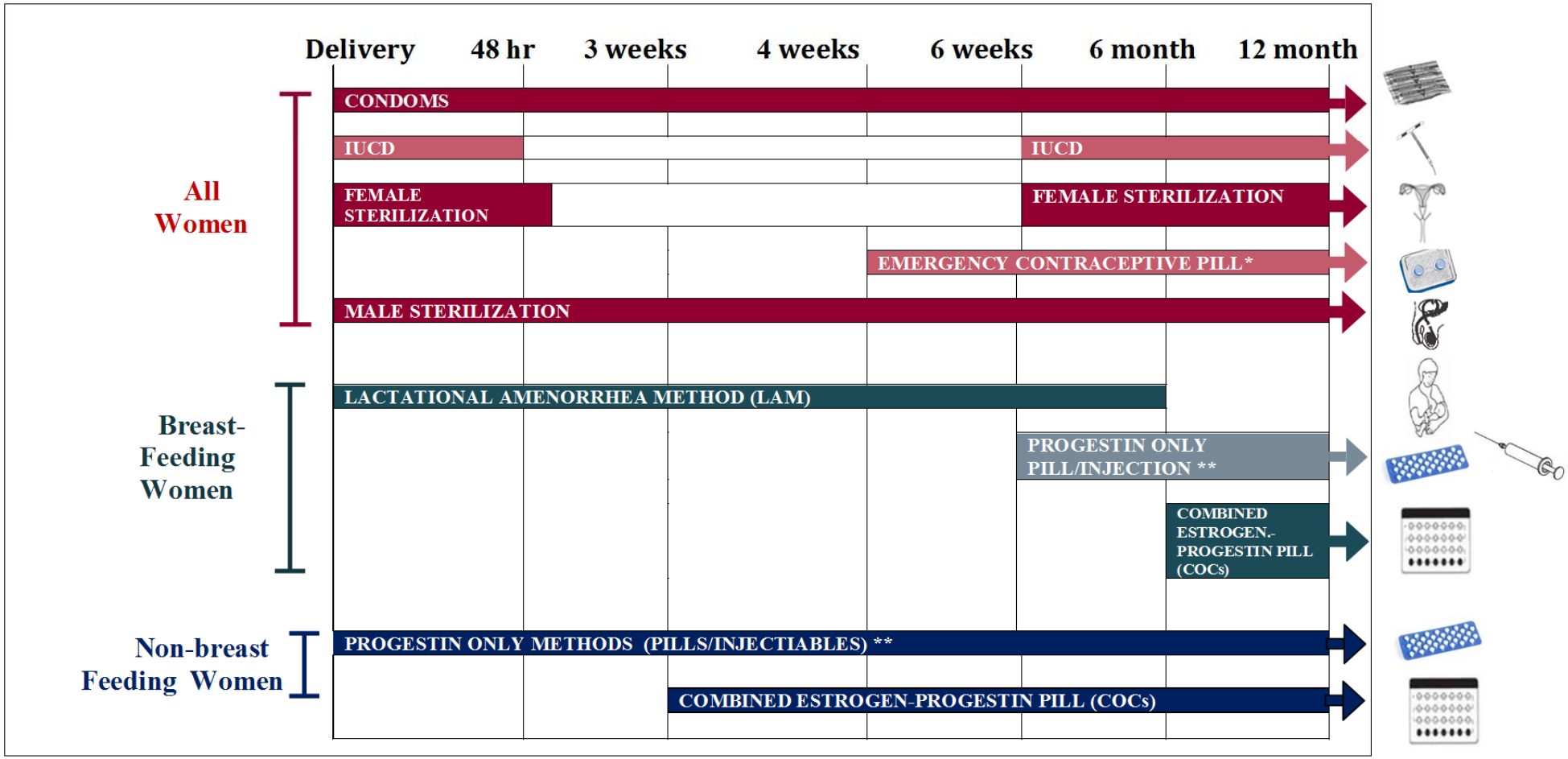
FAMILY PLANNING METHOD	FULLY BREAST FEEDING	PARTIALLY BREASTFEEDING OR NOT BREASTFEEDING
Lactational Amenorrhea Method	Immediately	(Not applicable)
Copper-bearing IUD	Post Placental insertion (within 10 minutes of delivery, only by trained providers), Immediate Postpartum <48 hours of delivery (only by trained providers) Postpartum >6 weeks for an interval insertion	
Female sterilization	Within 7 days, otherwise wait 6 weeks	
Male or Female condom	Immediately or when sex is resumed	
Fertility awareness methods or Standard days method (SDM)	When normal menstrual bleedings have returned or woman has had 3 regular menstrual cycles 26-32 days apart, she can prevent pregnancy by avoiding unprotected sex during 8th to 19th day.	
Combined oral contraceptives	6 months after childbirth**	3 weeks after childbirth if not breastfeeding**
Progestin-only methods (pills/injectables)	6 weeks after childbirth**	Immediately if not breastfeeding**
Vasectomy	Immediately or during wife's pregnancy*	

*If a man has a vasectomy during the first 6 months of his wife's pregnancy, it will be effective by the time she delivers her baby.

**Earlier use is not usually recommended unless other, more appropriate methods are not available or not acceptable.

The figure below shows the safe time for postpartum initiation of various family planning methods.

SAFE TIMES FOR POSTPARTUM INITIATION OF VARIOUS METHODS OF FAMILY PLANNING



*This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.

**This is available in private sector.

1.5 Family planning information to pregnant and new mothers

Information and counseling regarding postpartum care along with family planning need to be initiated during antenatal care. Counselors and providers can begin to counsel women on PPFP LAM and the transition but particularly PPIUCD and permanent methods for those interested.

New research recommends that providers need to strengthen their efforts to educate and counsel postpartum women on healthy timing and spacing of pregnancy and how the use of contraception for planning their families can significantly contribute to improved health for both women and their babies.

Health providers/counselors may give the following FP information to pregnant and new mothers:

1.5 (A) During antenatal period

- Importance of immediate and exclusive breastfeeding after delivery
- Discuss intentions of having more children
- Lactational Amenorrhea Method (LAM) and transition to other contraceptive options as reproductive intentions indicate
- For couples who plan to have more children: counseling for healthy timing and spacing of pregnancy and its benefits to women and their children
- Permanent methods or long acting temporary methods for couples who have completed their family

1.5 (B) During immediate postpartum (within 48 hours of delivery)

- Exclusive breastfeeding
- Discuss intentions of having more children
- For women who want another child:
  - Counseling for healthy timing and spacing of pregnancy and its benefits
  - LAM or other contraceptive options as reproductive intentions indicate
  - PPIUCD counseling, confirmation and provision if requested
  - Importance of postnatal care for the mother and newborn
- For women who have completed their family, provision of options for permanent methods or long acting temporary methods

1.5 (C) During postnatal care contact (within six weeks)

- Well-being of the mother and baby: rule out problems
- Discuss immunization status and schedule
- Counsel on exclusive breast feeding and LAM
- Discuss return to sexual activity
- Determine family planning use and provide appropriate method
- Importance of postnatal care for the mother and the baby and return visits

1.5 (D) Child health contacts during the first year/Immunization sessions

- All the first 6 points mentioned above in the 'During postnatal visit'
- Importance of infant care

Counselors and providers need to keep in mind that while counseling the women/couples, they provide the family planning messages, discuss their fertility intentions and desired family size in such a way that women/couples can make an informed contraceptive choice.

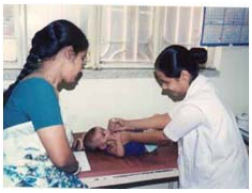


Table 3: Family Planning Messages

The FP Messages: For couples who desire a next pregnancy after a live birth	**For couples who decide to have a child after a miscarriage or abortion**	**For adolescents**
For the health of the mother and the baby, wait at least 2 years (24 months) from birth of the baby to next pregnancy. Consider using a family planning method of your choice during that time.	For the health of the mother, wait at least 6 months before trying to become pregnant again. Consider using a family planning method of your choice during that time.	For your health and to have a healthy baby, wait until you are at least 18 years of age, before trying to become pregnant. If you are sexually active, consider using a family planning method of your choice and avoid pregnancy until at least 18 years of age.

1.6 Return to Fertility (chances of becoming pregnant)

When the baby suckles the breast, it stimulates the production of the hormone prolactin, which helps milk production and suppresses ovulation.

More than 98% of women who ***exclusively breastfeed for the first six months postpartum*** AND ***who are not menstruating*** will not become pregnant. In contrast, a woman who does not exclusively breastfeed or who does not breastfeed at all can become pregnant as soon as four weeks after childbirth. The return to fertility, however, is unpredictable. Ovulation may occur and a woman can become pregnant even before her periods return.

Return to Fertility: A Distinction Between Postabortion and Postpartum Women

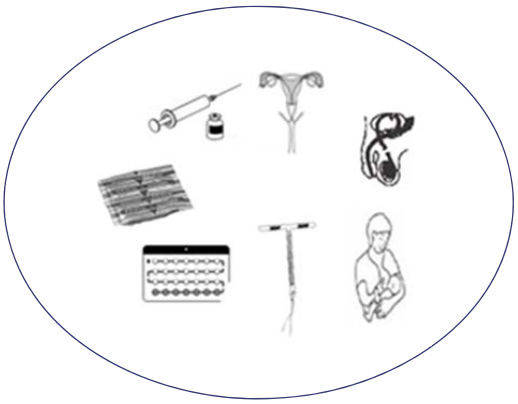
The return to fertility differs significantly for postabortion and postpartum women.
Following an abortion or miscarriage, a woman's fertility returns within 10 – 14 days (average 11 days). Women who have experienced an abortion or miscarriage should begin the use of contraceptive method immediately following the incident to prevent an unintended or unsafe pregnancy. Research shows that women who become pregnant again within six months of a miscarriage or abortion are much more likely to experience pregnancy related complications.

For postpartum women, it is a bit more complicated. Non-breastfeeding women can ovulate and become pregnant as soon as four weeks after delivery. Fertility is less predictable in breastfeeding women. If they are not exclusively breastfeeding, and start supplemental feeding of their babies, they are at risk of pregnancy, even if their menses has not yet returned. To avoid pregnancy, they should see a health care provider and start a FP method that is appropriate for them.

CHAPTER 2

TECHNICAL OVERVIEW OF FAMILY PLANNING METHODS FOR POSTPARTUM WOMEN

2.1 Basket of Contraceptives



A variety of family planning methods are available including those available to the postpartum client. Counselors/health providers need to inform and provide the clients with a basket containing different methods and help them choose a method, which suits them most. This is because clients differ, their situations and needs differ and accordingly they find different methods suitable for them. A client may prefer IUCD because of one-time effort while another may prefer LAM because she plans to exclusively breast feed and it is easy for her to return to the FP clinic to transition to another method when LAM no longer applies to her. Offering clients the available range of family planning methods is crucial to any family planning program trying to offer quality services. Informed choice by the client and quality counseling increases acceptance and continuation of the family planning method.

2.2 Method Characteristics

It is important for counselors/health providers to have a basic 'need to know' knowledge about common and available family planning methods so that they can provide correct information regarding them to their clients, help them to choose a method suitable for their situation, explain necessary details about the chosen method (method specific counseling), answer their questions on different methods, clear myths and misconceptions around methods, reassure them and discuss plans for follow-up.

Health providers should always rule out pregnancy when providing hormonal methods or IUCDs or before female sterilization. However, pregnancy tests may not be available in all clinics or affordable for all clients. In such cases, a checklist given below should be used. This checklist provides workers with an easy-to-use tool to help non-menstruating clients safely initiate their method of choice. The checklist is based on criteria for ruling out pregnancy recognized by the World Health Organization (WHO). Tests of the checklist's effectiveness in family planning clinics showed that the tool was more than 99% effective at ruling out pregnancy.[6]

[6]Stanback J, Qureshi Z, Sekadde-Kigondu C, Gonzalez B, Nutley T. "Checklist For Ruling Out Pregnancy Among Family-Planning Clients in Primary Care," Lancet; August 14, 1999; 354(9178):566

Checklist to be reasonably sure a woman is not pregnant

Ask these 6 questions:

1. Did you have a baby less than 6 months ago? If so, are you fully breastfeeding? Have you had no menstrual bleeding since giving birth?
2. Have you abstained from unprotected sex since your last menstrual bleeding or delivery?
3. Have you given birth in the last 4 weeks?
4. Did your last menstrual bleeding start within the past 7 days (or within 12 days if you plan to use an IUCD)?
5. Have you had a miscarriage or abortion in the past 7 days?
6. Have you been using a reliable contraceptive method consistently and correctly?

