Providing Long-Acting Reversible Contraception (LARC)

Course Notebook for Trainers
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Course Notebook for Trainers
Jhpiego is an international, non-profit health organization affiliated with The Johns Hopkins University. For 40 years, Jhpiego has empowered frontline health workers by designing and implementing effective, low-cost, hands-on solutions to strengthen the delivery of health care services for women and their families. By putting evidence-based health innovations into everyday practice, Jhpiego works to break down barriers to high-quality health care for the world’s most vulnerable populations.

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Acknowledgments

This learning resource package (LRP) was developed by Jhpiego, an affiliate of Johns Hopkins University, to meet the growing need among family planning trainers and service providers for a consolidated source of concise, up-to-date information on LARC. Some of the material in the LRP was adapted from prior publications by Jhpiego and a number of other organizations, including Bayer Pharma AG (Bayer) and Merck & Co, Inc. (MSD). References to non-Jhpiego documents are specifically cited within the text or acknowledged at the end of the manual. Jhpiego would like to extend special thanks to Bayer for access to its Jadelle training materials; to MSD for access to selected Implanon materials; to John Snow, Inc. for their contributions to the commodities and logistics section; to FHI 360 for their pregnancy checklist and quick reference eligibility guide; and to the Population Council for their balanced counseling strategy materials. Jhpiego would also like to extend appreciation to the World Health Organization for their globally recognized Medical Eligibility Criteria materials.

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Preface

The purpose of this learning resource package (LRP) is to provide health workers with a consolidated source of essential information on safe use of long-acting reversible contraception (LARC), specifically on the Copper T 380A IUD regular load, Copper T 380A IUD safe load, Jadelle, Sinoin-implant II, Implanon, and Implanon NXT (also known as Nexplanon).

The *Course Handbook for Learners* was designed for use with the IUD and implant reference manuals and the *Course Notebook for Trainers*. Please refer to these documents for more information about LARCs and how to implement training using this LRP.

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**The main objectives of this LRP are to enable and empower providers to:**

1. Explain to a client how LARCs prevent pregnancy;
2. Inform a client about the most common side effects of LARCs;
3. Screen clients requesting LARCs and determine whether further medical evaluation is needed;
4. Counsel clients interested in using an implant or IUD as a contraceptive method;
5. Insert two-rod and one-rod implants through simulation using the training arm model, and insert IUDs using the ZOE pelvic model before moving to clinical practice with clients requesting LARCs;
6. Provide post-insertion counseling on care and follow-up;
7. Use recommended infection prevention practices that minimize the risk of post-insertion/post-removal infections and transmission of pathogens;
8. Remove two-rod and one-rod implants through simulation using the training arm model, and remove IUD through simulation on pelvic model before moving to clinical practice with clients;
9. Manage common side effects and other health problems with LARCs; and
10. Develop an action plan to implement high-quality LARC services at the learner’s facility.
Overview

Before Starting this Training Course

This clinical training course is different from traditional training courses in three ways. First, it is based on the assumption that people participate in training courses because they:

- Are interested in the topic,
- Wish to improve their knowledge or skills, and thus their job performance, and
- Desire to be actively involved in course activities.

For these reasons, all of the course materials focus on the learner. The course content and activities are intended to promote learning, and the trainer will use the activities to engage the learners actively in learning.

Second, in this training course, the trainer and the learner are provided with a similar set of educational materials. The clinical trainer, by virtue of her/his previous training and experience, works with the learners as an expert on the topic and guides the learning activities. In addition, the trainer helps create a comfortable learning environment and promotes activities that assist the learner in acquiring new knowledge, attitudes, and skills.

Finally, the training approach used in this course stresses the importance of the cost-effective use of resources and application of relevant educational technologies, including humane training techniques. The latter encompasses the use of two anatomic models, the Reproductive Implant Training Arm (RITA) and the ZOE pelvic model, to minimize client risk and facilitate learning.

Components of the LARC Learning Resource Package

This clinical training course is built around the following components:


- A Course Handbook for Learners, which contains a course schedule and validated questionnaires and checklists that break down the skills or activities (e.g., counseling; implant and IUD insertion and removal) into essential steps

- This Course Notebook for Trainers, which includes questionnaire answer keys and detailed information for conducting the course

- PowerPoint presentation slides to aid in training

- Well-designed training aids, such as videos and anatomic models

- Competency-based performance evaluation

---

1 These are the reference manuals that are recommended for this course. They contain essential information on the following topics as well as others: counseling, indications and precautions for use, client assessment, recommended infection prevention practices, implant and IUD insertion and removal, follow-up care, management of side effects, and organization of services.
Using the LARC Learning Package

In designing the training materials for this course, particular attention has been paid to making them user-friendly and to permitting the course learners and clinical trainer the widest possible latitude in adapting the training to the learners' (group and individual) learning needs. For example, at the beginning of the course an assessment is made of each learner's knowledge and clinical skills, as well as the skills of the group as a whole. The results of this precourse assessment are then used jointly by the learners and the clinical trainer to adapt the course content as needed so that the training focuses on acquisition of new information and skills.

A second feature relates to the use of the reference manuals and the Course Handbook for Learners. The implant and IUD reference manuals are designed to provide all of the essential information needed to conduct the course in a logical manner. Because it serves as the text for the learners and as a reference for the clinical trainer, other hand-outs or supplemental materials are not needed. In addition, because the reference manual contains only information that is consistent with the course goals and objectives, it becomes an integral part of all classroom exercises—such as giving an illustrated lecture or providing problem-solving information.

The Course Handbook for Learners, on the other hand, serves as the road map that guides the learner through each phase of the course. It contains the course syllabus and course schedule as well as selected supplemental printed materials (checklists and course evaluation) needed during the course.

The Course Notebook for Trainers contains the same material as the Course Handbook for Learners as well as material specifically for the trainer. The material for the trainer includes guidance on preparing for the course, an expanded model course outline, a knowledge assessment questionnaire and answer key, competency-based qualification checklists, and a section on tips for conducting a training course.

In keeping with the training philosophy on which this course is based, all training activities, whether in the classroom or a clinic, will be conducted in an interactive, participatory manner. To accomplish this requires that the role of the clinical trainer continually change throughout the course. For example, she/he is an instructor when presenting a classroom demonstration, a trainer when conducting small group discussions or using role plays, and a coach when helping learners practice a procedure. Finally, when objectively assessing performance, she/he serves as an evaluator.
Introduction

Course Design

Successful completion of the course requires mastery of both the knowledge and the skills components, as well as satisfactory overall performance in providing LARC services to clients.

This training course differs from traditional courses in several ways:

- During the morning of the first day, learners are briefly tested (with the precourse questionnaire) to determine their individual and the group’s knowledge about the management of LARC services. The results are reviewed with the group to identify major areas for focus of the training.
- Classroom and clinic sessions focus on key aspects of service delivery (e.g., counseling of clients and how to provide services and manage side effects and other health problems).
- Progress in knowledge-based learning is measured before and during the course using a standardized written assessment (pre- and mid-course questionnaires).
- Clinical skills training builds on the learners’ previously mastered skills. Learners first practice on the anatomic models using a checklist that describes the key steps in insertion and removal of implants. In this way, they acquire the skills needed later to insert and remove implants with clients in a standardized way.
- Progress in learning new skills is documented using the counseling and clinical skills checklist.
- Each learner’s performance is assessed by a clinical trainer using competency-based skills checklists.

LARC service delivery is a team effort, requiring the knowledge and skill of trained clinicians (physicians, nurses, and midwives) and sometimes other types of health professionals, such as counselors.

All learners should be provided the opportunity to observe and perform all of the skills/activities associated with the safe delivery of implant services.

Evaluation

This clinical training course is designed to produce qualified LARC service providers. Qualification is a statement by the training institution(s) that the learner has met the requirements of the course in knowledge, skills, and practice. Qualification does not imply certification. Personnel can be certified only by an authorized organization or agency.

Qualification is based on the learner’s achievement in three areas:

1. Knowledge—A score of at least 85% on the mid-course questionnaire
2. Skills—Satisfactory performance of LARC counseling and clinical skills
3. Practice—Demonstrated ability to provide LARC services in the clinical setting
Responsibility for the learner’s achievement of qualification is shared by the learner and the trainer.

The evaluation methods used in the course are described briefly below:

- **Pre-/Mid-Course Questionnaire.** Give the assessment in the beginning of the course and then again when all subject areas have been presented (suggested on Day 3 or 4). A score of 85% or more indicates knowledge-based mastery of the material presented in the reference manual. For those scoring less than 85% on their first attempt, the clinical trainer should review the results with the learners individually and guide them on using the reference manual to learn the required information. Learners scoring less than 85% can take the course questionnaire again at any time during the remainder of the course. The trainer may decide to have an individual meeting with the learner to discuss knowledge areas that need strengthening.

- **Provision of Services (Practice).** During the course, it is the clinical trainer’s responsibility to observe each learner’s overall performance in providing LARC services using the checklists. The trainer will also use this opportunity to observe how each learner approaches client care. Providing client-centered care in a caring manner is a critical component of quality service delivery.

- **Checklists for LARC Counseling and Clinical Skills.** The clinical trainer will use these checklists to evaluate each learner as she/he counsels clients and inserts or removes LARCs with clients. Evaluation of the counseling skills of each learner may be done with clients; alternatively, it may be accomplished at any time during the course through observation during role plays. Evaluation of the clinical skills usually will be done on the last day of the course (depending on class size and client caseload). There are different checklists for the different types of contraceptive implants and IUDs. The implants include Jadelle or Sino-implant (II) (two-rod implants) and the Implanon or Implanon NXT (one-rod implants), and the implant checklists cover both counseling/insertion and counseling/removal. The IUD is the Copper T 380A IUD, and the checklist covers counseling and clinical skills.

In determining whether the learner is qualified, the clinical trainer(s) will observe and rate the learner’s performance for each step of the skill or activity. The learner must be rated “satisfactory” in each skill or activity to be evaluated as qualified.

The course trainer should observe and evaluate graduates again within three to six months after their qualification, while they are working in their institution, using the same counseling and clinical skills checklist. (At the very least, a skilled provider should observe the graduate after completing training.) This evaluation is important for several reasons. First, it not only gives the graduate direct feedback on her/his performance, but also provides the opportunity to discuss any start-up problems or constraints in service delivery (e.g., lack of instruments, supplies, or support staff). Second, and equally important, it provides the training center, via the clinical trainer, key information on the adequacy of the training and its appropriateness to local conditions. Without this type of feedback, training easily can become routine, stagnant, and irrelevant to service delivery needs.
Course Syllabus

Course Description
This five-day clinical training course is designed to prepare the learner to counsel individuals concerning the use of LARC as a family planning method and to become competent in inserting and removing implants and IUDs. The course also covers managing side effects and other health problems associated with their use.²

Course Goal
To give learners the capacity to provide quality long-acting contraceptive services

Learning Objectives
By the end of the training course, the learner will be able to:

1. Explain to a client how both implants and IUDs (i.e., long-acting reversible contraception) prevent pregnancy;
2. Inform a client about the most common side effects of LARCs;
3. Screen clients requesting LARCs and determine whether further medical evaluation is needed;
4. Counsel clients who are interested in using either a implants or IUD as a contraceptive method;
5. Insert two-rod and one-rod implants through simulation using the training arm model and insert IUDs using the ZOE pelvic model before moving to clinical practice with clients;
6. Provide post-insertion counseling on care and follow-up;
7. Use recommended infection prevention practices that minimize the risk of post-insertion/post-removal infections and transmission of pathogens.
8. Remove two-rod and one-rod implants through simulation using the training arm model, and remove IUD through simulation on pelvic model before moving to clinical practice with clients;
9. Manage common side effects and other health problems with LARCs; and
10. Develop an action plan to implement high-quality LARC services at the learner’s facility.

Training/Learning Methods
This training uses a variety of training and learning methods, which are outlined in the model course outline. These include the following:

- Illustrated lectures and group discussions

² Depending on the needs of the learners, the course may be given over a longer period (five to eight days). For example, additional sessions may be needed on counseling, infection prevention practices, or other aspects of implant service delivery.
- Individual and group exercises
- Role plays
- Simulated practice with the Jadelle Subdermal Implant Training model, the Reproductive Implant Training Arm (RITA), and the ZOE pelvic model
- Guided clinical activities (counseling and LARC insertion and removal)

**Training Materials**

This *Course Notebook for Trainers* is designed to be used with the following materials:

- Training aid PowerPoint presentations and videos
- Reproductive Implant Training Arm (RITA) for practicing implant insertion and removal
- ZOE pelvic model for practicing IUD insertion and removal
- Implants and IUD insertion and removal instruments kits, placebo implants, and “expired” Copper T 380A IUDs for use on simulation practice
- Active Implants and Copper T 380A IUD for clinical practice

**Learner Selection Criteria**

Learners for this course should be clinicians (physicians, nurses or midwives, or other country-specific designated mid-level providers) working in a health care facility (clinic or hospital) that provides family planning and/or women’s health services.

**Methods of Evaluation**

**Learner**

- Pre- and mid-course questionnaires
- Checklists for implants and IUD counseling and clinical skills (insertion and removal)

**Course**

- Course evaluation (to be completed by each learner)

**Course Duration**

Ten sessions are scheduled in a five-day sequence. The last afternoon can be a shorter segment than the rest of the training sessions and can be used an opportunity to address any questions.
Suggested Course Composition
(to ensure that learners have adequate clinical practice)

- 10 health care professionals
- Two clinical trainers

Course Outline
The course outline presented here is a model plan of the training to be delivered. It presents the learning methods needed to accomplish the learning objectives described in the course syllabus. For each enabling objective, there are suggestions regarding appropriate activities and needed resources and materials. The trainer may develop other practice activities and prepare case studies, role plays, or other learning activities that are specific to the country or group of learners.

The course outline is divided into five columns:

- **Time.** This section of the outline indicates the approximate amount of time to be devoted to each learning activity.

- **Learning Objectives.** This column notes the learning objectives for each activity.

- **Learning Assessment Methods.** This column describes the tools and strategies to be used to assess level of understanding or skills of the learner and to verify that participants are progressing toward each enabling objective.

- **Activities.** This column lists the learning activities (introductory activities, small-group exercises, clinical practice, etc.) as well as breaks during the course. The activities outline the flow of training.

- **Resources/Materials.** The fifth column in the course outline lists the resources and materials needed to support the learning activities.

A Few Important Notes:

- Because the course outline is based on the course schedule, changes or modifications to the schedule should be reflected in the outline as well (and vice versa). Should changes be required, a printable Word version of this outline is available on the CD (in the Additional Resources folder).

- Many of the materials mentioned in the outline are also available as hand-outs on the CD (in the Additional Resources folder).

