



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

Session 1

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

Rationale for Postpartum Care Inclusive of Family Planning

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



Objectives of Focused Postpartum Care

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



Training Goal and Objectives

- **Goal:**
 - By the end of the training, participants will be able to provide high-quality postpartum care, including family planning
- **Objectives:**
 - Provide essentials of maternal and newborn care, achieving 90% of the tasks/steps on the checklist with prompting
 - Understand that healthy timing and spacing of pregnancy saves lives
 - Explain LAM and transition to postpartum family planning to clients
 - Demonstrates competency in providing family planning to clients during the first postpartum year
 - Develops an action plan



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Goal:

Provide quality PFP services including counseling.

Objectives:

Understand the role of FP in reducing maternal and infant morbidity and mortality.

Describe the organization, management, and record keeping of PFP service.

Transfer learning from the training to the work site, through an action plan, support and supervision.

Why Postpartum/Postnatal Care Now?

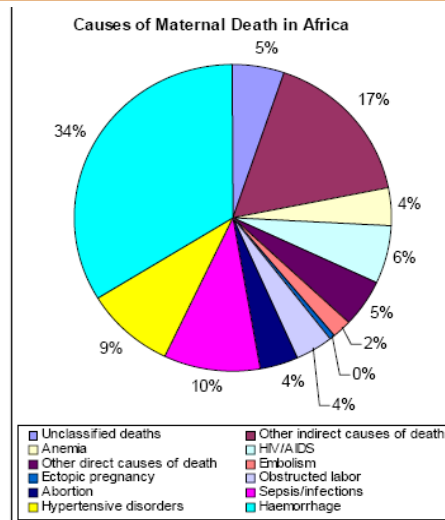
- **Improve maternal health:**
 - 60% of maternal deaths occur during the first postpartum week
- **Improve neonatal and infant health:**
 - 75% of neonatal deaths occur during the first postpartum week
- **Prevention of unintended pregnancies:**
 - We cited four countries that show 60–70 % of postpartum women report an unmet need for family planning during the 1st year postpartum



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We saw in earlier studies the prospective unmet need for postpartum family planning (Ross and Winfrey 2001). Women reported that they did not want to become pregnant within the next 2 years yet they were not using a method of family planning. The countries represented areas as diverse as East and West Africa, South Asia, and the Caribbean.

Cause of Maternal Death in Africa



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Source: Khan, Kalid S, Daniel Wojdyla, Lale Say, A Metin Gülmezoglu, Paul F.A. Van Look: 2006. "WHO analysis of causes of maternal death: a systematic review." *Lancet*; 367:1066-74.

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In this pie graph we can see that the major cause of maternal death in Sub-Saharan Africa is postpartum hemorrhage at 34% (WHO 2006 from *Lancet* 2006; 367: 1066-74); sepsis/infection is responsible for 10%. Hypertensive disorders and unsafe abortion (termination of an unwanted pregnancy) per WHO 2000, estimate between 15-30 women; 1,000 WRA have an unsafe abortion.

PPH is responsible for about 30% of MMR in Asia and 20% in LAC. But hypertensive disorders are responsible for over 25% of MMR in LAC.

About 60% of maternal mortality occurs during the first week postpartum (WHO 1997 and DHS Comparative Reports No. 15 Postpartum Care: Levels and Determinants in Developing Countries Alfred Fort, Monica Kothari, Noureddine Abderrahim, Macro International 12-06). On average, only 28% of women who have non-institutional birth receive postnatal care. The assumption that women who deliver in facilities have postpartum care is not always the case. Women who deliver in facilities **DO NOT** always receive adequate PNC.

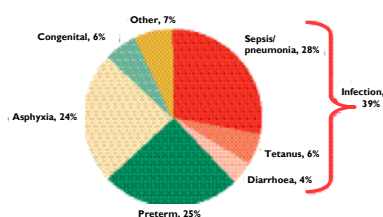
Causes of Neonatal Mortality in SSA

- Major causes of neonatal mortality:

- Infections: 39%
- Preterm: 29%
- Asphyxia: 24%

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

FIGURE 1.5 1.16 million newborn deaths in Africa – Why?



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

Source: Based on vital registration for one country and updated modeling for 45 African countries using 2004 birth cohort, deaths and other predictor variables. For more details see data notes on page 226 and for more details of estimation model see references^{16,17}



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Dr. Issakha Diallo of Advance Africa, a nongovernmental organization, presented the results of a recent study, which shows that 40-50% of infant deaths in developing countries are neonatal, and that spacing births by three years or more could reduce neonatal deaths by 50%.

Some conclusions of the study are that:

Birth intervals of three years or longer can substantially decrease the risk of newborn death.

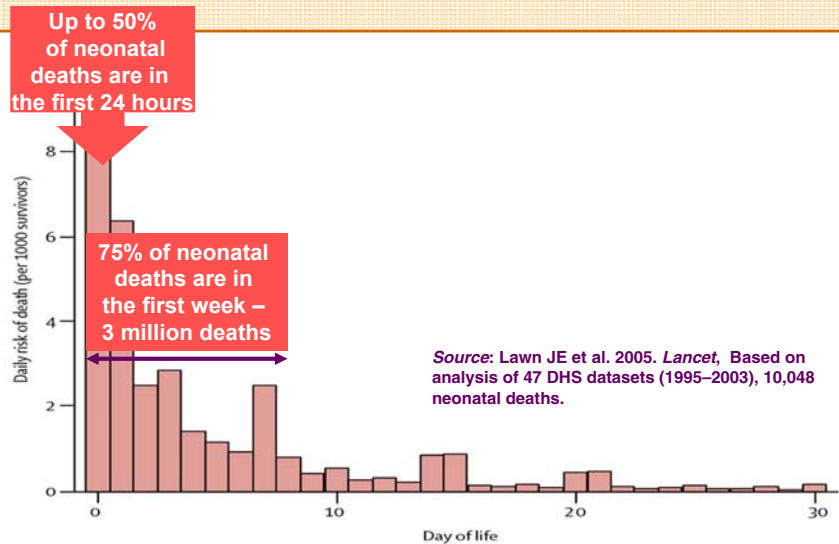
Infants are twice as likely to survive if the previous birth interval is at least two years.

Family planning can reduce maternal maternity by 20%.

Avoiding short birth intervals would lower both fertility and infant and child maternity.

Enabling women to realize their birth interval preferences would result in substantial decreases in both infant and child mortality and fertility.

4 Million Newborn Deaths - When?



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Data from DHS surveys in 47 countries--10,048 neonatal deaths. A very high proportion of deaths occur in the first hours and days after birth. Prevention of these early neonatal deaths will require improvements in care at the time of birth and improvements in care in the early neonatal period. 60% of maternal mortality rate occurs during the postpartum period, the first hours and days the most critical.



Postpartum Care

Session 2

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

Session Objectives

- **By the end of the session, participants will be able to:**
 - Describe essentials of maternal and newborn care during the postpartum period
 - Describe symptoms and management of postnatal complications

Start Postpartum Family Planning during ANC

- Discuss benefits of immediate and exclusive breastfeeding...LAM
- Discuss possibilities for long-acting methods:
 - Postpartum IUD insertion, or
 - Limiting future pregnancies... postpartum tubal ligation or vasectomy

Overview of Postpartum/Postnatal Care: Four Focused Visits

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



Visits are defined as provider gets history, does a focused exam. Makes assessment based on history and examination findings and then provides care and counselling appropriate to that patient and age of the baby.

Elements of Postpartum Care

- **Four focused visits of mother and baby**
- **Integrate at each visit:**
 - Essential maternal and newborn care
 - Danger signs
 - Family planning
 - Immunization
 - HIV counseling and testing



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ACCESS-FP strengthens the postpartum family care by promoting focused postpartum visits. The first is initiated ideally within the first 2 hours after birth and again within the first 48 hours; at 1-2 weeks, at 4 to 6 weeks and again as mothers transition from exclusive breastfeeding to a contraceptive method. Providers are oriented to assessing the mother and baby and linking family planning to immunization, PMTCT and other services. The content of each visit will be specific for care/evaluation required at the time of the visit. Overall the visits will include: danger signs, essential maternal and newborn care (maternal: VS, breast fundus, lochia) counseling on hygiene, newborn nutrition, exclusive breastfeeding, clean cord care, maintaining infant temperature, hygiene, infant growth monitoring and immunization, family planning information including LAM, HIV testing if status not known, supportive advice for HIV+ women to go to care and treatment, AFASS vs. EBF, ARVs to baby within 72 hours, cotrimoxazole, and referral for comprehensive counseling and care for HIV+ women and their babies.

Essentials of Maternal Postpartum Care (WHO 2007)

- **Assessment of maternal well-being:**
 - Prevention and detection of complications (e.g., infections, bleeding, anemia)
 - Anemia prevention and control (iron and folic acid supplementation)
- **Information and counseling on:**
 - Nutrition, safe sex, family planning and provision of some contraceptive methods
 - Advice on danger signs, emergency preparedness and follow-up
 - Provision of contraceptive methods



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During the first 2 hours after delivery, a mother needs to be carefully evaluated frequently (15 minutes, then every hour if no abnormal findings) MONITOR for pre-eclampsia and PPH.

The first hours postpartum are extremely important. During this time, caregivers should:

Assess maternal well-being, measure and record blood pressure and body temperature.

Assess for vaginal bleeding, uterine contraction and fundal height regularly. Massage the uterus every 15 minutes during the first 2 hours.

Identify signs of serious maternal complications, in particular hemorrhage, eclampsia and infections, and initiate treatment if necessary.

Basic Postpartum Care Provision

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



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Focused postpartum care means a quick assessment to r/o an emergency at beginning of the visit, then focus on the essential care for both mother and baby. Get her history on her pregnancy and delivery. Review labs, RPR, HIV, TT immunizations. Ask open-ended questions to elicit how the mother and baby are. For example, “How is the breastfeeding going ?” is better way to inquire about feeding than asking “are you breastfeeding?” In the same manner, inquire about how she is feeling, how the baby is sleeping, feeding, etc.

Focused postpartum care does not mean a comprehensive exam for everyone. If the mother does not have a complaint about her breasts, it's not necessary to palpate her breasts for masses. It is important to evaluate how well the baby is breastfeeding and the look at her breasts for possible cracked nipples. It is important to ask about family planning at immunization visits. Is the mother breastfeeding and practicing LAM? If not, is she aware of the return to fertility and health risks of having a closely spaced pregnancy? Is she aware of contraceptive methods that are safe for breastfeeding women who are not practicing LAM?

Basic Postpartum Care Provision (cont.)

- **Ongoing supportive care**
- **Basic care package:**
 - Breastfeeding and breast care
 - LAM and transition to other FP
 - Nutritional support
 - Self-care and other healthy practices
 - Complication readiness plan
 - HIV counseling and testing (VCT)
 - Immunizations and other preventive measures



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LAM and other methods of FP are discussed in more detail in upcoming PowerPoint presentations.

First Visit after Delivery:

*Quick check for danger signs to rule out emergency at beginning of visit

- **History:**
 - Time of delivery, place and complications at delivery, HIV and syphilis screening done? TT?
- **Any pain or bleeding now?**
- **Physical exam:**
 - Vital signs
 - Check conjunctiva
 - Abdomen: palpate fundus: firm? tender?
 - Bladder: When did she void last?
 - Gently inspect labia and perineum
 - Evaluate vaginal bleeding, amount, origin
 - Evaluate lochia color, amount, odor
- **Care/Counseling: Assist mother to nurse baby within 1st hour of care:**
 - Observe infant feeding, assist with correct latching technique, if needed
 - Advise delayed return to fertility with exclusive breastfeeding...LAM
- **Advise about danger signs:**
 - Complication **readiness**
 - Check for continuation medications/immunizations
- **Discuss family planning**
- **Return to clinic per schedule or earlier if danger signs arise**



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For women who delivered at a facility during first 2-4 hours, more frequent assessments will be made of BP, pulse, uterine fundus, bladder, breastfeeding. Temp check once during first 6 hours.

Quick check of danger signs to r/o emergency at beginning of visit.

Check for continuation of any therapy/medications/ immunizations (Fe supplement, vitamin A, de-worming anti-malarial, TT, ITN, ARV, PMTCT).

Discuss danger signs, routine care: hygiene, nutrition, rest, newborn care and **when to return.**

Discuss family planning intentions and options, SEE LAM or candidate for PPIUCD of BTL.

Essential Newborn Care Interventions

- **Initiation of breathing and resuscitation:**
 - Early asphyxia identification and management
- **Thermal protection:**
 - Prevent and manage newborn hypo/hyperthermia
- **Early and exclusive breastfeeding:**
 - Started within 1 hour after childbirth
- **Clean childbirth and cord care:**
 - Prevent newborn infection



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Care in the first hours includes:

- Provide thermal protection; through a warm environment ,and not separating the mother and the newborn to prevent hypothermia of the baby.
- Support frequent and exclusive breastfeeding . Assist the mother for good breast attachment.
- In case of a known HIV-positive mother, she has to decide about exclusive breastfeeding or replacement feeding if AFASS. She needs to consider whom she wants to inform about her HIV-positive status. The mother living with HIV needs support and counseling in these difficult decisions.
- Clean cord care.
- Weigh the baby.
- Examine the newborn to recognize problems early and to reach the mother about normal newborn' s reflexes.
- Teach the mother about danger signs.
- Administer vitamin K to the baby if country policy prescribes it, either by injection or orally.
- Start immunizations with BCG and hepatitis B vaccine, and the first dose of oral poliomyelitis vaccine, as recommended (WHO).

Essential Newborn Care Interventions (cont.)

- **Eye care:**
 - Prevent and manage ophthalmia neonatorum
- **Immunization:**
 - At birth: bacilli Calmette-Guerin (BCG) vaccine, oral poliovirus vaccine (OPV) and hepatitis B virus (HBV) vaccine (WHO recommendation)
- **Identification and management of sick newborn**
- **Care of preterm and/or low birth weight newborn**



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Nearly 30% of newborn deaths occur in LBW babies, many of whom are pre-term.

Intensive care is not needed to save the majority of these babies.

Identify the small baby (birth weight is < 2500 gms).

Assess for danger signs and manage or refer as appropriate.

Provide extra support for breastfeeding, including expressing milk and cup feeding if necessary... teach mother.

Maintain infant body temperature:

Skin-to-skin care between mother's breasts, keep baby's head covered, refer to KMC if indicated...teach mother.

Ensure early identification and rapid referral of babies who are unable to breastfeed or accept expressed breast milk.