If client answered	Then
"No" to all of the questions	1) Pregnancy cannot be ruled out 2) Give client a pregnancy test if available 3) Client should await menses 4) Provide her with a back-up method such as condoms, to use till then
"Yes" to any of the questions *and* she is free of signs and symptoms of pregnancy	1) Pregnancy is unlikely 2) Provide client with desired method

Some of the important characteristics of a method that are discussed with the client during family planning counseling are the following:

1. How does the method work and how to use it
2. How effective it is (how many pregnancies can it prevent among those who are using the method)
3. Benefits of the method
4. Limitations (side effects)
5. Eligibility (who can and who should not use the method)

The important characteristics of the commonly available family planning methods are listed below:

Condoms 

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Condoms (Use: can be started after birth and can be used throughout the postpartum and the extended postpartum period) ▪ Condoms are barrier methods that physically prevent sperms from uniting with the egg as they do not allow the ejaculation and sperms to be deposited in direct contact with the vagina ▪ There are both male and female condoms ▪ Male condoms are made of latex and are worn on the erect penis ▪ Female condoms are usually made of plastic and fit inside of the vagina	▪ Male condoms: with consistent and correct use: 2 typical use: 15 ▪ Female condoms: with consistent and correct use: 5 typical use: 21	▪ Moderately effective ▪ Effective immediately ▪ Only method that prevents STIs, including HIV/AIDS, as well as pregnancy (dual protection), when used correctly during intercourse ▪ No effect on breast milk production ▪ No hormonal side effects ▪ Can be stopped at any time ▪ Easy to keep stock handy, can be used by men of any age ▪ Can be used without initially seeing a health care provider ▪ Enables a man to take responsibility for preventing pregnancy and disease ▪ Male condoms are usually readily available free of cost at the government health facilities	▪ Latex condoms may cause itching for a few people who are allergic to latex ▪ A man's cooperation is necessary ▪ Many people connect condoms with immoral sexual activity ▪ May embarrass people to buy, ask partner to use, put on, take off, or throw away condoms ▪ Supplies must be readily available before intercourse begins ▪ Condoms should not be reused and should be discarded after every act of intercourse ▪ Some men or women may feel that it interferes with their sexual pleasure ▪ Female condoms currently may not be readily available	▪ Men and women of all reproductive ages are good candidates for using condoms.	▪ People allergic to latex

Note: Female condoms are also available nowadays in the market, but it is not included in government of India's family welfare program.

Lactational Amenorrhea Method (LAM)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Lactational Amenorrhea Method (LAM) (Use: Can be used for the first 6 months postpartum as long as all 3 criteria for LAM are met) Method uses the temporary infertility that occurs immediately after childbirth. (1) if women fully breastfeed (2) infertility may last as long six months (3) as long as the woman's menses have **not** returned.	Failure rate: ▪ Consistent and Correct Use (for 6 months): 0.9 ▪ Typical Use: 2	▪ Effective (1 to 2 pregnancies per 100 women during first six months of use) ▪ Exclusive breast feeding (EBF) promotes health benefits to the infant and increases survival ▪ Immediate breastfeeding provides additional protection against infections for the newborn ▪ Promotes mother and infant bonding ▪ Helps mother's uterus return to normal size quicker than non-breastfeeding women ▪ Effective immediately ▪ Does not interfere with intercourse ▪ No systemic side effects ▪ No medical supervision necessary ▪ No supplies required ▪ No cost ▪ Helps reduce the amount of bleeding by keeping the uterus contracted	▪ All three criteria need to be met for effectiveness ▪ May be difficult to practice due to social circumstances, like lack of privacy for breastfeeding in a joint family, working woman ▪ Does not protect against STIs and HIV ▪ Women who are infected with HIV or who have AIDS or taking antiretroviral (medicines for AIDS) can use LAM, however there is a chance that some percentage of infants will get HIV through breast milk. HIV affected women should only be encouraged to give replacement feeding, if the replacement feeding is acceptable, feasible, affordable, sustainable and safe. If available replacement feeding cannot meet these criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM	▪ Women who are fully breastfeeding, whose menses have not returned, and who are less than six months postpartum ▪ Women with HIV who use LAM should also be encouraged to use condoms	▪ Women who are not fully breastfeeding ▪ Postpartum women whose menses have returned ▪ Women who are more than six months postpartum

Oral Contraceptive Pills (OCPs)/Combined Oral Contraceptives (COCs)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Oral Contraceptives (Combined oral contraceptives or COCs) (Use: can be started by the woman after 6 months of childbirth. Woman should take one pill each day. If a woman misses pill, she should take the missed hormonal pill as soon as possible and keep taking pills as usual, one each day.) ▪ COCs contain the hormones estrogen and progesterone, which suppress ovulation	Failure rate: ▪ Consistent and Correct Use: 0.3 ▪ Typical Use: 8	▪ Effective (almost 100%) if used according to directions ▪ Highly effective, reversible, easy to use ▪ Effective within first 2 weeks ▪ Safe for most women ▪ Regulates the menstrual cycle ▪ Reduces menstrual flow (which may be useful to anemic women) ▪ Decreases the risk of ovarian and uterine cancer, benign breast disease, and incidence of acne ▪ Does not interfere with sexual intercourse ▪ Pelvic exam not required before use ▪ Can be provided by trained non-medical staff ▪ May help women who experience painful menstruation	▪ Must be taken every day ▪ Requires regular/ dependable supply ▪ Pills may cause side effects in some women, such as nausea, headache, bleeding between menses or mid-cycle bleeding, or weight gain ▪ Does not protect against STIs and HIV ▪ Risk of developing cardiovascular disease in women over 35 years of age and who smoke	▪ Women and couples who want an effective, reversible method ▪ Women having anemia due to heavy menstrual bleeding ▪ Women with an irregular menstrual cycle ▪ Women with family history of ovarian cancer ▪ Women with HIV/AIDS ▪ Women who are on ARVs ▪ Adolescents	▪ Breastfeeding women < 6 months postpartum ▪ Non-breastfeeding women < 3 weeks postpartum ▪ With advice of clinician, in case of following conditions: - Women with hypertension (BP 140/90 or worse) - Diabetes, (advanced or long standing), with vascular problems, or central nervous system (CNS), kidney, or visual disease ▪ Women who smoke > 15 cigarettes/day ▪ Women with the following conditions: – Deep vein thrombosis (DVT) – Heart disease – Bleeding disorders – Liver disease or tumors – Recurrent migraine headaches with focal neurological symptoms – Unexplained abnormal vaginal bleeding – Breast cancer – Currently taking anticonvulsants for epilepsy

Intrauterine Contraceptive Device (IUCD)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Intrauterine Contraceptive Device (IUCD) (Use: can be inserted in a woman immediately after childbirth upto 48 hours of delivery or after 6 weeks of childbirth) ▪ Copper-releasing IUCDs (Copper T 380A) slow sperm movement in the uterus ▪ A long-acting reversible method. Effective for 10 years of use	Failure rate: ▪ Consistent and Correct Use: 0.6 ▪ Typical Use: 0.8	▪ Very effective (with pregnancy rates of less than 1% during the first year of use) ▪ Available free of cost at government health facilities ▪ Highly effective, reversible FP method can be used for spacing or limiting ▪ Does not interfere with sexual intercourse ▪ No hormonal side effects with copper- bearing IUDs ▪ Immediately reversible with no delay in return to fertility ▪ Does not interfere with breastfeeding ▪ No interactions with any medicines ▪ Initial follow-up visit required after 6 weeks of insertion, then the woman needs to return to the clinic only if she has a problem ▪ Women do not need to purchase any supplies ▪ Can act as emergency	▪ Possibility of minor side effects which decrease after initial few months: – Longer and heavier menstrual periods – Bleeding or spotting between periods – More cramps or pain during periods ▪ Does not protect against STIs and HIV ▪ Requires a trained health care provider to insert and remove the IUD ▪ May be expelled spontaneously	Women who: ▪ Want a reliable long-term reversible method can be used for spacing or limiting ▪ Have just had a delivery or an abortion (if no evidence of infection) ▪ Are breastfeeding ▪ Have or had breast cancer ▪ Have headaches ▪ Have high blood pressure (>140/90 mm hg) ▪ Have heart disease ▪ Have diabetes ▪ Have liver or gallbladder disease ▪ Have epilepsy ▪ Have non-pelvic tuberculosis ▪ Are HIV positive and/or have AIDS who are clinically well	Women with the following conditions: ▪ Pregnancy ▪ Current PID, gonorrhea, or chlamydia ▪ High risk for gonorrhea or Chlamydia ▪ Women with AIDS who are not clinically well ▪ Immediate post-septic abortion ▪ Pelvic tuberculosis ▪ Distorted uterine cavity ▪ Unexplained abnormal vaginal bleeding ▪ Genital tract cancer (awaiting treatment) ▪ Puerperal sepsis ▪ 48 hours to less than 6 weeks postpartum ▪ Malignant trophoblastic disease For PPIUCD – ▪ Pelvic infections ▪ Puerperal sepsis ▪ Prolonged rupture of

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
		contraceptive method when inserted within 5 days of unprotected sex			membranes for more than 18 hours ▪ Unresolved postpartum hemorrhage ▪ Substantial genital trauma from the delivery in which IUCD insertion may cause problem

Injectable Contraceptives (Progestin Only) or Inj. Depot Medroxy Progesterone Acetate (DMPA)

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Injectable Contraceptives (Progestin Only) (Use: can be started by the woman after 6 weeks of child birth) ▪ DMPA (Depot Medroxyprogesterone Acetate) contains the hormone progesterone, which suppresses ovulation. ▪ It is given by injection once every 12 weeks. ▪ The method has a grace period of effectiveness of 4 weeks before or after the scheduled date for the next injection.	Failure rate: ▪ Consistent and Correct Use: 0.3 ▪ Typical Use: 3 ▪ Very effective (with pregnancy rates of less than 1% when used according to instructions)	▪ Very effective and easily reversible ▪ Few side effects. ▪ Does not interfere with sexual intercourse. ▪ No daily action required ▪ No effect on breast milk production, when it is started 6 weeks after childbirth ▪ May help prevent ovarian cancer ▪ For some women, may help prevent iron-deficiency anemia, reduce epileptic seizures. ▪ Pelvic exam not required before use. ▪ Rapidly effective (<24 hours).	▪ May produce minor side effects such as light spotting, bleeding, amenorrhea, or weight gain. ▪ Delayed return to fertility, on average women get pregnant 10-12 months after discontinuation, but can take longer. ▪ Requires regular injection every three months. ▪ Available at a cost in the private health facilities and at the chemists' shop ▪ Currently not available routinely in the public health facilities ▪ Does not protect against STIs and HIV. ▪ Causes changes in menstrual bleeding patterns. Frequently spotting for the first 6 months and then amenorrhea.	▪ Breastfeeding women (as soon as six weeks after childbirth) ▪ Women of any reproductive age or parity, including adolescents ▪ Women who have had an abortion or miscarriage ▪ Women who have blood pressure <160/110 mm Hg, blood clotting problems, or sickle cell disease ▪ Women who smoke (any age) ▪ During the immediate postpartum women who are not breastfeeding ▪ Breastfeeding women whose babies are 6 weeks or older ▪ Women with HIV/AIDS ▪ Women using ARVs ▪ Adolescents	Women who: ▪ Are pregnant ▪ Are breastfeeding and < 6 weeks postpartum ▪ Have high blood pressure (> 160/100 mm Hg) ▪ Have diabetes with vascular disease ▪ Have current or past ischemic heart disease ▪ Have unexplained abnormal vaginal bleeding ▪ Have or had breast cancer ▪ Have liver disease ▪ Have multiple risk factors for arterial cardiovascular disease (i.e., older age, smoking, diabetes, and hypertension). ▪ Have deep vein thrombosis, vascular or heart disease, or stroke.

Note: This method is available in the market, but it is not currently included in Government of India's family welfare program.