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3 The course size will be limited by the available space (classroom and demonstration areas/rooms) at the training facility and the number of potential implant clients.
<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives Subject Title</th>
<th>Learning Assessment Method</th>
<th>Activities</th>
<th>Resources/Materials</th>
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</thead>
</table>
| 30 minutes | **Opening**  
Welcome  
Introductions, Expectations, Logistics, Training Norms, Orientation to Training Materials  | **Questionnaire**  
(the same questionnaire is used for pre-course and mid-course assessment) | **Complete Course Questionnaire**  
Responses from learners in interactive discussion  
Course questionnaire (section: indications, precautions, and client assessment) | **Prepared flip chart**  
**Markers**  
**Providing Contraceptive Implants: Reference Manual**  
**IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual**  
**Course Handbook for Learners**  
**Trainer’s Notebook:** Pre-course/Mid-Course Questionnaire  
**Learner’s Handbook:** Individual and Group Assessment Matrix |
| 30 minutes | **Assess learners’ pre-course knowledge**  
Identify individual and group learning needs |                                                                                       | **Interactive Discussion:** Ask learners about key points  
**Key Points:**  
• Efficacy of implants >99%  
• Effective for 3–5 years (depending on product)  
• Common side effects |                                                                                       |
| 30 minutes | **Contributes to Training Objectives 1 and 2**  
Overview of contraceptive implants | Responses from learners in interactive discussion  
Course questionnaire (section: indications, precautions, and client assessment) | **PPT 1:** Overview of one-rod and two-rod implants |                                                                                       |
<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives Subject Title</th>
<th>Learning Assessment Method</th>
<th>Activities</th>
<th>Resources/Materials</th>
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<tbody>
<tr>
<td>30 minutes</td>
<td>Contributes to Training Objectives 1 and 2</td>
<td></td>
<td><strong>Interactive Discussion:</strong> Ask learners about key points</td>
<td>PPT 2: Overview of IUDs</td>
</tr>
<tr>
<td></td>
<td>Overview of IUDs</td>
<td></td>
<td><strong>Key Points:</strong></td>
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<td></td>
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<td></td>
<td>• Both LARCs highly effective</td>
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<td></td>
<td></td>
<td></td>
<td>• Efficacy of IUDs &gt; 99%</td>
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<td></td>
<td>• Effective for up to 12 years (5 years for levonorgestrel-releasing IUS)</td>
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<td></td>
<td></td>
<td>• Common side effects</td>
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<tr>
<td>15 minutes</td>
<td>Break</td>
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<tr>
<td>30 minutes</td>
<td>Contributes to Training Objective 3</td>
<td></td>
<td><strong>Interactive Discussion:</strong> Ask learners about key points</td>
<td>PPT 3: WHO Medical Eligibility Criteria and LARC</td>
</tr>
<tr>
<td></td>
<td>WHO Medical Eligibility Criteria for LARC</td>
<td></td>
<td><strong>Key Points:</strong></td>
<td>Chapter 3 in <em>Providing Contraceptive Implants: Reference Manual</em></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• WHO MEC are evidence-based, citing safety of providing implants for women who have medical conditions or special circumstances</td>
<td>Chapter 4 in <em>IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</em></td>
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<tr>
<td></td>
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<td></td>
<td>• Implants are safe and effective for most women.</td>
<td>Appendix C in <em>Providing Contraceptive Implants: Reference Manual</em>: WHO MEC Quick Reference Guide</td>
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<td></td>
<td></td>
<td></td>
<td>• IUDs are okay for nulligravidas.</td>
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<td>Time</td>
<td>Learning Objectives Subject Title</td>
<td>Learning Assessment Method</td>
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| 75 minutes | Contributes to Training Objectives 3 and 4                              | Observation of role plays using checklist steps 1–9 | **Group Activity:** Play the “telephone” game, which demonstrates that complicated information is difficult to retain. Clients are more likely to retain information that is relevant to them. Have the group sit in a circle and state that the rules are that the whisperer can make the statement only once, and then the listener has to pass on what she/he hears to the next person. The trainer then whispers, “**People remember 25% of what they hear; 45% of what they hear and see; and 70% or more of what they hear, see, and experience on their own.**”  
**Group Discussion** on how the message could have been communicated more effectively.  
**Key Points:**  
- Show the bar graph (hide during the activity).  
- Information is relevant to their needs today.  
- Client or learner is actively engaged in the discussion—not just listening.  
**Demonstration:** Trainer asks a learner to play the role of a client interested in implants and DMPA. The trainer demonstrates steps 1–5 on the algorithm.  
**Role Play:** Learners pair up to role play provider and client through steps 1–5, and then reverse roles.  
**Demonstration:** Trainer asks a learner to play the role of a client interested in an IUD. She does not wish to become pregnant again until her 2-month-old baby is at least 2 years old. The trainer demonstrates steps 6–12 on the algorithm.  
**Role Play:** Learners pair up to role play provider and client through steps 6–12, and then reverse roles. Invite several learners to present their role plays (steps 1–12) for group feedback. Allow the learners doing the role play to provide their own feedback first. Then the rest of the learners provide feedback, starting with what was done well and then areas for improvement. | Chapter 2 in *Providing Contraceptive Implants: Reference Manual*  
Appendix A: Counseling Guidelines in *Providing Contraceptive Implants: Reference Manual*  
Balanced Counseling Strategy materials: Print and share any of the materials from the BCS site that are relevant in the country: [http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service](http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service)  
Course Handbook for Learners: Counseling Role Play Scenarios  
Bar graph that trainer has made to represent 25% of what is heard, 45% what is heard and seen, and 70%+ what is heard, seen, and experienced. |
<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives Subject Title</th>
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<tbody>
<tr>
<td>1 hour</td>
<td><strong>Session Two: Day One, Afternoon (13:30–17:30)</strong></td>
<td><strong>25 minutes</strong> Assess learners’ precourse knowledge. Identify individual and group learning needs.</td>
<td><strong>Review Precourse Questionnaire</strong></td>
<td><strong>Course Notebook for Trainers:</strong> Questionnaire Answer Key</td>
</tr>
<tr>
<td></td>
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<td>Results of course questionnaire (the same questionnaire is used for precourse and mid-course assessment)</td>
<td><strong>Exercise:</strong> Group grades questionnaires and completes Individual and Group Assessment Matrix.</td>
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<tr>
<td>25 minutes</td>
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<td><strong>Demonstration:</strong> Half of the learners observe one- or two-rod implant insertion on RITA model. Introduce the checklist and refer to it throughout the demonstration. Invite a learner to read aloud the steps in the checklist as the trainer demonstrates. Also use the animated video showing insertion. The other half of the learners observes IUD insertion while following along on their checklist.</td>
<td><strong>Chapter 5 in Providing Contraceptive Implants: Reference Manual</strong></td>
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<td></td>
<td><strong>Chapter 5 in IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</strong></td>
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<td></td>
<td><strong>Course Handbook for Learners:</strong> Checklists for IUD and implant insertion</td>
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<td>Videos, screen, laptop, and multimedia projector</td>
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</table>
## Model Long-Acting Reversible Contraceptive Methods Course Outline (Standard Course: 5 Days, 10 Sessions)

<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives Subject Title</th>
<th>Learning Assessment Method</th>
<th>Activities</th>
<th>Resources/Materials</th>
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</thead>
<tbody>
<tr>
<td>90 minutes</td>
<td>Contributes to Training Objectives 4-6 Practice on LARC models using checklists</td>
<td></td>
<td><strong>Simulated Practice in Small Group Work:</strong> Divide the learners into groups of three: one is the client, one is the observer (reading the checklist), and the third is the provider. Ensure that there are four or five stations set up for learners to practice with model arms and ZOE pelvic models, handwashing materials, instruments, gloves, sharps containers, and decontamination pails. Learning IUD insertion takes longer than learning implant insertion. Ensure that the learners move from the pelvic to the arm models. In many countries, women prefer contraceptive implants to IUDs. The trainers should decide if this is the case in the country where the training is taking place. If so, the learners should practice implants so that they are prepared for the clinical practicum the following morning. There will be more time for practice on the models until ALL demonstrate LARC competency on the models.</td>
<td>Stations with pelvic and arm models, syringes, needles, antiseptic solution, sterile gloves, gally pot, forceps, pick-ups, cotton balls, implants (expired ones or placebo implants), surgical tape, bandage to wrap after insertion, a method of hand hygiene, sharps container and decontamination bucket, IUD insertion kits (speculum, tenaculum, ring forceps, gally pot, uterine sound and expired IUDs) Chapters 2 and 4 in <em>Providing Contraceptive Implants: Reference Manual</em> Chapters 4 and 5 in <em>IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</em> Appendix A in <em>Providing Contraceptive Implants: Reference Manual</em> Balanced Counseling Strategy materials: Print and share any of the materials from the BCS site that are relevant in the country: <a href="http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service">http://www.popcouncil.org/research/the-balanced-counseling-strategy-plus-a-toolkit-for-family-planning-service</a> Course Handbook for Learners: Checklists for implant and IUD insertion</td>
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<td>Time</td>
<td>Learning Objectives Subject Title</td>
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<td>Activities</td>
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| 10 minutes | Review the day’s activities      |                           | **Discussion:** Ask the learners for key aspects of counseling and providing contraceptive implant and IUD services. (The instructor will need to provide structure for this.)  
Briefly tell learners about the next day’s activities.  
Ask the learners complete a short evaluation form. | Short evaluation form, to be filled out anonymously and handed in; instructor reviews feedback after the group has left for the day |
| End of Day | Ask learners to write one thing that was helpful and one thing that needs to be improved. Provide suggestions and give them a piece of paper—learners’ names should not be on their papers. **Assignments:** Learners are asked to skim Chapter 1 and focus on Chapters 2–5 and 8. They should also review BCS cards, especially cards 13–18, if they are relevant to their work. Remind learners that tomorrow morning’s session starts in the clinical setting and they should come in clinic-appropriate attire and bring identification (if necessary). Trainers debrief for 30 minutes. |

**Session Three: Day Two, Morning (08:30–12:30)**

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<th>Time</th>
<th>Learning Objectives Subject Title</th>
<th>Learning Assessment Method</th>
<th>Activities</th>
<th>Resources/Materials</th>
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</thead>
</table>
| 15 minutes | Contributes to Training Objectives 5 and 6  
Clinical practicum on LARC services |                           | Meet at clinical site per instructions provided the day before. Ensure no more than five learners per trainer.  
**Demonstration:** Trainer inserts implant with a client. Learners follow procedure using checklist. | **Course Handbook for Learners:** Checklists for implant and IUD insertions  
White lab coat                                                                                         |
| 15 minutes | Contributes to Training Objectives 5 and 6  
Clinical practicum on LARC services |                           | **Demonstration:** Trainer inserts an IUD with a client. Learners follow procedure using checklist.  
IUD insertion and removal checklist                                                                        |                                                                                                            |
| 105 minutes| Contributes to Training Objectives 5 and 6  
Clinical practicum on LARC services |                           | **Clinical Practice:** Divide into smaller groups.  
**Competency-Based Evaluation in Clinical Setting:** By trainer using checklist  
**Competency-Based Evaluation in Simulated Setting:** By trainer using checklist | **Course Handbook for Learners:** Checklists for implant insertions  
The trainers may need to divide the group so that those who demonstrated competency on the model remain at the clinic setting with a trainer and the others remain in the classroom to continue practicing. Depending on the number of trainers and clinical settings, a second group of learners can go to another clinical site. |
<p>| 15 minutes | Return to classroom and break     |                           |                                                                                                                                                |                                                                                                            |</p>
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<tr>
<th>Time</th>
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<tr>
<td>30 minutes</td>
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<td><strong>Clinical Conference</strong>: Learners present their clinical cases on counseling, infection prevention practices, clinical insertion, and post-insertion counseling.</td>
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<td>60 minutes</td>
<td><strong>Contributes to Training Objective 7</strong>&lt;br&gt;<strong>Infection prevention discussion</strong></td>
<td>Interactive discussion with responses from learners</td>
<td><strong>Discussion</strong>: Infection prevention practices needed for method-specific counseling and client instructions following insertion or removal&lt;br&gt;&lt;br&gt;&lt;strong&gt;Demonstrations**: Correct handwashing, use of high-level disinfection (HLD) and putting on sterile gloves, making decontamination solution and alcohol rub</td>
<td>Chapter 4 in <em>Providing Contraceptive Implants: Reference Manual</em>&lt;br&gt;Chapter 3 in <em>IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</em>&lt;br&gt;Appendixes D and E in <em>Providing Contraceptive Implants: Reference Manual</em>&lt;br&gt;Materials for demonstration</td>
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<td>1 hour</td>
<td>Lunch</td>
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<td>Time</td>
<td>Learning Objectives Subject Title</td>
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| 90 minutes | **Session Four: Day Two, Afternoon (13:30–17:30)** | **Competency-based evaluation in skills lab by trainer using checklist** | **Classroom Practice:** Learners practice IP practices through skills lab. Skills lab set-up of above demonstrations on IP practice, decontamination, washing, and HLD, and making alcohol hand scrub:  
  - **Station 1:** Handwashing: water, soap, and paper towel; handrub (learners can make their own: 2 ml of glycerin in 100 mL of 60–90% ethyl or isopropyl alcohol); and containers  
  - **Station 2:** Putting on sterile gloves: several packs of sterile gloves of different sizes (7–8)  
  - **Station 3:** Two pails decontamination, wash with scrub brush, and personal protective gear (waterproof apron, heavy duty gloves, and face shield). Learners will make correct chlorine solution, so make sure to have chlorine, measuring cup, and water to make a 5% solution (formula: total parts water+(% concentrate/%dilute)–1) See: http://reprolineplus.org/resources/reference-manual-infection-prevention-guidelines-healthcare-facilities-limited-resources | Chapter 4 in *Providing Contraceptive Implants: Reference Manual*  
Chapter 3 in *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual*  
Appendixes D and E in *Providing Contraceptive Implants: Reference Manual*  
Materials for Skills Lab:  
- Pails (3)  
- Chlorine bleach (note concentration to make correct dilution)  
- Measuring cup to make correct chlorine solution  
- Scrub brush  
- Water-impermeable apron  
- Household gloves  
- Face shield  
- Alcohol at 60% (enough so that each learner can make alcohol handrub in 100 mL containers)  
- Enough 100 mL containers with securely closed tops  
- Sharps box |
| 15 minutes | Break | | | |
### Model Long-Acting Reversible Contraceptive Methods Course Outline (Standard Course: 5 Days, 10 Sessions)