For HIV-positive mothers, provide AFASS criteria and assist mother to decide how to feed her baby.

For more on care of preterm or low birth weight newborn, look for Kangaroo Mother Care; go to www.who.int/reproductive-health/publications/kmc/text.pdf for the training manual.

Support for Mother-Baby-Family Relationships

- **Bonding:**
 - Encourage touching, holding, exploring
 - Encourage rooming-in
- **Support:**
 - Encourage sharing in care of newborn
 - Assist in devising strategies for overcoming challenges
- **Information:**
 - Discuss key aspects of postpartum and newborn care
 - Encourage questions



Support for Mother-Baby-Family Relationships (cont.)

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

Breastfeeding and Breast Care



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



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Exclusive breastfeeding is the best for infant survival and recommended by WHO. Try to explain to new mothers and their families the benefit of colostrum and giving only breast milk.

Breastfeeding Best Practices

- **Best practices:**
 - Only COLOSTRUM, no pre-lacteal feeds
 - Giving first breastfeed within 1 hour of birth
 - Correct positioning to enable good attachment of the newborn
 - Breastfeeding on demand
 - Psycho-social support to breastfeeding mother
- **Additional advice:**
 - Use both breasts at each feed; do not limit time at either
 - Ensure adequate sleep/rest – take nap when baby sleeps
 - Ensure adequate food/fluid intake – glass of fluids per feed; extra meal per day



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Colostrum is rich in antibodies and offers protection to the infant. It also acts as a natural laxative to empty the newborn of meconium.

WHO recommends exclusively breastfeeding during the first 6 months for infant survival and continue to breast feed, adding complementary foods during the infant's first 2 years.

Breast milk is perfectly suited for infants. The hind milk is rich in nutrients and calories, so it's important for the mother to empty her breasts during feeding (*Myles Textbook for Midwives, Bennett/Brown, Twelfth Edition*).

Immunological adaptations, neonates demonstrate a marked susceptibility to infections, particularly those gaining entry through the mucosa of the respiratory and gastro-intestinal systems. Breast milk, and especially colostrum, provides the infant with passive immunity in the form of *lactobacillus bifidus*, lactoferrin, lysozymes and secretory IgA, among others.

Macrophages and neutrophils are among the most common leucocytes in human milk and they surround and destroy harmful bacteria by their phagocytic activity.

Secretory IgA and interferon are important anti-infective agents produced in abundance by lymphocytes in human milk.

Immunoglobulins IgA, IgG, IgM and IgD are all found in human milk.

Lysozyme is present in breast milk in concentrations 5,000 times greater than in cows' milk. It is a well-known general anti-infective agent and its activity appears to increase during lactation.

Return to Fertility

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

Return to Sexual Activity

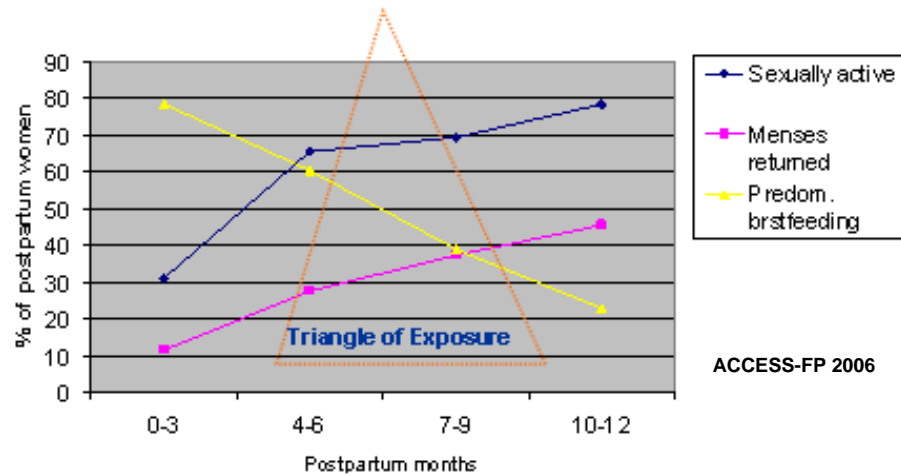
- **Sexual relations and safer sex:**
 - Avoidance of sex for at least 2 weeks and until it is comfortable
 - Increased susceptibility to STIs during postpartum period
 - Abstinence or mutually monogamous sex with uninfected partner – only sure protection
 - Consistent use of condoms
 - Avoidance of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



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Discuss that return to fertility and birth spacing is a good opportunity to initiate discussions on return to sexual activity. Most couples want to know and may be too timid to ask about return to sexual activity.

Return to Sexual Activity: Nigeria



ACCESS-FP 2006



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This slide highlights the events that put a postpartum woman at risk for an unintended pregnancy. The timeframes will vary from country to country, based on breastfeeding practices.

Nutritional Support

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



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To support lactation and maintain maternal reserves, most mothers will need to eat about 500 additional calories every day. This is an increase of 20-25% over the usual intake before pregnancy.

Well-nourished mothers who gain enough weight during pregnancy need less because they can use body fat and other stores accumulated during pregnancy.

Lactation also increases the mother's need for water, so it is important that she drink enough to satisfy her thirst.

Vitamin A in high doses such as 200,000 IU (60mg) should NOT be given to women who may be in the early stages of pregnancy. Therefore a good time is shortly after birth for the first dose and the second dose should be at least 24 hours later and up to 6 weeks postpartum (Paho 2001).

Vitamin A is necessary for growth, infection prevention and sight. Mothers who take vitamin A can pass it in appropriate amounts to their babies in breast milk.

Nutritional Support (cont.)

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

Self-Care and Other Healthy Practices

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

Preventive Measures

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

Immunization and Other Preventive Measures – Tetanus Toxoid for Mothers

Tetanus Toxoid Immunization Schedule	
TT Injection	Due
TT 1	At first contact with woman of childbearing age or as early as possible in pregnancy (at 1 st ANC visit)
TT 2	At least 4 weeks after TT 1
TT 3	At least 6 months after TT 2
TT 4	At least 1 year after TT 3
TT 5	At least 1 year after TT 4



If in a country most women of childbearing age have not been immunized with tetanus toxoid (TT) in their infancy or before pregnancy, it is recommended that they receive the first dose (TT1) at first contact during pregnancy, and TT2 at least 4 weeks after TT1. TT3 should be given at least 6 months after TT2. The two remaining doses should be given after subsequent intervals of one year minimum. If pregnant women have documentation of prior receipt of tetanus toxoid-containing vaccines in early childhood or at school age, they may receive a booster dose during pregnancy.

Immunization Schedule Recommended by WHO

Age	Vaccine
Birth	BCG, OPV-0, Hep B*
6 weeks	DTP-1, OPV-1, Hep B* Hip-1**
10 weeks	DTP-2, OPV-2, Hep B*, Hip-2**
14 weeks	DTP-3, OPV-3, Hep B*, Hip-3**
9 months	Measles, Hep B* Yellow Fever ***
* Only 3 doses of Hep B are needed for protection	** Hib stands for <i>Haemophilus influenzae</i> type b. *** In countries where indicated



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The following schedule is recommended during pregnancy and postnatally:

Soon after birth, BCG is recommended in all populations at high risk of tuberculosis infection. The starting dose of oral poliomyelitis vaccine (OPV 0) is also recommended soon after birth, and the first dose of hepatitis B vaccine (HB 1) in those countries where perinatal transmission is frequent.

At the age of 6 weeks, the first dose of the combined vaccines against diphtheria, pertussis and tetanus (DPT 1) is given as well as the OPV 1 dose, and the HB 2 dose. In countries with a low perinatal transmission rate of hepatitis B, the HB 1 dose may be given at this age.

At 10 weeks DPT 2 and OPV 2 are given, and HB 2 in countries with a low transmission rate.

At 14 weeks DPT 3 and OPV 3 are given, and HB 3 in all countries.

Official WHO policy calls for the inclusion of hepatitis B vaccination in the childhood vaccination programs of all countries, and as of 2005, this has been accomplished in over 150 countries. Despite the cost, which continues to fall, it is part of the routine schedule in countries with a hepatitis B carrier prevalence of 2 percent or higher; in reality, this includes virtually all developing countries. In countries where mother-to-child transmission of hepatitis B is a major cause of infection, such as in Southeast Asia, it is essential that the first dose of hepatitis B vaccine be given to the newborn within the first 48 hours of life, as this represents post-exposure prophylaxis. The second dose is given along with DTP1 and the third dose is usually given along with either DTP2 or DTP3. In countries where mother-to-child transmission is not so important (as in most of Africa), the vaccine can be commenced at the same time as DTP and follow the same schedule as for DTP. In many countries supported through GAVI, a combined DTP-HB vaccine is being introduced. Hepatitis B vaccine is also available in a combined pentavalent DTP-HB+Hib vaccine, in which the liquid DTP-HB vaccine is used to reconstitute the freeze-dried Hib vaccine. Hepatitis B vaccine is also available on its own in a monovalent preparation.

At 9 months measles, HB if third dose not yet given, and yellow fever in countries where indicated.

An estimated 400,000 childhood deaths each year are attributed to Hib, which is a key cause of both bacterial meningitis and severe pneumonia. Like hepatitis B vaccine, Hib has been categorized by GAVI as a "new and underutilized vaccine" and, as such, receives special support. Worldwide, as of 2005, it has been introduced into childhood vaccination programs in 96 countries, including 19 countries where GAVI has financially supported its use in the form of combination vaccines that also contain DTP and hepatitis B. Like DTP, Hib is given in three doses at 6, 10 and 14 weeks. The major obstacle to more widespread use of Hib is the high cost, which is almost \$3.00/dose in monovalent form, and \$3.80/dose as part of pentavalent vaccine (including DTP and hepatitis B). The issue of cost and financing of Hib vaccine is currently the subject of much attention by GAVI. Source: USAID/GH/HIDN/Child Survival and Health Grants Program—TRM—**Immunization** -2006.

Complication Readiness Plan

- **At first visit after birth:**
 - Introduce concept and each element
 - Assist in developing plan
- **Return visits:**
 - Check arrangements made
 - Note changes and problems
- **Components:**
 - Appropriate health care facility for emergency care
 - Emergency transportation
 - Emergency funds
 - Decision-maker/decision-making process
 - Support person/companion
 - Blood donor
 - Danger signs for mother and newborn

Complication Readiness Plan for Clients

- **Danger signs:** ensure that woman and family know maternal and newborn danger signs
- What to do if danger signs present:
 - **Where to go for help (facility)**
 - **Who will help her get there (\$)**
 - **When to go (as soon as problem starts)**



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Maternal

Vaginal bleeding (heavy or sudden increase), breathing difficulty, foul-smelling discharge from vagina or tears/incisions, verbalization/behavior indicating she may hurt self or baby/hallucinations, fever, severe abdominal pain severe headache, blurred vision, convulsions/loss of consciousness

Infant

Breathing difficulty, convulsions, spasms, loss of consciousness, or arching back, cyanosis (blueness), fever, cold to touch, bleeding, jaundice, pallor, diarrhea, persistent vomiting or abdominal distension, not feeding / poor sucking, pus or redness of umbilicus, eyes, or skin, swollen limbs or joint floppiness, lethargy

Maternal Danger Signs

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



Postpartum Hemorrhage (PPH)

- Major cause of maternal mortality
- Occurs in 10% of all deliveries
- ANC risk assessment cannot predict PPH
- Bleeding may occur at a slow rate; PPH is not recognized until the woman is in shock

SBA's Provide AMTSL (Active Management of the Third Stage of Labor) for ALL Women

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

Puerperal Pyrexia

- **When is puerperal pyrexia present?**
 - Oral temperature rises to 38°C or higher:
 - On two or more occasions
 - During the first 14 days postpartum

Causes of Puerperal Pyrexia

- **Genital tract infection**
- **Urinary tract infection**
- **Mastitis or breast abscess**
- **Superficial leg vein thrombophlebitis**
- **Respiratory tract Infection**
- **Other infections**

Management: Perform Good History and Exam

- **History:**
 - Preterm or pre-labor rupture of membranes
 - A long labor
 - Operative delivery incomplete placenta or membranes
 - Patient feels generally unwell
 - Lower abdominal pain
- **Examination:**
 - Fever – usually develops in first 24 hours after delivery
 - Rigors may occur
 - Marked tachycardia
 - Lower abdominal tenderness
 - Offensive lochia
 - Episiotomy wound or perineal/vaginal tears

Management of Genital Tract Infection

- **Prevention:**
 - Strict asepsis during delivery
 - Reduction in number of vaginal exams
 - No routine AROM
 - No routine episiotomy
 - Give antibiotics if PROM >18 hours
 - Advise client to abstain until lochia has no bloody or brown tinge 4–6 weeks
- **Signs and Symptoms:**
 - Lower abdominal pain
 - Tender uterus
 - Purulent, foul-smelling lochia
 - Fever (> 38°), rapid pulse, confusion
- **Treatment:**
 - IV fluids, monitor intake and output
 - Antibiotics: ampicillin, gentamicin and metronidazole
 - Test hemoglobin levels



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Per WHO Integrated Management of Pregnancy and Childbirth: a guide for essential practice, 2006:

Ampicillin 2g IV/IM then 1gm every 6 hours,
plus gentamicin 80mg IM every 8 hours,
plus metronidazole 500 mg IV every 8 hours.

Detect for Newborn Abnormalities within 48 Hours after Delivery

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



Recognizing Newborn Danger Signs

- **Convulsions**
 - **Fast breathing > 60/minute**
 - **Severe chest in-drawing**
 - **Nasal flaring**
 - **Bulging fontanels**
 - **Many skin pustules or big boil**
 - **Axillary temp < 35.5 > 37.5**
 - **Wet cord with blood, pus**
 - **Jaundice**
 - **Floppy**
 - **Distended abdomen**
- **Treatment:**
 - Give first dose IM ampicillin and gentamicin
 - Treat to prevent low blood sugar
 - Warm neonate skin to skin if temp <36.5 or feels cool
 - Advise mother to keep baby **continue breastfeeding**
 - Refer **URGENTLY** to hospital



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Teach mothers and their families to bring their infants for care if they see any danger signs.