Progestin Only Pills (POPs) or Mini Pills

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Progestin Only Pills (POPs) or Mini Pills (Use: can be started by the woman after 6 weeks of child birth) ▪ POPs contain a low dose of progestin, which is similar to the hormone, progesterone. ▪ POPs work by thickening the cervical mucus and preventing ovulation.	Failure rate: ▪ Consistent and Correct Use: 0.3 ▪ Typical Use: 8 ▪ More Effective for breastfeeding Women	▪ Safe for nearly all women ▪ Highly effective, reversible, easy to use. ▪ Decreases risk of ovarian and uterine cancer, benign breast disease, and acne. ▪ Does not interfere with sexual intercourse. ▪ Can be provided by trained non-medical staff. ▪ May be beneficial for women who experience painful menstruation.	▪ Must be taken every day. ▪ Requires regular/ dependable supply. ▪ POPs often cause irregular spotting and cycles particularly for women who are not breastfeeding. ▪ Pills may cause side effects in some women, such as nausea, headache, changes in bleeding patterns, break- through bleeding, or weight gain. ▪ Does not protect against STIs and HIV.	▪ Women and couples who want an effective, reversible method. ▪ Breastfeeding women can begin this method as soon as six weeks postpartum. ▪ Can be used by women who smoke, have anemia now or in past, have varicose veins. ▪ Women with HIV ▪ Women who cannot use COCs ▪ Adolescents	Women who: ▪ Are breastfeeding an infant less than six weeks old ▪ Have severe liver problems ▪ Have blood clots in legs or lungs ▪ Are taking medications for seizures or rifampicin for TB ▪ Have or have had breast cancer

Female Tubal Ligation

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Female Tubal Ligation (Time: can be done by trained and skilled specialist within 7 days after giving birth; and anytime 6 weeks or more after childbirth) ▪ Blocks the fallopian tubes by ligation, clips, or bands and/or cut to prevent sperm and egg from uniting ▪ A permanent method that is not easily reversible ▪ Written consent of the woman undergoing the procedure is required ▪ Two methods: Postpartum tubal ligation and interval tubal ligation ▪ Women should know that other effective, reliable, safe and long-term reversible methods are also available	Failure rate: 0.5	▪ Very effective (with pregnancy rates of less than 1% during the first year of use) ▪ Simple surgery performed on women under local anesthesia ▪ Permanent procedure ▪ Effective immediately ▪ Nothing to remember, no supplies needed, no repeat clinic visits required after initial follow-up visits on 7th day to cut the stitches ▪ Does not interfere with sexual intercourse ▪ No effect on breast milk production ▪ No known long-term side effects or health risks ▪ Can be performed any time during the menstrual cycle when it is reasonably sure that the woman is not pregnant	▪ Uncommon complications of surgery include: – Infection – Bleeding at the incision – Internal infection or bleeding – Injury to internal organs ▪ Requires a trained provider and health facility providing the service ▪ Does not protect against STIs and HIV ▪ Short-term discomfort/pain following procedure	As per national guidelines, any woman who fulfills following criteria:- Married woman (ever married) - Woman is above 22 years and below 49 years of age - Has at least 1 child of age more than 1 year, if the ligation is not being done for any medical reason ▪ Women who have completed their families ▪ Women who just gave birth (within 7 days) ▪ Women who are breastfeeding ▪ Women with HIV or AIDS can safely have a tubal ligation, if they have chosen a permanent method	▪ Women who are not sure of their reproductive goals ▪ Women who have not been counseled and do not understand the permanent nature of the procedure and may regret later ▪ Women with any of the following conditions should delay tubal ligation until the condition is resolved: - Current thromboembolic disorder - Current ischemic heart disease - Prolonged immobilization or leg surgery - Unexplained abnormal vaginal bleeding - Genital cancer - Current PID or within the past 3 months - Active viral hepatitis - Iron-deficiency anemia with a hemoglobin less than 7 g/dl - Acute bronchitis or pneumonia

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
					- Prolonged rupture of membranes - Severe hemorrhage, sepsis, fever during or right after childbirth - Should not be performed on a woman with HIV/AIDS who is not clinically well

Vasectomy 

MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
Vasectomy (can be done on men anytime) ▪ Permanent voluntary sterilization for men ▪ Blocks the vas deferens (tubes carrying sperms in the man) and prevents sperms from entering the semen ▪ A permanent method that is not easily reversible and is highly effective ▪ Written consent is required from the man undergoing the procedure ▪ Methods: - Conventional - No Scalpel Vasectomy (NSV)	Failure rate: 0.2	▪ Very effective (with pregnancy rates of less than 1% during the first year of use) ▪ Permanent procedure ▪ Not effective immediately after the procedure. The man needs to use condoms for the first 3 months after the procedure for the ejaculate to have no sperms ▪ Does not interfere with sexual intercourse ▪ Simple surgery performed under local anesthesia by trained providers ▪ No known long-term side effects. ▪ No repeat clinic visits required, no supplies needed, except the use of condoms for the first 3 months ▪ Easier to perform than tubal ligation ▪ No change in sexual function. ▪ No effect on hormone production	▪ Is permanent ▪ Delayed effectiveness (requires at least 3 months or 20 ejaculations for procedure to be effective) ▪ Requires minor surgery by a trained provider ▪ Does not protect against STIs and HIV ▪ Scrotal support to be maintained for the initial few days to prevent pain and collection of bleeding at the operation site	▪ Men who want to limit their families ▪ Men of any reproductive age ▪ Men who have completed their families ▪ Men whose wives have age, parity, or health problems that might pose a serious health risk if they became pregnant ▪ Men with HIV, AIDS or who are on ARVs can safely undergo vasectomy	▪ Men with any of the following conditions should delay vasectomy until the condition is resolved: - Current STI - Scrotal skin infection - Acute genital tract infection - Acute systemic infection - Symptomatic heart disease, clotting disorders, or diabetes - Men with AIDS who are not clinically well ▪ The following conditions require a provider with extensive experience and skills in performing the vasectomy: - Previous scrotal surgery - Undescended testes and proven fertility - Inguinal hernia - Large varicocele

2.3 Options for Emergency Contraception (EC)

Emergency contraception is a back-up method for any woman, who presents with a history of unprotected sex in the last 5 days, not seeking a pregnancy and the provider is reasonably sure that she is not pregnant. Woman can use EC within the first 5 days after unprotected intercourse (the sooner the better) to prevent an unwanted pregnancy. Emergency Contraceptive Pills (ECP) and Copper bearing IUCDs can be used as emergency contraception.

Emergency contraceptive pills (ECP) are not suitable for use as a regular family planning method because ECP is not as effective as another family planning method used regularly. The failure rates of ECPs are more than that of regular modern contraceptives like IUCD and COCs. The following is the correct dose for ECP: Levonorgestrel (progestin only) 1.5 mg (single tablet or two tablets of 0.75 mg) pills. The ECPs are supplied under the National Family Welfare Program, Government of India to all public sector health facilities.
These pills should be taken within 72 hours (3 days) of unprotected sex.
However, ECPs can prevent pregnancy when taken up to 5 days of unprotected sex. The sooner ECPs are taken after unprotected sex, the better they prevent pregnancy.

If **Cu bearing IUCD** is used as an emergency contraceptive within 5 days of unprotected sex, it can be continued as an ongoing method of contraception if the woman does not want children and desires to continue with the method after proper counseling and does not have any condition making IUCD inappropriate for her.

In case the client or the provider does not have EC available, the COCs can be used for emergency contraception in the dose: COC (35 mcg) 4 tablets within 120 hours/5 days of unprotected sexual intercourse and then 4 more tablets 12 hours later; nausea and vomiting should be anticipated.

Emergency Contraceptive Pill (ECP)
(Can be used anytime after 4 weeks of childbirth)

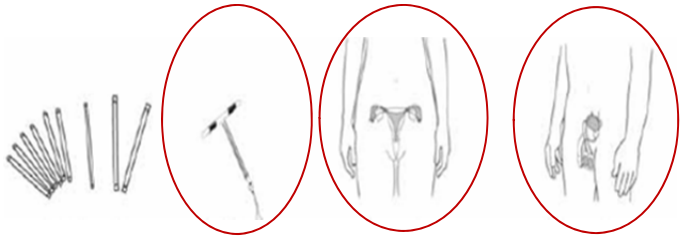
MECHANISM OF ACTION	FAILURE RATE (expressed in no. of pregnancies per 100 women using the method over the first year)	EFFECTIVENESS AND BENEFITS	LIMITATIONS/ SIDE EFFECTS	WHO CAN USE THE METHOD	WHO SHOULD NOT USE THE METHOD
EC Pills *This is not a regular Family Planning Method.* It works by possibly inhibiting ovulation, thickening cervical mucus and affecting transport of sperm or egg depending on the period of the menstrual cycle.	Consistent and Correct Use: (progestin only) 1 (combined) 2	▪ Moderately effective (ECPs should be taken within 3 days (72 hours) of unprotected sex. ECPs can prevent pregnancy if taken up to 5 days of unprotected sex, the sooner it is taken after unprotected sex, the better they prevent pregnancy. Use of ECPs reduces the risk of pregnancy by 85%) ▪ Can help prevent pregnancy after unprotected sex, contraceptive method failure or rape. ▪ Can be taken up to 3 days (72 hours) or up to 5 days (120 hours) after unprotected intercourse, sooner the better. ▪ Is available over-the-counter without prescription ▪ Is available at all government health facilities free of cost	▪ Must be taken within 5 days (120 hours) of unprotected intercourse ▪ Does not protect against STIs and HIV ▪ Possibility of side effects like nausea, vomiting, headache, dizziness, fatigue and breast tenderness. These side effects generally do not last more than 24 hours ▪ Availability may be limited due to bias or misunderstanding of how the method works, or the need for a prescription from a physician ▪ Does not protect unwanted pregnancy from unprotected intercourse after taking the ECPs even if it is on the next day	All women who have had unprotected intercourse for any reason	▪ Anyone with a known pregnancy since emergency contraception will not interrupt a pregnancy ▪ There are no contraindications to progestin only dedicated ECPs

The figure (below) shows the contraceptive effectiveness of family planning methods.

Comparing Effectiveness of Family Planning Methods

More effective

Less than 1 pregnancy per 100 women in 1 year

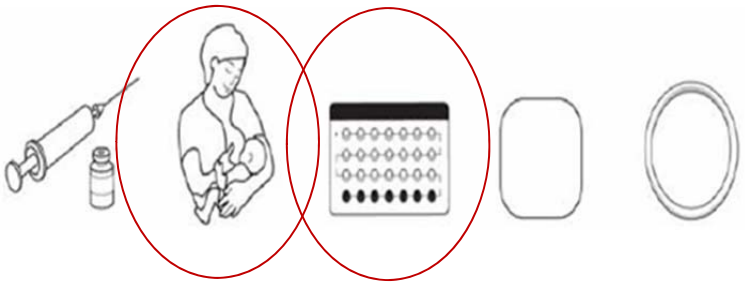


Implants IUD Female Sterilization Vasectomy

How to make your method more effective

Implants, IUD, female sterilization: After procedure, little or nothing to do or remember

Vasectomy: Use another method for first 3 months



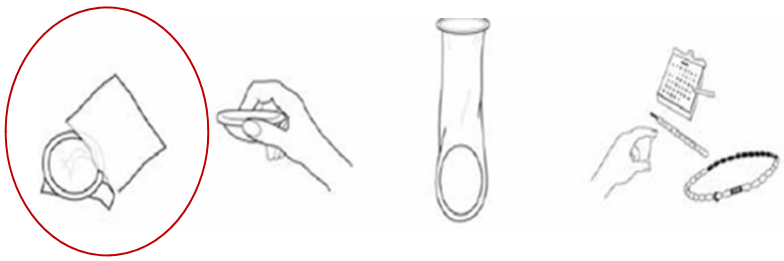
Injectables LAM Pills Patch Vaginal ring

Injectables: Get repeat injections on time

Lactational Amenorrhea Method, LAM (for 6 months): Breastfed often, day and night

Pills: Take a pill each day

Patch, ring: Keep in place, change on time



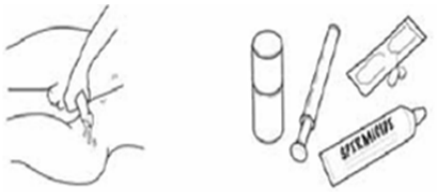
Male condoms Diaphragm Female Fertility awareness

Condoms, diaphragm: Use correctly every time you have sex.

Fertility awareness methods: Abstain or use condoms on fertile days. Newest methods (Standard Days Method and Two Day Method) may be easier to use.

Less effective

About 30 pregnancies per 100 women in 1 year



Withdrawal Spermicides

Withdrawal, spermicides: Use correctly every time you have sex.

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World Health Organization

Sources:

Steiner MJ, Trussell J, Mehta N, Condon S, Subramaniam S, Bourne D. Communicating contraceptive effectiveness: a randomized conrolled trial to inform a World Health Organization family planning handbook. *Am J Obstet Gynecol 2006; 195(1):85-91*

World Health Organization/Department of Reproductive Health and Research (WHO/RHR), Johns Hopkins Bloomberg School of Public Health (JHSPH)/Center for Communication Programs (CCP). *Family Planning: A Global Handbook for Providers.* Baltimore, MD and Geneva: CCP and WHO, 2007.

Trussell J. Choosing a contraceptive: efficacy, safety, and personal considerations. In: Hatcher RA, Trussell J, Stewart F, Nelson AL, Guest F, Kowal D, eds. *Contraceptive Technology*, Nineteenth Revised Edition. New York: Ardent Media, Inc., in press.

CHAPTER 3

FAMILY PLANNING COUSELING APPROACH AND COMMUNICATION SKILLS

3.1 Counseling

In providing family planning services, a good face to face interaction between the client and provider or counselor is the key to meeting client's needs and forms a cornerstone of good-quality services. When counseling is a partnership, in which clients and counselors (or service providers) communicate openly, share information, express emotion, and ask and answer questions freely, clients are more satisfied, understand and recall information better, use contraceptive more effectively, and live healthier lives.

Goal of family planning counseling is to help clients to

- Make better choices about contraceptive methods
- Use their chosen method(s) well
- Continue to use their methods

Good family planning counseling procedures have two major elements and occur when:

1. **Mutual trust** is established **between client and provider or counselor**. The provider or counselor shows respect for the client and identifies and addresses her/his concerns, doubts, and fears regarding the use of contraceptive methods
2. The **client and counselor or service provider give and receive relevant, accurate, and complete information** that enables the client to make a decision about family planning

Good family planning counseling "takes two". In other words, the client and provider both play important roles.