<table>
<thead>
<tr>
<th>Time</th>
<th>Learning Objectives Subject Title</th>
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</table>
| 30 minutes | Contributes to Training Objective 8 | Competency-based evaluation in a simulated setting by trainer using removal checklist | Interactive Presentation: Use video presentation to discuss removal procedure.  
Video showing removal of Jadelle and/or Implanon  
Course Handbook for Learners: Checklist for Implant Counseling and Clinical Skills: Removal  
Jadelle Subdermal Implant Training Model or RITA (training arm) with trocar, insertion/removal kit, and placebo rods |
| 90 minutes | Contributes to Training Objective 8 Implant and IUD removal | Competency-based evaluation in a simulated setting by trainer using removal checklist | Clinical Practice: Learners pair up: one practices implant removal on the training arm while the other assesses performance using the checklist; then they switch roles. Then they practice IUD insertion and removal on ZOE model.  
Counseling Practice: Practice counseling on procedure, follow-up, and if client desires another family planning method or desires another pregnancy. | Chapter 8 in *Providing Contraceptive Implants: Reference Manual*  
Chapter 5 in *IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual*  
Course Handbook for Learners: Checklists for removal of IUDs and implants |
<p>| 15 minutes | Review the day’s activities | | Discussion | |
| End of Day | Ask learners to write one thing that was helpful and one thing that needs to be improved. Provide suggestions and give them a piece of paper—learners’ names should not be on the paper. Give Assignment: Learners are to practice removals on the training arm in the evening (one model per team of two learners) and perform a minimum of 10 removals. Reading Assignment: Reference manual: Chapters 6 in <em>IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</em> and Chapters 6–9 in <em>Providing Contraceptive Implants: Reference Manual</em>; remind them to meet at the clinic in the morning. Trainers debrief for 30 minutes. |</p>
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<tr>
<th>Time</th>
<th>Learning Objectives Subject Title</th>
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<th>Activities</th>
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<tr>
<td>30 minutes</td>
<td><strong>Session Five: Day Three, Morning (08:30–12:30)</strong>&lt;br&gt;Contributes to Training Objective 8 LARC clinical practicum (observation)</td>
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<td>Meet at clinical site per instructions provided the day before. &lt;br&gt;Ensure no more than five learners per trainer. &lt;br&gt;&lt;strong&gt;Demonstration:&lt;/strong&gt; Trainer demonstrates implant removal with a client. Learners follow procedure using checklist.</td>
<td>White lab coat &lt;br&gt;&lt;strong&gt;Course Handbook for Learners: &lt;/strong&gt;Checklists for removal of IUDs and implants</td>
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<td>120 minutes</td>
<td><strong>Session Five: Day Three, Morning (08:30–12:30)</strong>&lt;br&gt;Contributes to Training Objectives 5, 6, and 8 LARC clinical practicum (practice)</td>
<td>Competency-based evaluation in clinical setting by trainer using checklists</td>
<td><strong>Clinical Practice:</strong> Provide implant and IUD services to available clients under supervision of the trainer. &lt;br&gt;&lt;strong&gt;Course Handbook for Learners: &lt;/strong&gt;Checklists for insertion and removal of implants (any that apply in country)</td>
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<td>30 minutes</td>
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<td><strong>Clinical Conference:</strong> Learners discuss their clinical experience in terms of counseling, infection prevention practices, and clinical skills.</td>
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<td>60 minutes</td>
<td><strong>Session Five: Day Three, Morning (08:30–12:30)</strong>&lt;br&gt;Contributes to Training Objective 9 Managing side effects and potential problems</td>
<td>Group presentation Course questionnaire (section: Follow-Up, Side Effects, and Other Problems)</td>
<td><strong>Small Group Work:</strong> Divide the group into five small groups and ask each group to use the reference manual to look up their assigned side effects or other problems for both implants and IUDs. &lt;br&gt;&lt;strong&gt;Group 1:** Menstrual changes &lt;br&gt;&lt;strong&gt;Group 2:** Lower pelvic pain; increased menstrual cramping &lt;br&gt;&lt;strong&gt;Group 3:** Vaginal discharge &lt;br&gt;&lt;strong&gt;Group 4:** Weight gain &lt;br&gt;&lt;strong&gt;Group 5:** Other health problems &lt;br&gt;Allow 30 minutes for the groups to develop a response; then give each group five minutes to present.</td>
<td>Chapters 6 and 7 in Providing Contraceptive Implants: Reference Manual &lt;br&gt;Chapter 6 in IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</td>
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<tr>
<td>1 hour</td>
<td>Lunch</td>
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## Model Long-Acting Reversible Contraceptive Methods Course Outline (Standard Course: 5 Days, 10 Sessions)

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<tr>
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<td></td>
<td><strong>Session Six: Day Three, Afternoon (13:30–17:30)</strong></td>
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</table>
| 30 minutes | Evaluate class understanding | Course questionnaire (use questionnaire now for end-of-training assessment) | **Administer Mid-Course Questionnaire:** Instruct learners to put their number on the questionnaire and not their name.  
One trainer will need to score the questionnaires. One trainer will need to meet with any learner who did not score 85% or above and review the gap. The trainer should present the information so that the learner understands and succeeds. | **Course Notebook for Trainers:**  
Course questionnaire |
| 60 minutes | Contributes to Training Objective 10 Monitoring and evaluating LARC services |   | **Interactive Discussion:** Ask the learners why monitoring and evaluation is important; brainstorm how to report on reasons clients request early removal.  
**Managing Forecasting and Resupply** registers (for review and discussion by the group) |   | **Chapter 9 in Providing Contraceptive Implants: Reference Manual**  
Examples of local facility data collection tools and forecasting/supply registers |
| 60 minutes | Contributes to Training Objective 10 Develop action plan to implement LARC services |   | **Interactive Discussion:** Ask the learners how they plan to bring what they have learned in the training to their facility.  
**Small Group Work:** Divide learners up so that they are in small groups with other learners from their facility or district (or similar type grouping). Ask them to use the illustrative action plan and blank template to plan for contraceptive implant and IUD service provision at their facility. |   | **Course Handbook for Learners:**  
Blank Action Plan  
Illustrative example of action plan  
**Chapter 9 in Providing Contraceptive Implants: Reference Manual** |
<p>| End of Day | Ask learners to write one thing that was helpful and one thing that needs to be improved. Provide suggestions and give them a piece of paper—learners’ names should not be on the paper. <strong>Reading Assignment:</strong> Review implant reference manual for possible questions about setting up implants services. Remind learners to meet at the clinic in the morning. Trainers debrief for 30 minutes. |   |   |   |</p>
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<thead>
<tr>
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<td></td>
<td><strong>Session Seven: Day Four, Morning (08:30–12:30)</strong></td>
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<tr>
<td>120 minutes</td>
<td>Contributes to Training Objectives 4–8 Clinical practicum</td>
<td>Competency-based evaluation in clinical setting by trainer using counseling, insertion, and removal checklists</td>
<td>Learners practice counseling, insertion, and removal of implants and IUDs on clients under supervision of trainers.</td>
<td>Course Notebook for Trainers: Checklists for implant and IUD insertion and removal</td>
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<tr>
<td>60 minutes</td>
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<td>Clinical Conference: Learners discuss their clinical experience in terms of counseling, infection prevention practices, and clinical skills.</td>
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<td>30 minutes</td>
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<td>Review end-course questionnaires. Redistribute so that each learner has his own questionnaire; review answers and areas for ongoing improvement.</td>
<td>Course Notebook for Trainers: Course Questionnaire Answer Key</td>
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<td>1 hour</td>
<td>Lunch</td>
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<td><strong>Session Eight: Day Four, Afternoon (13:30–17:30)</strong></td>
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<tr>
<td>120 minutes</td>
<td>Contributes to Training Objective 10 Implementation of LARC clinical services at learner’s site</td>
<td>Action plans: Each group presents an action plan (5 minutes each) and allows feedback from co-learners and trainers</td>
<td>Small Group Work: Divide learners up so that they are in a small group with other learners from the same facility, district, or similar type grouping (continuation of the action plan started on Day 3). Consider clinic flow, privacy issues, staffing to allow for LARCs every day, supplies, instruments, commodities, and storage of sterile and HLD materials.</td>
<td>Course Handbook for Learners: Blank Action Plan Illustrative example of action plan Chapter 9 in Providing Contraceptive Implants: Reference Manual</td>
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<td>60 minutes</td>
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<td>Interactive Discussion: Each group presents action plan (5 minutes each) and allows feedback from co-learners and trainers.</td>
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<td>End of Day</td>
<td>Daily evaluation: Ask learners to write one thing that was helpful and one thing that needs to be improved. Provide suggestions and give them a piece of paper</td>
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</table>
# Model Long-Acting Reversible Contraceptive Methods Course Outline (Standard Course: 5 Days, 10 Sessions)

<table>
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<tbody>
<tr>
<td><strong>Session Nine: Day Five, Morning (8:30–12:30)</strong></td>
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<tr>
<td>120 minutes</td>
<td>Learners practice counseling, insertion, and removal of implants and IUD on clients under supervision of trainers.</td>
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<tr>
<td></td>
<td>Learners practice counseling, insertion, and removal of implants and IUD on clients under supervision of trainers.</td>
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<td>Ensure that the learners demonstrate competency on clients. If there are not enough IUD clients, have the learners demonstrate on the ZOE model.</td>
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<td></td>
<td><strong>Course Notebook for Trainers:</strong> Checksheets for implant insertion and removal</td>
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<td>15 minutes</td>
<td>Break</td>
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<tr>
<td>60 minutes</td>
<td>Clinical review</td>
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<tr>
<td>45 minutes</td>
<td>Learners discuss their clinical experience in terms of counseling, infection prevention practices, and clinical skills.</td>
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<td>1 hour</td>
<td>Lunch</td>
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<td><strong>Session Ten: Day Five, Afternoon (13:30–14:30)</strong></td>
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<tr>
<td>15 minutes</td>
<td>Course evaluation</td>
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<tr>
<td>45 minutes</td>
<td>Recognition of learners’ progress and hard work</td>
<td>Closing</td>
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<td>Certificates of completion</td>
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Counseling Role Play Scenarios for Day 1 Counseling Activity

1. You are a 23-year-old married woman who has two young children. You want to wait two to three years before getting pregnant again. Your husband is not interested in family planning. You have not used modern contraceptive methods before. Your youngest child is 5 months old, and you are breastfeeding. You are very worried about using the IUD and refuse it if offered. You are not sure of your HIV status, but you think your husband had many partners before marriage. You have never been screened for cervical cancer.

2. You are a 26-year-old woman who gave birth four weeks ago. You have started mix feed because you are going back to work during the day in about two weeks and do not have enough milk to express. You previously used a three-month injectable but now want to change to a different method because you are tired of injections. You are on antihypertensive medication and your blood pressure is controlled.

3. You are an 18-year-old girl. You started your menstrual bleeding six days ago. You are sexually active in a mutually monogamous relationship. You want to avoid getting pregnant and want something easy to use to prevent pregnancy. Neither you nor your boyfriend wants to use condoms. Later on in the consultation you reveal that you had unprotected sex two days ago.

4. You are a 30-year-old married woman who does not want to have any more children. You already have four (your youngest child is 3 months old) and are tired and fed up with being pregnant. Your husband is interested in more children. He likes having sex frequently and does not like using condoms. You are afraid of injections. You have had mild seizures in the past and have taken medicine for them, but not since after your second pregnancy.
## Illustrative Action Plan to Add LARC Services
(for Action Planning Activities on Days 3 and 4)

<table>
<thead>
<tr>
<th>Activity</th>
<th>Who Is Responsible</th>
<th>Date This Activity Is Completed</th>
<th>Resources Needed To Achieve This Activity</th>
<th>Accomplished And Verified</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provide debrief on training with supervisor</td>
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<td>Training materials</td>
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<td></td>
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<td>Summary of training</td>
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<td>Share checklist and WHO Medical Eligibility Criteria on LARC</td>
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<td>WHO Medical Eligibility Criteria</td>
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<td>Checklists for counseling, insertion, and removal</td>
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<tr>
<td>Ensure that facility has space, privacy, instruments, and materials for</td>
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<td>Implant reference manual, Chapter 9</td>
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<td>safe and high-quality LARC services</td>
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<tr>
<td>Review infection prevention standards and practices</td>
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<td>Implant reference manual, Chapter 4</td>
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<td>IUD reference manual, Chapter 3</td>
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<td>Staffing</td>
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<td>Implant reference manual, Chapter 9</td>
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<td>Logistics</td>
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<td>Implant reference manual, Chapter 9</td>
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<tr>
<td>On-the-job training</td>
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<td>Chapters 1-5 in <em>IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual</em> and Chapters 1-7 in <em>Providing Contraceptive Implants: Reference Manual</em></td>
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<td>Counseling and clinical skills checklists for implants and IUDs</td>
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### Blank Action Plan to Add LARC Services

(For Learners to Use DURING Action Planning Activities on Days 3 and 4)

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<thead>
<tr>
<th>Activity</th>
<th>Who Is Responsible</th>
<th>Date This Activity Is Completed</th>
<th>Resources Needed To Achieve This Activity</th>
<th>Accomplished And Verified</th>
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</table>
**Knowledge Assessment**

**How the Results Will Be Used**

**Precourse**

The main objective of the *Precourse Questionnaire* is to assist both the *clinical trainer* and the *learner* as they begin their work together by assessing what the learners, both individually and as a group, know about the course topic. Providing the results of the precourse assessment to the learners enables them to focus on their individual learning needs. In addition, the questions alert learners to the content that will be presented in the course.

The questions are presented in a multiple choice format. A special form, the *Individual and Group Assessment Matrix*, is provided to record the scores of all learners. Using this form, the trainer and learners can quickly chart the number of correct answers for each of the 25 questions. By examining the data in the matrix, the group members can easily determine their collective strengths and weaknesses and jointly plan how best to use the course time to achieve the desired learning objectives.

*For the clinical trainer*, the questionnaire results will identify particular topics that may need additional emphasis during the learning sessions.

*For the learners*, the learning objective(s) related to each question and the corresponding chapter(s) in the reference manual are noted beside the answer column. To make the best use of the limited course time, learners are encouraged to address their individual learning needs by studying the designated chapter(s).

Before distributing the precourse questionnaire, the trainer should develop a key that has a listing of the learners’ names and a randomly assigned number for each learner. This key is only for the trainers. Give the learners their randomly assigned numbers with instructions to keep their numbers to themselves. The learners will write their number rather than their name on both the pre- and mid-course questionnaire. In this way, the learners can keep their questionnaire results confidential.

**Mid-Course**

The same questionnaire used at the beginning of the course will be used later in the course to assess knowledge acquisition. The questionnaire may be administered at the end of Day 3, so that the trainer has opportunity to address content that learners need to study further, or at the end of the course for a final assessment of learners’ knowledge.
# LARC Training Course: Individual and Group Assessment Matrix

<table>
<thead>
<tr>
<th>Question Number</th>
<th>Correct Answers (Learners)</th>
<th>CATEGORIES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td></td>
<td>Overview</td>
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<tr>
<td>2.</td>
<td></td>
<td>Counseling</td>
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<tr>
<td>3.</td>
<td></td>
<td>Infection Prevention</td>
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<tr>
<td>4.</td>
<td></td>
<td>Indications And Client Assessment</td>
</tr>
<tr>
<td>5.</td>
<td></td>
<td>Method Provision (Insertion And Removal)</td>
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<tr>
<td>6.</td>
<td></td>
<td>Side Effects</td>
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<td>7.</td>
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<td>25.</td>
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</table>
Precourse Questionnaire

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

**Overview**

1. Long-acting reversible contraceptives are best for a woman who:
   a. Does not want to have any more children
   b. Wants an effective, easy-to-use contraceptive method
   c. Has AIDS and is on antiretroviral therapy

2. The Copper T 380A IUD is effective for:
   a. 5 years
   b. 7 years
   c. 12 years

3. If inserted within the first days of menses, contraceptive implants are effective in preventing pregnancy:
   a. Within 24 hours
   b. Within 7 days
   c. After the next menses

4. Research studies confirm that IUDs are safe and extremely effective for:
   a. Women with current gonorrhoea or chlamydia
   b. Older women who already have many children
   c. Most women

**Counseling**

5. For a woman in good health, a contraceptive method is **BEST** selected by the:
   a. Woman herself
   b. Physician providing health services to the woman
   c. Woman’s husband

6. Which of the following may help a woman feel more confident about using contraceptive implants?
   a. Telling her that you think it’s the best method
   b. Comparing the effectiveness and side effects of contraceptive implants to other methods
   c. Stating that 98% of women using contraceptive implants experience no side effects, and the continuation rate is over 90%
7. During balanced counseling, the health worker:
   a. Provides in depth information on all of the family planning methods available so the client has comprehensive information to make her choice
   b. Asks questions and listens to the responses to eliminate family planning methods that are not appropriate for the client, and explains why to the client
   c. Uses the counseling cards to ask the client questions in front of other clients so that they hear information about family planning methods

8. Post-insertion counseling should inform the woman of common side effects of IUD use, such as:
   a. Heavy vaginal discharge requiring frequent personal hygiene (douching)
   b. Increased menstrual bleeding and cramping for first few months
   c. Increased risk of heart disease or stroke

**Infection Prevention**

9. To make items safer to handle during the cleaning process, instruments and gloves first should be:
   a. Rinsed in water and scrubbed with a brush before disinfecting by boiling
   b. Soaked in 0.5% chlorine solution for 10 minutes before cleaning
   c. Soaked overnight in 8% formaldehyde