Local Bacterial Infection



- **Symptoms:**
 - Umbilicus red or draining pus
 - Pus or discharge from ear
 - Skin pustules
- **Treatment:**
 - Oral cotrimoxazole or amoxicillin for 5 days
 - Teach mother to give medication at home
 - Follow up in 2 days

Jaundice

- **Severe Jaundice:**
 - Yellow palms and soles
 - Neonate < 24 hours or older than 14 days
- **Jaundice:**
 - Palms and soles not yellow
- **Treatment:**
 - Treat to prevent low blood sugar
 - Warm neonate skin to skin if temp < 36.5° or feels cool
 - Advise mother to keep baby warm on way to hospital (referral)
 - Follow up in 2 days
 - Give home care
 - Advise mother to return immediately if jaundice becomes severe



Low Birth Weight (LBW) Babies

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



38

The kangaroo method is strongly recommended to all units in developing countries treating LBW babies without modern equipment. Please see WHO Kangaroo Mother Care: A practical guide, 2003, for guidelines as well as national and institutional protocols. Provide extra support for breastfeeding, including expressing milk and cup feeding if necessary... teach mother to maintain infant body temperature, skin-to-skin care between mother's breasts, keep baby's head covered, refer to KMC if indicated.

Summary

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



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Quality Planning Initiatives
Addressing women's needs for reproductive health

39

Integrate mother and newborn postpartum visits and care.



Definition and Overview of Postpartum Family Planning

Session 3

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

Session Objectives

- **By the end of this session, participants will be able to:**
 - Define postpartum contraception
 - Discuss the rationale for postpartum family planning
 - Explain the benefits of birth spacing
 - Describe postpartum return of fertility

Definitions

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



3

Postpartum period (or puerperium), as defined by the World Health Organization (1998), is the period that begins immediately after delivery of the placenta and lasts up to 42 days (or six weeks). Postpartum care is provided for both mother and child, its main elements varying according to the time during the postpartum period when it is given. The terms “postpartum care” and “postnatal care” are sometimes used interchangeably; however, postnatal is more often used to refer to the care of the newborn. In the section discussing maternal and infant mortality, the first hours through the first week are a critical time both for mother and baby. WHO further includes the first 6 months to monitor mother and baby around issues of breastfeeding, family planning and immunizations. Demonstrated in programs that promote LAM, ACCESS-FP has included the first year to support transition from LAM to another modern method, first year immunizations to the infant, and encouraging the mother to continue to breastfeed her baby and to continue a method of contraception.

Unmet Need: Fertility Preferences of Postpartum Women

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

Source: Ross JA and Winfrey WL, 2001.

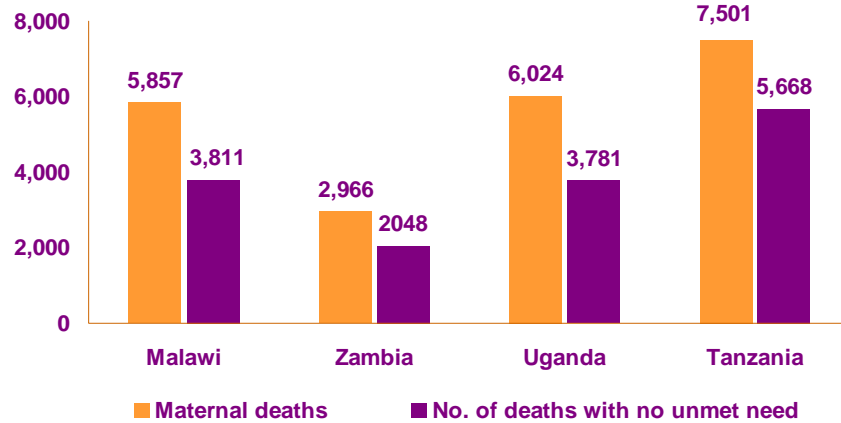


4

As we saw in earlier slides, when women were asked, “Would you like your next child within the next 2 years?” more than 90% did not. The re-analysis of the DHS data indicated that between 60% and 70% of postpartum women did not desire another pregnancy in the next 2 years yet were not using a method of contraception. They had an unmet need for family planning.

Benefits of Eliminating Unmet Need for Family Planning

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



5

This slide demonstrates theoretically the number of maternal deaths that could have been avoided if unmet need for family planning was met. Nearly 65% of postpartum women during the first year postpartum have an unmet need as compared to 14% of women of women in the reproductive age who are not in their first year postpartum (Guttmacher Institute 2006 *Guttmacher Policy Review* Winter 2006, Volume 9, Number 1).

Contraception after Childbirth: Basic Care and Services

- **Promote healthy timing and spacing of pregnancy**
- **Encourage exclusive breastfeeding and LAM**
- **Counsel on return to fertility**
- **Increase contraception choices**
- **Integrate family planning into other MCH programs, immunization and PMTCT**



6

Postpartum family planning incorporates components of both MCH and FP to help reduce unmet family planning needs.

Service Contacts Are Multiple, But Not Systematically Integrated

Country	ANC	PPC*	BCG
Bangladesh 2004 DHS	56%	27%	93%
Haiti 2003 DHS	85%	45%	73%
Kenya 2003 DHS	88%	55%	87%

* : Fort A et al. Postpartum Care. DHS Comparative Reports 15.



7

As this slide shows, many women receive antenatal care and getting their baby immunized has been moderately successful. However postpartum care is abysmal.

Why is this? Is it all about the baby? What about the woman as a community member?

Miss No Opportunity!

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

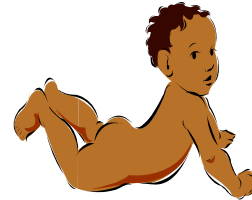


8

Infants are seen 5 times by the health care system during their first year for immunizations. Ask the woman when she comes in with her baby how is the breastfeeding going, how is she spacing out her next pregnancy to provide healthy timing? Does she need any method of family planning?

Extended Postpartum (6–9 Months)

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



Up to 5-10% of postpartum women conceive in the first year after pregnancy. They are at risk for poor maternal and fetal outcomes. At 6 months when mothers introduce complementary foods, they cannot rely on LAM and need to transition to another method. At 6 months, all hormonal methods are suitable for breastfeeding women who can prevent pregnancy, with hormonal contraception and continue to breastfeed.

Healthy Timing and Spacing of Pregnancy

- **Girls should wait until they are at least 18 years old before they conceive for the first time**
- **Healthy timing and spacing of pregnancy decreases the risk of preterm, low birth weight and other adverse outcomes:**
 - Couples should wait 2 years after the birth of their last baby before trying to conceive
 - Couples should wait 6 months after an abortion or miscarriage before they conceive

Source: WHO Technical Consultation on Birth Spacing, Geneva, 13-15 June 2005.



10

WHO Technical Consultation on Birth Spacing Geneva, Switzerland 13-15 June 2005

After a live birth, the recommended interval before attempting the next pregnancy is at least 24 months in order to reduce the risk of adverse maternal, perinatal and infant outcomes such as increased risk of fetal death, prematurity, LBW and SGA.

The basis for the recommendation is that waiting 24 months before trying to become pregnant after a live birth will help avoid the range of birth-to-pregnancy intervals associated with the highest risk of poor maternal, perinatal, neonatal and infant health outcomes. In addition, this recommended interval was considered consistent with the WHO/UNICEF recommendation of breastfeeding for at least 2 years.

Healthy Timing and Spacing of Pregnancy

- **Pregnancy spacing:**
 - Birth to pregnancy intervals: couples should wait 2 years after the last birth before trying to conceive again
 - Reduces risks of having a pre-term infant or low birth weight infant
 - Allows mother to breastfeed her baby for up to 2 years
 - Reduces pregnancy risks to mother



11

WHO 2005 Technical Consultation on Birth Spacing

Can you identify benefits of healthy birth spacing?



Birth Spacing Saves Mothers' and Babies' Lives

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



Healthy Timing and Spacing of Pregnancy Lowers Risks for:

- **For Children:**
 - Small for gestational age
 - Low birth weight
 - Preterm birth
 - Fetal death
 - Neonatal death
 - Infant death
 - Stunted and underweight child
 - Child death
- **For Mothers:**
 - Anemia
 - Puerperal endometritis
 - Premature rupture of membranes
 - Third trimester bleeding
 - Malnutrition
 - Maternal death



14

Can you tell me some of the benefits of healthy timing and spacing for mother and baby?

Other Benefits of Healthy Timing and Spacing of Pregnancy

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



15

According to Cleland and al. in the *Lancet* Sexual and Reproductive Health Series 11/06, he stated, “ In most African countries, contrary to the impression presented by numerous pronouncements from eminent leaders and current funding patterns, high fertility and rapid population growth represent a bigger threat to achievement of the MDG than HIV/AIDS.”

Return to Fertility

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

Return to Fertility: Effect of Lactation

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



17

Frequent breastfeeding /suckling or on-demand feeding blocks ovulation and therefore menses, and ovulation is very low while the mother nourishes the baby only by breastfeeding.

Huffman, S. L. and Lobbok, M. H. (1994). Breastfeeding in family planning programs: A help or a hindrance? *International Journal of Gynaecology and Obstetrics*, 47 Suppl, S23-31; discussion S31-2.

Return to Fertility: Effect of Lactation (cont.)

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



18

Campbell OM and Gray RH. *Am J Obstet Gynecol.* 1993 Jul;169(1):55-60

Characteristics and determinants of postpartum ovarian function in women in the United States. Two thirds of women ovulated before their first vaginal bleeding, but 47% of those cycles had decreased luteal-phase pregnanediol excretion.

Breastfeeding frequency and suckling duration were significant predictors of the risk of ovulation ($p < 0.001$). Supplementation with bottle feeding was associated with a reduction in breastfeeding.

All non-breastfeeding mothers menstruated within the first 12 weeks postpartum compared with just 20% of breastfeeding mothers. First ovulation occurred on average 45 days after delivery among non breastfeeding mothers and 189 days among breastfeeding mothers.

Family Planning

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

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



Summary

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

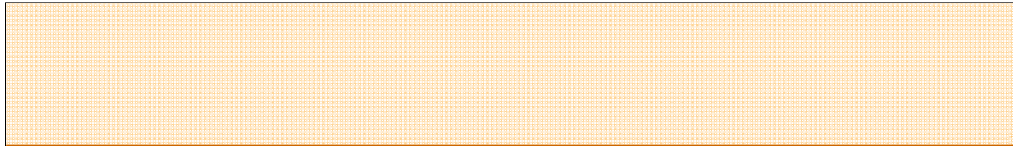




Preventing Mother-to-Child Transmission of HIV

Session 4

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



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

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



Risk Factors for MTCT

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

MTCT Risk Factors

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

MTCT Risk Factors (cont.)

Obstetric:

- Invasive fetal monitoring
- Prolonged rupture of membranes
- Routine episiotomy
- Placental disruption
- Vaginal delivery

MTCT Risk Factors: Infant

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

*AFFASS: Is replacement feeding **A**ceptable? **F**easible? **A**ffordable? **S**ustainable? **S**afe? If all of these answers are **YES**, HIV-infected mothers should avoid all breastfeeding. If any of the answers are **NO**, she should breastfeed **exclusively** during the first 6 months of life or until AFASS is yes. After 6 months, the mother needs to introduce complementary foods. The mother should continue to breastfeed until replacement feeding is AFASS.



7

Use the **A.F.A.S.S.** method (5 essential criteria): Is replacement feeding **A**ceptable? **F**easible? **A**ffordable? **S**ustainable? **S**afe? If all of these answers are **YES**, the HIV-infected mother should avoid all breastfeeding. If any of the answers are **NO**, she should breastfeed **exclusively** during the first 6 months of life or until AFASS is yes. After 6 months, the mother needs to introduce complementary foods. If the mother reports that replacement feeding is not AFASS, then this mother should continue to breastfeed until replacement feeding is AFASS.

Counseling and Testing for HIV

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

HIV Counseling and Testing

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



9

WHO and UNAIDS guidelines on HIV testing 30-05-07
<http://www.who.int/mediacentre/news/releases/2007> Recommendation for health facility.

Integration of HIV with FP

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



10

Desgrees-Du-Lou, A., Msellati, P., Viho, I., Yao, A., Yapi, D., Kassi, P., et al. (2002). Contraceptive use, protected sexual intercourse and incidence of pregnancies among African HIV-infected women. DITRAME ANRS 049 Project, Abidjan 1995-2000. *International Journal of STD & AIDS*, 13(7), 462-68.

Rutenberg, N., & Baek, C. (2005). Field experiences integrating family planning into programs to prevent mother-to-child transmission of HIV. [Review] [12 refs]. *Studies in Family Planning*, 36(3), 235-45.

Contraception and HIV Acquisition

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



11

N-9 is found in almost all spermicidal agents to date, 5-2007. Spermicidal agents are not recommended in areas where risk of HIV is high.

Postpartum FP and HIV

- HIV-positive women who are not breastfeeding need a family planning method choice immediately
- HIV-positive women who are breastfeeding may practice LAM, but will need to choose another method when LAM no longer applies
- **Counsel all women (even when status is unknown) about the importance of postpartum FP:**
 - Benefits of exclusive breastfeeding and LAM
 - Significance of safer sex and dual protection
 - Available contraceptive choices
 - Healthy timing and spacing if future pregnancy desired



12

WHO. HIV transmission through breastfeeding: A review of available evidence. Geneva, WHO, 2004.

Population Report (INFO Project) March 2006. *Better Breastfeeding, Healthier Lives.*

AFASS Counseling

- **In the MASHI study (Botswana), breastfeeding improves survival of HIV-infected infants:**
 - @ 6 months BF 8% IMR vs. FF 32% IMR (p=0.004)
 - @ 24 months BF IMR 30% vs. FF 45% IMR (p=0.14)
- **Promoting EBF in the general population may reduce HIV transmission by HIV mothers who do not know their status via reductions of mixed breastfeeding.**

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



13

- A Acceptable
- F Feasible
- A Affordable
- S Safe
- S Sustainable

Postpartum Care for HIV+ Women and Their Babies

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

Based on computer modeling. Source: Reynolds HW. 2006. *Sexually Transmitted Diseases* 33(6): 350–356, June.



14

Newborns born to HIV-positive mothers

- Nevirapine/ARV per national protocol
- Cotrimoxazole syrup per national protocol
- Check National Protocol for HIV screening for infant
 - PCR screening for infant Dried Blood Spot (DBS):
 - If initial is negative, need to repeat 6 weeks after mother stops breastfeeding
 - Antibody testing
 - Initiate at 6 weeks repeat at 3 months then again at 15-18 months check national protocols
- AFASS help mother determine if supplemental feeding is acceptable. Will her mother-in-law accept supplemental feeding too?