Clients can take active role in counseling by:

- Answering the provider's questions fully and honestly
- Sharing their FP and reproductive health needs and desires
- Asking questions to ensure that they understand what the provider is saying

Provider needs to ensure that clients get opportunities to fulfill the above points.
Provider's role includes:

- Assuring clients that their information will remain confidential
- Providing accurate and relevant FP information
- Listening carefully to the client's needs and desires
- Supporting the client's choices

Good FP counseling benefits clients in many ways, including:

- Facilitating their participation
- Enabling them to be more active in decision making
- Helping them to learn how to use methods better
- Increasing the chance they will return for follow up
- Increasing their satisfaction

3.2 Key points of Counseling

1. The sensitive nature of reproductive health/family planning requires that clients' right to privacy, confidentiality, respect, and dignity are always ensured.
2. Counseling is a two-way communication process in which **both client and counselor** actively participate that enables the client to decide if s/he wants to practice family planning and choose an appropriate method as per their need.
3. Counseling is an **ongoing process** and must be part of every client provider interaction in health care delivery.
4. The decision to adopt a particular method must be a **voluntary, informed decision** made by the client.
5. It is the **responsibility of the counselor or service provider to ensure** that the **client is fully informed** and **freely chooses** and consents to use a contraceptive method.
6. An **informed client** who has been given her method of choice **is a satisfied client**, and is more likely to continue with the method.

3.3 General Counseling

- Usually takes place as a **first step of family planning counseling** to orient the client to benefits of and methods available for family planning
- Reproductive goals and needs of clients discussed
- Client concerns addressed
- General information about methods/options given
- Questions answered
- Misconceptions/myths discussed and clarified
- Decision-making and **method choice begins**

3.4 Method-specific Counseling

- Decision-making and **method choice made**
- More information on method choice given
- Screening process and procedures explained
- Instructions about how and when to use method given
- Problems and common side effects discussed
- What to do if there are problems, discussed

- When to return for follow-up, discussed
- Client should repeat back key instructions to demonstrate she has understood the key points of the method use correctly
- Client given handouts/information to take home when available
- Myths and misconceptions are discussed and clarified

3.5 Return/Follow up counseling

- Elicit client experience and satisfaction with the method
- Problems and side effects discussed and managed
- Continuing use encouraged unless major problems exist
- Key instructions should be repeated
- Questions answered and client concerns addressed
- Encourage satisfied clients to talk to other couples to adopt this method

3.6 Counseling the four types of FP clients

Counseling should be flexible to accommodate client's individual needs (**client-centered counseling**). Family planning clients typically fall into one of the following four categories:

- New clients with no method in mind
- New clients with a method in mind
- Returning clients with no problem or concerns
- Returning clients with problems or concerns

The table below lists the essential tasks for counseling different categories of clients:

ESSENTIAL COUNSELING TASKS FOR			
NEW CLIENTS WITH NO METHOD IN MIND	**NEW CLIENTS WITH A METHOD IN MIND**	**RETURNING CLIENTS WITH NO PROBLEMS OR CONCERNS**	**RETURNING CLIENTS WHO ARE EXPERIENCING PROBLEMS OR HAVE CONCERNS**
▪ Discuss the client's situation, plans, and what is important to her about a method ▪ Determine if she is breastfeeding an infant < 6 months (if she is, do not explain methods with estrogen) ▪ Ask her if her partner will participate in using FP (If not, don't explain methods that involve partner such as condoms)	▪ Check that the client's understanding of the method is accurate ▪ Support the client's choice, if the client is medically eligible for the method ▪ Help the client choose another method, if needed ▪ Discuss how to use the method	▪ Ask friendly question about how the client is doing with the method ▪ If needed, answer all client's questions ▪ Provide more supplies or routine follow up ▪ Schedule a return visit	▪ Explore and understand the problem ▪ Help the client resolve the problem: Is the problem side effects, or difficulty using the method? ▪ If needed, help the client change methods ▪ If needed, help the client understand

▪ Help the client consider methods that might suit her. If needed, help her reach a decision ▪ Support the client's choice ▪ Give key instructions on use ▪ Discuss how cope with any side effects ▪ Mention that methods switching is possible and allowed ▪ Schedule a return visit	▪ Tell the client about possible side effects and how to cope with them ▪ Provide the method/supplies ▪ Schedule a return visit		and manage side effects ▪ Schedule a return visit

3.7 Principles and Quality Issues of Counseling

When a client seeks family planning service, counseling plays a vital role for helping her take best decision about family planning for herself as per her needs, based on accurate information and a range of contraceptive options. To counsel effectively, a counselor while communicating with the client should always follow the principles of counseling.

1. Counseling should take place **in a private quiet place** where client and provider ONLY can hear each other, and with sufficient **time** to ensure that all necessary information, client's concerns and medical requirements are discussed and addressed.
2. **Confidentiality** must be ensured, both in the process of counseling and the handling of client records.
3. It is essential that counseling take place in a **non-judgmental, accepting, and caring atmosphere**.
4. The provider should use the **language**, which the client is able to **understand** (e.g., local dialect, simple, culturally appropriate vocabulary, no complex technical medical terminology).
5. Counselor must use good **interpersonal communication** skills, including the ability to question effectively, listen actively, summarize and paraphrase client's comments or problems, and adopt a non-judgmental, helpful manner.
6. The client should not be overwhelmed with information. The **most important messages should be discussed first** (e.g., what the client must do to use method correctly and safely), be brief, simple, and specific. For example, if she is breastfeeding an infant less than 6 months, do not describe COCs now. Repeating critical information is the most effective way to reinforce the message.

   Repeat, repeat, repeat!!
7. Use audiovisual aids and contraceptive samples to help the client better understand her chosen method.

8. Always **verify that the client has understood** what has been discussed. Have the client repeat back the most important messages or instructions.

3.8 Adapting the Counseling Process

Most providers will need to adapt the counseling process according to the area, culture, and physical environment they are working in and the need and situation of the clients such as newly married couple, sexually active married/unmarried adolescent, women/couples wanting to space/limit pregnancies, women with HIV/AIDS, working women.

In some service delivery settings the demand for services is so high that physical staffing, and time constraints prevent counselors and providers to spend quality time with client privately. In such situation, the counselor needs to utilize the available short time adequately by first understanding from the client what she knows already, so that counselor can fill the knowledge gaps, rectify her misconceptions with logic and address her concerns.

In other settings, some clients actually prefer to be with her mother or husband or mother-in- law in the counseling session due to cultural factors. In these situations, the counselor needs to adapt the counseling process in such a way that overall counseling is done when client is with her relative. Then counselor should ask personal questions in private regarding eligibility for the method, which are not culturally appropriate to ask in front of any other person. Similarly such a client should be given an opportunity to share her concerns regarding the family planning method, in private.

The factors that a counselor always has responsibility for and most control over are:

- Tolerance, empathy, and supportive attitude
- Respect for clients, listen carefully and be non-judgmental
- Aware of technical knowledge regarding contraceptives
- Belief in and knowledge that family planning saves lives and improves families' quality of life

Limitations due to lack of space, staff, and supplies must be addressed by counselors and providers creatively and with the health facility staff as a team. Cultural factors must always be taken into account, and client comfort levels and individual needs should be satisfied as much as possible by counselors and providers.

3.9 Informed Choice

3.9.1 **"Informed"** means that:

- **Clients have the clear, accurate, and specific information that they need to make their own reproductive health choices.** Counselors/service providers (counselors) should provide the information on each available and appropriate method of family planning and can help clients use the method effectively and safely.
- **Clients understand their own needs.** They have thought about their own situation and service providers (counselors) can help them match methods of family planning to their own needs.

3.9.2 **"Choice"** means that:

- **Clients have a range of family planning methods to choose from**. Counselors/service providers should offer a variety of different methods to suit people's different needs. If a method is not available at a particular center, clients should be referred to the nearest facility providing the service while providing another method that the client can use until she can go to the referral site.
- **Clients make their own decisions.** Clients always select from the available methods for which they are medically eligible. Service providers or counselors should not pressure clients to make a certain choice or to use a certain method.

3.9.3 Counselors and service providers have important role to play in encouraging clients to make informed choice.

<u>What a counselor can do for encouraging clients to make informed choice:</u>

- Explain the range of all methods available (this assumes that a variety of methods actually are available or that an effort is made to obtain or refer the client to an appropriate facility)
- Information on risks of not using any method, such as risks associated with pregnancy/childbirth versus risks associated with contraceptive use
- Provide clear, unbiased information on the advantages/disadvantages of different methods
- Explain possible side effects/complications with different methods
- Tailor counseling and advice to each client's expressed needs and personal situation
- Give clients their desired family planning methods unless it is medically inappropriate
- Explain how to use the method chosen safely and effectively. Ask the client to tell you how she will take the chosen method of family planning
- Respect the client's decision even if she chooses a less effective method than you would advice
- Respect the client's decision to switch from one method to another
- Respect the client's decision to refuse any services

3.10 Rights of Clients

Introduction to Rights of the Client

To be effective, counseling must be based on the establishment of trust and respect between the client and counselor. For establishing this partnership of trust, it is important for counselors and providers of family planning services to remember that clients have certain rights.

The International Planned Parenthood Federation (IPPF) statement of 10 client rights is outlined below:

Clients' Rights

1. *Information* about family planning,
2. *Access* to all service delivery systems and health care providers
3. *Choice* of adopting, switching, or discontinuing methods
4. *Safety* in the practice of family planning
5. *Privacy* during discussions and physical examinations
6. *Confidentiality* of all personal information
7. To be treated with *dignity*, courtesy, consideration, and attentiveness
8. *Comfort* while receiving services
9. *Continuity* of care for as long as the client desires
10. To express their *opinions* about the quality of services received

Source: Huezo, 1993 (151)

The knowledge of clients' rights helps counselors and providers to consider and fulfill expectations of family planning clients, which lead to clients' satisfaction and is important for quality family planning services.

The Rights of Family Planning Clients

1. Right to Information
   All clients have a right to information on the benefits of family planning for themselves and for their families. They also have a right to know where and how to obtain more information and services for planning their families. When seeking family planning services, **clients have the right to know the names of the people who serve them, to learn about family planning choices, and to have all their questions answered honestly and accurately.**

2. Right to Access
   All individuals have a right to obtain family planning services regardless of sex, age, religion, caste, color, marital status, or location.

3. Right of Choice
   Individuals and couples have the right to decide freely whether or not to practice family planning. When seeking contraceptive services, clients should be given the freedom to choose their preferred method of contraception and to decide for or against any treatment and to change mind and make new choices when they want.

4. Right to Safety
   Family planning clients have a right to safety in the practice of family planning. Safety relates to the quality of service provision, including both the adequacy of the service delivery facility itself and the technical competence of the service providers. Ensuring the client's right to safety includes assisting the client in making an appropriate choice of contraceptive, screening for contraindications, using the appropriate techniques for providing the method (if applicable), teaching the client about the proper use of the method, and ensuring proper follow-up. The conditions in service delivery sites, together with the materials and instruments, should be adequate for the provision of safe services. Any complications or major

side effects should receive appropriate treatment. If this treatment is not available at a particular service site, the client should be referred to another facility.

5. Right to Privacy
   When discussing her/his needs or concerns, the client has a right to an environment in which s/he feels confident. **The client should be aware that her/his conversation with the counselor or service provider will not be overheard by others**.

   Physical examinations should be carried out in an environment in which the client's right to bodily privacy is respected.

6. Right to Confidentiality
   The client should be assured that any information s/he provides or any details of the services received will not be communicated to third party without her/his consent. Any breach of confidentiality could cause the client to be shunned by the community or could negatively affect the matrimonial status of the client. It may also lessen a target group's confidence and trust in the staff of a service delivery program. In accordance with the principle of confidentiality, service providers and counselors should refrain from talking about clients outside of the health facility and health team. Client records should be kept closed and should be filed immediately after use. Similarly, access to client records should be controlled.

7. Right to Dignity
   Family planning clients have a right to be treated with courtesy, consideration, attentiveness, and with full respect of their dignity, regardless of their level of education, social status, age or any other characteristics which could single them out or make them vulnerable to abuse. In recognition of this basic right, counselors and service providers must be able to put aside their personal, gender, marital, social, or intellectual prejudices and attitudes while providing services.
8. Right to Comfort
   Clients have the right to feel comfortable when receiving services. This right of the client is intimately related to adequacy of service delivery facilities and quality of services (e.g., service delivery sites should have proper ventilation, lighting, seating, and toilet facilities). The client should spend only the amount of time on the premises reasonably required to receive services. The environment in which the services are provided should be in keeping with the cultural values, characteristics, and demands of the community.

9. Right of Continuity
   Clients have a right to receive contraceptive services and supplies for as long as they need them. The services provided to a particular client should not be discontinued unless this is a decision made jointly between the provider and the client. Referral and follow-up are two other important aspects of a client's right to service continuity.

10. Right of Opinion

Clients have the right to express their views on the service they receive. Clients' opinions on the quality of services, whether in the form of thanks or complaint, as well as their suggestions for changes in service provision, can be very useful to a program's ongoing effort to monitor, evaluate, and improve its services.

3.11 Three Kinds of Communication in Family Planning

Effective communication is the cornerstone of family planning counseling. There are typically three different types of communication activities in family planning program; motivating, informing and counseling. To have a clear understanding of counseling, it is important to differentiate it from other kinds of family planning communication activities (motivating and informing) to see how each type can affect client's choices.