10. Surgical (metal) instruments that have been decontaminated and thoroughly cleaned can be high-level disinfected by:
    a. Placing them in a dry heat oven at 100°C for 20 minutes
    b. Soaking them for 30 minutes in fresh 1–3% iodine solution
    c. Boiling them for 20 minutes

11. To reduce the risk of infection, before insertion or removal of a contraceptive implant, the health worker:
    a. Prepares the incision site with antiseptic only
    b. Asks the client to wash her upper inner arm with soap and water and then prepares the incision site with an antiseptic
    c. Prepares the site with an antiseptic and gives a three-day course of antibiotics

12. Standard precautions are intended for use with what kinds of patients?
    a. All patients
    b. Only patients living with HIV/AIDS or Hepatitis B
    c. Only patients with a known infection
Indications and Client Assessment

13. Which of the following MUST be included when screening a potential contraceptive implants client?
   a. A complete medical history, general examination, and pelvic examination
   b. A pelvic examination only if indicated—for example, to rule out pregnancy
   c. Basic laboratory tests for hemoglobin and liver function tests

14. A pelvic examination must be included in the examination of a prospective IUD client to:
   a. Collect specimens to test for sexually transmitted infections
   b. Do a Pap smear
   c. Determine the shape, position, size, and consistency of the uterus

15. A woman who has a past history of deep vein thrombophlebitis:
   a. Cannot use a contraceptive implant (category 4)
   b. Can use a contraceptive implant if there are no other available family planning options (category 3)
   c. Can use a contraceptive implant (category 2)

16. IUD insertion is contraindicated if a woman has:
   a. Trichomoniasis or monilia
   b. A current case of gonorrhea or chlamydia
   c. HIV infection

Method Provision (Insertion and Removal)

17. The IUD may be safely inserted:
   a. Any time during the menstrual cycle, provided the woman is not pregnant
   b. Only during the woman’s menses
   c. 48 hours after delivery

18. Contraceptive implants that have been inserted into the fat under the skin:
   a. May be easier to remove
   b. May be less effective because the hormone is released more slowly from the implant
   c. May be difficult to remove

19. What is the most important first step to facilitate removal of Jadelle implants after counseling the client?
   a. Advise her to thoroughly wash the arm that has the implant
   b. Provide 5 cc of local anesthesia over the implant
   c. Palpate the arm that has the implant and mark where the tips of the rods are felt
20. While inserting an IUD, the provider should:
   a. Withdraw the inserter tube to release the arms of the IUD after the inserter reaches the fundus
   b. Always use sterile gloves for insertion
   c. Provide a local anesthetic at 5 and 7 o’clock

21. Which of the following is a reason to remove an IUD:
   a. The woman requests removal for any reason
   b. The client has gonorrhea and accepts treatment
   c. The IUD thread is too long

**Side Effects and Problems**

22. What is a common menstrual change among Implanon users?
   a. Amenorrhea in about half of the users
   b. Irregular menses in the first three months, which may later become regular
   c. An increase in dysmenorrhea among 77% of users

23. A contraceptive implant user MUST return to the clinic if she has:
   a. Pus and bleeding at the insertion site
   b. Bruising at the insertion site
   c. Irregular bleeding or spotting

24. Following the insertion of an IUD, a woman should return to the clinic:
   a. Any time to discuss side effects or other problems, or if she wants to change the method
   b. After her next period or in three to six weeks (or at least within three months)
   c. In 12 years (for Copper T 380A), to have it removed or replaced

25. If a woman becomes pregnant with an IUD in place she is more likely to:
   a. Have a child with birth defects
   b. Have increased vaginal discharge if the IUD is left in place
   c. Develop a uterine infection if the IUD is left in place
Precourse Questionnaire—Answer Key

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Checklists for LARC Counseling and Clinical Skills

Using the Checklists

The checklists for LARC counseling and clinical skills focus on the key steps in the entire procedure. As the learner progresses through the course and gains experience, dependence on the checklists decreases and the learner becomes more competent. During the learning process, the checklists are used by the learner to guide each step, by trainers and peers as they coach learners, and by trainers as they evaluate learners’ performance during and at the end of the course. The checklists can also be used by learners when they are providing services in a clinical situation, to rate one another’s performance. The rating scale used is described below.

More information about the skills in the checklists can be found in Providing Contraceptive Implants: Reference Manual and IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual (chapters on counseling, insertion, and removal, and sections on the balanced counseling strategy) as well as in the training DVD. This facilitates learner review of essential information.

There are five checklists that can be used as part of this learning resource package:

- Checklist for Two-Rod Implants (Jadelle and Sino-implant II) Counseling and Clinical Skills: Insertion
- Checklist for One-Rod Implanon Implants Counseling and Clinical Skills: Insertion
- Checklist for One-Rod Implanon NXT Implants Counseling and Clinical Skills: Insertion
- Checklist for Contraceptive Implant Counseling and Clinical Skills: Removal
- Checklist for Regular Copper T 380A IUD Counseling and Clinical Skills

The checklists in the Course Handbook for Learners and reference manual are the same as the checklists provided here in the Course Notebook for Trainers. The clinical trainer will use them to evaluate each learner’s performance at the end of the course.

The learner is not expected to perform all of the steps or tasks on the checklists correctly the first time she/he practices them. Instead, the checklists are intended to:

- Assist the learner in learning the correct steps and the sequence in which they should be performed (skill acquisition); and
- Measure progressive learning in small steps as the learner gains confidence and skill (skill competency).

Before using the checklists, the clinical trainer will review the entire counseling, insertion, and removal process, with the learners following along on the checklist. To ensure active participation, some trainers ask the learners to call out the steps. In addition, each learner will have the opportunity

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4 In some countries, Sino-implant II is registered under the trade name Zarin.
to witness a counseling demonstration session, LARC insertion and removal using an appropriate training model (Rita or ZOE), and/or the activity being performed in the clinic with a client. Thus, by the time the group breaks up into teams to begin practicing and rating each other’s performance, each learner should be familiar with the processes for counseling a client and inserting and removing both IUDs and contraceptive implants.

Used consistently, the checklists enable each learner to chart her/his progress and to identify areas for improvement. Furthermore, the checklists are designed to make communication (especially coaching and feedback) between the learner and the clinical trainer easier and more helpful. When using a checklist, the learner and clinical trainer should work together as a team. For example, before the learner attempts the skill or activity for the first time, the clinical trainer (or person rating the learner, if not the clinical trainer) should briefly review the steps involved and discuss the expected outcome. In addition, immediately after the skill or activity has been completed, the clinical trainer or rater should meet with the learner. The purpose of this meeting is to provide positive feedback regarding the learner’s progress and to define the areas (knowledge, attitude, or practice) that need improvement in subsequent practice sessions.
Checklist for Two-Rod Implants (Jadelle and Sino-Implant II) Counseling and Clinical Skills: Insertion

Rate the performance of each step or task observed using the following rating scale:

<table>
<thead>
<tr>
<th>Place a “Y” in the case box if the step/task is performed satisfactorily, an “N” if it is not performed satisfactorily, or an “X” if it is not observed.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Satisfactory:</strong> Performed the step or task according to the standard procedure or guidelines</td>
</tr>
<tr>
<td><strong>Unsatisfactory:</strong> Unable to perform the step or task according to the standard procedure or guidelines</td>
</tr>
<tr>
<td><strong>Not Observed:</strong> Step, task, or skill not performed by the learner during evaluation by clinical trainer</td>
</tr>
</tbody>
</table>

### Checklist For Two-Rod Implants (Jadelle and Sino-Implant II) Counseling and Clinical Skills: Insertion

<table>
<thead>
<tr>
<th>Step/Task</th>
<th>Cases</th>
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</thead>
<tbody>
<tr>
<td><strong>PRE-INSERTION COUNSELING</strong></td>
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<tr>
<td>1. Greet the client respectfully and with kindness.</td>
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<td>2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.</td>
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<td>3. Display the balanced counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client’s response:</td>
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<td>- Does the client want more children in the future?</td>
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<td>- Is she breastfeeding an infant &lt; 6 months old?</td>
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<tr>
<td>- Will her partner use condoms?</td>
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<tr>
<td>- Has she not tolerated an family planning method in the past?</td>
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<tr>
<td>4. Continue with balanced counseling, using the cards to:</td>
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<tr>
<td>- Give information about the methods on the cards that are left.</td>
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<tr>
<td>- Discuss side effects and efficacy.</td>
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<tr>
<td>- Help the client choose a method.</td>
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<tr>
<td>- Confirm the client’s method choice.</td>
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<tr>
<td>5. Review medical eligibility:</td>
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<tr>
<td>- Read from the client brochure in language the client understands (e.g., “Method not advised if you ...”).</td>
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<tr>
<td>6. Review Client Screening Checklist to determine if two-rod implants are an appropriate choice for the client.</td>
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<tr>
<td>7. Perform (or refer for) further evaluation, if indicated.</td>
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<tr>
<td>8. Assess the woman’s knowledge about the major side effects of implants:</td>
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<tr>
<td>- Confirm that the client accepts possible menstrual changes with implants.</td>
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<tr>
<td>9. Describe the insertion procedure and what to expect.</td>
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</tbody>
</table>

### INSERTION OF TWO-ROD IMPLANTS

#### Getting Ready

<table>
<thead>
<tr>
<th>Step</th>
<th>Cases</th>
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</thead>
<tbody>
<tr>
<td>1. Determine that the required sterile or high-level-disinfected instruments and two implant rods are present.</td>
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<tr>
<td>2. Wash hands thoroughly and dry them.</td>
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<td>3. Check to be sure that the client has thoroughly washed and rinsed her entire arm.</td>
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<td>4. Tell the client what is going to be done and encourage her to ask questions.</td>
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<td>5. Position the woman’s arm and place a clean, dry cloth under her arm.</td>
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<tr>
<td>6. Mark the position on her arm for insertion of rods 6 cm to 8 cm above the elbow</td>
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<tr>
<td>Step/Task</td>
<td>Cases</td>
</tr>
<tr>
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<tr>
<td>fold (this should form a &quot;V&quot; pattern).</td>
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<tr>
<td>7. Put on sterile pair of hand gloves.</td>
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</tr>
</tbody>
</table>

**Pre-Insertion Tasks**

1. Set up sterile field and place implant rods and trocar on it.
2. Prepare insertion site with antiseptic solution.
3. Place sterile or high-level-disinfected drape over the arm (optional).
4. Inject 2 mL of 1% lidocaine just under the skin, raising a wheal at the insertion point and advancing up to 5 cm along the insertion track. Gently massage the area of infiltration.
5. Advance the needle about 4–5 cm and inject 1 mL of local anesthetic in each of two subdermal tracks.
6. Check for anesthetic effect before making skin incision.

**Insertion**

1. Insert trocar directly subdermally.
2. While tenting the skin, advance trocar and plunger to mark (1) nearest hub of trocar.
3. Remove plunger and load first rod into trocar with gloved hand or forceps.
4. Reinsert plunger and advance it until resistance is felt.
5. Hold plunger firmly in place with one hand and slide trocar out of incision until it reaches plunger handle.
6. Withdraw trocar and plunger together until mark (2) nearest trocar tip, just clear of incision (do not remove trocar from skin).
7. Move tip of trocar away from end of rod and hold rod out of the path of the trocar.
8. Redirect trocar about 15° and advance trocar and plunger to mark (1).
9. Insert the second rod using the same technique.
10. Palpate rods to check that two rods have been inserted in a V-distribution.
11. Palpate incision to check that both rods are 5 mm clear of incision.
12. Remove trocar only after insertion of second rod.
13. Optional: Ask the client to palpate the two rods prior to dressing.

**Post-Insertion Tasks**

1. Remove drape and wipe the client’s skin with alcohol.
2. Bring edges of incision together and close it using surgical tape; then cover it with a Band-Aid or tape on a piece of sterile gauze (2x2).
3. Apply pressure dressing snugly.
4. Before removing gloves, dispose materials by:
   - Placing used needle (without capping) and trocar in sharps container, and
   - Placing waste materials in leak-proof container or plastic bag.
5. Remove gloves by turning inside out and place them in leak-proof container or plastic bag.
6. Wash hands thoroughly and dry them.
7. Complete client record, including drawing position of rods.
### Checklist For Two-Rod Implants (Jadelle and Sino-Implant II) Counseling and Clinical Skills: Insertion

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<td><strong>POST-INSERTION COUNSELING</strong></td>
<td></td>
</tr>
<tr>
<td>1. Instruct the client regarding wound care and make a return visit appointment, if necessary.</td>
<td></td>
</tr>
<tr>
<td>2. Discuss what to do if the client experiences any problems or side effects following insertion.</td>
<td></td>
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<td>3. Assure the client that she can have rods removed at any time if she desires.</td>
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<td>6. Observe the client for at least 15–20 minutes before sending her home.</td>
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</table>

**Comments:**

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________

**Observation Summary (tick as appropriate):**

| Model practice satisfactory | Yes ___ No ___ | NA ___ |
| Clinical practice satisfactory | Yes ___ No ___ |
| Competent in two-rod implants | ____ | Not competent in two-rod implants ____ |

**Action Plan – Check all that apply:**

- ____ Could become competent with additional experience (more cases) supervised by a competent provider/trainer
- ____ Follow-up visit in 3–6 months
- ____ Other (specify)

**Assessor’s name:**

**Assessor’s signature:**

**Date:**
Checklist for One-Rod Implanon Implants Counseling and Clinical Skills: Insertion

Rate the performance of each step or task observed using the following rating scale:

Place a “Y” in the case box if the step/task is performed satisfactorily, an “N” if it is not performed satisfactorily, or an “X” if it is not observed.

**Satisfactory:** Performed the step or task according to the standard procedure or guidelines

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

**Not Observed:** Step, task, or skill not performed by the learner during evaluation by clinical trainer

<table>
<thead>
<tr>
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<tbody>
<tr>
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</tr>
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</tr>
<tr>
<td>2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.</td>
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<td>3. Display the balanced counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client’s response:</td>
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<td>9. Describe insertion procedure and what to expect.</td>
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**INSERTION OF ONE-ROD IMPLANT**

**Getting Ready**

1. Determine that the required materials and the one-rod implant are present.
2. Wash hands thoroughly and dry them.
3. Check to be sure that the client has thoroughly washed and rinsed her arm.
4. Tell the client what is going to be done and encourage her to ask questions.
### Checklist For One-Rod Implanon Implants Counseling And Clinical Skills: Insertion

<table>
<thead>
<tr>
<th>Step/Task Activity</th>
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<tbody>
<tr>
<td>5. Position the woman’s arm and place a clean, dry cloth under her arm.</td>
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<td>7. Put on a pair of clean examination gloves.</td>
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#### Pre-Insertion Tasks

1. Prepare the insertion site with antiseptic solution.
2. Inject 1 mL of 1% lidocaine just under the skin, raising a wheal at the insertion point and advancing up to 5 cm along the insertion track. Gently massage the area of infiltration.
3. Check for anesthetic effect before applying the sharp needle.

**Insertion**

1. Using the no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)
2. Visually verify the presence of the implant inside the metal part of the needle.
3. Stretch the skin around the insertion site with thumb and index finger. Alternatively, stretch the insertion site skin by slightly pulling with thumb.
4. Using the needle, puncture the skin at a 20° angle and insert only up to the bevel of the needle.
5. Release the skin. Lower the applicator to a horizontal position.
6. Gently advance, while lifting the skin, forming a tent, until inserting the full length of the needle without using force. Keep the applicator parallel to the surface of the skin.
7. Break the seal of applicator. Turn the obturator 90 degrees.
8. Fix the obturator with one hand against the arm and with the other hand slowly pull the needle out of the arm; never push against the obturator.
9. Remove the needle and apply pressure to the opening site.
10. Palpate to check that the rod is in place. Optional: Ask the client to palpate the implant before dressing.