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

- **The mother:**

- Has cracked nipples, abscesses or other breast problems
- Has symptoms for HIV-related disease

Or

- **The baby:**

- Has sores in his/her mouth
- Has an inflamed gut from mixed feeding

Babies of HIV+ Mothers

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



Remaining Faithful Is More Important Now than Ever! Protect Your Family!

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





Values Clarification Activity

Session 5

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

Session Objectives

- **By the end of this session, participants will be able to:**
 - Identify personal values that may act as barriers to quality service provision
 - Recognize and accept differing opinions and attitudes regarding reproductive health issues
 - Minimize the effect of personal values on service provision and counseling

Activity

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



Statement 1

Family planning should be made available to married people only



Statement 2

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



Statement 3

Married women requesting FP services must have their husband's written consent



Statement 4

Women who have only one child don't need information about postpartum family planning



Statement 5

Information about emergency contraception should not be available to unmarried women



Statement 6

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



Statement 7

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



Key Points

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



11

Providers need to recognize their own biases. Reproductive health inclusive of family planning is a human right according to the international community as demonstrated in Cairo ICPD 1994. Providers should be mindful what their own national standards recommend as well as the international standards cited below.

The Program of Action, adopted by 179 governments, marked a new understanding among world bodies—that population and development are inextricably linked, and that women's empowerment is the key to both. And, for the first time, the reproductive and sexual health and rights of women became a central element in an international agreement on population and development.

Recognizing that the ultimate goal is the improvement of the quality of life of present and future generations, the objective is to facilitate the demographic transition as soon as possible in countries where there is an imbalance between demographic rates and social, economic and environmental goals, while fully respecting human rights. This process will contribute to the stabilization of the world population, and, together with changes in unsustainable patterns of production and consumption, to sustainable development and economic growth. Countries should give greater attention to the importance of population trends for development. Countries that have not completed their demographic transition should take effective steps in this regard within the context of their social and economic development and with full respect of human rights. Countries that have concluded the demographic transition should take necessary steps to optimize their demographic trends within the context of their social and economic development. These steps include economic development and poverty alleviation, especially in rural areas, improvement of women's status, ensuring of universal access to quality primary education and primary health care, including reproductive health and family planning services, and educational strategies regarding responsible parenthood and sexual education. Countries should mobilize all sectors of society in these efforts, including nongovernmental organizations, local community groups and the private sector. In attempting to address population growth concerns, countries should recognize the interrelationships between fertility and mortality levels and aim to reduce high levels of infant, child and maternal mortality so as to lessen the need for high fertility and reduce the occurrence of high-risk births.



Postpartum Family Planning Counseling

Session 6

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

Session Objectives

- **By the end of this module, participants will be able to:**
 - Define basic elements of PFP counseling
 - Understand benefits of counseling
 - Describe effective counseling techniques
 - Close the counseling session

Postpartum Family Planning Counseling: Purpose

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



3

As seen by earlier data, postpartum women are usually very motivated to space their next pregnancy. Health care providers and community based workers need to provide information and counseling about postpartum contraception.

Family Planning Counseling: Benefits

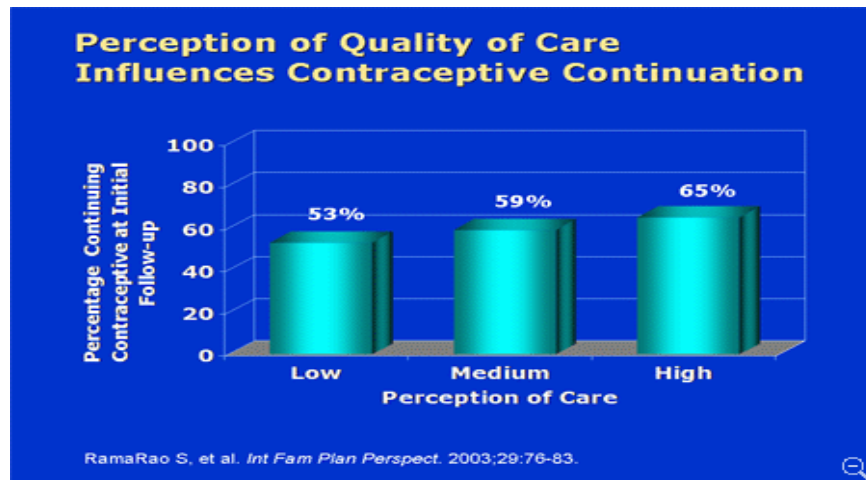
- Increases acceptance
- Promotes effective use
- Improves continuation
- Increases client satisfaction
- Dispels rumors and misconceptions



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Quality Counseling and Care Increases Family Planning Use



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Source: Contraception Online, Baylor University.

5

In this study 1,728 new family planning users were interviewed to assess the quality of care they received from family planning service providers and whether or not the perceived quality of care had an impact on contraceptive continuation. Perception of quality care was associated with: 1) assessment of patient's needs, 2) the information conveyed by the provider, 3) the choices offered and the patient receiving her method of choice, 4) whether the patient was treated well by the provider, and 5) whether she was linked to follow-up services. A 16- to 24-month follow-up study showed that women's continuation with contraceptive use increased with their rating of the level of quality of care. While all scores increased between the initial and follow-up visits, there was a 12% difference in the probability of contraceptive continuation between those who perceived low-quality care versus those who perceived high-quality care. At a second follow-up, that difference jumped to 22%, with 75% of those perceiving high-quality care continuing their contraceptive use. This study illustrates how effective counseling can positively influence contraceptive continuation and impact contraceptive success.

Reference:

RamaRao S, Lacuesta M, Costello M, Pangolibay B, Jones H. The link between quality of care and contraceptive use. *Int Fam Plan Perspect* 2003, 29: 76-83.

Family Planning Counseling: Rights of the Client

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



6

The principles of counseling are based on clients' rights and assure:

Confidentiality

Privacy

Voluntary choice

Informed consent

Client-centered reproductive health care

Effective Communication

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



Communication

- **Communication is essential in counseling and includes:**
 - **Verbal communication:**
 - Open-ended questions
 - Reflecting feelings (paraphrasing)
 - **Non-verbal communication:**
 - Body gestures
 - Facial expressions



8

Non-verbal cues are perceived more than verbal ones.

Role play: ask a participant to be a postpartum mother. The trainer (or another participant) role plays a very busy provider who looks at her watch and writes notes while she is speaking and reads the script. The second time, the trainer looks at the client, waits until she responds and says the same script.

Script: introduces self and says “ are you breastfeeding? OK, good. Offering the breast to the baby on demand, night and day, helps your baby grow and protect him from becoming sick. Breast milk is all your baby needs. Everything he needs is in breast milk, even enough water. By breastfeeding your baby, you are also protecting yourself against another pregnancy so quickly. Doctors have seen that couples who wait until their last child is two years old before they try to get pregnant, are less likely to have small, weak babies.

Ask the participants after these two demonstrations what the health message was. Inquire about the style of presenting health messages.

Family Planning Education

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



Family Planning Counseling

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



10

- Behavior change communication is listening, understanding and then negotiating with people and communities for long-term, positive changes in health behavior. Information isn't enough to change behavior.

Family Planning Counseling Process

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



11

Briefly explain methods, no need to go into full details unless the client asks questions. Sometimes too much information can overwhelm the client.

The GATHER Approach

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



Being a Good Counselor

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

Being a Good Counselor (cont.)

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

Source: Gallen, Lettenmaier and Green 1987; Lettenmaier and Gallen 1987.



Key Points for PFP Counseling

- **Promote exclusive breastfeeding and LAM:**
 - Four criteria of LAM: Exclusive, mother is amenorrheic, infant is 6 months or less, and transition to other modern method when one of the three criteria does not apply
- **Advise on return to fertility**
- **Counsel on healthy timing and spacing of pregnancy:**
 - Couples should wait 2 years after the birth before they try to get pregnant again
- **Ask about limiting versus spacing:**
 - Have the client and her partner finished their family size? Are they interested in permanent methods?
 - Has the mother expressed a request for BTL at time of delivery?
- **Increase FP method mix**
- **Integrate FP into MCH services**



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Healthy timing and spacing of pregnancy also includes that couples should wait 6 months after a miscarriage or abortion before they try to get pregnant again.

When to Start Contraception

Timing depends on:

- Breastfeeding status
- Method of choice
- Reproductive goals



Photo: Catharine McKaig.

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Breastfeeding is not the same as LAM. The counselor needs to explore if the baby is receiving any other feeding, how old the baby is, and if the mother is amenorrheic. The counselor also should discuss a transition plan for the client when LAM no longer applies.

Breastfeeding Women

- **Protected for at least 6 months if using LAM:**
 - Fully or nearly fully breastfeeding
 - Less than 6 months postpartum
 - Menses has not returned
- **Protected up to 6 weeks if not using LAM:**
 - At 6 weeks can use progestin only methods safely
- **IUD can be inserted 4 weeks or greater postpartum**
- **Condoms can be used at any time**
- **Perfect time for vasectomies for couples who want to limit**



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All couples who have completed their families may choose to limit future pregnancies and opt for sterilization. Couples must understand that this is a permanent method. A woman can have a BTL during the immediate postpartum period at the hospital. All women who have no obstetrical contraindications can also receive a postplacental IUD by a provider who is trained in postplacental insertion. The technique is different from interval, and expulsion is a bit higher than interval. However, with a counseled client and a trained provider, a PPIUD is another option. For those couples who opt for a vasectomy, they must use an alternative method for 3 months after vasectomy when he is no longer passing sperm. If the partner has a vasectomy shortly after the birth of his last child, the woman can use LAM or another method during the next 3 months and be protected.

Non-Breastfeeding Women

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

Family Planning Counseling: Method Failure

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



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Contraception after Childbirth: Basic Care and Services

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

Closing a Counseling Session

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

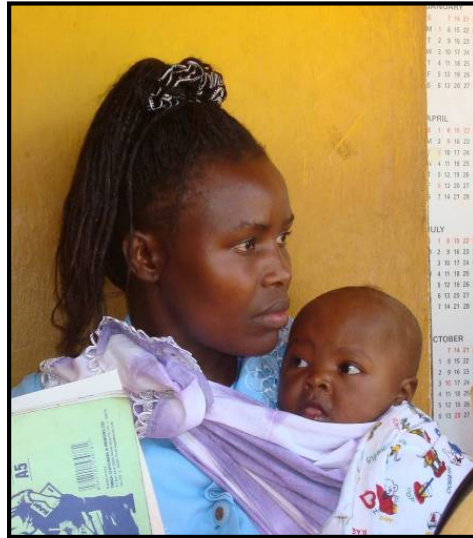


Photo: Angela Nash-Mercado, Jhpiego. 21



Medical Eligibility Criteria for Contraceptive Methods

Session 7

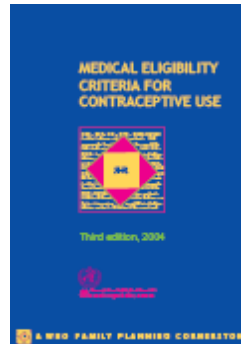
Jhpiego in partnership with Save the Children, Constella Futures, The Academy for Educational Development, The American College of Nurse-Midwives and IMA World Health

Session Objectives

- **By the end of this session, participants will be able to:**
 - Describe who can use the various contraceptive methods based on medical criteria defined by WHO (Medical Eligibility Criteria)
 - Use the resource tool from FHI

Medical Eligibility Criteria for Contraceptive Use (MEC)

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



<http://www.who.int/reproductive-health/publications/mec/mec.pdf>



Purpose of the Medical Eligibility Criteria (MEC)

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



What is answered by the MEC?

The MEC identify which contraceptive or FP method can be safely used in the presence of a given individual characteristic or medical condition



WHO Medical Eligibility Criteria Classification Categories

Classification	With clinical judgment	With limited clinical judgment
1	Use method in any circumstances	Yes Use the method
2	Generally use: advantages outweigh risks	Yes Use the method
3	Generally <u>DO NOT</u> use: risks outweigh advantages	No Do not use the method
4	Method not to be used	No Do not use the method

WHO Medical Eligibility Criteria: HIV/AIDS and Copper IUDs

HIV/AIDS	2 nd Ed. Category	3 rd Ed 2004 Category	
		I	C
High risk of HIV	3	2	2
HIV-infected	3	2	2
AIDS	3	3	2
Clinically well on ARV therapy		2	2



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WHO MEC 3rd Edition: evidence among women at risk of HIV, copper IUD did not increase risk of HIV acquisition (55-85).

Among IUD users, there is limited evidence showing no increased risk of overall complications or infection-related complications when comparing HIV-infected women with non-infected women. Furthermore, IUD use among HIV-infected women was not associated with increased risk of transmission to sexual partners (55).

WHO technical working group is looking at the evidence and considering the health condition of HIV and AIDS (clinically well on ART) as a category 1.

Quick Reference Chart for the WHO Medical Eligibility Criteria for Contraceptive Use –
to initiate or continue use of combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), norethisterone enantate (NET-EN), copper intrauterine device (Cu-IUD)

CONDITION	COC	DMPA/ NET-EN	Cu-IUD	CONDITION	COC	DMPA/ NET-EN	Cu-IUD
Age				Known hyperlipidemias			
Menarche to 39 years							
40 years or more				Cancers			
Menarche to 17 years				Cervical			C
18 years to 45 years				Endometrial			I C
More than 45 years				Ovarian			I C
Menarche to 19 years				Cervical ectropion			
20 years or more				Breast disease			
Hulliparus				Undiagnosed mass	**	**	
Breastfeeding			*	Family history of cancer			
Less than 6 weeks postpartum				Current cancer			
6 weeks to 6 months postpartum				Uterine fibroids without cavity distortion			
6 months postpartum or more				Endometriosis			
Smoking				Trophoblast disease (malignant gestational)			
Age < 35 years				Vaginal bleeding patterns			
Age ≥ 35 years, < 15 cigarettes/day				Irregular without heavy bleeding			
Age ≥ 35 years, ≥ 15 cigarettes/day				Heavy or prolonged, regular and irregular			
Hypertension				Unexplained bleeding			I C
History of hypertension where blood pressure:				Cirrhosis			
CANNOT be evaluated				Mild			
Is controlled and CAN be evaluated				Severe			
Systolic 140 – 159 or diastolic 90 – 99				Current symptomatic gall bladder disease			
Systolic ≥ 160 or diastolic ≥ 100				Cholelithiasis			
Headaches				Related to the pregnancy			
Non-migrainous (mild or severe)	I C			Related to oral contraceptives			
Migraine without aura (age < 35 years)	I C	I C		Hepatitis			
Migraine without aura (age ≥ 35 years)	I C	I C		Active			
Migraines with aura	I C	I C		Client is a carrier			
History of deep venous thrombosis				Liver tumors			
Superficial thrombophlebitis				STIs/PID			
Complicated valvular heart disease				Current/persistent cervicitis, chlamydia, gonorrhea			I C
Ischemic heart disease/stroke				Vaginitis			
Diabetes				Current pelvic inflammatory disease (PID)			I C
Non-vascular disease				Other STIs (excluding HIV/hepatitis)			
Vascular disease or diabetes of > 20 years				Increased risk of STIs			
Malaria				Very high individual risk of exposure to STIs			I C
Non-pelvic tuberculosis				HIV			
Thyroid disease				High risk of HIV or HIV-infected			
Iron deficiency anemia				AIDS			
Sickle cell anemia				No antiretroviral therapy (ART)			I C
				Not clinically well on ART therapy			I C
				Clinically well on ART therapy			
				Use of:			
				Griseofulvin			
				Rifampicin			
				Other antibiotics			

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

I/C (Initiation/Continuation): A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. For example, a client with current PID who wants to initiate IUD use would be considered as Category 4, and should not have an IUD inserted. However, if she develops PID while using the IUD, she would be considered as Category 2. This means she could generally continue using the IUD and be treated for PID with the IUD in place. Where I/C is not marked, a woman with that condition falls in the category indicated – whether or not she is initiating or continuing use of the method.