Comparison of motivating, informing and counseling

	Motivating	Informing	Counseling
Goal	To encourage (or discourage) a behavior Increase acceptors Achieving a target	Increased knowledge and awareness of FP methods and services Better informed clients	Helping client to make his/her own informed decision Satisfied clients
Content	What the counselor or service provider thinks the client should do The opinion of a counselor/ service provider, or the policy of the program	Facts-should be complete and accurate Facts may be incomplete	Exchange and sharing of facts, client's perspective-needs, opinions and feelings
Focus	Motivator highlights just the advantages Motivator makes the decision for client	Disseminates factual information	Counselor talks of both advantages and limitations and thus facilitates decision making by the client
Direction of communication	Mostly one-way	One-way	Two way
Bias	Biased	Biased or objective	Objective
Location	Anywhere	Anywhere	Private atmosphere

Counseling is one of the critical components of family planning service delivery and should not be replaced by motivation and informing. A motivated and well-informed client should also receive counseling.

3.12 Effective Counselor and Communication Skills

3.12.1 Effective Counselor

In order to provide "Quality of Care" in the family planning counseling services, it is very important that the counselor can provide effective counseling. In order to provide effective counseling, a counselor should have good interpersonal communication skills.

A health care provider or counselor spends a great deal of time engaged in interpersonal communication with clients, their families, community members and colleagues. People communicate verbally through their words and their tone of voice, and nonverbally through their actions, facial expressions, and general "body language." Counselors must be conscious of using the right words and tone of voice, as well as open and friendly body language to communicate effectively.

To communicate effectively, the counselor needs to have certain **qualities, knowledge and skills:**

3.12.2 Qualities

An effective counselor:

- Has desire to work with people
- Believes in and is committed to the basic values and principles of family planning and client rights
- Has friendly attitude towards clients
- Is comfortable with human sexuality and with the expression of feelings
- Is accepting, respectful, non-judgmental, and objective when dealing with clients
- Has gentle and supportive attitude towards clients
- Is aware of her/his own values, limitations
- Has unbiased attitude towards different population groups and different FP methods
- Has tolerance for values that differ from one's own
- Has empathy for clients
- Understands and is sensitive to cultural and psychological factors (such as family or community pressures) that may affect a client's decision to adopt family planning
- Always maintains clients' privacy and confidentiality

3.13 Knowledge needed by FP providers

About clients

- Local culture, including fertility norms and sexual practices
- Factors that may inhibit clients from asking questions or expressing their needs and concerns
- Signs that indicate the client may not be making a well-considered decision
- Factors inhibiting successful contraceptive use

About contraception and family planning methods

- Common misconceptions about family planning
- Contraceptive methods (benefits, risks, effectiveness and mechanisms of action for all available methods)
- Instructions for clients about how to use each method correctly and safely
- What clients should do in the event of complications or side effects due to contraceptive methods
- How to prevent the spread of sexually transmitted diseases (including infections with HIV)
- Follow-up services and counseling
- Referrals for complications

About counseling for family planning

- Primary purpose of counseling; to help clients make informed, voluntary and well-considered decisions regarding fertility and contraception
- Importance of confidentiality
- Distinction between counseling, informing and motivation
- Responsibilities of a family planning provider

About the family planning program

- Government policies on family planning
- Client eligibility requirements for different methods
- Referral networks and procedures for FP services and other RH services
- Record keeping requirements

FP service delivery centre requirements

- Adequate space and seating arrangement that ensures privacy during counseling sessions
- Clean environment
- Sample of contraceptives to show and explain to clients
- IEC materials on contraceptives to show the clients
- Gentle and courteous staff
- Knowledgeable and helpful staff
- Adequate availability of FP method supplies

3.14 Skills of Counselor

An effective counselor possesses strong technical knowledge of contraceptive methods and:

- Creates a comfortable atmosphere for the client by conveying interest, concern and friendliness
- Speaks in a soft, gentle tone of voice and uses words that the client understands
- Presents information clearly in simple terms
- Encourages the client to ask questions and express any concerns
- Listens carefully to what clients have to say and notice how they say it
- Asks questions effectively to encourage the client to share information and feelings
- Asks only one question at a time and waits with interest for the answer
- Poses questions clearly, using both open- and close-ended questions

- Uses visual aids and explain technical information in language that the client understands
- Recognizes when to refer the client to a specialist or other provider
- Provides feedback, every now and then repeats what client has shared to make sure that the counselor understands what the client is saying
- Treats each client as an individual
- Answers questions clearly and objectively
- Keeps silent sometimes and gives clients time to think, ask questions, and talk
- Recognizes and correctly interprets nonverbal cues and body language of the client
- Looks directly at clients when they speak
- Applies good **interpersonal communication skills**, and counseling techniques

3.15 Communication Skills

Health care providers need to explore the many different communication skills, which can be nonverbal and verbal when communicating with clients. Sometimes, without realizing it, providers communicate one message verbally, while communicating the opposite message nonverbally.

Nonverbal communication is a complex and often unconscious mixture of actions, behaviors, and feelings, which reveal the way we really feel about something. Nonverbal communication is especially important because it communicates to clients the level of interest, attention, warmth, and understanding we feel towards them.

3.15.1 Difference between verbal and non-verbal communication

Verbal Communication	Nonverbal Communication
Refers to **words and their meaning** ▪ Begins and ends with what we say ▪ Is largely conscious and controlled by the individual speaking	▪ Refers to **actions, gestures, behaviors, and facial expressions** which express feelings, without speaking, how we feel ▪ Is complex and largely unconscious ▪ Often reveals to the observant the real feelings or message being conveyed

3.15.2 Non-verbal Communication

Non-verbal behavior may be positive or negative. The following are some examples:

3.15.2 (A) Positive nonverbal cues include:

- Leaning towards the client
- Smiling, not showing tension
- Presenting facial expressions which show interest and concern
- Maintaining eye-contact with the client
- Making encouraging gestures such as nodding ones head

3.15.2 (B) Negative nonverbal cues include:

- Reading from a chart
- Sitting with the arms crossed
- leaning away from the client
- Glancing at ones watch
- Yawning or looking at papers or elsewhere
- Frowning
- Fidgeting
- Not maintaining eye-contact

3.15.3 Verbal Communication

Some important verbal communication skills are mentioned below:

3.15.3 (A) Active Listening

Active listening is more than just hearing what a client says. It involves hearing and understanding what is being communicated. It involves listening in a way that communicates empathy, understanding and interest.

Active listening will include observing and responding to non-verbal signals of the client as well as the tone of the voice used during the communication.

Active listening is an important skill counselors/service providers need to learn and practice as it allows the communicator to gain an accurate understanding of the client's situation, communicate interest and concern and encourages open and honest client communication.

3.15.3 (B) Verbal Encouragement

Service providers can express interest and understanding by giving brief verbal responses such as "I see" or "Right". This type of response is the verbal equivalent to nodding ones head.

Verbal encouragement demonstrates that the service provider is listening and encourages the client to continue talking. It is especially useful for clients who are shy.

3.15.3 (C) Tone of Voice

Tone of voice is an important component in building rapport. How you say what you say is important because the emotion in your voice communicates a message that could give your client a different meaning from what you intended.

It isn't what you say: it's the way you say it, gets results. In communication, mouth contributes 10%, eyes 20%, head 30% and heart 40%.

3.15.3 (D) Using Simple Language

Another way to make clients comfortable is to use appropriate language. Technical information needs to be provided considering the level of education and language of each client.

Clients may become confused, angered or intimidated by language they do not understand. Using appropriate simple language helps prevent misunderstanding, encourages clients to ask questions and helps clients to make informed decisions.

Using simple language does not only apply to medical words. Many of the words the counselors/service providers use frequently such as *counseling, family planning follow-up and referral* may not be understood by or may have different meanings for clients. Always explain terms or double check with clients to ensure clients' understanding.

3.15.3 (E) Giving feedback

Feedback means communicating a response to what was seen, heard or felt. It requires paying attention to details. Clarifying, identifying and reflecting feelings, giving verbal encouragement, showing empathy and non-verbal communication are all different forms of giving feedback. Giving effective feedback requires other skills that are necessary to counseling: Objectivity, respect for listeners' feelings, positive verbal and non-verbal communication.

Giving constructive feedback in a client interaction can help build a good client-provider relationship.

3.15.3 (F) Empathy

It's the ability to understand person's feelings and experiences from his or her perspective. Trying to understand another person's thought and feelings by trying to put oneself in another person's situation is not enough, we must communicate to her/him that we feel and appreciate what he/she is going through. The expression does not only have to be verbal: non-verbal forms of communication may be also very effective in helping to show that we comprehend the client's situation.

Conveying empathy is important because it helps the client to feel she has been heard and understood, helps her feel respected and accepted and it facilitates the building of trust and rapport.

3.15.3 (G) Being Non-judgmental

One of the pre-requisites of effective communication is respecting clients. Respect can be shown by being non-judgmental and by recognizing the client's right to do things and hold opinions that he/she does.

While being non-judgmental means accepting the client's special qualities without judging or condemning him/her, it does not mean that everything a client does or thinks can or should be condoned. For example: sexual abuse etc. cannot be condoned.

3.15.3 (H) Asking open-ended and close-ended questions

Asking questions is important to accurately assess a client's needs and knowledge early in the counseling and to actively involve the client throughout the counseling session. There are two categories of questions, based on the kind of answer that they bring forth:

- *Close-ended questions* usually require only a brief, exact response, often just one word such as 'yes', 'no' or a number or fact. These are good questions for gathering important medical and background information quickly. E.g.:
  - How old are you?
  - When was your last menstrual period?
  - How many children do you have?
- *Open-ended questions* allow the possibility of longer responses and are useful for exploring client's opinions, feelings and understanding on how to use a FP method. These questions are more effective in determining what the client needs (in terms of information or emotional support) and what s/he already knows. E.g.:
  - How can we help you today?
  - What have you heard about this family planning method?
  - Why did you decide to use the same method as your sister?
  - Tell me how you are going to take your oral contraception?

Both types of questions have important role in counseling. However, relying too heavily on close-ended questions limits client's involvement in information sharing and decision making. Asking more open-ended questions helps clients in exploring their options and feelings and help counselors/service providers facilitate the decision making process.

3.16 Some acronyms to help communication

Counselors/service providers should **remember ROLES** when communicating with clients:

R = **Relax** the client by using facial expressions showing concern.
O = **Open up** the client by using a warm and caring tone of voice.
L = **Lean** towards the client, not away from her/him.
E = Establish and maintain **eye contact** with the client.
S = **Smile**

The CLEAR Method of Verbal Communication

Providers should always remember to be *CLEAR*.

C = Use **clear** and **simple language**.
L = **Listen to what the client is saying**.
E = **Encourage** the client that they will be able to use the method with good results.
A = **Ask** for feedback from the client and acknowledge that their concerns and opinions are valid.

R = Have the client **repeat** back the key points that you have told them about using the method.

The importance of using **clear** and **simple language** cannot be overemphasized.
Remember to discuss the most important messages **first** and **last** with the client because the client will be more likely to remember them.

CHAPTER 4

ELEMENTS OF COUNSELING ON POSTPARTUM FAMILY PLANNING AND IMMEDIATE POSTPARTUM IUCD

4.1 The GATHER Approach for Family Planning Counseling

Counseling often has 6 elements, or steps. Each letter in the word GATHER stands for, as follows:
G: Greet
A: Ask
T: Tell
H: Help
E: Explain
R: Return

GATHER is a useful memory aid to help counselors/service providers to remember the basic steps in the counseling process and to add structure to a complex activity. It can be adapted to meet each individual client's needs.

The counselor can change the order of the steps of GATHER according to the needs of the client, but it is good practice to follow the established GATHER sequence to avoid leaving out important steps.

Every element in GATHER counseling contributes to client's informed choices. The following are the six elements of a successful counseling session. The second column describes the counselor's actions in general terms.