#### Post-Insertion Tasks

1. Wipe the client’s skin with alcohol.
2. Bring edges of incision together and close it using surgical tape; then cover it with a Band-Aid or tape on a piece of sterile gauze (2x2).
3. Apply pressure dressing snugly.
4. Before removing gloves, dispose materials by:
   - Placing used needle (without capping) and trocar in sharps container, and
   - Placing waste materials in leak-proof container or plastic bag.
5. Remove gloves by turning inside out and place them in leak-proof container or plastic bag.
6. Wash hands thoroughly and dry them.
7. Complete client record, including drawing position of rod.

### POST-INSERTION COUNSELING

1. Instruct the client regarding wound care and make return visit appointment, if necessary.
### Checklist For One-Rod Implanon Implants Counseling And Clinical Skills: Insertion

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**Comments:**

________________________________________________________________________
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**Observation Summary (tick as appropriate):**

| Model practice satisfactory | Yes ___ No ___ | Clinical practice satisfactory | Yes ___ No ___ |
| NA ___ | Competent in one-rod implants (Implanon) | Not competent in one-rod implants (Implanon) |
|       |       |       |

**Action Plan – Check all that apply:**

- ___ Could become competent with additional experience (more cases) supervised by a competent provider/trainer
- ___ Follow-up visit in 3–6 months
- ___ Other (specify)

**Assessor’s name:**

**Assessor’s signature:**

**Date:**
Checklist for One-Rod Implanon NXT Implants Counseling and Clinical Skills: Insertion

Rate the performance of each step or task observed using the following rating scale:

- Place a “Y” in the case box if step/task is performed satisfactorily, an “N” if it is not performed satisfactorily, or an “X” if it is not observed.

  **Satisfactory:** Performed the step or task according to the standard procedure or guidelines

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| **INSERTION OF ONE-ROD IMPLANT**                                        |       |
| **Getting Ready**                                                        |       |
| 1. Determine that the required materials and the one-rod implant are present. |       |
| 2. Wash hands thoroughly and dry them.                                  |       |
| 3. Check to be sure that the client has thoroughly washed and rinsed her arm. |       |
| 4. Tell the client what is going to be done and encourage her to ask questions. |       |
## Checklist For One-Rod Implanon NXT Implants Counseling And Clinical Skills: Insertion

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### Pre-Insertion Tasks

1. Prepare the insertion site with antiseptic solution.  
2. Inject 1 mL of 1% lidocaine applied just under the skin, raising a wheal at the insertion point and advancing up to 5 cm along the insertion track. Gently massage the area of infiltration.  
3. Check for anesthetic effect before applying the sharp needle.

### Insertion

1. Using the no-touch technique, remove the sterile disposable one-rod implant applicator from its blister pack and remove the needle shield. (Make sure not to touch the part of the needle to be introduced into the body.)  
2. Hold the applicator just above the needle at the textured surface area and remove the transparent protection cap from the needle containing the implant.  
3. Visually verify the presence of the implant inside the metal part of the needle.  
4. Stretch the skin around the insertion site with thumb and index finger. Alternatively, stretch the insertion site skin by slightly pulling with thumb.  
5. Sit down for the insertion. Using the needle, puncture the skin at a 30° angle and insert only up to the bevel of the needle.  
6. Lower the applicator to the horizontal position so that it is parallel to the surface of the skin while continuing to tent or lift the skin with the needle tip.  
7. While lifting the skin with the tip of the needle, slide the needle to its full length toward the guide mark. Make sure that the entire length of the needle is inserted under the skin by visualizing applicator from the side in your sitting position.  
8. While keeping the applicator in the same position and the needle inserted to its full length with one hand, unlock the purple slider by pushing it slightly down using the other hand.  
9. Move the slider fully back until it stops, leaving the implant now in its final subdermal position and locking the needle inside the body of the applicator.  
10. Remove the applicator.  
11. Palpate to check that one rod is in place. Optional: Ask the client to palpate the implant prior to dressing.

### Post-Insertion Tasks

1. Wipe the client’s skin with alcohol.  
2. Bring edges of incision together and close it using surgical tape; then cover it with a Band-Aid or tape on a piece of sterile gauze (2x2).  
3. Apply pressure dressing snugly.  
4. Before removing gloves, dispose materials by:  
   - Placing used needle (without capping) and trocar in sharps container, and  
   - Placing waste materials in leak-proof container or plastic bag.
### Checklist For One-Rod Implanon NXT Implants Counseling And Clinical Skills: Insertion

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<td>5. Remove gloves by turning inside out and place them in leak-proof container or plastic bag.</td>
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<td>7. Complete client record, including drawing position of rod.</td>
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#### POST-INSERTION COUNSELING

1. Instruct the client regarding wound care and make a return visit appointment, if necessary.
2. Discuss what to do if the client experiences any problems or side effects following insertion.
3. Assure the client that she can have implant removed at any time if she desires.
4. Ask the client to repeat the instructions and answer the client’s questions.
5. Complete client card indicating which implant she received and when she needs to return for removal.
6. Observe the client for at least 15–20 minutes before sending her home.

### Comments:

________________________________________________________________________
________________________________________________________________________
________________________________________________________________________

### Observation Summary (tick as appropriate):

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<tr>
<th>Model practice satisfactory</th>
<th>Yes</th>
<th>No</th>
<th>NA</th>
<th>Competent in one-rod implants (Implanon NXT)</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Clinical practice satisfactory</td>
<td></td>
<td></td>
<td></td>
<td>Not competent in one-rod implants (Implanon NXT)</td>
<td></td>
<td></td>
</tr>
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</table>

Action Plan – Check all that apply:

- [ ] Could become competent with additional experience (more cases) supervised by a competent provider/trainer
- [ ] Follow-up visit in 3–6 months
- [ ] Other (specify)

Assessor’s name:

Assessor’s signature: Date:
Checklist for Implant Counseling and Clinical Skills: *Removal*

Rate the performance of each step or task observed using the following rating scale:

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<tbody>
<tr>
<td><strong>Step/Task</strong></td>
</tr>
<tr>
<td><strong>PRE-REMOVAL COUNSELING</strong></td>
</tr>
<tr>
<td>1. Greet the client respectfully and with kindness.</td>
</tr>
<tr>
<td>2. Listen carefully to the client’s reason for removal to determine if she wants another method, is hoping to get pregnant, or wants to replace her implant.</td>
</tr>
<tr>
<td>3. Confirm with the client what her intentions are. Provide family planning counseling if appropriate.</td>
</tr>
<tr>
<td>4. Describe the removal procedure and what to expect. If she intends to have another implant, discuss with her where it will be inserted.</td>
</tr>
<tr>
<td>5. Ensure that the client is not allergic to the topical antiseptic or the local anesthetic that is available.</td>
</tr>
<tr>
<td><strong>REMOVAL OF IMPLANT ROD(S)</strong></td>
</tr>
<tr>
<td><strong>Getting Ready</strong></td>
</tr>
<tr>
<td>1. Determine that sterile instruments and other required materials for removal are available. Make sure a new implant is available if reinserting a new implant.</td>
</tr>
<tr>
<td>2. Check that the client has thoroughly washed and rinsed her arm.</td>
</tr>
<tr>
<td>3. Tell the client what is going to be done and encourage her to ask questions.</td>
</tr>
<tr>
<td>4. Position the woman’s arm and place a clean, dry cloth under her arm.</td>
</tr>
<tr>
<td>5. Palpate the rod(s) to determine point for removal.</td>
</tr>
<tr>
<td>6. With a waterproof marker, mark the client’s arm where the tip of the rod(s) is palpated.</td>
</tr>
<tr>
<td><strong>Pre-Removal Tasks</strong></td>
</tr>
<tr>
<td>1. Wash hands thoroughly and dry them.</td>
</tr>
<tr>
<td>2. Put sterile gloves on both hands.</td>
</tr>
<tr>
<td>3. Arrange instruments and supplies.</td>
</tr>
<tr>
<td>4. Prepare removal site with antiseptic solution twice.</td>
</tr>
<tr>
<td>5. Inject a small amount of local anesthetic (1% without epinephrine) at the incision site and under the end of the rod(s).</td>
</tr>
<tr>
<td>6. Check for anesthetic effect before making skin incision.</td>
</tr>
<tr>
<td><strong>Removal</strong></td>
</tr>
<tr>
<td>1. Push down the proximal end of the implant to stabilize it; a bulge may appear, indicating the distal end of the implant.</td>
</tr>
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</table>
## Checklist For Implant Counseling And Clinical Skills: Removal

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<td>2. Make a small (2 mm) incision below the ends of rod(s).</td>
<td></td>
</tr>
<tr>
<td>3. Push the end of rod toward the incision to remove it.</td>
<td></td>
</tr>
<tr>
<td>4. Grasp the end of rod with curved (mosquito or Crile) forceps.</td>
<td></td>
</tr>
<tr>
<td>5. Clean off fibrous tissue sheath that covers the tip of rod with sterile gauze (or scalpel—dull side).</td>
<td></td>
</tr>
<tr>
<td>6. Grasp exposed end of rod with second forceps. Gently remove and inspect the rod to ensure that it is intact before placing it in a bowl containing 0.5% chlorine solution for decontamination.</td>
<td></td>
</tr>
<tr>
<td>7. Ensure that the complete rod has been removed; show it to the client.</td>
<td></td>
</tr>
<tr>
<td>8. If this is a two-rod system, repeat steps 1–7.</td>
<td></td>
</tr>
</tbody>
</table>

**Re-Inserting Implant (one or two rods)**

<table>
<thead>
<tr>
<th>Step/Task</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The new implant rod(s) can be reinserted along the same track as the recently removed implant (if the woman chooses to have a new implant inserted).</td>
<td></td>
</tr>
<tr>
<td>2. Provide additional local anesthesia by infiltrating 1% lignocaine along the track(s) of the previously removed implant(s).</td>
<td></td>
</tr>
<tr>
<td>3. Wait for 1–2 minutes for the anesthetic to take effect.</td>
<td></td>
</tr>
<tr>
<td>4. Insert the one- or two-rod implant as per insertion steps (including post-insertion steps and post-insertion counseling).</td>
<td></td>
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**Post-Removal Tasks**

<table>
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<tr>
<td>1. Wipe the client’s skin with alcohol.</td>
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<td>2. Bring edges of incision together and close it using surgical tape; then cover it with a Band-Aid or tape on a piece of sterile gauze (2x2).</td>
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<td>3. Apply pressure dressing snugly.</td>
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<td>4. Before removing gloves, dispose materials by:</td>
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<td>• Placing used needle (without capping) and trocar in sharps container, and</td>
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<td>5. Remove gloves by turning inside out and place them in leak-proof container or plastic bag.</td>
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<td>2. Discuss what to do if any problems occur and answer the client’s questions.</td>
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<td>3. Counsel the client regarding new contraceptive method and provide one, if desired.</td>
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<td>4. Observe the client for at least 15–20 minutes before sending her home.</td>
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Comments:

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Observation Summary *(tick as appropriate)*:

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Action Plan – Check all that apply:

- [ ] Could become competent with additional experience (more cases) supervised by a competent provider/trainer
- [ ] Follow-up visit in 3–6 months
- [ ] Other (specify)

Assessor’s name: _________________________________

Assessor’s signature: ____________________________ Date: ________________________________
Checklist for Regular Copper T 380a IUD Counseling and Clinical Skills

Rate the performance of each step or task observed using the following rating scale:

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<thead>
<tr>
<th>Pre-Insertion Counseling</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Greet the client respectfully and with kindness.</td>
</tr>
<tr>
<td>2. Rule out pregnancy by asking the six questions to be reasonably sure that the woman is not pregnant.</td>
</tr>
<tr>
<td>3. Display the balanced counseling cards, and if the client has already identified a method, provide focused counseling on that method. Otherwise, ask the following four questions and eliminate cards according to the client’s response:</td>
</tr>
<tr>
<td>- Does the client want more children in the future?</td>
</tr>
<tr>
<td>- Is she breastfeeding an infant &lt;6 months old?</td>
</tr>
<tr>
<td>- Will her partner use condoms?</td>
</tr>
<tr>
<td>- Has she not tolerated an family planning method in the past?</td>
</tr>
<tr>
<td>4. Continue with balanced counseling, using the cards to:</td>
</tr>
<tr>
<td>- Give information about the methods on the cards that are left.</td>
</tr>
<tr>
<td>- Discuss side effects and efficacy.</td>
</tr>
<tr>
<td>- Help the client choose a method.</td>
</tr>
<tr>
<td>- Confirm the client’s method choice.</td>
</tr>
<tr>
<td>5. Review medical eligibility:</td>
</tr>
<tr>
<td>- Read from the client brochure in language the client understands (e.g., “Method not advised if you ....”).</td>
</tr>
<tr>
<td>6. Review Client Screening Checklist to determine if the IUD is an appropriate choice for the client.</td>
</tr>
<tr>
<td>7. Perform (or refer for) further evaluation, if indicated.</td>
</tr>
<tr>
<td>8. Assess the woman’s knowledge about the major side effects of IUDs.</td>
</tr>
<tr>
<td>- Confirm that the client accepts possible menstrual changes with IUDs.</td>
</tr>
<tr>
<td>9. Describe the insertion procedure and what to expect.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>IUD INSERTION</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Client Assessment</strong> (Use Appendix B in the IUD reference manual to confirm that the woman is eligible for IUD use.)</td>
</tr>
<tr>
<td>1. Review the client’s medical and reproductive history.</td>
</tr>
<tr>
<td>2. Ensure that equipment and supplies are available and ready to use.</td>
</tr>
<tr>
<td>3. Ask the client to empty her bladder and wash her perineal area.</td>
</tr>
<tr>
<td>4. Help the client onto the examination table.</td>
</tr>
<tr>
<td>5. Tell the client what is going to be done, and ask her if she has any questions.</td>
</tr>
</tbody>
</table>
## Checklist for Regular Copper T 380a IUD Counseling and Clinical Skills

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>6.</td>
<td>Wash hands thoroughly and dry them.</td>
</tr>
<tr>
<td>7.</td>
<td>Palpate the abdomen.</td>
</tr>
<tr>
<td>8.</td>
<td>Wash hands thoroughly and dry them again.</td>
</tr>
<tr>
<td>9.</td>
<td>Put clean gloves on both hands.</td>
</tr>
<tr>
<td>10.</td>
<td>Inspect the external genitalia.</td>
</tr>
</tbody>
</table>

**Note:**
- If findings are normal, perform the bimanual exam first and the speculum exam second.
- If there are potential problems, perform the speculum exam first and a bimanual exam second.

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>11a.</td>
<td>Perform a bimanual exam (see note above).</td>
</tr>
<tr>
<td>11b.</td>
<td>Perform rectovaginal exam only if indicated.</td>
</tr>
<tr>
<td>11c.</td>
<td>If rectovaginal exam is performed, change gloves before continuing.</td>
</tr>
<tr>
<td>12.</td>
<td>Perform a speculum exam if indicated.</td>
</tr>
</tbody>
</table>

(Note: If laboratory testing is indicated and available, take samples now.)