* Breastfeeding does not affect initiation and use of the IUD. Regardless of breastfeeding status, postpartum insertion of the IUD is Category 2 up to 48 hours postpartum, Category 3 from 48 hours to four weeks, and Category 1 four weeks and after.

** Evaluation should be pursued as soon as possible.



Source: <http://www.who.int/reproductive-health/youth/whomec/>

Case Studies

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



Photo: Catharine McKaig.

See attached cases



Lactational Amenorrhea Method (LAM)

Session 8

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

LAM: Mechanism of Action

1. Nipple stimulation
2. Let-down reflex
3. Milk production
4. Suppression of ovulation
5. Amenorrhea



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What is LAM versus breastfeeding?

- **Lactational Amenorrhea Method (LAM) is a contraceptive method that uses a pattern of breastfeeding that can effectively suppress ovulation and prevent pregnancy**
- **Breastfeeding is a method of infant feeding, not a contraceptive method**

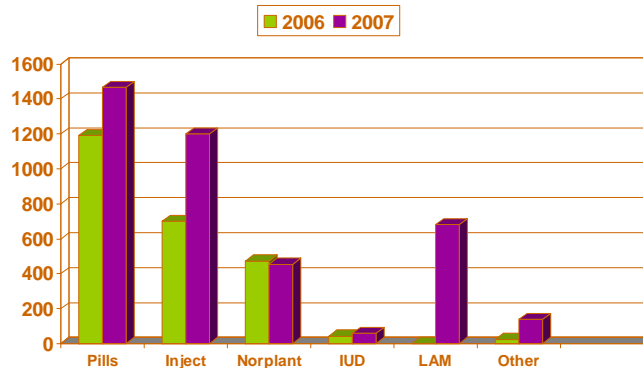


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A woman practicing LAM knows all 3 criteria to effectively contracept.

Burkina Faso: Revitalize LAM and Transition Counseling and Service

- Advocacy on LAM and transition to other methods
- LAM training combined with CTU
- Messages simplified on exclusive breastfeeding
- Support supervision: note accomplishments for service providers



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ACCESS-FP worked in Burkina Faso with IRH-Georgetown to revitalize LAM--with an emphasis on transition to other methods. What we saw was promising, as immediate counseling, which is needed to make sure breastfeeding is well established, served an entry point for discussing pregnancy risk, reinforcing exclusive breastfeeding and transition to other FP methods that are compatible with breastfeeding when she is no longer using LAM. The data are from 9 health facilities in Ouagadougou.

Is Bleeding Menstrual or a Postpartum Discharge?

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

LAM: Contraceptive Benefits – What are they?

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



LAM: Non-Contraceptive Benefits

- **For child:**
 - Passive immunization and protection from other infectious diseases
 - Best source of nutrition
 - Decreased exposure to contaminants in water, other milk or formulas, or on utensils
- **For mother:**
 - Lessens iron depletion by suppressing menses
 - Strengthens mother-baby bond
 - No cultural or religious conflict

LAM: Limitations

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



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LAM: Client Instructions

- **Breastfeed from both breasts on demand**
- **Breastfeed at least once during night**
- **Do not substitute other food or liquids for breast milk meal**

LAM: Client Instructions for Contraception

- **Always keep a backup method of contraception, such as condoms, readily available. Use it if:**
 - Your menses returns
 - You begin supplementing your baby's diet
 - Your baby reaches 6 months of age
- **Consult your health care provider or clinic before stopping LAM to transition to another FP method**
- **If you or your partner is at high risk for STIs, including the AIDS virus, you should use condoms as well as LAM**

Breastfeeding and Breast Care

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



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Breast Engorgement – due to inadequate removal of milk from the breast. Common causes include:

Other feeds given before starting breastfeeding

Delayed starting of breastfeeds

Long intervals between feeds

Early removal of the baby from the breast while breastfeeding

Bottle-feeding and any other restrictions on breastfeeding

Treatment – express breast milk, analgesia, breast support with a firm bra. Continue breastfeeding.

Breastfeeding Problems

- **Flat nipples:**
 - Gently compress and roll the nipple between the thumb and index finger to try to make it more erect before feeding.
 - Inverted nipples are rare; treat as for flat nipples.
- **Sore nipples:**
 - Usually resulting from poor positioning or attachment; may result in cracked nipples.
 - Correct position and attachment; continue breastfeeding.
- **Cracked nipples:**
 - Correct position and attachment
 - Wash nipple once daily with water only; expose nipple to air and sun as much as possible. Apply a drop of milk on nipple after each feed. Continue breastfeeding. Avoid medicated creams as they may worsen soreness.

Breastfeeding Problems (cont.)

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

Breastfeeding Problems (cont.)

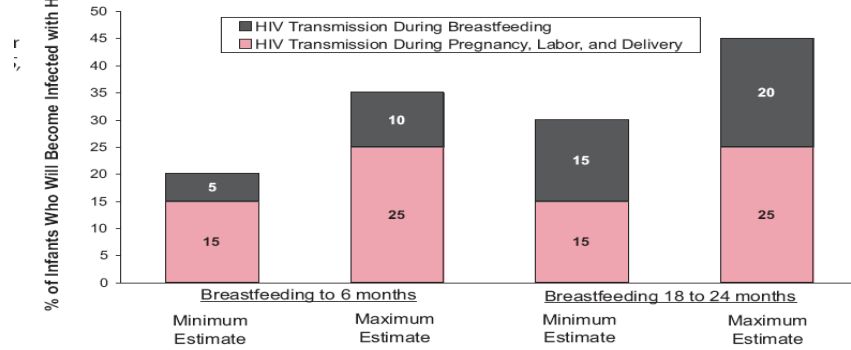
- **Blocked duct – due to baby not suckling well on a particular segment of the breast, resulting in the thick milk blocking the milk duct, leading to a painful hard swelling**
- **Treatment:**
 - Improving suckling position – frequent feeding of the baby on the affected breast in different suckling positions to improve emptying
 - Massaging the lump toward the nipple to promote emptying of the breast
 - Resting and wearing loose clothes

Breastfeeding Problems (cont.)

- **Mastitis: resulting from infection of a blocked duct or an engorged breast. May result in formation of an abscess.**
- **Treatment:**
 - Express the milk frequently and continue breastfeeding
 - Analgesia and/or warm compress
 - Antibiotics may be necessary
 - Rarely incision and drainage of the abscess
 - Restart breastfeeding from the affected breast as soon as possible

Risk of HIV Transmission

Figure 2. Estimated Risk of HIV Infection in Infants and Young Children
*Minimum and Maximum Estimated Percentage of Infants Who Will Become Infected with HIV During Pregnancy, Labor, and Delivery and During Breastfeeding, by Length of Breastfeeding**



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



Source: WHO 2003.

Safer Practices on Breastfeeding for HIV-Infected Mothers

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



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Exclusive feeding:

Reduces the risk of HIV transmission by half, compared with mixed feedings, and

Helps to prevent death from other illnesses

Mothers should wean when replacement feeding is AFASS. At 6 months, mothers need to introduce complementary feeding. Again, they need to be counseled on AFASS. If replacement milk is not AFASS, then she needs to continue to breastfeed and give complementary food. If possible, the mother can express milk and flash heat (milk is placed in a clean glass jar place in a pan of water and brought to a boil and then removed to cool or mix with porridge). *

Assess and treat mastitis, cracked nipples and infant thrush, all of which increase the risk of HIV transmission.

Sources:

Israel-Ballar, Journal of AIDS 2005,

Tropical Medicine 2006

Key LAM Messages

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





Hormonal Contraceptive Methods

Session 9

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

Session Objectives

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

Hormonal Methods

- **Progestin-only contraceptives:**
 - Implants
 - Injectables
 - Progestin-only pills (POPs)
- **Combined estrogen-progestin methods:**
 - Combined oral contraceptives (COCs)
 - Monthly injectables (Mesigyna, Cyclofem)

QUESTION ???

- **When can a breastfeeding woman begin using a progestin-only contraceptive?**



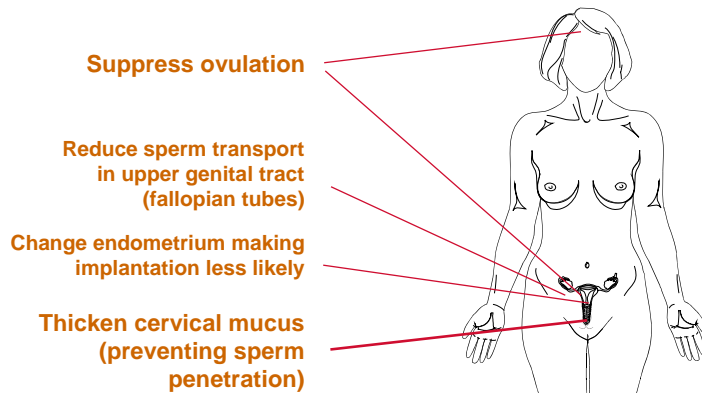
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If using LAM, she is already using a reliable method (98% effective), if not using LAM, progestin-only method at 6 weeks. Combined hormonal is okay at 6 months.

Progestin-Only Contraceptives: Breastfeeding Women

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

Progestin-Only Contraception – POPs: Mechanisms of Action



Progestin-Only Pills (POPs)

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

Progestin-only Pills	Progestin Content	Amount (µg)
Microlut®	Levonorgestrel	300
Micronor®	Norethindrone	350
Ovrette®	Norgestrel	75

All of the pills contain progestin. A woman using POPs needs to take them continuously.

POPs: Contraceptive Benefits

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

POPs: Contraceptive Benefits (cont.)

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

POPs: Non-Contraceptive Benefits

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

POPs: Limitations

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

Progestin-Only Injectable Contraceptives (PICs)

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



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Depot-medroxyprogesterone acetate (also Depo)

NET EN: 2 months, also called Noristerat, norethindrone enanthate, norethisterone enanthate

For non-postpartum women: Start during first 7 days after LMP, or can use any time reasonably sure woman is not pregnant.

PICs: Contraceptive Benefits

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

* Source: Trussell et al. 1998. Note: This efficacy rate refers only to DMPA.



PICs: Contraceptive Benefits (cont.)

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

PICs: Noncontraceptive Benefits

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



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PICs: Limitations

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



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Many women experience amenorrhea after 2-3 injections.

Combined Estrogen-Progestin Methods: Breastfeeding Women

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

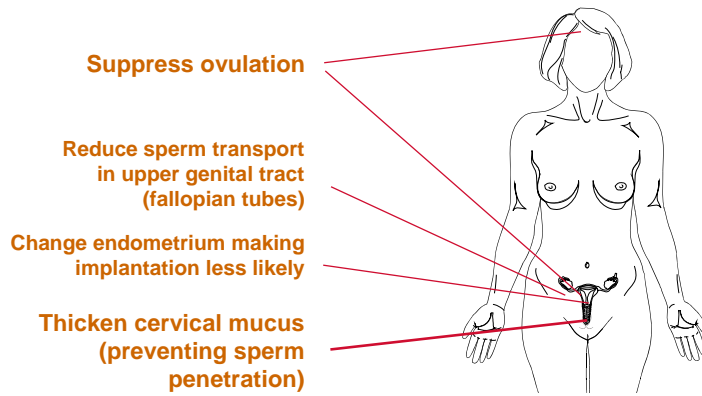
Source: WHO 2004.



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Monthly injectables also contain estrogen: Cyclofem, Mesigyna. These are not progestin-only methods and not encouraged for breastfeeding women during the first 6 months.

Combined Oral Contraception – COCs: Mechanisms of Action



Combined Estrogen-Progestin Methods

- **Breastfeeding:**
 - DO NOT use combined estrogen-progestin methods within the first 6 weeks postpartum
 - NOT recommended during the first 6 months postpartum
- **Non-Breastfeeding:**
 - NOT recommended to use combined estrogen-progestin methods during the first 3 weeks postpartum
 - Safe to start after 3 weeks post-delivery

COCs: Contraceptive Benefits

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

Source: Hatcher et al. 1998.



COCs: Non-Contraceptive Benefits

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

COCs: Limitations

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

QUESTIONS ???

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

Summary

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



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Emergency Contraception

Session 10

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

Emergency Contraception (EC)

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



2

- Regular oral contraception pills used in a special higher dosage. ECPs are a higher dosage of the same hormones found in daily COCs (4 OCP with dose of 30 or 35 mcg ethinylestradiol or 2 tablets of 50 mcg ethinylestradiol every 12 hours for 24 hours only).
- Progestin-only pills such as postinor are also ECP.
- Used within 120 hours of unprotected sex (but as soon as possible after unprotected sex).

EC is only method that can be used after unprotected sex to prevent pregnancy.

- **Millions of unintended pregnancies and abortions could be averted with EC.**
- **Worldwide, unintended pregnancies lead to at least 20 million unsafe abortions each year, and the death of some 80,000 women.**
- **EC does not cause an abortion. It is not RU486 or Mifipristone.**

Emergency Contraception (cont.)

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

Should there be “limits” on EC use?