Tasks conducted under GATHER approach

G: Greet	▪ Express respect and friendliness ▪ Give clients your full attention as soon as you meet them ▪ Be polite, friendly and respectful: Greet clients, introduce yourself, and offer them seats ▪ Ask how you can help. Determine purpose of visit ▪ Explain what will happen during the visit ▪ Assure the client that all information discussed will be confidential ▪ Talk in a private place, where no one else can hear
A: Ask	▪ Ask client about their reasons for coming ▪ Ask for all the information needed to complete client records ▪ Ask the client if she has a method in mind and assess her knowledge for accuracy ▪ Ask the client if she is currently breastfeeding a baby < 6 months ▪ Ask the client if her husband will participate in using family planning such as condoms or periodic abstinence ▪ Ask the client if she desires more children in the future ▪ Listen to the answers to these questions which will guide the provider/counselor to methods most appropriate for the client's current needs

	▪ Help clients express their feelings, needs, wants, and any doubts, concerns, or questions ▪ Ask clients about their experience with family planning methods that concern them ▪ Keep questions open, simple, and brief. Look at your client as you speak ▪ Show your interest and understanding at all times. Express empathy. Avoid judgments and opinions
T: Tell	▪ Tell the client about the available methods and possible choices that would best meet the client's current needs based on her responses to the questions asked above ▪ Information should be personalized—that is, put in terms of the client's own life If clients are choosing a family planning method: ▪ Ask which methods interest them. If no medical reason prevents it, clients should get the method they want ▪ Ask what they know about the chosen methods. (If a client has important information wrong, gently correct the mistake) ▪ Give brief information with 4-5 facts about the methods that are appropriate for the client's needs: 1. Effectiveness as commonly used 2. Briefly, how to use the method 3. Common side effects ▪ Use samples and other audiovisual materials if possible ▪ Explain that condoms are the only family planning method that offers reliable protection against STDs ▪ Ask if the client wants to learn more and answer client concerns and questions
H: Help	▪ Help the client to choose a method. Tell clients that the choice is theirs. Offer advice as a health expert, but avoid making the clients' decisions for them ▪ To help clients choose, ask them to think about their plans and family situations ▪ Help clients think about the results of each possible choice ▪ Ask if the client wants anything made clearer. Reword and repeat information as needed ▪ Once a client states a choice, ask about specific conditions in which the method is not suitable (Refer to the table and column, who should not use the method, in chapter 2 for such conditions). If a method would not be safe, clearly explain why. Then help the client choose another method ▪ Check whether the client has made a clear decision. Specifically ask, "What have you decided to do?" Wait for the client to answer
E: Explain	After the client has made a choice: ▪ Give supplies or the chosen method, if appropriate ▪ If the method or services cannot be given at once, tell the client how, when, and where they will be provided ▪ Explain how to use the method ▪ Describe possible side effects and what to do if they occur ▪ Explain when to come back for routine follow-up or more supplies, if needed ▪ Explain any medical reasons to return ▪ Ask the client to repeat instructions. Make sure the client remembers and understands ▪ If possible, give the client printed material to take home ▪ Mention emergency oral contraception ▪ Thank the client for coming and invite her back whenever she wishes, or if side effects bother her
R: Return	▪ Schedule and carry out return visit and follow-up of client At a follow-up visit: ▪ Ask if the client has any questions or anything to discuss. Treat all concerns seriously ▪ Ask if the client is satisfied. Have there been problems? ▪ Help the client handle any problems

	▪ Ask if any health problems have come up since the last visit. Check if these problems make it better to choose another method or treatment. Refer clients who need care for health problems ▪ Check if the client is using the method or treatment correctly ▪ Check whether the client might need STI protection now ▪ If a client is not satisfied with a temporary family planning method, ask if she or he wants to try another method. Help the client choose, and explain how to use. Remember—changing methods is normal. No one really can decide on a method without trying it. Also, a person's situation can change, making another method a better choice ▪ If a woman wants her IUD taken out, arrange for this. If she plans pregnancy, suggest where to get prenatal care

4.2 Elements of postpartum counseling

Postpartum family planning counseling should be initiated during focused antenatal care. Counseling needs to continue, if appropriate during early labor, and prior to discharge from the facility. Check to see if the client has indicated interest in PPIUCD (postpartum intrauterine contraceptive device) or PPTL (postpartum tubal ligation).

Elements of postpartum family planning (PPFP) counseling include:
- Immediate and exclusive breastfeeding
- Benefits of healthy pregnancy spacing
- Return to sexual activity
- Return to fertility
- Lactational amenorrhea method and transition to other methods
- FP methods available to use while breastfeeding

While most counseling occurs between a provider and a client, in some situations it may be useful-indeed critical-to involve a woman's husband or other important decision-maker, such as her mother-in-law, in counseling. Couples' or group counseling that addresses FP provides men and other family members with important information on the health, social and economic benefits of FP, and an opportunity to discuss how they can act to protect their health and the health of their wives, daughters and children.

4.3 Elements of Immediate Postpartum IUCD (PPIUCD) Counseling

In settings where women lack awareness about IUCDs or where misinformation about the method is very prevalent, quality education and counseling are critical to overcome barriers to IUCD use.

This section will focus on counseling specific to the PPIUCD.

Postpartum IUCD counseling occurs in various stages:
- General health education, often group-based, about postpartum family planning methods and options

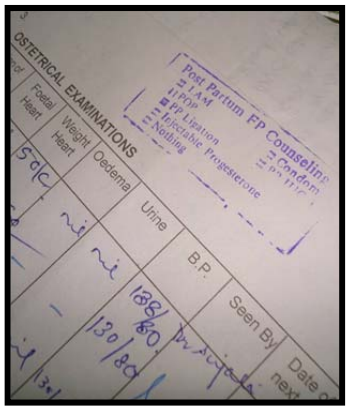
- Individual counseling about postpartum methods where a women/couple considers and makes an informed choice for a method that is well suited to her/their individual needs and circumstances in the postpartum period

4.4 Immediate Postpartum IUCD Counseling

Because the most effective approach to PPIUCD services is to insert the device immediately following the delivery of the placenta, it is essential that women be counselled about PPIUCDs during the antenatal period. A system should be established to determine if women who attend ANC clinic have been counselled and have chosen a postpartum FP method.

- Health education can be provided to all attendees of the clinic by a trained counsellor during ANC. Then individual counseling can be provided to women and couples before, during or after the antenatal evaluation. Those who express interest in the PPIUCD should be provided specific information, as outlined below:

Figure: ANC Record Sample



- A woman's choice about PPFP should be noted clearly on her antenatal card or record. This is especially true for those women who choose the PPIUCD. This stamp or specific notation in the ANC record (see figure) will alert delivery room staff to women who have chosen the PPIUCD so preparations can be made to provide the method immediately following delivery of the placenta. The notation on the ANC card should be obvious and noticeable so that it serves as a reminder to antenatal care providers and is easily checked by staff in the labor and delivery area.
- Labor room staff should check the ANC card for this information when the woman presents for delivery care.

4.5 Antenatal Counseling

The counseling process should be tailored to the individual woman's needs following GATHER approach.

Counseling may be done by trained counsellors, with reinforcement and clarification by the health care provider. Counseling is best done when the counselor uses visual aids (poster, demonstration IUCD) during counseling and assesses the woman's understanding.

After gaining woman's confidence, the following information should be given in method specific counseling -

Textbox: Client Messages about Basic Attributes of the PPIUD

Providing correct information about the IUCD and its insertion immediately postpartum is a very important component of counseling to potential PPIUCD clients, especially in regions where awareness about the method is low or misinformation about the method is prevalent.

What it is	The IUCD is a small plastic device that is inserted into your uterus.
When is it inserted	It is inserted either immediately after the placenta comes out, during a caesarean section or within the first two days after delivery, while you are still in the healthcare facility. This makes it very convenient for you, because by the time you leave the hospital, you will already have your family planning method working for you.
Who can use it	Most postpartum women can safely use the IUCD, including those who are young, breastfeeding, or do hard work. It is especially good for women who think they are finished having children, but want to delay sterilization until they are certain. Some women should not use the IUCD, including women who have a misshaped uterus or have a high personal risk of sexually transmitted infection Sometimes women develop an infection during the time of birth. They should wait until after the infection has been treated to have the IUCD inserted.
Effectiveness	The IUCD is more than 99% effective at preventing pregnancy, making it one of the most effective, reversible contraceptive methods currently available.
Mechanism of action	The IUCD prevents pregnancy by preventing the sperm from fertilizing the egg.
Breastfeeding	Using an IUCD postpartum will not affect how you breastfeed your baby and will not change the amount or quality of your breastmilk.
Course of protection	The IUCD begins to work immediately and the Copper T is effective for up to 10 years.
Side effects	Copper-bearing IUCDs (e.g., the Copper T) have fewer side effects than hormonal methods (e.g., the pill), but sometimes cause an increase in the amount, duration, and painfulness of menstrual periods. These symptoms are usually not noticed by postpartum women, especially those who are breastfeeding, because they lessen or go away in the first few months after insertion.
Health benefits and possible risks **Warning signs**	The IUCD is very safe at preventing pregnancy. When it is inserted postpartum, about 5–10 women out of 100 will find that the IUCD has fallen out during the first three months. If this happens, you should return to the clinic and have another IUCD inserted to continue protection against pregnancy. Woman should return to the clinic as soon as possible if she has any of the following: ▪ Foul smelling vaginal discharge different from usual lochia ▪ Lower abdominal pain especially if accompanied by not feeling well, fever and chills ▪ Concerns the IUCD has fallen out
Protection from HIV and other STIs	The IUCD offers no protection against HIV or other STIs. Only barrier methods (e.g., the condom) help protect against exposure to HIV and other STIs. If you think you have a "very high personal risk" for certain STIs you should not use the IUCD.

Cost and convenience	PPIUCD is inexpensive and available free of cost in government health facility. The IUCD will be placed before you leave the healthcare facility after delivery.
Additional action and removal.	In most cases, only one follow up visit to the clinic is required at 6 weeks postpartum. Once the IUCD is inserted, no additional actions are needed on your part. You don't need any supplies and don't need to purchase anything additional. When you have the IUCD, you should come to the clinic to have it removed. You will be able to get pregnant right away after it is removed. If you want to continue to use it for a long time, you can use it for 10 years and then have it replaced with another one.

4.6 If not counselled in antenatal period, when else can women be counseled for PPIUCD insertion?

Women should be ideally counselled in the antenatal period for PPIUCD services. This allows multiple opportunities to address the woman's concerns and answer her questions. As well, it allows for a discussion with the husband or other family members if that is considered to be an important part of the counseling process. If this is not possible because the woman did not receive ANC, or received it at a facility where PPFP counseling is not practiced, or her choice is not noted on her ANC record, it is acceptable to counsel women at other times, such as:

During an antenatal admission: if a woman is undergoing evaluation or treatment for an antenatal complication, she may be counselled for PPIUCD. This is actually a good time to discuss the health benefits of birth spacing for both her and her baby
During early labour: if a woman presents in early labour (she is relatively comfortable, with infrequent contractions, and able to concentrate on the information being provided) she can be counselled for a PPIUCD. It would be important that she understand that the method is non-permanent and she can change her mind at any time
On the first postpartum day: for women who could not be counselled prior to delivery, they can receive counseling on the first postpartum day
Prior to scheduled caesarean section: women who arrive to the hospital for a scheduled caesarean section can be counselled about insertion of an IUCD during the caesarean section

In general, due to the stress of labour, a woman should *NOT* be counselled for the first time about PPIUCD during active labour. The intensity of labour does not make it a good time to make an informed choice about contraception, and it is unlikely that they will be able to focus sufficiently on the information to be able to provide consent.

4.7 Post Insertion Counseling

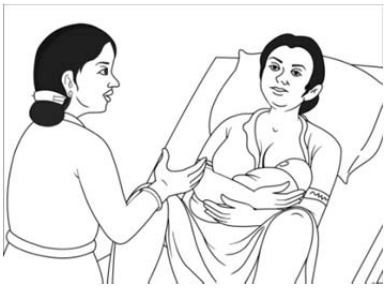
Following insertion of the IUCD, the provider who has done the insertion should review key features of the PPIUCD with the woman.

IUCD side effects and normal postpartum symptoms
Importance of breastfeeding and that the PPIUCD does not affect breastfeeding or breast milk
When to return for IUCD –

- Come after 6 weeks for first check-up (when you come for your child's vaccination)- Whenever you plan to become pregnant, come for Cu T removal
- After 10 years when the effect of CuT is over, come for removal/change

Need to come back at any time if she has a concern or experiences warning signs

- High fever, shivering
- If period is delayed
- Pain in lower abdomen, pain during intercourse
- If facing any problem with the thread/feeling lower part of Cu-T/piercing/Cu-T has come out
- Unusual bleeding from vagina
- Dirty/foul smelling discharge from vagina



For women who receive a postplacental or an intracaesarean insertion, this counseling is best done the following day, when the woman is better able to concentrate on the messages. If the insertion was done within 2 days postpartum, the post insertion counseling can be done shortly after the insertion.

CHAPTER 5

ROLES AND RESPONSIBILITIES OF COUNSELOR AND PERFORMANCE STANDARDS FOR COUNSELING

5.1 Following are the suggested roles and responsibilities of the counselor with respect to PPFP and PPIUCD services:

A. Creating a trusting relationship with the client
B. Checking the understanding of client regarding PPFP and if they have any specific method in mind.
C. Explaining in detail about PPIUCD, if client is interested in using IUCD
D. Maintaining records of PPIUCD insertions, follow-up and removal
E. Telephonically following-up with clients and sending reminders for first follow-up visit

A. Creating a trusting relationship with the client

- Discuss the reasons why the client is being counseled
- Treat client with respect and dignity
- Engage in frank and open discussion with client
- Provide support to client during decision making for healthy timing and spacing of pregnancy
- Discuss issues and concerns with client
- Allow the client to make informed choice by informing her about the methods that are available and appropriate for her, considering the breastfeeding status

B. Checking the understanding of client of need regarding PPFP and if they have any specific method in mind

Specifically check for clients' understanding of:

- Healthy timing and spacing of pregnancy
- Return of fertility in postpartum period
- Available contraceptives for postpartum period including PPIUCD and safe time for initiation of various FP methods in the postpartum period for breastfeeding and non-breastfeeding women
- If client has a specific method in mind, check that the client's understanding of the method is accurate and support the client's choice, if the client is medically eligible for the method. Help the client choose another method, if needed

C. Explaining in detail about PPIUCD

Explain to the client who chooses to use IUCD after delivery:

- Discuss how the method is used: Time of insertion in the immediate postpartum period and the screening process before insertion

- Mechanism of action: How PPIUCD prevents pregnancy
- Effectiveness: The failure rate/ pregnancy rate after using PPIUCD
- Features and benefits of the method
- Side-effects: with reassurance that these are not harmful and would subside on their own after initial few months
- Need to return to facility for follow-up: the mandatory and the optional situations for follow-up
- Encourage client to ask questions and answer all client's queries and concerns; rectify client's myths and misconceptions, if any

D. Maintaining records of PPIUCD insertions, follow-up and removal

PPIUCD insertions are being done in labour room, emergency ward, operation theatre and postpartum ward. There are PPIUCD insertion registers at each of these places. The counselor has to collate these data and enter it to the MIS. The same is done for follow-up and removal. The counselor might be asked to submit the collated monthly report to the concerned authority. The suggested format for collating the monthly data is given below.