## Pre-insertion and Insertion Steps

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Give the client an overview of the insertion procedure. Remind her to let you know if she feels any pain.</td>
</tr>
<tr>
<td>2.</td>
<td>Gently insert the high-level-disinfected (HLD) or sterile speculum to visualize the cervix (if not already done), and cleanse the cervical os and vaginal wall with antiseptic.</td>
</tr>
<tr>
<td>3.</td>
<td>Gently grasp the cervix with an HLD (or sterile) tenaculum and apply gentle traction.</td>
</tr>
<tr>
<td>4.</td>
<td>Insert the HLD (or sterile) sound using the no-touch technique to fundus. Place ring forceps next to uterine sound at the cervix and carefully remove both sound and forceps together. Note where the ring forceps is on the uterine sound to determine uterine measurement.</td>
</tr>
<tr>
<td>5.</td>
<td>Load the IUD in its sterile package.</td>
</tr>
<tr>
<td>6.</td>
<td>Set the blue depth-gauge to the measurement of the uterus.</td>
</tr>
<tr>
<td>7.</td>
<td>Carefully insert the loaded IUD, and release the arms of the IUD into the uterus using the withdrawal technique.</td>
</tr>
<tr>
<td>8.</td>
<td>Gently push the insertion tube upward again until you feel a slight resistance (to ensure arms of IUD are in fundus).</td>
</tr>
<tr>
<td>9.</td>
<td>Withdraw the rod, and partially withdraw the insertion tube until the IUD strings can be seen.</td>
</tr>
<tr>
<td>10.</td>
<td>Use HLD (or sterile) sharp Mayo scissors to cut the IUD strings to 4 cm length if needed.</td>
</tr>
<tr>
<td>11.</td>
<td>Gently remove the tenaculum and speculum and place in 0.5% chlorine solution for 10 minutes for decontamination.</td>
</tr>
<tr>
<td>12.</td>
<td>Examine the cervix for bleeding.</td>
</tr>
<tr>
<td>13.</td>
<td>Ask how the client is feeling and begin performing the post-insertion steps.</td>
</tr>
</tbody>
</table>

## Post-Insertion Steps

**SKILL/ACTIVITY PERFORMED SATISFACTORILY**

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Before removing the gloves, place all used instruments in 0.5% chlorine solution for 10 minutes for decontamination.</td>
</tr>
<tr>
<td>2.</td>
<td>Properly dispose of waste materials.</td>
</tr>
<tr>
<td>3.</td>
<td>Process gloves according to recommended IP practices.</td>
</tr>
</tbody>
</table>
### Checklist for Regular Copper T 380a IUD Counseling and Clinical Skills

| 4. | Wash hands thoroughly and dry them. |
| 5. | Provide post-insertion instructions (key messages for IUD users): |
| | * Basic facts about her IUD (e.g., type, how long effective, when to replace/remove) |
| | * No protection against STIs; need for condoms if at risk |
| | * Possible side effects |
| | * Warning signs (PAINS) |
| | * How to check for possible IUD expulsion |
| | * When to return to clinic |

#### IUD REMOVAL

**Pre-Removal Steps**

1. Ask the woman her reason for having the IUD removed.
2. Determine whether she will have another IUD inserted immediately, start a different method, or neither.
3. Review the client’s reproductive goals and need for STI protection, and counsel as appropriate.
4. Ensure that equipment and supplies are available and ready to use.
5. Ask the client to empty her bladder and wash her perineal area.
6. Help the client onto the examination table.
7. Wash hands thoroughly and dry them.
8. Put new HLD gloves on both hands.

#### Removing the IUD

1. Give the client an overview of the insertion procedure. Remind her to let you know if she feels any pain.
2. Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic.
3. Alert the client immediately before you remove the IUD.
4. Grasp the IUD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.
5. Apply steady but gentle traction, pulling the strings toward you, to remove the IUD. **Do not use excessive force.**
6. Show the IUD to client.
7. Place the IUD in 0.5% chlorine solution for 10 minutes for decontamination.
8. If the woman is having a new IUD inserted, insert it now if appropriate. (If she is not having a new IUD inserted, gently remove the speculum and place it in 0.5% chlorine solution for 10 minutes for decontamination.)
9. Ask how the client is feeling and begin performing the post-removal steps.
### Checklist for Regular Copper T 380a IUD Counseling and Clinical Skills

#### Post-Removal Steps

1. Before removing the gloves, place all used instruments and the IUD in 0.5% chlorine solution for 10 minutes for decontamination.
2. Properly dispose of waste materials.
3. Process gloves according to recommended IP practices.
4. Wash hands thoroughly and dry them.
5. If the woman has had a new IUD inserted, review key messages for IUD users. [If the woman is starting a different method, provide the information she needs to use it safely and effectively (and a back-up method, if needed).]

### Comments:


### Observation Summary *(tick as appropriate):*

<table>
<thead>
<tr>
<th>Model practice satisfactory</th>
<th>Yes ____ No ____</th>
<th>Clinical practice satisfactory</th>
<th>Yes ____ No ____</th>
</tr>
</thead>
<tbody>
<tr>
<td>Competent in implant removal</td>
<td>____</td>
<td>Not competent in implant removal</td>
<td>____</td>
</tr>
</tbody>
</table>

**Action Plan – Check all that apply**

- ____ Could become competent with additional experience (more cases) supervised by a competent provider/trainer
- ____ Follow-up visit in 3–6 months
- ____ Other (specify)

**Assessor’s name:**

**Assessor’s signature:** ____________ **Date:** ____________
## LARC Course Evaluation

Please indicate your opinion of the course components using the following rating scale:

<table>
<thead>
<tr>
<th>5-Strongly Agree</th>
<th>4-Agree</th>
<th>3-No Opinion</th>
<th>2-Disagree</th>
<th>1-Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>COURSE COMPONENT</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1 The precourse questionnaire helped me to study more effectively.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2 The role play sessions on counseling skills were helpful.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3 There was sufficient time scheduled for practicing counseling through role play and with clients and volunteers.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4 The training slide set and DVD/video helped me get a better understanding of implant procedures prior to practicing with the training arm.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5 The practice sessions with the training arm and pelvic model made it easier for me to perform LARC insertion and removal with clients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>6 There was sufficient time scheduled for practicing implants and IUD insertion and removal with clients.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>7 The interactive training approach used in this course made it easier for me to learn how to provide LARC services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>8 Four days were adequate for learning how to provide LARC services.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>9 I feel confident in LARC insertion and removal.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>10 I feel confident in using the infection prevention practices recommended for implants and IUDs.</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### ADDITIONAL COMMENTS (use reverse side if needed)

1. What topics (if any) should be **added** (and why) to improve the course?

2. What topics (if any) should be **omitted** (and why) to improve the course?
Appendix 1: Powerpoint Thumbnails

Overview of Contraceptive Implants

What Are Contraceptive Implants?
- Hormonal implants are a progestin-only product; they contain no estrogen.
- The rods are inserted just under the skin (subdermally) on the inner side of a woman’s upper arm by means of a minor surgical procedure with local anesthetic.
- They come in one-rod and two-rod variations, depending on the product. The main difference between products is their effective life, and the way in which you insert the rods.

Effective Life
- If inserted anytime before the expiration date (shelf life), a set of Jadelle rods is effective for 5 years, and a set of Sino-implant (II) rods is effective for 4 years. Implanon and Implanon NXT are each effective for 3 years.
- The rods should be removed by the end of the final year of effective life.
- If desired, a new set of rods may be inserted in the same location immediately following removal.

How Do Contraceptive Implants Prevent Pregnancy?
- With all implants, pregnancy is prevented through a combination of mechanisms.
- The two primary means are:
  - Production of thick cervical mucus, which prevents sperm penetration, and
  - Inhibition of ovulation.

How Effective Are They?
- One of the most effective and long-lasting methods:
  - Less than 1 pregnancy per 100 women using implants over the first year (5 per 10,000 women).
- Implants start to lose effectiveness sooner for heavier women:
  - For women weighing 80 kg or more, Jadelle implants become less effective after 4 years of use. These users may want to replace their implants sooner.
  - One can extrapolate the same of other implants, and may elect to remove them one year earlier than their effective life. (Note that the protection afforded by the final year of a contraceptive implant in a heavier woman is still much more effective than most other methods.)
- Return of fertility after implants are removed: No delay.
Implants and STIs

Note: Because implants do not protect women from hepatitis B, AIDS, and other sexually transmitted infections (STIs), clients at risk for STIs should be encouraged to use a condom in addition to their hormonal contraception method. This combination of barrier and hormonal contraception constitutes "dual protection" against unplanned pregnancy and STIs/HIV.

What Are the Advantages of Contraceptive Implants?

- Very effective
- Easy to use
- Provide continuous protection for up to 3-5 years (depending on product)
- Convenient, comfortable, and reversible
- Immediate return to fertility
- Side effects resolve immediately after removal
- Few complications
- Suitable for nearly all women
- High continuation rates

Common Side Effect: Irregular Vaginal Bleeding

First several months:
- Lighter bleeding and fewer days of bleeding
- Irregular bleeding
- Infrequent bleeding
- No monthly bleeding

After about 1 year:
- Lighter bleeding and fewer days of bleeding
- Irregular bleeding
- Infrequent bleeding

Side Effects of Contraceptive Implants

<table>
<thead>
<tr>
<th>Method</th>
<th>Cumulative Percentage of Women</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vaginal discharge</td>
<td>24.3</td>
</tr>
<tr>
<td>Headache</td>
<td>23.5</td>
</tr>
<tr>
<td>Pelvic pain</td>
<td>20.4</td>
</tr>
<tr>
<td>Weight increase</td>
<td>13.9</td>
</tr>
<tr>
<td>bloatedness</td>
<td>10.7</td>
</tr>
<tr>
<td>Breast pain</td>
<td>8.8</td>
</tr>
<tr>
<td>Breast tenderness</td>
<td>7.7</td>
</tr>
<tr>
<td>Cervical</td>
<td>7.5</td>
</tr>
<tr>
<td>Nausea</td>
<td>6.7</td>
</tr>
</tbody>
</table>

Side effects reported more than once.


How to Prevent Client Dissatisfaction with Side Effects

- Side effects may cause concern among clients and cause early removal.
- Good counseling before insertion increases clients satisfaction and continuation rates.
- Careful explanation of the side effects before inserting implant rods, as well as reassurance that rarely are they a health risk, helps in decreasing concerns.

Complications

Uncommon:
- Infection at insertion site (most infections occur within the first 2 months after insertion).
- Difficult removal (rare if properly inserted and provider is skilled at removal).

Rare:
- Expulsion of implant (expulsions most often occur within the first 4 months after insertion).
- Adverse events are very rare.
Correcting Misunderstandings

- Implants:
  - Stop working once they are removed. Their hormones do not remain in a woman's body.
  - Can stop monthly bleeding, but this is not harmful. Blood is not building up inside the woman.
  - Do not make women infertile.
  - Do not move to other parts of the body.
  - Substantially reduce the risk of ectopic pregnancy.

Who Can and Cannot Use Implants

- Nearly all women can use implants safely and effectively, including women who:
  - Have or have not had children
  - Are not married
  - Are of any age, including adolescents and women over 40 years old
  - Have just had an abortion, miscarriage, or ectopic pregnancy
  - Smoke, regardless of age or number of cigarettes
  - Are breastfeeding (6 weeks after childbirth)
  - Have anemia now or in the past
  - Have varicose veins
  - Are living with HIV

When to Begin

- Women can begin using implants:
  - Without a pelvic examination
  - Without any blood tests or other routine laboratory tests
  - Without cervical cancer screening
  - Without a breast examination
  - Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant
Overview of Intrauterine contraceptive Devices (IUDs)

Presenters
Date

Types of IUDs

- Copper-bearing:
  - Copper T 380A
  - TCu 200C
  - Multiload Cu250 and Cu375
  - Nova-T
  * This learning package focuses on the Copper T 380A

- Levonorgestrel-releasing intrauterine system (IUS):
  - Mirena
  - Skyla

Copper-Bearing IUDs: Mechanisms of Action

- Interference with ability of sperm to pass through uterine cavity
- Decreases sperm motility and function
- Thickens cervical mucus
- Alternates the uterine and tubal environment

IUDs: Basic Attributes

- Highly effective (failure rate less than 1% in first year of use)
- Long-term protection (at least 12 years)
- Effective immediately
- Immediate return to fertility upon removal

IUDs: Other Reasons Women Like Them

In addition to reasons listed on previous slide:

- No hormonal side effects
- Inexpensive over time
- Convenient:
  - No day-to-day action needed
  - After first routine check-up, no need to return to clinic unless experiencing problems
  - No additional supplies needed
Resurgence of Interest in the IUD

- Despite persistent misconceptions, IUD users have higher satisfaction rates (99% versus 91% for pill users) and continuation rates than users of many other methods.
- Recent research has lead to important changes in WHO MEC.
- Risk of PID in IUD users is negligible.
- The IUD is appropriate for most women, including...

Resurgence of Interest in the IUD (cont.)

- Woman with the following characteristics/conditions:
  - Under 20 years of age and/or nulliparous.
  - HIV-infected and clinically well.
  - AIDS and on antiretroviral therapy (ART) therapy and clinically well.
  - History of ectopic pregnancy.
  - History of PID (assuming no known risk factors for sexually transmitted infections [STIs]).
  - Living in area with high STI prevalence (assuming no known risk factors for STIs).

IUDs: Side Effects

Menstrual problems:
- Increase in menstrual bleeding (up to 50%) and associated cramping/pain.
- Worse during first few months.
- Most common reason for removal.
- Cramping may occur during insertion and for several days afterward.
- Spotting/light bleeding may occur for the first few days or months after insertion.

How long are IUDs Effective?

- IUDs are effective up to 12 years, but can be used for shorter intervals too.
- What does the date on the package mean?
- Date that the package is still sterile—has nothing to do with the length of time that the IUD is effective.

How Effective Are They?

- One of the most effective and long-lasting methods.
- Less than 1 pregnancy per 169 women using IUDs over the first year (5 per 10,000 women).
- Weight has no impact on efficacy of copper IUDs. Return of fertility after implants are removed: No delay.

True or False?

- Women who have never been pregnant can use an IUD. TRUE
- IUD causes ectopic pregnancy. FALSE
- The IUD causes PID. FALSE
- A woman who has ever had STIs cannot use an IUD. FALSE
- A woman who has an IUD in place and gets gonorrhea must have her IUD removed. FALSE
- The IUD makes users sterile. FALSE
- Women living with HIV can use IUDs. TRUE
IUDS and STIs

Note: Women at risk for Gonorrhea or Chlamydia are not good candidates for IUDs.
- How do you determine?
- Advise the woman of the risk of developing PID if she is exposed to GC and Chlamydia.
- This risk is increased if she or her partner have multiple partners

How to Prevent Client Dissatisfaction with Side Effects

- Side effects may cause concern among clients and cause early removal.
- Good counseling before insertion increases clients satisfaction and continuation rates.
- Careful explanation of the side effects before inserting an IUD, as well as reassurance that rare events are a health risk, helps in decreasing concerns.

IUDs: Complications

Expulsion (uncommon):
- May be spontaneously expelled (2–8%)
- More common in first 3 months and during menstrual period

Uterine perforation (rare <1.5/1000 cases)
- Usually occurs during insertion
- Serious complications are rare

Infection (<1%)
- Increase in risk only in 20 days after insertion
- Due not to IUD itself, but to nonsterile insertion technique

When to Begin

Women can begin using IUDs:
- Without any blood tests or other routine laboratory tests
- Without cervical cancer screening
- Without a breast examination
- Even when a woman is not having monthly bleeding at the time, if it is reasonably certain she is not pregnant

Summary

- The IUD is a safe, very effective method for most women.
- Menstrual problems are the most common side effect and frequent cause for discontinuation.
- Few conditions are contraindications for IUD use.
- Some conditions present a problem for IUD initiation (insertion), but not continuation.
WHO Medical Eligibility Criteria and Contraceptive Implants

Presenters
Date

Providing Contraceptive Implants

What are the WHO Medical Eligibility Criteria?
- MEC identify when contraceptive method can be safely used in the presence of a given individual characteristic or medical condition.
- The MEC give guidance to providers for clients with medical conditions or special circumstances.