- **The only disadvantage of repeated EC use is that clients have more effective contraception available**
- **No need to limit:**
 - Discuss better contraception options, and
 - Provide EC

Emergency Contraception: Counseling

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



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Emergency Contraception: Benefits

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



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Because emergency contraception is used infrequently, its effectiveness cannot be measured in the same way as other contraceptive methods that are used more frequently. A more accurate measurement of the efficacy of emergency contraception can be obtained by comparing the number of pregnancies in a study with the number of pregnancies that would have been expected without treatment.

If nothing used after unprotected sex: 8 in 100 get pregnant

If 100 women use levonorgestrel (type of progestin) after unprotected sex, 1 would get pregnant—an 88% reduction.

If 100 women use COCs in the ECP dose: 2 would get pregnant—75% reduction.

An analysis of data from 8 studies using the levonorgestrel show an efficacy between 59-94% effective. With combined dosing, COCs (Yuzpe regimen that is higher doses of combined oral contraception) showed effectiveness rates of 56% to 89%.

Trusell 2007.

Emergency Contraception: Limitations

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

Women Who May Need Emergency Contraception

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

Think to Offer Emergency Contraception to Women Who:

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

Who Should Not Use Emergency Contraception

- **Women with a known pregnancy:**
 - *Because emergency contraception will not stop a pregnancy after it is started*



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This is the only reason not to offer EC to a client.

Types of EC Pills (ECPs)

- **Progestin-only OCs: levonorgestrel-only, in preferred regimen, one dose of 1.5 mg**
(or can be in 2 doses of 0.75 mg, 12 hrs apart)
→88% reduction in risk (1/100 will get pregnant)
- **Combined OCs: 2 doses of pills containing ethinyl estradiol (0.01 mg) and levonorgestrel (0.5 mg) taken 12 hrs apart**
→75% reduction in risk (2/100 will get pregnant)



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Progestin (levonorgestrel) -only ECPs—somewhat more effective, and side effects—N&V—less (6% vs. 23%).

Sometimes specially packaged—this is what is called “Plan B” in the U.S. or Postinor in other countries.

QUESTION ???

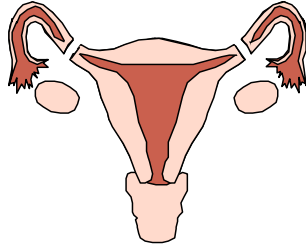
- **Within what timeframe after unprotected sexual intercourse will emergency contraceptive pills be effective?**

ECP Effectiveness and Time

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



Possible Mechanisms of Action of ECPs



Depending on when used during cycle, may:

- Inhibit or delay ovulation
 - Affect sperm and ovum function
-
- EC pills do not interrupt an established pregnancy

The precise mechanism is not known. Most of the evidence indicates that fertilization is prevented either by inhibition or delay of ovulation or by effects on the sperm.

POPs: Instructions for Use as Emergency Contraception (High-Dose)

Preferred:

- **Step 1: Take 2 tablets (1.5 mg of LNG) orally within 120 hours of unprotected intercourse:**
Total = 2 tablets
- **Step 2: If no menses (vaginal bleeding) within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy**
- **Effectiveness: 2% failure rate when used correctly**
- **Safety:**
 - No long-term problems in nearly all women
 - Less nausea (and vomiting) than with COCs

COCs: Instructions for Use as Emergency Contraception (Low-Dose)

Preferred:

- **Step 1: Take 4 tablets of a low-dose COC (30–35 µg EE) orally within 120 hours of unprotected intercourse.**
- **Step 2: Take 4 more tablets in 12 hours after first dose:**
Total = 8 tablets
- **Step 3: If no menses (vaginal bleeding) within 3 weeks, the client should consult the clinic or service provider to check for possible pregnancy.**



COCs: Instructions for Use (High-Dose)

Alternative:

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

¹ Source: Ellertson C et al. 2003. Modifying the Yuzpe regimen of emergency contraception: A multicenter randomized, controlled trial. *Obstet Gynecol* 101:1160–1167.



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If high-dose COCs are not available to use as emergency contraceptives, use low-dose COCs .

Summary

- **Emergency contraception can be used to prevent pregnancy after unprotected sexual intercourse**
- **Combined oral contraceptives or progestin-only contraceptives can be used for emergency contraception within 120 hours of unprotected sexual intercourse**



Non-Hormonal Contraceptive Methods and Birth Spacing after Childbirth

Session 11

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

Session Objectives

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

Non-Hormonal Methods

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

Barrier Methods: Condoms

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

*Source: Trussell et al. 1998.



Advantages of Condoms

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



Disadvantages of Condoms

- Person must be motivated to use condoms
- May decrease sensation
- Poor reputation
- May be embarrassing to purchase, ask partner to use or dispose of
- Can be weakened if used with oil-based lubricants—may break during use
- Some men or women may be allergic to latex
- Supplies must be readily available before intercourse begins

IUD

- IUDs are among the most reliable and cost-effective long-acting method of contraception available to women today.
- IUD offers a level of protection comparable to female sterilization, with the added advantage of easy and rapid reversibility.
- IUD prevents pregnancy by preventing fertilization; the copper in the IUDs is spermicidal. Copper causes a sterile body inflammatory reaction that is toxic to sperm in the uterine cavity, making them incapable of fertilization.



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Cu 380A up to 12+ years according to WHO.

Progesterone-containing: Mirena is effective for 5 years.

IUDs (Cu-T)

- **IUDs can be inserted:**
 - Post-placental within 10 minutes after expulsion
 - During C/Section
 - Within 48 hours of childbirth
- **If not inserted within 48 hours of delivery, insertions should be delayed for 4–6 weeks**
- **Expulsion rates can be higher with postpartum IUD insertion (PPIUD) than with interval insertions:**
 - Some studies show that insertion within 10 minutes of delivery of placenta is better than other times before hospital discharge
 - High fundal placement has lower expulsion rates



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Postpartum IUD insertion requires a different insertion technique from interval IUD insertion. Health providers need training in PPIUD insertion before inserting IUDs in the immediate postpartum.

Important Programmatic Characteristics of IUDs

- **Effectiveness is comparable to female sterilization:**
 - 12–13 yrs with Cu-T (*approved*)
 - Cheaper to provide than other methods
 - Quickly and completely reversible
- **Very safe for most women (including immediately postpartum, postabortion or interval; breastfeeding; young; nulliparas; and HIV-positive women)**

IUDs: Programmatic Considerations

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



Dispelling Myths about IUDs

IUDs...

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



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Common Concerns about IUDs: New Information

- Pelvic inflammatory disease (PID)
- Infertility
- HIV/AIDS

Medical Evidence: Low PID Rates and Infertility among IUD Users

- **First 20 days: highest risk for PID due to insertion:**
 - Woman already has chlamydia that was undetected
- **Beyond 20 days: PID risk is same as if no IUD:**
 - 99.8% of women with IUDs have no problems with PID
- **IUD use NOT associated with infertility:**
 - The real culprit is chlamydia trachomatis (and GC), not the IUD!



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Farley et al. Intrauterine devices and pelvic inflammatory disease: An international perspective. *Lancet* 1992; 339: 785-788.

IUD Use and HIV: Three Main Questions

- Does IUD increase risk of HIV acquisition by the woman using it?
 - NO
- Does use of IUD by HIV-infected women increase their other health risks?
 - NO
- Does the HIV-infected IUD user increase risk to HIV-negative male partner?
 - NO

Postpartum Female Sterilization

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



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Method appropriate for couples who have decided to limit their family size. This is a permanent method, couples must be aware of other methods for spacing.

Female Sterilization: Effectiveness

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

Male Sterilization: Vasectomy

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



Male Sterilization: Vasectomy

- **Highly effective in preventing pregnancy (99.6–99.8% effective):**
 - Comparable to female sterilization, implants, IUDs in preventing pregnancy
- **Not effective immediately:**
 - WHO recommends use of backup contraception for 3 months after the procedure
- **Counseling prior to procedure to confirm client's desire of permanent method**



Vasectomy: Safety

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

Vasectomy: Crucial Programmatic Facts

- **Men in every region and cultural, religious and socio-economic setting show interest in vasectomy, despite common assumptions about negative male attitudes or societal prohibitions**
- **However, men often lack full access to information and services, especially male-centered programming, which has been shown to result in greater uptake of vasectomy**



Fertility Awareness Methods

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



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Once menses returns in the breastfeeding woman, it is still irregular. A woman needs to have at least 2 cycles that are 26 to 32 days apart before she can rely on SDM (IRH).

Fertility Awareness Methods

- **Advantages:**

- Inexpensive
- Not necessary to acquire supplies at clinic/dispensary

- **Disadvantages:**

- Most methods unreliable in postpartum women
- Postpartum women, especially when breastfeeding, need to have 4 menstrual cycles, the most recent cycle is 26 to 32 days long
- Partner's cooperation needed in periodic abstinence or using condoms during fertile period



Coitus Interruptus (CI)/Withdrawal

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

CI: Effectiveness

- **When used perfectly, effectiveness can be as high as 95%**
- **With typical usage, effectiveness about 75–81%**

Advantages and Disadvantages?





Managing Side Effects of Family Planning Methods

Session 12

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

Session Objectives

- **By the end of this session, participants will be able to:**
 - Describe common side effects of various FP methods
 - Discuss management of side effects of FP methods



Combined Oral Contraceptives: Common Side Effects

- **Change in menses (frequently resolved in first 3 months):**
 - Spotting
 - Break-through bleeding
- **Nausea**
- **Acne (improvement usually)**
- **Breast fullness or tenderness (mastalgia)**
- **Mood changes may cause loss of libido**



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COCs: Managing Common Side Effects

- **Change in menses (spotting and breakthrough bleeding):**
 - Check to see if client is taking COCs correctly
 - Reassure that will resolve
 - Check to see if on rifampicin; change to DMPA
 - If not resolved after 3 months, advise different COCs
- **Nausea:**
 - Advise to take pill with evening meal or at bedtime with a snack



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Is the client able to remember to take OCPs on a regular basis? If she repeatedly forgets, she may be at risk for an unintended pregnancy and may be a better candidate for DMPA or IUD.

Check to see if she is on any other medication (for TB or anticonvulsants).

See if spotting is blood or vaginal discharge. Is she symptomatic for an infection, post-coital bleeding?

COCs: Managing Common Side Effects (cont.)

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



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Sometimes a client needs a trial of 3 months to see if she will become acclimated to the pill. Listen to the client. If she is unhappy about these side effects, she probably will not continue. Assess the client and try to change her to a different pill or method.

COCs: Evaluate for Potential Problems

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

COCs: Evaluate for Potential Problems (cont.)

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

COCs: Warning Signs

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

Progestin-Only Methods (POPs, PICs and Implants): Side Effects

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

Progestin-Only Methods: Management of Amenorrhea

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



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If woman isn't pregnant and wants regular cycles, then consider COCs.

Progestin-Only Methods: Management of Bleeding or Spotting

- **Prolonged spotting (> 8 days) or moderate bleeding:**
 - Reassure that it is common among POP non-lactating users
 - Check for gynecologic problem (e.g., cervicitis)
- **Short-term treatment:**
 - COCs (30–50 µg EE) for 1 cycle,¹ or
 - Ibuprofen (up to 800 mg 3 times daily x 5 days)

¹ Remind client to expect bleeding after completing COCs.



Progestin-Only Methods: Warning Signs

- **Return to clinic if any of the following occur:**
 - Delayed menstrual period after several months of regular cycles (may be sign of pregnancy)
 - Severe lower abdominal pain
 - Heavy or prolonged bleeding

Progestin-Only Methods: Treatment of Common Side Effects

Side Effects	Management
Irregular or heavy bleeding	Check for gynecologic problem Counseling and reassurance COCs, NSAIDs or oral estrogens
Headache	Nonnarcotic analgesics
Weight change	Diet history, advice and exercise
Breast tenderness	Support bra
Breast discharge	Decreased nipple stimulation
Acne	Diet, cleansers and topical antibiotics



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Serious problems are rare and most can be alleviated with simple treatments. If side effects are not treated, however, they may prompt users to stop using implants. It is especially important to treat menstrual bleeding changes, which occur in most users, because these changes are a common reason for discontinuation. This table shows treatments for the most common side effects.

IUDs: Common Side Effects

- **Copper-releasing:**
 - Heavier menstrual bleeding
 - Irregular or heavy vaginal bleeding
 - Intermenstrual cramps
 - Increased menstrual cramping or pain
 - Vaginal discharge
- **Progestin-releasing:**
 - Amenorrhea or very light menstrual bleeding/spotting

IUDs: Possible Other Problems

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

IUDs: Management of Vaginal Bleeding Problems

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



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Frequently, heavier menses and dysmenorrhea subside after the body has acclimated to the IUD (+/- 3 months).

IUDs: Management of Cramping and Pain

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

Management of Partner Complaints about Feeling IUD String

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



IUDs: Indications for Removal

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



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If a woman who already has an IUD come to the health center due to an STI or PID, WHO 2004 Medical Eligibility Criteria report the client needs to be treated, but that she can keep the IUD if she wants to continue with it. Partner needs treatment too.

Warning Signs for IUD Users

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



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If a client has an STI, treat the infection and the partner if possible. The IUD does not have to be taken out as long as the client has been treated and she wants the IUD.

Condoms: Management of Common Side Effects

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

* Better to use condoms without nonoxynol-9.



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Polyurethane condoms made from plastic have a slightly higher breakage and slippage than latex condoms (9.8 as compared to 2.3) (Guttmacher Institute Policy 1999). In the same study, a higher pregnancy rate among latex users than polyurethane users in typical use, 7.0 vs. 5.1, but with correct consistent use, pregnancy rate 1.1 for latex and 2.4 for polyurethane. In addition, the polyurethane users used EC 50% more frequently than did latex users (although overall rate was still low).