E. Telephonically following-up with clients and sending reminders for first follow-up visit

All the PPIUCD clients' consent has to be taken for telephonic reminders for follow-up while taking down their phone numbers during PPIUCD insertion. The counselor reminds the clients after 1 month of insertion, telephonically, regarding their first follow-up at 6 weeks at the facility and asks certain questions to find out how the client is doing with PPIUCD. The counselor should keep record of clients' telephone contact numbers, which might be needed in future (even after the first follow up at 6 weeks), if any client follow up study for PPIUCD is planned and implemented.

POSTPARTUM IUCD FOLLOW-UP (FU) REGISTER FORMAT

S. No	Indoor Reg No	Name	Age	Phone No	Date of insertion	Type of PPIUCD insertion *(Tick appropriate column)*			Name of provider who inserted PPIUCD	Due date of FU	Actual date of FU	Type of FU *(Tick appropriate column)*		Time of FU *(Tick appropriate column)*		Finding of FU *(Tick appropriate column)*					Action taken for complica -tions	Reason for removal	Remarks
						Postpartum (within 10 min.)	Immediate PP (within 48 hrs.)	Intracesarean				Clinic Visit	-Telephonic	Up to 6 weeks	After 6 weeks	Expulsion	Infection	Missing Strings	Other Complaints (Specify)	No Complaint			

5.2 Checklists and Performance Standards

The counseling checklist for family planning and performance standards for immediate postpartum IUCD (PPIUCD) counseling contain the steps or tasks performed by the counselor when counseling a client for family planning or PPIUCD respectively. These serve as guides for the skills needed for counseling a client on FP or PPIUCD.

Using the Checklists for Learning

The checklist and performance standards are designed to be used for both learning and assessment. The early phases of learning are known as skills acquisition. During this time **the learners use the checklists and performance standards to**:

- Understand the steps of the procedure. The trainer introduces the skill by describing the steps and how they are accomplished
- Follow along as the trainer/facilitator demonstrates counseling through role-play. The learners will use the checklists and performance standards as a guide to the sequence and correct performance of the individual steps of the procedure
- Guide her own counseling skills during role-play. The learner will practice the counseling skill in the role-play with the assistance and support from colleagues and trainers. The checklist and performance standards help the learner to learn the steps of the counseling skill and provide a mechanism for colleagues and trainers to provide explicit feedback on performance. The learner should ensure that they are able to perform every step correctly, and should seek feedback from colleagues and coaches
- Check whether s/he is ready for formal assessment by the trainers. Ultimately, the learner will need to be assessed by the trainer to determine competency in the skill being practiced. Since the skill will be assessed by the trainer using the exact same checklist and performance standard, the learner can rate their own readiness for assessment by comparing their mastery of the skill using the checklist and performance standards
- Guide practice at the real counseling. Once a skill is mastered in the training, learners will be ready to counsel clients on FP and PPIUCD and the supervisor can use the checklist or performance standards to correct and enhance performance of the provider

Using the Checklist for Assessment

The same checklists are used by the trainer for assessment of competency in family planning or PPIUCD counseling. That phase of learning, known as skill competency, is determined by the trainer using the checklists as objective measures of the achievement of all the steps of the procedure. The checklists and performance standards therefore are used for assessment by the trainers and learners in the following ways:

- Use the checklists as templates for feedback. Under the column marked CASES, trainers should rate whether a learner correctly performed the step in the following way:

> **Trainers:** Use this tool when the learner is ready for assessment of competency in the counseling skill.
>
> Place a "✓" in case box if step/task is performed **satisfactorily**, an "**X**" if it is **not** performed **satisfactorily**, or **N/O** if not observed.
>
> **Satisfactory:** Performs the step or task according to the standard procedure or guidelines
>
> **Unsatisfactory:** Unable to perform the step or task according to the standard procedure or guidelines
>
> **Not Observed:** Step or task not performed by participant during evaluation by trainer

- Use the checklists to determine if a learner is competent. When the trainer and the learner both state they are ready, the checklists are used to assess competency. Since the checklists are focused listing of all the necessary steps of the counseling, it is expected that the learner will perform all the steps correctly
- For certification of competency. At the bottom of the checklists is a box for the trainer signs certifying that the learner performed the skill competently

CHECKLIST 1: FAMILY PLANNING COUNSELING

(To be used for practicing and assessment of the FP counseling skill)

This checklist is for counseling woman/couple at any time on various methods of family planning

Place a "✓" in case box if step/task is performed **satisfactorily**, an "**X**" if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

Participant _____ **Date Observed** _____

CHECKLIST FOR FAMILY PLANNING COUNSELING (Some of the following steps/tasks should be performed simultaneously)						
STEP/TASK	**CASES**					
PREPARATION FOR COUNSELING						
1. Ensures room is well lit and there is availability of chairs and table.						
2. Prepares equipment and supplies.						
3. Ensures availability of writing materials (eg., client file, daily activity register, follow-up cards).						
4. Ensures privacy.						
SKILL/ACTIVITY PERFORMED SATISFACTORILY						
GENERAL COUNSELING SKILLS						
1. Greets the woman with respect and kindness. Introduces self.						
2. Confirms woman's name, address and other required information.						
3. Offers the woman a place to sit. Ensures her comfort.						
4. Reassures the woman that the information in the counseling session is confidential.						
5. Tells the woman what is going to be done and encourages questions. Responds to the woman's questions/concerns.						
6. Gives a brief description of the family planning methods available.						
7. Uses body language to show interest in and concern for the woman.						
8. Asks questions appropriately and with respect. Elicits more than "yes" and "no" answers.						
9. Uses language that the woman can understand.						

CHECKLIST FOR FAMILY PLANNING COUNSELING (Some of the following steps/tasks should be performed simultaneously)					
STEP/TASK	**CASES**				
10. Appropriately uses visual aids, such as posters, flipcharts, drawings, samples of methods and anatomic models.					
11. Discusses the health benefits to mother and baby of waiting at least two years after the birth of her last baby before she tries to conceive again.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
SPECIFIC FAMILY PLANNING COUNSELING					
1. Asks the woman if she has a method in mind. Did she have any problems with that method or does she have any questions or concerns about that method?					
2. Asks the woman does she want more children.					
3. Discuss with the woman the benefits of healthy timing and spacing of pregnancy.					
4. Ask the woman if her husband will contribute to using family planning such as using condoms					
5. Asks the woman if she is currently breastfeeding.					
6. Is she EBF, amenorreic and her infant <6 months (LAM)?					
7. Ask the woman what the first day of her last menses was					
8. Asks the woman if she has any history of medical problems (TB, seizures, irregular vaginal bleeding, liver disease, unusual vaginal discharge & pelvic pain, clotting disorder, breast or genital cancer).					
9. Assesses the woman's risk for STIs and HIV/AIDS, as appropriate.					
10. Briefly provides general information about each contraceptive method that is appropriate for that woman based on her responses to questions 1-9: ▪ How to use the method ▪ Effectiveness ▪ Common side effects ▪ Need for protection against STIs including HIV/AIDS					
11. Clarifies any misinformation the woman may have about family planning methods.					
12. Asks which method interests the woman. Helps the woman chose a method.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
METHOD-SPECIFIC COUNSELING – once the woman has chosen a method					
1. Performs a physical assessment that is appropriate for the method chosen, if indicated, refers the woman for evaluation. (BP for hormonal, pelvic for IUCD)					

CHECKLIST FOR FAMILY PLANNING COUNSELING (Some of the following steps/tasks should be performed simultaneously)					
STEP/TASK	**CASES**				
2. Ensures there are no conditions that contraindicate the use of the chosen method. ▪ If necessary, helps the woman to find a more suitable method					
3. Tells the woman about the family planning method she has chosen: ▪ Type ▪ How to take it, and what to do if she is late taking her method ▪ How it works ▪ Effectiveness ▪ Advantages and non-contraceptive benefits ▪ Disadvantages ▪ Common side effects ▪ Danger signs and where to go if she experiences any					
4. Provides the method of choice if available or refers woman to the nearest health facility where it is available.					
5. Asks the woman to repeat the instructions about her chosen method of contraception: ▪ How to use the method of contraception ▪ Side effects ▪ When to return to the clinic					
6. Educates the woman about prevention of STIs and HIV/AIDS. Provides her with condoms if she is at risk.					
7. Asks if the woman has any questions or concerns. Listens attentively, addresses her questions and concerns.					
8. Schedules the follow-up visit. Encourages the woman to return to the clinic at any time if necessary.					
9. Records the relevant information in the woman's chart.					
10. Thanks the woman politely, says goodbye and encourages her to return to the clinic if she has any questions or concerns.					
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
FOLLOW-UP COUNSELING					
1. Greets the woman with respect and kindness. Introduces self.					
2. Confirms the woman's name, address and other required information.					
3. Asks the woman the purpose of her visit.					
4. Reviews her record/chart.					
5. Checks whether the woman is satisfied with her family planning method and is still using it. Asks if she has any questions, concerns, or problems with the method.					

CHECKLIST FOR FAMILY PLANNING COUNSELING (Some of the following steps/tasks should be performed simultaneously)					
STEP/TASK	**CASES**				
6. Explores changes in the woman's health status or lifestyle that may mean she needs a different family planning method.					
7. Reassures the woman about side effects she is having and treats them if necessary.					
8. Asks the woman if she has any questions. Listens to her attentively and responds to her questions or concerns.					
9. Performs any necessary physical assessment.					
10. Provides the woman with her contraceptive method (e.g. the pill, DMPA, condoms, etc.)					
11. Schedules return visit as necessary-tells her. Thanks her politely and says goodbye. ▪ Records info in her chart					

CHECKLIST 2: POSTPARTUM IUCD COUNSELING IN THE WARD

(To be used for practicing and assessment of the FP counseling skill)

This checklist is for counseling woman, who has just delivered, for postpartum family planning. This counseling can be done in postpartum ward. After getting information on all the methods of family planning, if the woman shows interest in IUCD (CuT), she should be counseled on PPIUCD according to the steps given in this checklist

Place a "✓" in case box if step/task is performed **satisfactorily**, an "**X**" if it is **not** performed **satisfactorily**, or **N/O** if not observed.

Satisfactory: Performs the step or task according to the standard procedure or guidelines

Unsatisfactory: Unable to perform the step or task according to the standard procedure or guidelines

Not Observed: Step or task not performed by participant during evaluation by trainer

Participant _____ **Date Observed** _____

CHECKLIST FOR POSTPARTUM FAMILY PLANNING (PPFP) COUNSELING IN THE WARD (Some of the following steps/tasks should be performed simultaneously)					
STEP/TASK	**CASES**				
SKILL/ACTIVITY PERFORMED SATISFACTORILY					
GENERAL COUNSELING SKILLS					
1. Greets the woman with respect and kindness. Introduces self.					
2. Arranges all items and supplies needed for counseling.					
3. Ensures the documents are available (for example: Client's file, daily activity register, flip book, follow up card, etc).					
SPECIFIC FAMILY PLANNING COUNSELING CONTENT					
1. Asks the woman if she is breastfeeding and offer help to get her started. ▪ Discuss benefits for the baby once baby is attached to the breast ▪ Discuss that exclusive breastfeeding also offers 98% protection against pregnancy					
2. Discuss the 3 criteria: Exclusive breastfeeding, no menses, and the baby is less than 6 months.					
3. Asks the woman if she and her husband plan to have more children.					