Available at: http://www.who.int/reproductive-health/who/medical-eligibility-categories.pdf

What is the Purpose of the WHO MEC?
- Guide health workers to provide family planning on the best available evidence.
- Address and change misconceptions about who can safely use a family planning method.
- Reduce medical policy and practice barriers that are not evidence-based.
- Improve quality, access, and use of family planning services.

WHO Medical Eligibility Criteria Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>Clinical Judgment</th>
<th>Limited Clinical Judgment</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>3</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

Case Studies: Use the WHO MEC Quick Reference Chart

- B.H. is a 23-year-old P3 who has a 4-month-old breastfeeding baby. She wants to avoid another pregnancy for at least 2 more years. She requests FP implants. Can she use them? Why or why not?
- F.O. is a 20-year-old nulligravida who wants to avoid pregnancy. Her last menstrual was 2 weeks ago and she requests FP implants. Can she use them? Why or why not?
- R.F. is a 30-year-old P3 who is living with HIV and requests FP implants. Can she use them? Why or why not?
- J.B. is a 35-year-old P4 who is currently on DMPA. She is requesting another DMPA but her BFP is 160/100. Is she a candidate for implants?
- L.B. is a 24-year-old P1 who has a seizure disorder and is taking anticonvulsant medication. She requests FP implants. Can she use them? Why or why not?

Objectives
- By the end of the session, learners will be able to understand who can use contraceptive implants based on WHO Medical Eligibility Criteria (MEC).
- Use the job aid: Quick Reference Chart Job Aid (FHI 360), full WHO MEC 2010.
### 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), progestin-only implants, copper intrauterine device (Cu-IUD)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>COC</th>
<th>DMPA</th>
<th>Implants</th>
<th>Cu-IUD</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnancy</td>
<td>Less than 6 weeks postpartum</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>6 weeks to &lt; 6 months postpartum</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Postpartum (non-breastfeeding)</td>
<td>&lt; 21 days</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
</tr>
<tr>
<td>VRE = venous thrombosis</td>
<td>&lt; 21 days with other risk factors for VTE*</td>
<td>NC</td>
<td>NC</td>
<td>NC</td>
</tr>
<tr>
<td>Postabortion</td>
<td>Immediate post-septic</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Smoking</td>
<td>Age ≥ 35 years, &lt; 15 cigarettes/day</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Multiple risk factors for cardiovascular disease</td>
<td>History of where BP cannot be evaluated</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Hypertension</td>
<td>BP is controlled and can be evaluated</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Deep venous thrombosis (DVT) and pulmonary embolism (PE)</td>
<td>History of DVT/PE</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Known thrombogenic mutations</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Known hyperlipidemias</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Complicated valvular heart disease</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Systemic lupus erythematosus</td>
<td>Positive or unknown antiphospholipid antibodies</td>
<td>I</td>
<td>C</td>
<td>I</td>
</tr>
<tr>
<td>Severe thrombocytopenia</td>
<td>Immunosuppressive treatment</td>
<td>I</td>
<td>C</td>
<td>I</td>
</tr>
<tr>
<td>Headaches</td>
<td>Non-migraines (mild or severe)</td>
<td>I</td>
<td>C</td>
<td>I</td>
</tr>
<tr>
<td>Migraine without aura (age &lt; 55 years)</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Migraine with aura (age ≥ 35 years)</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>LC</td>
<td>Initiation/Continuation: A woman may fall into either one category or another, depending on whether she is initiating or continuing to use a method. Where LC is not marked, the category is the same for initiation and continuation.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NA</td>
<td>Not Applicable: Women who are pregnant do not require contraception.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>NC</td>
<td>Not Covered: The condition is not part of the WHO classification for this method.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>*</td>
<td>Other risk factors for VTE include previous VTE, thrombophilia, immobility, transfusion at delivery, BMI &gt; 30 kg/m², postpartum hemorrhage, immediately post-delivery, prior edema, and smoking.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>**</td>
<td>Evaluation of an undiagnosed mass should be pursued as soon as possible.</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>***</td>
<td>Anticoagulants include phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 3 for implants.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### Contraindications

- **Unexplained vaginal bleeding (prior to evaluation):**
  - COC: I
  - DMPA: C
  - Implants: C
  - Cu-IUD: C

- **Gestational trophoblastic disease:**
  - COC: C
  - DMPA: C
  - Implants: C
  - Cu-IUD: C

- **Cancers:**
  - Cervical (including treatment)
  - Endometrial
  - Ovarian
  - Breast disease:
    - Unilateral mass
    - Postoperative with no evidence of current disease for 5 years
    - Cervical cancer
  - STIs/MCP:
    - Current sexually transmitted infections (STIs)
    - Chlamydia
    - Gonorrhea
    - Vaginitis
    - Chronic pelvic inflammatory disease (PID)
    - Other STIs (excluding HIV/hepatitis)
    - Increased risk of STIs
  - Pelvic tuberculosis:
    - Very high individual risk of exposure to STIs
    - Diabetes:
      - Nephropathy/retinopathy/neuropathy
      - Diabetes for > 20 years
    - Symptomatic gall bladder disease (current or medically treated)
      - Related to pregnancy
    - Cholestasis (history of):
      - Related to oral contraceptives
    - Hepatitis:
      - Acute or flare
      - Chronic or client is a carrier
    - Cirrhosis:
      - Mild
      - Severe
    - Liver tumors (hepatocellular adenoma and malignant hepatoma):
      - High risk of HIV or HIV-infected
    - HIV:
      - No antiretroviral therapy (ART)
      - Clinically well on ART therapy
      - Not clinically well on ART therapy
    - Drug interactions:
      - Rifampin or rifabutin

**This chart shows a complete list of all conditions classified by WHO as Category 3 and 4.**


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**Providing LARC: Course Notebook for Trainers**

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Appendix 2: Tips for Trainers

Creating a Positive Learning Environment

In addition to organizing the course, the trainer must be able to give presentations, conduct demonstrations, and lead other course activities—effectively and efficiently. This requires:

- Careful preparation;
- Timely execution of a plan for course preparation,
- Ensuring that the physical classroom and clinical environment are well suited to learning, and
- Effective training/facilitation skills (discussed in the next section).

Well-planned and well-executed classroom and clinical sessions help to create a positive learning environment. And a positive learning environment is critical to learning.

Being an Effective Clinical Trainer

Equally important as careful planning and preparation to creating a positive learning environment is skilled facilitation. Health professionals conducting clinical skills courses are continually changing roles. They are most like traditional instructors when they are presenting illustrated lectures (graphics slides presentations) and giving classroom demonstrations. Once they have demonstrated a clinical procedure, they shift to the role of the coach as the learners begin practicing. Throughout the course, they act as trainers—especially when conducting small group discussions and using role plays, case studies, and clinical simulations—as they help learners progress toward greater independence and confidence in the desired competencies.

Creating an Environment Where Learning Is Easy (or Easier)

The environment within which learning occurs has a tremendous impact on the quality of the learning experience. A positive learning environment maximizes the effectiveness of training, thereby helping learners to achieve the course objectives. Because the clinical trainer sets the tone for the course, how she/he delivers information is the key to establishing and maintaining a positive learning environment during training—in other words, how something is said is as important as what is said. The effective trainer creates an atmosphere of capability, one that supports the learners’ sense that not only can they build competence in the new knowledge, skills, and attitudes being taught, they can ultimately master them and apply them in their work to improve services in the communities they serve. Learners need to feel that they can achieve, and the trainer helps to build that feeling by creating and maintaining a positive learning environment—largely through effective facilitation.

Characteristics of an Effective Trainer and Coach

An effective trainer has the following qualities:

- Is proficient in the skills to be taught
- Encourages learners in learning new skills
- Promotes open (two-way) communication
- Provides immediate feedback:
Informs learners whether they are meeting the course objectives

Does not allow a skill or activity to be performed incorrectly (i.e., gently guides the learner toward the correct way to do something as soon as she/he begins to make mistakes)

Gives positive feedback as often as possible

Avoids negative feedback and instead offers specific suggestions for improvement

Seeks and is able to receive feedback:

- **Asks for it** (Talk to clinical skills trainers—and learners— who will be direct with you about your performance. Ask them to be specific and descriptive about ways you can be more effective.)

- **Directs it** (If you need additional information/input to answer a particular question or pursue a learning goal, ask for it. For example, during a demonstration, you might ask: “Does everyone have a clear view of how I am holding the instrument?”)

- **Accepts it** (Do not defend or justify your behavior. Listen to what people have to say and thank them. Use what is helpful; quietly discard the rest.)

Recognizes that training can be stressful and knows how to **manage learner as well as trainer stress**:

- Uses appropriate humor

- Observes learners and watches for signs of stress

- Provides regular breaks

- Provides changes in the training routine when needed

- Focuses on learner successes as opposed to failures

**Coaching** is a training technique in which the trainer:

- Describes the skills and client interactions that the learner is expected to learn;

- Demonstrates (models) the skills in a clear and effective manner using learning aids, such as slide sets, videos, and anatomic models; and

- Provides detailed, specific feedback to learners as they practice the skills and client interactions, using the anatomic model and actual instruments (if appropriate), in a simulated clinical setting and as they provide services to actual clients during practicum.

The characteristics of an **effective coach** are basically the same as those of an **effective trainer**; the characteristics especially important for the coach include the following:

- Being patient and supportive

- Providing praise and positive reinforcement

- Correcting learners’ errors while maintaining learners’ self-esteem

- Listening and observing
Understanding How People Learn

Being an effective clinical skills trainer also depends on understanding how adults learn. The trainer must have a clear understanding of what the learners need and expect, and the learners must have a clear understanding of why they are there. Adults who attend courses to acquire new knowledge, attitudes, and skills share the characteristics described below.

They require learning to be relevant. The trainer should offer learners learning experiences that relate directly to their current or future job responsibilities. At the beginning of the course, the objectives should be stated clearly and linked to job performance. The trainer should take time to explain how each learning experience relates to the successful accomplishment of the course objectives.

They are highly motivated if they believe learning is relevant. People bring high levels of motivation and interest to learning. Motivation can be increased and channeled by the trainer who provides clear learning goals and objectives. To make the best use of a high level of learner interest, the trainer should explore ways to incorporate the needs of each learner into the learning sessions. This means that the trainer needs to know quite a bit about the learners, either from studying background information about them or by allowing learners to talk early in the course about their experience and learning needs.

They need participation and active involvement in the learning process. Few individuals prefer just to sit back and listen. The effective trainer will design learning experiences that actively involve the learners in the training process. Examples of how the trainer may involve learners include the following:

- Allowing learners to provide input regarding schedules, activities, and other events
- Questioning and feedback
- Brainstorming and discussions
- Hands-on work
- Group and individual projects
- Classroom activities

Adult learners desire a variety of learning experiences. The trainer should use a variety of learning methods, including the following:

- Audiovisual aids
- Illustrated lectures
- Demonstrations
- Brainstorming
- Small group activities
- Group discussions
- Role plays, case studies, and clinical simulations
**They desire positive feedback.** Learners need to know **how they are doing**, particularly in light of the objectives and expectations of the course. Is their progress in learning clinical skills meeting the trainer’s expectations? Is their level of clinical performance meeting the standards established for the procedure? **Positive feedback provides this information.** Learning experiences should be designed to move from the known to the unknown or from simple activities to more complex ones. This progression provides positive experiences and feedback for the learner. To give positive feedback, the trainer can:

- Give verbal praise either in front of other learners or in private;
- Use positive responses during questioning;
- Recognize appropriate skills while coaching in a clinical setting; and
- Let the learners know how they are progressing toward achieving learning objectives.

They have **concerns about their abilities.** The trainer must recognize that many learners fear failure and embarrassment in front of their colleagues. Learners often have concerns about their ability to:

- Fit in with the other learners;
- Get along with the trainer;
- Understand the content of the training; and/or
- Perform the skills being taught.

They need an **atmosphere of safety.** The trainer should open the course with an introductory activity that will help learners feel at ease. It should communicate an atmosphere of safety so that learners do not judge one another or themselves. For example, a good introductory activity is one that acquaints learners with one another and helps them to associate the names of the other learners with their faces. Such an activity can be followed by learning experiences that support and encourage the learners.

They need to be recognized as **individuals** with unique backgrounds, experiences, and learning needs. A person’s past experiences are a good foundation upon which the trainer can base new learning. To help ensure that learners feel like individuals, the trainer should:

- Use learners’ names as often as possible;
- Involve all learners as often as possible;
- Treat learners with respect; and
- Allow learners to share information with others during classroom and clinical instruction.

Adult learners must maintain their **self-esteem.** Learners need to **maintain high self-esteem** to deal with the demands of a clinical training course. Often the clinical methods used in training are different from clinical practices used in the learners’ clinics. The trainer must show respect for the learners, no matter what practices and beliefs they hold to be correct, and continually support and challenge them. This requires the trainer to:

- Reinforce those practices and beliefs embodied in the course content;
Provide corrective feedback when needed, in a way that the learners can accept and use with confidence and satisfaction;

Provide training that adds to, rather than subtracts from, their sense of competence and self-esteem; and

Recognize learners’ own career accomplishments.

They have **high expectations** for themselves and their trainer. People attending courses tend to set **high expectations both for the trainers and for themselves**. Getting to know their trainers is a real and important need. Trainers should be prepared to talk modestly, and within limits, about themselves, their abilities, and their backgrounds.

They have **personal needs** that must be taken into consideration. All learners have personal needs during training. Taking timely breaks and providing the best possible ventilation, proper lighting, and an environment as free from distraction as possible can help to reduce tension and contribute to a positive learning atmosphere.

**Skill Development and Assessment: The Coaching Process**

No matter what type of skill the trainer is demonstrating—whether a psychomotor or hand skill, a clinical decision-making skill, or a communication skill—the coaching methodology for skill development includes these steps or phases:

- **Demonstration** of the clinical skill by the trainer, using models, simulations, and an assessment tool (usually a checklist) to outline critical steps. For clinical decision-making, demonstration of the skill entails explaining to learners the rationale for each decision made. In this way, learners are walked through the thought process of a provider who is proficient in clinical decision-making.

- **Practice** of the skill by the learner (using the same checklist) with feedback from the trainer, first in simulation and then with clients.

- **Assessment** of the learner’s skill competency by the trainer in simulation and then with clients (using the same checklist).

These three phases can be broken down further into the following steps:

- First, during interactive classroom presentations, **explain** the skill or activity to be learned.

- Next, using a video or slide set, show the skill or activity to be learned.

- Following this, **demonstrate** the skill or activity using an anatomic model (if appropriate), role play (e.g., counseling demonstration), or clinical simulation.

- Then, allow the learners to **practice** the demonstrated skill or activity with an anatomic model or in a simulated environment (e.g., role play, clinical simulation). The trainer functions as a coach during this step.

- After this, **review** the practice session and give constructive feedback.
After adequate practice, **assess** each learner’s performance of the skill or activity on models or in a simulated situation, using the competency-based checklist.

After a certain level of competence is gained with models or **practice** in a simulated situation, have learners begin to practice the skill or activity with clients under a trainer’s guidance.

Finally, **assess** the learner’s ability to perform the skill according to the standardized procedure, as outlined in the competency-based checklist.