Condoms: Management of Other Problems

- **Diminished sexual pleasure:**
 - If decreased sensitivity is not acceptable, help client choose another method
- **Condom breaks or breakage suspected (before intercourse):**
 - Discard and use new condom
 - Do not use petroleum or vegetable based oils or lubricants
- **Condom breaks or slips off during intercourse:**
 - Consider using emergency contraception



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Infection Prevention (IP)

Session 13

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

IP: Objectives

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

IP: Universal Precautions

- **Consider every person (client or staff) infectious**
- **Wash hands:**
 - Every time you put on and take off gloves
 - The most practical procedure for preventing cross-contamination (person to person)
- **Wear gloves before touching anything:**
 - Mucous membranes, blood or other body fluids, or soiled instruments/ items
- **Use physical barriers:**
 - Protective goggles, face masks and aprons if splashes and spills of any body fluids are anticipated



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IP: Principles

- **Use safe work practices:**
 - Not recapping or bending needles
 - Safely passing sharp instruments
 - Properly disposing of medical waste
- **Isolate patients only if secretions (airborne) or excretions (urine or feces) cannot be contained**
- **Process instruments and other items (decontaminate, clean, high-level disinfect or sterilize) using recommended infection prevention (IP) practices**



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Physical isolation of a patient in a separate room is recommended if s/he is likely to contaminate the environment or cannot help to maintain precautions against transmission (e.g., infants, children, patients with altered mental status). This is recommended for diseases that are transmitted through airborne secretions (e.g., tuberculosis).

Isolating HIV-positive patients is NOT recommended. Universal precautions for each patient ARE recommended.

IP: Risk of Disease Transmission

Source of exposure	HBV (%)	HIV (%)
Skin puncture (broken skin)	27-37	0.3-0.4
Mucocutaneous	5	< 0.1

Sources: Gerberding 1995; Seelf 1978.



5

As shown in this table, the risk of HBV transmission is much higher than that of HIV. Even with direct exposure to blood through a puncture, the risk of HIV is 0.3; 97.7% of those exposed will not contract the disease. On the other hand, 27-37% of those exposed to HBV will contract the disease. Health care workers should be aware of their potential risk for HBV and HIV and the role of infection prevention in preventing transmission.

IP: Accidental Exposure to HBV-Infected Blood

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

Source: Bond et al 1982.



IP: Practices for Reducing the Risk of Disease Transmission

- **Between clients and staff:**
 - Handwashing
 - Use of gloves (service provider and cleaning staff)

IP: Practices for Reducing the Risk of Disease Transmission (cont.)

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

IP: Handwashing Practices

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

: Larsen 1995.



IP: Handwashing

- **Handwashing may be the single most important procedure in preventing infection.**
- **Wash hands:**
 - Before and after examining any client (direct contact)
 - After removing gloves because gloves may have holes in them
 - After exposure to blood or any body fluids (secretions and excretions), even if gloves were worn

IP: Alcohol Solution for Surgical Handscrub

Formula

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

IP: Skin and Mucous Membrane Preparation

- Do not shave hair at the operative site (if necessary, trim hair close to skin surface immediately before surgery)
- Ask the client about allergic reactions before selecting an antiseptic solution
- Wash first with soap and water if visibly soiled
- Apply antiseptic starting from the operative site and working outward in a circular motion for several inches

IP: Cervical and Vaginal Preparations

- **Ask the client about allergic reaction to antiseptic**
- **Apply antiseptic solution liberally to the cervix (2 or 3 times) and then to vagina:**
 - It is not necessary to prep the external genital area if it appears clean
 - If area is heavily soiled, it is better to have the client wash her genital area thoroughly with soap and water before starting the procedure

IP: Protective Barriers

- **Wear gloves:**
 - When performing a procedure in the clinic or operating room
 - When handling soiled instruments, gloves and other items
 - When disposing of contaminated waste items (cotton, gauze or dressings)
- **Wear protective goggles, face masks and aprons:**
 - If splashes and spills of any body fluids are likely



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When cleaning instruments, wear heavy-duty rubber gloves

IP: Effectiveness of Methods for Processing Instruments

	Effectiveness (removal or inactivation of microbes)	End point
Decontamination	Kills HBV and HIV	10 minute soak
Cleaning (water only)	Up to 50%	Until visibly clean
Cleaning (detergent with rinsing water)	Up to 80%	Until visibly clean
Sterilization ¹	100%	Autoclave, dry heat or chemical for recommended time
High-level disinfection ¹	95% (does not inactivate some endospores)	Boiling, steaming or chemical for 20 minutes

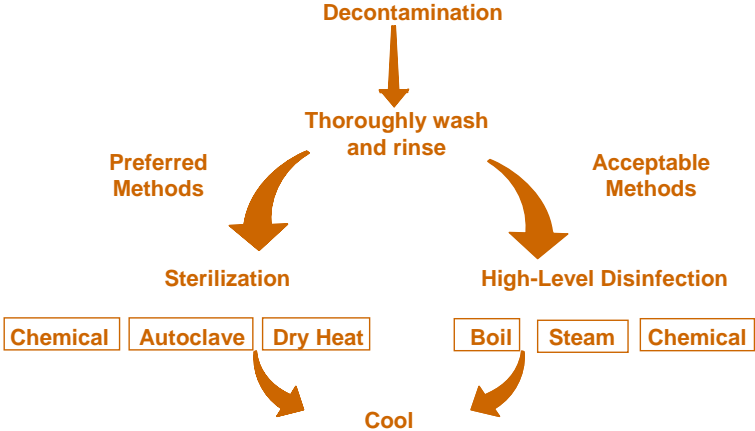
¹ Prior decontamination and thorough cleaning required.



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Addressing unmet need for reproductive health

IP: Processing Soiled Instruments and Other Items



IP: Decontamination

- **Principles:**

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

- **Practices:**

- Place instruments and reusable gloves in 0.5% chlorine solution after use
- Soak for 10 minutes and rinse immediately
- Wipe surfaces (exam tables) with chlorine solution

IP: Instructions for Preparing Dilute Chlorine Solutions

$$\text{Total parts (TP) (H}_2\text{O)} = \left[\frac{\% \text{ Concentrate}}{\% \text{ Dilute}} \right] - 1$$

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

$$\text{Total parts (TP) (H}_2\text{O)} = \left[\frac{5\% \text{ Concentrate}}{.5\% \text{ Dilute}} \right] - 1 = 9 \text{ Total parts (TP) (H}_2\text{O)}$$



IP: Instructions for Preparing a Chlorine Solution from a Powder

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

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

$$\text{Gram/Liter} = \left[\frac{.5\% \text{ Dilute}}{35\% \text{ Concentrate}} \right] \times 1000 = 14.2 \text{ Gram/Liter}$$

IP: Cleaning

- **Principles:**

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

- **Practices:**

- Wash with detergent and water
- Scrub instruments until visibly clean
- Thoroughly rinse with clean water

IP: Sterilization

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

IP: Sterilization (cont.)

- **Practices:**

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

IP: High-Level Disinfection

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

Source: Favero 1985; McIntosh et al. 1994.



IP: High-Level Disinfection— Boiling

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



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Boiling instruments for 20 minutes will kill all microorganisms except bacterial endospores. In fact, most microorganisms will be inactivated if heated to 80° C for 10 minutes. The boiling point of water is 1.1° C lower for each 1,000 feet in altitude; even at altitudes up to 5,500 meters (18,000 ft), the temperature will be adequate for HLD. **Note:** The highest temperature that boiling water will reach is 100° C (212° F) at sea level.

IP: High-Level Disinfection— Steaming

■ Practices:

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

: McIntosh 1994.

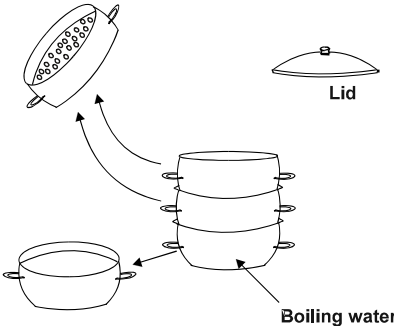


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IP: Steamer Used for High-Level Disinfection



IP: Chemical High-Level Disinfection

- **Practices:**
 - Cover all items completely with disinfectant
 - Soak for 20 minutes
 - Rinse with boiled water
 - Air dry before use and storage

IP: Preparing a High-Level Disinfected Container

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

IP: Waste Disposal

- **Principles:**

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

- **Practices:**

- Wearing utility gloves, place contaminated items (gauze or cotton) in leak-proof container (with a lid) or plastic bag
- Dispose by incineration or burial

IP: Traffic Flow and Activity Patterns

- **Goal: To eliminate level of microbial contamination in areas where “clean activities” take place:**
 - Procedure rooms
 - Surgical areas
 - Areas for final processing and instrument storage
- **Number of microorganisms in area is related to number of people present and their activity**



Overview of Family Planning and Statutory and Policy Requirements

Session 14

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

Session Objectives

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



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By the end of the presentation, participants should be able to:

- Describe key components of each of the major FP requirements.
- Provide examples of preventive measures and regular monitoring activities.
- Briefly describe how and where to access human and material resources.
- Describe key components of the HIV/AIDS requirements.

FP Legislative and Policy Requirements

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



Tiahrt Amendment (1999): Overview

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

Tiaht Amendment: Applicability

- **Which kinds of assistance does Tiaht apply?**
 - Applies to family planning activities funded from any account (not just CSH)
 - Applies to FP service delivery projects to which USAID provides FP assistance
 - Applies to funds, technical assistance, commodities and training
- **To which entities does Tiaht apply?**
 - Applies to US NGOs, foreign NGOs, public international organizations and foreign governments



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The Tiahrt Amendment is a statutory requirement that applies only to funds for family planning activities (from any account) appropriated under the Foreign Assistance Act of 1961, as amended.

More specifically, Tiahrt applies to service delivery projects, which are discrete, self-contained family planning activities that deal directly with “acceptors” (people) to which USAID provides assistance. These projects would include, for example, publicly operated clinics, mobile outreach/seasonal clinics, commercial or private clinics and community-based services when USAID provides support for any of these projects.

The Tiahrt requirements do not apply to USAID assistance for other kinds of population activities that are not conducted by or for the direct benefit of a specific family planning service delivery project -- such as broad information campaigns, surveys and data collection, strategic planning, evaluation, biomedical and social science research and publications.

It applies when any kind of assistance is provided for FP service delivery projects (such as improving the project's management capability and not just service delivery support), regardless of whether the assistance is in the form of cash, technical assistance, commodities or training.

Tiahrt applies to all US NGOs, foreign NGOs, public international organizations (PIOs, such as the WHO), and foreign governments.

[Note: throughout the presentation, unless specified as USG, the term “governments” refers to foreign governments. Also, we use the term “assistance” to mean “aid” for different activities, not a type of implementation instrument (as in “acquisition and assistance”).]

Tiarht Amendment Requirements: Requirement (1) — Targets and Quotas

- Service providers or referral agents shall not implement or be subject to quotas/targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning
- Quantitative estimates or indicators for budgeting and planning purposes are permitted



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The idea behind this provision is that when individual service providers are subject to quotas related to numbers of acceptors or births, this may affect their behavior in ways that do not ensure voluntarism.

Here are some definitions of the terms used:

Service provider and referral agent under the Tiarht clause are people who implement the service delivery project and who deal directly with acceptors or clients.

A quota or target is a predetermined, numerical goal that a service provider or referral agent is assigned or required to affect or achieve.

The Tiarht clause relating to targets exempts indicators and goals used for planning, budgeting, and reporting. We will discuss other situations like social marketing and performance-based financing initiatives in a moment. The key point to remember is that targets **assigned to individuals are prohibited**.

Tiahrt Amendment Requirements: Requirement (2) — No Incentives/Financial Rewards

- **No payments of incentives, bribes, gratuities or financial reward to:**
 - (A) An individual in exchange for becoming a family planning acceptor
 - (B) Program personnel for achieving a numerical target or quota of total number of births, number of family planning acceptors or acceptors of a particular method of family planning

Tiahrt Amendment Requirements: Requirement (3) — No Denial of Rights or Benefits

- **No denial of rights or benefits as a consequence of an individual's decision not to accept family planning**
- **Rights or benefits include access to participate in any program of general welfare or right of access to health care**



Tiahrt Amendment Requirements: Requirement (4) — Comprehensible Information Required

- **Family planning acceptors must receive comprehensible information on the health benefits and risks of the method chosen**
- **Comprehensible information can be provided in many forms such as counseling, posters, brochures and package inserts**



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Efficacy and how to use method chosen, main health benefits, health reasons not to use, and most common side effects of method chosen. Wall charts or flip charts advisable to meet comprehensible criteria.

Tiaht Amendment Requirements: Requirement (5) — Experimental FP Methods

- **Experimental contraceptive drugs, devices and medical procedures may be provided only in the context of a scientific study in which participants are advised of potential risks and benefits**
- **USAID has regulations regarding human subjects; support for any such research must be carried out in accordance with these regulations**



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USAID has regulations regarding research on human subjects (set forth in an ADS), and support for any research on such experimental methods must be carried out in accordance with these regulations.

Tiaht Amendment Guidance

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

Tiahrt Amendment

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



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Since the Tiahrt Amendment was enacted in 1999, USAID has reported to Congress violations in three countries: Peru in 2001 and Guatemala and the Philippines in 2006. We are going to briefly review these situations in order to help you understand how problems can occur, and lessons we have learned.

Peru: The existence of sterilization campaigns in Peru in the 1990s was the motivation for writing the Tiahrt Amendment. In 1998 the MOH ended these campaigns and USAID took a number of actions to ensure voluntarism throughout its program. One of these was the institution of an annual client survey. In late 2000 USAID/Peru was notified that preliminary results from the survey revealed evidence of Tiahrt violations. Specifically, women who had used one facility reported that they were offered clothes for their children, and/or work and food in exchange for accepting to be sterilized. It is not known whether these incentives were actually provided. Others reported that they were threatened with the denial of benefits, including the loss of certain health services, the loss of free health services, and/or the loss of food support if they did not agree to be sterilized. The respondents accepted to be sterilized and retained their benefits. **Lessons learned** from this experience include:

- When there is a policy change, not everybody gets the message. Despite the changes instituted by the MOH to ensure voluntarism, and support provided by USAID to implement them, there was still one facility that continued operating under the old system. Information dissemination and monitoring must work together.
- The monitoring system was effective in identifying the problem.
- The Mission's close collaboration with the MOH and the Ombudsman's Office was a real asset in implementing the policy changes and following up to address the violations. There was a high level of local "ownership."

Guatemala: A local NGO was a major implementer of USAID's family planning program. The group operated a system of paying bonuses to referral agents for meeting performance targets. Originally this system had covered a variety of reproductive health services, but later it was limited to voluntary sterilization. The Mission discovered the system when a secretary noticed what appeared to be double payments in a tax exemption form submitted by the NGO. The CTO worked with the NGO to end the practice. **Lessons learned** include:

- The referral agents considered the target to be low and nearly always met them (due to high demand for VS). Nevertheless, the specific linking of performance bonuses to achievement of acceptance targets was a violation.
- Both senior leadership and field staff of the local NGO had a low level of awareness of the specifics of the Tiahrt requirements. This underlines the importance of ensuring that partners understand the requirements (even long-term partners).