CHECKLIST FOR POSTPARTUM FAMILY PLANNING (PPFP) COUNSELING IN THE WARD (Some of the following steps/tasks should be performed simultaneously)					
STEP/TASK	**CASES**				
4. Asks the woman when she and her husband would like to have more children (if applicable). Tell the woman the benefit of healthy spacing of pregnancy (if applicable).					
5. Tell the woman the risks of another pregnancy before the return of her menses if she is not fully breastfeeding her baby.					
6. Tell her that there are methods of contraception that are available that will not affect the quantity or quality of her breastmilk such as IUCD, which can be inserted within 48 hours of childbirth; progestin-only pills, DMPA, condoms					
7. Remind the client that withdrawal is not very effective; 25 women in 100 will become pregnant.					
8. Ask her if she would like any information about these methods.					
9. Leave the client information sheet and invite her to ask question or concern, she might have about postpartum family planning method or if she is interested for any method.					
10. Advice that to ensure her health and the health of her baby, she should wait at least 2 years after this birth before trying to get pregnant.					
11. Based on client's prior knowledge and interest, briefly explain the benefits, limitations and use of the following methods: LAM, Condoms, IUCD, female sterilization.					
12. Show the samples of methods and explain the effectiveness of various methods.					
13. Correct any misconception about family planning methods.					
14. Help the client to choose a method ▪ Give the client additional information that she may need and answer any question ▪ Assess her knowledge about the selective method					
15. If the client has chosen to get IUCD inserted within 48 hours of delivery, determine if she can safely use the method (Chapter 2, Table on IUCD, last column lists all such conditions in which woman will not be eligible to use IUCD and PPIUCD)					
16. Discuss key information about the PPIUCD with the client – ▪ Effectiveness: Prevents almost 100% of pregnancies ▪ How does the IUCD prevent pregnancy: Causes a chemical change that					

CHECKLIST FOR POSTPARTUM FAMILY PLANNING (PPFP) COUNSELING IN THE WARD (Some of the following steps/tasks should be performed simultaneously)					
STEP/TASK	**CASES**				
damages the sperm before the sperm and egg meet ▪ How long does the IUCD prevent pregnancy: Can be used as long as she likes, even up to 10 years ▪ The IUCD can be removed at any time by a trained provider and fertility will return immediately					
17. Discuss the following advantages of PPIUCD ▪ Simple placement immediately and within 48 hours of delivery ▪ Does not affect breastfeeding ▪ Long acting but reversible					
18. Discuss the following limitations of PPIUCD ▪ Heavier and more painful menses especially first few cycles. May not be noticed by the client after PPIUCD insertion ▪ Does not protect against STIs, including HIV/AIDS ▪ IUCD might come out on its own					
19. Discuss the following warning signs, which are rare, but if she has any of the following, she should return to the clinic as soon as possible ▪ Foul smelling vaginal discharge different from the usual lochia ▪ Lower abdominal pain, especially if accompanied by not feeling well, fever or chills, especially in the first 3 weeks after insertion ▪ Concerns that she might be pregnant ▪ Concerns that the IUCD has fallen out					
20. Check that the woman understands- ▪ Allow the client to ask questions ▪ Ask the client to repeat key information					
21. Next steps- ▪ If client cannot arrive at a conclusion, ask her to plan for a discussion with her husband/family and a follow up discussion with you or doctor ▪ Make note on the client's record card about her postpartum contraceptive choice or which method interests her ▪ If she chooses IUCD, make arrangement for insertion ▪ If PPIUCD is inserted, ask her to come back after 6 hours					

PERFORMANCE STANDARDS FOR
IMMEDIATE POSTPARTUM INTRAUTERINE DEVICE (PPIUCD) COUNSELING

The list of performance standards for ensuring quality of PPIUCD counseling are given in the column 1 of the table below. For assessment of each performance standard, the verification criteria are given in the column 2.

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N, N/A1	Y/N, N/A	COMMENTS
AREA 1: INITIAL CLIENT ASSESSMENT AND COUNSELING DURING ANTENATAL CARE; RETURN VISIT				
Instructions for the Assessor: Observe standards 1-6 in woman/women receiving immediate postpartum family planning counseling during antenatal visit				
1. **The provider uses recommended general counseling techniques during ANC for Postpartum Family Planning.**	**Observe in the appropriate services area that the provider:**			
	▪ Shows respect for the woman and helps her feel at ease			
	▪ Encourages the woman to explain needs, express concerns and ask questions			
	▪ If appropriate, includes woman's husband or important family member with woman's consent			
	▪ Listens carefully			
	▪ Respects and supports the woman's informed decisions			
	▪ Checks the woman understanding			
2. **Provider/counselor provides information on all benefits of pregnancy spacing and explores woman's knowledge about postpartum family planning methods** Use the *Postpartum Family Planning Counseling Job Aid* to	**Observe that the provider/counselor:**			
	▪ Explores woman's knowledge about the benefits of pregnancy spacing.			
	▪ Asks about previous family planning methods used and knowledge about all family planning methods including PPFP (LAM, POPs, postpartum ligation, condoms and PPIUCD).			
	▪ Addresses any related needs such as protection from sexually transmitted infections, including HIV and support for condom use.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N, N/A1	Y/N, N/A	COMMENTS
facilitate this task	▪ Corrects misinformation or wrong believes.			
	▪ Asks if the woman has any particular method in mind, which she wants, otherwise discusses the woman's situation, plans and what is important to her about a method.			
	▪ Helps woman consider suitable methods. If needed, helps her reach a decision.			
	▪ Supports the woman's choice.			
3. The provider does a brief screening assessment and determines whether the IUCD is an appropriate method for women interested in PPIUCD (This step will be performed by doctor only)	**If the woman is interested in the PPIUCD observe that the provider:**			
	Asks the woman if she has:			
	— Any history of unusual bleeding between menstrual periods or bleeding after intercourse before she became pregnant			
	— Been told that she has any type of cancer in genital organs, pelvic tuberculosis			
	— Been told that she has rheumatic diseases such as lupus, which has increased risk of bleeding			
	— Increased personal risk of having gonorrhea or chlamydia infections			
	— AIDS, and neither on ARV therapy nor clinically well			
	▪ If none of the above conditions are present, tells the woman that IUCD is an appropriate option for her and she may use it			
	▪ Proceeds with method specific counseling for this method [NOTE: Tells the woman that she will be reassessed in labor/immediately postpartum and other postpartum criteria will be considered at that time].			
4. Provider/counselor gives key information including advantages and limitations	**Observe that the provider:**			
	▪ Uses visual aids (poster, shows IUCD) during counseling.			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N, N/A1	Y/N, N/A	COMMENTS
about PPIUCD	▪ Discusses the following advantages:			
	— Effectiveness: prevents almost 100% of pregnancies			
	— Immediate placement after delivery			
	— No further action required by the woman			
	— It can be removed at any time by a trained provider			
	— Immediate return of fertility upon removal of the IUCD			
	— Does not affect breastfeeding			
	— Long-acting and reversible: Can be used to prevent pregnancy for a short time or as long as 10 years			
	▪ Provides information about when the woman should return for a check-up			
	▪ Discusses the following limitations:			
	— Heavier and more painful menses, especially first few cycles but not noticed during the postpartum period			
	— Does not protect against STIs, including HIV/AIDS			
	— Some risk of expulsion when inserted postpartum			
	▪ Discusses the following warning signs and explains that she should return to the hospital as soon as possible if she has any of the following:			
	— Foul smell vaginal discharge different from the usual lochia			
	— Lower abdominal pain, especially if accompanied by not feeling well, fever or chills			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N, N/A1	Y/N, N/A	COMMENTS
	— Has a concern that she might be pregnant			
	— Has a concern that the IUCD has fallen out			
5. Provider/counselor documents to alert other care providers that the woman has chosen postpartum IUCD	**Observe that the provider:**			
	▪ Documents on ANC card that woman has been counseled and requests PPIUCD			
	▪ Instructs the woman to bring the card and tell the provider in the hospital when she comes in labor to deliver that she wants an IUCD immediately after delivery.			
	▪ Gives the woman the card that shows that she has consented to immediate postpartum insertion of the IUCD.			
AREA 2: COUNSELING AND CLIENT ASSESSMENT DURING EARLY LABOR OR POSTPARTUM PERIOD **Instructions for the Assessor:** The Supervisor/Head of the Unit may observe standards 6-9 in sequence with women receiving postpartum family planning counseling during early labor and postpartum period.				
6. The provider re-confirms with the woman in early labor that she has chosen the IUCD as an immediate postpartum FP method.	**Observe that the provider:**			
	▪ Greets the woman (and companion, if present) with respect.			
	▪ Confirms the woman's identification information (name, age, parity).			
	▪ If the woman is in labor, provider is sensitive to the woman's discomfort and stops the discussion during contractions/labor pains.			
	▪ Determines, that the woman has indicated consent and meets criteria for post-placental/postpartum insertion.			
	▪ Determines that the woman still desires the IUCD postplacental/postpartum.			
7. The provider counsels and screens a woman (who was not identified during ANC for the	**Observe that the provider/counselor:**			
	▪ Identifies those women in early labor and postpartum period who are			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N, N/A1	Y/N, N/A	COMMENTS
immediate postpartum IUCD) during early labor OR within 48 hrs of delivery.	interested in the immediate postpartum IUCD			
	▪ If woman is in early labor or immediate postpartum, ensures woman is comfortable and capable of making an informed choice.			
	▪ Performs a brief screening assessment and determines whether the immediate PPIUCD is an appropriate method for the woman (done by doctor).			
	▪ Provides method-specific information about immediate postpartum IUCD.			
	▪ Makes a note in the hospital record and notifies other care providers that woman has chosen immediate postpartum insertion of the IUCD.			
	▪ Where appropriate, makes arrangements for immediate postpartum IUCD insertion before discharge			
8. The provider ensures the IUCD is an appropriate immediate postpartum contraceptive method for a woman in early labor/ postpartum woman (within 48 hrs of delivery). **(This step will be performed by doctor).**	**Observe that the provider:**			
	Reviews the woman during early labor and immediate postpartum period, using the ***Pre-Insertion Screening Job Aid***, to rule out the following conditions:			
	- More than 18 hours from rupture of membranes to delivery of the baby			
	- Unresolved postpartum hemorrhage			
	- Signs and symptoms of reproductive tract infection o Fever o Severe lower abdominal pain o Foul smelling discharge			
	- Extensive genital trauma where the repair would be disrupted by post placental/postpartum placement of the IUCD			
9. The provider demonstrates good client-provider interaction.	**Observe that the provider:**			
	▪ Provides the woman an opportunity to ask questions; answers her (and companion's, if present) questions.			
	▪ Maintains privacy and confidentiality for the woman			

PERFORMANCE STANDARDS	VERIFICATION CRITERIA	Y/N, N/A1	Y/N, N/A	COMMENTS
	▪ Listens carefully to the woman or her companion			
	▪ Speaks respectfully and professionally with the woman in clear and simple language.			
	▪ Ensures that the woman understands the information provided.			
POST INSERTION COUNSELING				
10. The provider provides post insertion instructions to the woman. **Note: This needs to be done for cesarean section patients on the 2nd or 3rd day postpartum.**	**Observe if the provider:**			
	▪ Notes the type of IUCD insertion and date of insertion on the discharge card.			
	▪ Reviews IUCD side effects and normal postpartum symptoms with the woman.			
	▪ Tells the woman when to return at 6 weeks for IUCD/PNC/newborn checkup.			
	▪ Tells the woman about the warning signs for IUCD.			
	▪ Emphasizes that she should come back at any time she has a concern or experiences warning signs			
	▪ Tells the woman how to check for expulsion and what to do in case of expulsion.			
	▪ Assures woman that IUCD will not affect breastfeeding and breast milk.			
	▪ Ensures that the woman understands post insertion instructions.			
	▪ Gives written post insertion instructions.			

Y=Yes; N=No; N/A=Not Applicable

References

1. "Clients who receive the method they want are more likely to continue use", *Pariani, S., et al, 1991, Does choice make a difference to contraceptive use? Evidence from East Java. "Studies in Family Planning" 22(6):384-390*
2. Comprehensive Counseling for Reproductive Health: An integrated curriculum – participant's handbook by EngenderHealth, 2003
3. Enhancing Quality for Clients: The Balanced Counseling Strategy; Program Brief No. 3: July 2003; Frontiers in Reproductive Health, Population Council
4. Family Planning: A Global Handbook for Providers, World Health Organization Department of Reproductive Health and Research (WHO/RHR) and Johns Hopkins Bloomberg School of Public Health/Center for Communications Programs (CCP), INFO Project (2008 update)
5. Family Planning Counseling: A curriculum prototype, trainer's manual, AVSC International, New York, 1995
6. Global Health eLearning Center, USAID. Course: Family Planning Counseling; http://www.globalhealthlearning.org
7. Healthy Timing & Spacing of Pregnancy, A Trainer's Reference Guide, August 2008; The Extending Service Delivery Project, USAID
8. International Planned Parenthood Federation. *Rights of the client.* London: 1991.
9. IUD Guidelines for Family Planning Services Programs: A Problem-Solving Reference Manual 3rd Edition – JHPIEGO, 2006
10. IUD Toolkit; http://www.maqweb.org/iudtoolkit/service_delivery/keyiudcounselingcomponents.shtml
11. Population Reports: GATHER Guide to Counseling. Series J, Number 48, Published by the Population Information Program, Center for Communication Programs, The Johns Hopkins University School of Public Health, 111 Market Place, Suite 310, Baltimore, Maryland 21202, USA. Volume XXVI, Number 4, December 1998
12. Population Reports: "New Attention to the IUD: Expanding Women's Contraceptive Options to Meet Their Needs". Series B, Number 7, Baltimore, Johns Hopkins Bloomberg School of Public Health, The INFO Project, February 2006.
13. Population Reports, Series J, No.50, Informed Choice in Family Planning: Helping People Decide (2001)
14. Postpartum Family Planning for Healthy Pregnancy Outcomes: A Training Manual, February 2009; The Extending Service Delivery Project, USAID
15. Postpartum Family Planning (PPFP): Training. www.k4health.org;
16. http://www.K4health.org/toolkits/ppfp/training
17. Providing Postpartum IUCD Clinical Services: Reference Manual, January 2010 (Draft); USAID, SIFPSA, NRHM, Access
18. "Use of contraception is highest when people have access to a range of contraceptive methods", Ross, J., et al, 2002 Contraceptive method choice in developing countries