Philippines: The Tiahrt Amendment applies to service delivery sites nationwide in the Philippines because the Mission donates contraceptive commodities that go into the national supply. The violation occurred in two local government units (equivalent of districts) that receive commodities, but not other USAID support for service delivery. Facilities were found to be assigning targets for numbers of family planning acceptors to clinic midwives and community health workers. Staff reported that they routinely did not meet the targets, and that although consequences included the possibility of a negative performance evaluation, they were not given any incentive for meeting targets. The violation was discovered while looking into allegations about incentives and quality of care issues. **Lessons learned** include:

- Monitoring needs to be done everywhere that Tiahrt applies, even where the only assistance provided is contraceptives and even where there are not implementing partners on the ground to assist monitoring efforts.
- All recipients of USAID FP assistance must understand the requirements.
- The term "targets" may be commonly used in certain health systems. In most locations they did not function in the ways that are prohibited, so hearing the term is not automatically a trigger. Detailed questioning about how targets are used at each facility is required.

Tiaht Amendment Requirement to Report Violations

- **The Tiaht Amendment specifically requires that violations be reported to Congress:**
 - A single violation of requirements (1),(2), (3) or (5) must be reported
 - A pattern or practice of violations of requirement (4) must be reported
 - USAID Administrator makes determination of violation
 - USAID must notify Congress within 60 days of the Administrator's determination that a violation occurred



Policy Determination 3: Overview

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



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Payment cannot be used as an incentive to accept, provide or refer to voluntary sterilization service.

Accepting reasonable payment for a procedure based on country and program-specific basis is not considered an incentive, provided it is reasonable.

Policy Determination 3 — Applicability

- **To which kind of assistance does PD-3 apply?**
 - Applies to family assistance from any account (not just CSH)
 - Applies where USAID funds are used for whole or partial direct support of the performance of voluntary sterilization activities
- **To which entities does PD-3 apply?**
 - Applies to US NGOs FNGOs, public international organizations and governments



Other Voluntarism Requirements

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



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The DeConcini Amendment states that FP projects must offer, either directly or through referral/information, a broad range of FP methods and services. This applies to all funds for FP activities.

The Livingston Amendment states that in awarding grants for natural family planning, no applicant shall be discriminated against due to commitment to provide only natural FP; must still comply with Deconcini.

The Kemp-Kasten Amendment and Related Provisions state that no funds may be made available to organizations or programs which, as determined by the President, support or participate in the management of a program of coercive abortion or involuntary sterilization. This applies to all foreign assistance funds, all entities.

The application of Kemp-Kasten prohibits U.S. support for UNFPA, which the President has determined supports forced abortion and sterilization in China via its support to the Chinese Government's family planning program.

Policies Related to Abortion Services

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



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Siljander: Prohibits using funds to lobby for or against abortion.

Biden: Prohibits using funds for any biomedical research related to abortion.

Helms Amendment

- **No foreign assistance funds may be used to perform or motivate/coerce people to practice abortions**
- **To what kind of assistance does Helms apply?**
 - To all foreign assistance funds
 - To USAID-funded activities only
- **To which kind of entities does Helms apply?**
 - Applies to US NGOs, foreign NGOs, PIOs and governments



Helms amendment initiated in 1973

Mexico City Policy

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



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Key definitions: abortion as a method of family planning means for the purpose of spacing births including for the physical or mental health of the mother, due to method failure, or menstrual regulation.

Actively promoting abortion means providing advice or information regarding the benefits and availability of abortions as a method of family planning counseling, referrals.

The MCP applies only to foreign NGOs. “Foreign NGOs” means non-US NGOs. It only applies when a foreign NGO receives funds for family planning activities (from any account). It is generally more important to consider the nature of the activities, rather than the source of the funds.

This is an organizational requirement. It applies to all activities carried out by an organization, regardless of whether the funds are from USAID or non-USAID sources.

The policy applies to cooperative agreements and grants, but not contracts. It applies to all types of support - including funds, transferred goods, and services - even in the absence of a formal agreement. A separate certification form is not required – an organization certifies its compliance with the policy by signing its award agreement (in which the provisions are contained).

Mexico City Policy Exclusions

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



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Passive referral means that the client realizes that she is pregnant and specifically asks where she can have a safe legal abortion. This only applies in countries where abortion is legal. In this case, the provider can give information where the client can get a safe abortion.

Family Planning Requirements Review

- **Requirements are either statutory or policy:**
 - Statutory: Tiarht, Deconcini, Livingston, Kemp-Kasten, Helms, Bidan, Siljander
 - Policy: PD-3 (agency), Mexico City Policy (Executive)
- **Requirements generally relate to voluntarism/informed choice or abortion:**
 - Voluntarism/informed choice: Tiarht, PD-3, DeConcini, Livingston, Kemp-Kasten
 - Abortion: Mexico City Policy Helms, Bidan, Siljander
- **Requirements apply to particular kinds of assistance:**
 - Apply to all foreign assistance—Kemp-Kasten, Helms, Bidan, Siljander
 - Apply to FP assistance—Tiarht, PD-3, Deconcini, Livingston, Mexico City Policy
- **Requirements apply to particular types of entities:**
 - Apply to US NGO foreign NGO, PIOs, governments—all statutes, PD-3
 - Apply ONLY to foreign NGOs-Mexico City Policy
- **Requirements apply to particular types of agreements:**
 - Apply to all foreign agreements-all statutes, PD-3
 - Apply to all grants/CA only—Mexico City Policy



Ensuring Compliance

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

Monitoring

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



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Ask open-ended questions such as how is staff performance evaluated, compensated, and motivated when checking on compliance for USAID FP policies.

HIV/AIDS Requirements: Overview

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



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The U.S. Leadership Against HIV/AIDS, TB and Malaria Act was enacted in 2003 and authorizes appropriations for HIV/AIDS, tuberculosis and malaria for fiscal years 2004-2008.

Certain provisions of the Leadership Act are implemented in USAID's Acquisition and Assistance Policy Directive 05-04 that was issued on June 9, 2005 and remains in effect.

HIV/AIDS Requirements: Medically Accurate Information Requirement

- **Information provided about condoms must be medically accurate:**
 - Such information must be consistent with USAID's fact sheet entitled, "USAID: HIV/STI Prevention and Condoms"
 - This provision applies to all recipients, including PIOs
 - This provision must be included in all subawards



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If providing information about condoms is not already a part of your project or agreement, then you don't have to start. However, if you are providing information (e.g., through brochures or verbal counseling), then the information must be medically accurate.

"Medically accurate information" can be found in USAID's Condom Fact Sheet, available on the USAID Web site. There is a link in the AAPD-0504.

HIV/AIDS Requirements: Leadership Act Requirement — Implementation of Section 301(d)

- **Conscience clause:**
 - A recipient is not required to use a multisectoral (ABC) approach or to participate in a prevention method to which it has a religious or moral objection
 - This provision applies to all recipients, including PIOs
 - This provision must be included in all subawards



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A religious or moral objection to a particular prevention method does not constitute a basis for excluding recipients from awards.

HIV/AIDS Requirements: Leadership Act Requirement — Implementation of Section 301(e)

- **No USG funds for HIV/AIDS activities may be used to promote or advocate the legalization or practice of prostitution or sex trafficking:**
 - This does not restrict the provision of HIV/AIDS prevention, care and treatment to individuals
- **This provision applies to all recipients, including PIOs**
- **This provision must be included in all subawards**



HIV/AIDS Requirements: Leadership Act Requirement — Implementation of Section 301(f)

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



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For specific questions about your program or agreement, please speak with your Contract Officer or Agreement Officer.

HIV/AIDS Requirements: Section 301(f) Policy Requirement

- **USAID will not review organizations' policies prior to award. The organizations will have to determine whether they can comply with the provisions of the AAPD.**

HIV/AIDS Requirements: Certification Requirement

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



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HIV/AIDS Requirements: Applicability — Which Funds Are Affected?

- All funds (regardless of account) used for HIV/AIDS activities: GHAI, CSH, ESF, FSA, SEED

FP/HIV Integrated Programs

- **Different organizations may be responsible for different types of activities, and therefore be subject to different requirements:**
 - Both activities → both requirements (FP and AAPD 05-04)
 - HIV/AIDS activities only → AAPD 05-04 only
 - FP activities only → FP requirements only
 - Including MCP for foreign NGOs



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In the case of integrated HIV/AIDS and family planning programs, any partner that receives USAID funding for both purposes must comply with the respective requirements applicable to each activity (including MCP for foreign NGOs).

However, in an integrated program, an organization at the sub-level may not necessarily do both family planning and HIV/AIDS activities.

In such case, a partner that receives funds solely for HIV/AIDS activities will be subject to the AAPD 05-04 requirements but will not be subject to the family planning requirements. Similarly, a partner that receives funds solely for family planning activities will be subject to family planning requirements (including MCP for foreign NGOs) but will not be subject to the AAPD 05-04 requirements.

Material Resources

- **Summary of USAID Family Planning Requirements**
- **Contract information bulletins/AAPDs**
- **Tiahrt guidance documents**
- **All available at:**
 - http://www.usaid.gov/our_work/global_health/pop/#policy



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Information on the details of the requirements is available on the USAID Web site.



How to Implement Your Family Planning Skills in Your Facility: Transfer of Learning

Session 15

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

Why do we do training?

- **To ensure that worker have the skills and knowledge to do the job**



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Have you ever attended a training event and returned to your work but never implemented what you learned? Research has shown that, typically, less than 30% of what people learn is actually ever used on the job. Transfer of learning is important for supervisors, trainers, learners and co-workers for a number of reasons: - Transfer of learning is in the best interest of clients. Health care workers participate in a learning event to acquire new knowledge and skills to improve their ability to meet the needs of their clients. - Improving the transfer of learning enhances the quality of services—and may lead to increased client satisfaction. - Learning interventions can be expensive. Improving the transfer of learning helps to protect these investments.

Transfer of Learning

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



Why focus on transfer of learning?

- **Improves quality of client services**
- **Encourages and empowers learners**
- **Improves accountability for implementation**
- **Helps supervisors keep current to evidence based medical practices and standards**



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- Learners are motivated to perform well at their jobs when they are able to apply what they have learned. The support and guidance of supervisors, trainers and co-workers can encourage and empower learners to make changes and improve performance. - Supervisors and learners are more accountable for implementing new knowledge and skills if there is early agreement on what will occur after training. An action plan outlines these agreements. - Investing in the final outcome of training helps trainers to prepare interventions that meet the specific needs of learners and health care delivery sites, and finally - Although supervisors may not be proficient in all of the clinical services provided by the health care workers they supervise, being involved in the transfer of learning process can help them stay up to date.

What are the barriers?

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



What performance factors affect transfer of learning?

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



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- Are there clear job expectations? Do learners know how and under what circumstances they will be expected to apply what they have learned?
- Do learners receive feedback from their supervisor (and others) on the performance of their new skills? Feedback is especially important if learners are still working towards complete mastery of a new skill.
- Do learners have the physical environment and tools they need (for example, supplies and instruments) to apply the new knowledge and skills they have acquired during training? Have learners acquired knowledge and learned skills that can be applied immediately in the site where they work? Or, on the other hand, are they trying to figure out how to adapt what they have learned to fit the reality of their situation?
- Are learners motivated to apply the new skills? Does applying their new skills make their job easier or more satisfying?
- Do learners have support from the entire organization to help them implement the new skills and techniques they have learned? Has the administration made the necessary adaptations to processes and procedures to support the changes that they hope to institute through staff training?

Well-designed training interventions should consider the impact of these factors. When necessary, tailored non-training interventions should be designed to facilitate and ensure the success of training interventions.

Although you and your organization may not have the capability to design and implement specialized non-training interventions, it is important to consider the impact of all performance factors on learners' ability to apply what they have learned. The key to success for any type of intervention is the support that the organization provides to ensure proper implementation through ongoing monitoring and updates.

Action Plan

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



7

An action plan is a written document that describes the steps that supervisors, trainers, learners and co-workers develop to help maximize the transfer of learning. Action plans can be a tool for keeping track of expectations, commitments and the resources needed to accomplish learning goals.

A preliminary action plan is used before the start of the intervention to ensure agreement about the expectations for the learning intervention for all of the stakeholders, including supervisors, trainers, learners and co-workers.

During the learning intervention, the action plan is refined by the learner and the trainer to document exactly how the new knowledge and skills will be implemented at the work site.

After the intervention, the detailed written document is used to share the plan with supervisors, co-workers and other stakeholders to ensure that everyone is clear about the expectations and about their responsibilities for ensuring that the learners receive the support they need to be successful.

The action plan should be a living document that is revised as necessary to reflect accomplishments and changes to the plan.

Develop Action Plan

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



8

- Provide example of Action Plan developed in MAQ Transfer of Learning and discuss with participants.
- Ask participants what are some actions that they could do to improve postpartum care including PFPF; another participant or trainer could write down suggestions.
- Ask participants how they might be able to get those actions listed above done.
- Ask participants who will do the listed action.
- When the participants understand the process, ask them to pair up with co-workers to work on developing an action plan.

Support and Supervision Monitoring

- **Trainers will support learners by monitoring and evaluating learners' progress**
- **Support successes in activities on action plan**
- **Make adjustments involving all of the staff identified in the action plan**



9

Ensuring that learners are followed up and supported after an intervention is one of the most important investments that can be made. Ideally, events that take place after learning should be considered part of the intervention. - One of the best ways to provide ongoing support is to monitor learner progress so that “support” can be targeted to the learner’s, or more accurately the worker’s, changing needs. - As the situation evolves, make adjustments in how the goals of the intervention will be achieved. Use the written action plan to document changes. It is important to make adjustments and involve all the stakeholders in the decisions so that everyone remains clear about the goals and expectations and what their individual responsibilities are. Ideally, every training and learning intervention will include a plan for monitoring and evaluating the success of the intervention. You will notice that the matrix includes several specific suggestions regarding assessment, monitoring and evaluation that should be incorporated as appropriate. - Transfer of learning can only be measured by evaluating performance on the job. Although using pre- and post-knowledge and skills tests can tell you whether learners have gained knowledge and skills, these tests do not indicate whether the learner can perform on the job. To document transfer, some observation of a learner’s performance on the job, against a set standard for desired performance, must be conducted.

Resources for Transfer of Learning

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