During initial skill acquisition, the trainer demonstrates the skill as the learner observes. As the learner practices the skill, the trainer functions as a coach and observes and assesses performance. When demonstrating skill competency, the learner is now the person performing the skill as the trainer evaluates performance.

| **Assessment is a continuous process:** Formative assessment is used to help develop learner competence, while summative assessment is used to help evaluate and make decisions about learner competence. |
| **In formative assessment,** the focus is on giving feedback to learners, helping them to improve their performance and prepare for later assessments. Formative assessment has been described as “assessment for learning.” |
| **In summative assessment,** the results are recorded and used to determine whether the learner should move on to a next phase in the course (such as from working with models to working with actual clients) and, ultimately, pass the course. Summative assessment is sometimes described as an “assessment of learning” and is used to formally assess and document learner progress at specific times. |

**Note:** Assessment tools such as written knowledge assessments, skills checklists, and performance standards should not be modified by trainers. These tools have been created and validated by a group of experts to ensure that skills are developed and assessed in a standardized manner, and that the tools provide an accurate means of measuring learner competency and ultimately determining qualification.

**Using Effective Presentation Skills**

It is also important to use effective presentation skills. The trainer’s ability to establish and maintain a positive learning climate during training depends on how she/he delivers information because the **trainer sets the tone** for the course. In any course, **how** something is said may be just as important as **what** is said. Some common techniques for effective presentations are listed below:

- **Follow a plan and use trainer’s notes**, which include the session objectives, introduction, body, activity, audiovisual reminders, summary, and evaluation.

- **Communicate in a way that is easy to understand.** Many learners will be unfamiliar with the terms, jargon, and acronyms of a new subject. The trainer should use familiar words and expressions, explain new language, and attempt to relate to the learners during the presentation.

- **Maintain eye contact with learners.** Use eye contact to “read” faces. This is an excellent technique for establishing rapport and getting feedback on how well learners understand the content.

- **Project your voice** so that those in the back of the room can hear clearly. Vary volume, voice pitch, tone, and inflection to maintain learners’ attention. Avoid using a monotone voice, which is guaranteed to put learners to sleep!
Avoid the use of slang or repetitive words, phrases, or gestures that may become distracting with extended use.

Display enthusiasm about the topic and its importance. Smile, move with energy, and interact with learners. The trainer’s enthusiasm and excitement are contagious and directly affect the morale of the learners.

Move around the room. Moving around the room helps ensure that the trainer is close to each learner at some point during the session. Learners are encouraged to interact when the trainer moves toward them and maintains eye contact.

Use appropriate audiovisual aids during the presentation to reinforce key content or help simplify complex concepts.

Be sure to ask both simple and more challenging questions.

Provide positive feedback to learners during the presentation.

Use learners’ names as often as possible. This will foster a positive learning climate and help keep the learners focused on the presenter.

Display a positive use of humor related to the topic (e.g., humorous stories, cartoons on a transparency or flip chart, cartoons for which learners are asked to create captions).

Provide smooth transitions between topics. Within a given presentation, a number of separate yet related topics may be discussed. When shifts between topics are abrupt, learners may become confused and lose sight of how the different topics fit together in the bigger picture. Before moving on to the next topic, the trainer can ensure that the transition from one topic to the next is smooth by:

- Providing a brief summary;
- Asking a series of questions;
- Relating content to practice; or
- Using an application exercise (case study, role play, etc.).

Be an effective role model. The trainer should be a positive role model in appearance (appropriate dress) and attitude (enthusiasm for the course) and by beginning and ending the session at the scheduled times.

Teaching Clinical Decision-Making

Clinical decision-making is the systematic process by which skilled providers make judgments regarding a client’s condition, diagnosis, and treatment. Although the process can be difficult to teach, it can be broken down into a series of steps to facilitate discussion and learning, as shown below. As the trainer facilitates learning activities and assessments, she/he should identify—and encourage learners to try to identify—“where they are” in the clinical decision-making process. And depending on where they are, the trainer can employ a range of strategies to bring learners into, and help them navigate through, the clinical decision-making process.
Assessment or gathering information: In the provision of implant services, this step may occur during counseling (e.g., learning about the couple’s fertility intentions) or screening (e.g., identifying any medical reasons why the method should be withheld).

Diagnosis or interpreting the information: In the provision of implant services, this step may occur after counseling and screening are completed (e.g., determining that a woman who has chosen the implant can safely have one inserted).

Implementation: This step begins with ensuring that the woman has been properly counseled and screened and confirming her choice, continues with the actual insertion, and ends with post-insertion counseling. (Is this method her choice? Is she having any problems?).

An important strategy in teaching clinical decision-making is to be sure that learners are aware of this step-by-step process and what occurs in each step. They also must understand that although there is a sequence of steps for clinical decision-making, movement through the steps is rarely linear or sequential. Rather, it is an ongoing, circular process in which the provider moves back and forth between the steps as the clinical situation changes and different needs or problems emerge.

Another key strategy in teaching clinical decision-making is to provide as much experience and practice in decision-making as possible. This experience, together with clinical knowledge, is a key component of successful decision-making. Teachers should:

- Expose learners to as many and as wide a variety of clients as possible;
- Put learners in the clinical setting as early as possible and provide careful guidance as they gain their experience;
- Give learners as much structured independence as possible; they must be given the opportunity and time to draw their own conclusions and consider their own decisions; and
- Provide learners with a forum (e.g., case studies) for comparing their decisions with the decisions made by others.

Finally, the trainer should give learners feedback on how the clinical decision-making process was applied in a given situation. This will strengthen future performance more effectively than focusing on whether or not the “correct answer” was identified. In fact, a wrong answer for the right reason should receive more positive feedback than a right answer for the wrong reason.

Tools for teaching clinical decision-making, such as job aids, are presented throughout the learning resource package. The role plays have been designed to facilitate the teaching of decision-making by reinforcing the steps involved in the process. However, tools alone will not effectively teach clinical decision-making. The trainer must take an active role in discussing, questioning, explaining, and challenging learners about how decisions are being made each time one of these tools is used—for example, “What were you thinking when you asked the client that question?” “Why did you advise the client that the implant was not a good choice for her?” And this kind of interaction must continue as the learners move into the clinical setting to work with clients.
Clinical decision-making is a difficult skill to teach. But by beginning early in the course and continually providing practice opportunities and guidance—whether by using the tools included in this learning resource package or through experience with clients—trainers will help learners more fully understand the decision-making process and develop their decision-making skills. As a result, the quality of care received by clients will be improved.

Conducting Learning Activities

Every session (or learning activity) conducted during a course should begin with an introduction to capture learner interest and prepare the learner for learning. After the introduction, the trainer may deliver content using an illustrated lecture, demonstration, small group activity, or other learning activity. Throughout the presentation, questioning techniques can be used to encourage interaction and maintain learner interest. Finally, the trainer should conclude the presentation with a summary of the key points or steps.

Delivering Interactive Presentations

Introducing Presentations

The first few minutes of any presentation are critical. Learners might be thinking about other matters or wondering what the session will be like, or they might have little interest in the topic. The introduction should:

- Capture the interest of the entire group and prepare learners for the information to follow;
- Make learners aware of the trainer’s expectations; and
- Help foster a positive learning climate.

The trainer can select from a number of techniques to provide variety and ensure that learners are not bored. Many introductory techniques are available, including the following:

- **Reviewing the session objectives.** Introducing the topic by a simple restatement of the objectives keeps the learner aware of what is expected of her/him.

- **Asking a series of questions about the topic.** The effective trainer will recognize when learners have prior knowledge concerning the course content and encourage their contributions. The trainer can ask a few key questions, allow learners to respond, discuss answers and comments, and then move into the body of the presentation.

- **Relating the topic to previously covered content.** When a number of sessions are required to cover one subject, relate each session to previously covered content. This ensures that learners understand the continuity of the sessions and how each relates to the overall topic. Where possible, link topics so that the concluding review or summary of one presentation can introduce the next topic.

- **Sharing a personal experience.** There are times when the trainer can share a personal experience to create interest, emphasize a point, or make a topic more job-related. Learners enjoy hearing these stories as long as they relate to the topic and are used only when appropriate.
- **Relating the topic to real-life experiences.** Many training topics can be related to situations most learners have experienced. This technique not only catches the learners’ attention, but also facilitates learning because people learn best by “anchoring” new information to known material. The experience may be from the everyday world or relate to a specific process or piece of equipment.

- **Using a case study, clinical simulation, or other problem-solving activity.** Problem-solving activities focus attention on a specific situation related to the training topic. Working in small groups generally increases interest in the topic.

- **Using a video/DVD or other audiovisual aid.** Use of appropriate audiovisual aids can be stimulating and generate interest in a topic.

- **Giving a classroom demonstration.** Most clinical training courses involve equipment, instruments, and techniques that lend themselves to demonstrations, which generally increase learner interest.

- **Using a game, role play, or simulation.** Games, role plays, and simulations generate tremendous interest through direct learner involvement and therefore are useful for introducing topics.

- **Relating the topic to future work experiences.** Learners’ interest in a topic will increase when they see a relationship between training and their work. The trainer can capitalize on this by relating the objectives, content, and activities of the course to real work situations.

**Using Questioning Techniques**

Questions can be used at any time to:

- Introduce a topic;
- Increase the effectiveness of the illustrated lecture;
- Promote brainstorming; or
- Supplement the discussion process.

Use a variety of questioning techniques to maintain interest and avoid a repetitive style.

- **Ask a question of the entire group.** The advantage of this technique is that those who wish to volunteer may do so; however, some learners might dominate while others might not participate.

- **Target the question to a specific learner by using her/his name before asking the question.** The learner is aware that a question is coming and can concentrate on the question and respond accordingly. The disadvantage is that once a specific learner is targeted, others might not concentrate on the question.

- **State the question, pause, and then direct the question to a specific learner.** All learners must listen to the question in case they are asked to respond. The primary disadvantage is that the learner receiving the question might be caught off guard and need to ask the trainer to repeat the question.
The key in asking questions is to avoid a pattern. The skilled trainer uses all three of the above techniques to provide variety and maintain the learners’ attention. Other techniques include the following:

- **Use learners’ names** during questioning. This is a powerful motivator and also helps ensure that all learners are involved.

- **Repeat a learner’s correct response.** This provides positive reinforcement to the learner and ensures that the rest of the group heard the response.

- **Provide positive reinforcement for correct responses** to keep the learner involved in the topic. Positive reinforcement may take the form of praising a learner, displaying a learner’s work, using a learner as an assistant, or using positive facial expressions, nods, or other nonverbal actions.

- **When a learner’s response is partially correct,** the trainer should reward the correct portion and then improve the incorrect portion or redirect a related question to that learner or to another learner.

- **When a learner’s response is incorrect,** the trainer should make a noncritical response and restate the question to lead the learner to the correct response.

- **When a learner makes no attempt to respond,** the trainer may wish to follow the above procedure or redirect the question to another learner. Come back to the first learner after receiving the desired response and involve her/him in the discussion.

- **When learners ask questions,** the trainer must determine an appropriate response by drawing upon personal experience and weighing the individual’s needs against those of the group. If the question addresses a topic that is relevant but has not been previously discussed, the trainer can either:
  - Answer the question and move on; or
  - Respond with another question, thereby beginning a discussion about the topic.

**Summarizing Presentations**

A **summary** is used to reinforce the content of a presentation and provide a review of its main points. The summary should:

- Be brief;
- Draw together the main points; and
- Involve the learners.

Many summary techniques are available to the trainer:

- **Asking the learners for questions** gives learners an opportunity to clarify their understanding of the instructional content. This can result in a lively discussion focusing on those areas that seem to be the most troublesome.

- **Asking the learners questions** that focus on major points of the presentation helps the learners summarize what they have just heard.
Administering a practice exercise or test gives learners an opportunity to demonstrate their understanding of the material. After the exercise or test, use the questions as the basis for a discussion by asking for correct answers and explaining why each answer is correct.

Using a game to review main points provides some variety, when time permits. One popular game is to divide learners into two teams, give each team time to develop review questions, and then allow each team to ask questions of the other. The trainer serves as moderator by judging the acceptability of the questions, clarifying answers, and keeping a record of team scores. This game can be highly motivational and serve as an excellent summary at the same time.

Facilitating Group Discussions
The group discussion is a learning method in which most of the ideas, thoughts, questions, and answers are developed by the learners. The trainer typically serves as the facilitator and guides the learners as the discussion develops.

Group discussion is useful at the following times:
- At the conclusion of a presentation
- After viewing a video
- Following a clinical demonstration or skills practice session
- After reviewing a case study or clinical simulation
- After a role play
- Any other time when learners have prior knowledge or experience related to the topic

Attempting to conduct a group discussion when learners have limited knowledge of or experience with the topic often will result in little or no interaction and thus an ineffective discussion. When learners are familiar with the topic, the ensuing discussion is likely to arouse learner interest, stimulate thinking, and encourage active participation. This interaction affords the trainer an opportunity to:
- Provide positive feedback;
- Stress key points;
- Develop critical thinking skills; and
- Create a positive learning climate.

The trainer must consider a number of factors when selecting group discussion as the learning strategy:
- Discussions involving more than 15 to 20 learners are sometimes difficult to lead and might not give each learner an opportunity to participate.
- Discussion requires more time than an illustrated lecture because of the extensive interaction among the learners.
A poorly directed discussion may move off target and never reach the objectives established by the trainer.

If control of the discussion is not maintained, a few learners might dominate while others lose interest.

In addition to a group discussion that focuses on the session objectives, there are two other types of discussions that can be used in a training situation:

- General discussion that addresses learners’ questions about a learning event (e.g., why one type of episiotomy is preferred over another)
- Panel discussion in which a moderator conducts a question-and-answer session with panel members and learners

Follow these key guidelines to ensure successful group discussions:

- Arrange seating to encourage interaction (e.g., tables and chairs set up in a U-shape or a square or circle so that learners face each other).
- State the topic as part of the introduction.
- Shift the conversation from the trainer to the learners.
- Act as a referee and intercede only when necessary.
  Example: “It is obvious that Seema and Radhika are taking two sides in this discussion. Seema, let me see if I can clarify your position. You seem to feel that . . . .”
- Summarize the key points of the discussion periodically.
  Example: “Let’s stop here for a minute and summarize the main points of our discussion.”
- Ensure that the discussion stays on the topic.
- Use the contributions of each learner and provide positive reinforcement.
  Example: “That is an excellent point, Rosminah. Thank you for sharing that with the group.”
- Minimize arguments among learners.
- Encourage all learners to get involved.
- Ensure that no single learner dominates the discussion.
- Conclude the discussion with a summary of the main ideas. The trainer must relate the summary to the objective presented during the introduction.

Facilitating a Brainstorming Session

Brainstorming is a learning strategy that stimulates thought and creativity and is often used in conjunction with group discussions. The primary purpose of brainstorming is to generate a list of ideas, thoughts, or alternative solutions that focus on a specific topic or problem. This list may be used as the introduction to a topic or form the basis of a group discussion. Brainstorming requires that learners have some background related to the topic.
The following guidelines will facilitate the use of brainstorming:

- Establish ground rules.

  *Example:* “During this brainstorming session we will be following two basic rules. All ideas will be accepted and Jim will write them on the flip chart. Also, at no time will we discuss or criticize an idea. Later, after we have our list of suggestions, we will go back and discuss each one. Are there any questions? If not . . . .”

- Announce the topic or problem.

  *Example:* “During the next few minutes we will be brainstorming and will follow our usual rules. Our topic today is ‘indications and contraindications for Jadelle and the WHO medical eligibility criteria.’ I would like each of you to think of at least one indication. Maria will write these on the board so that we can discuss them later. Who would like to be first? Yes, Joel . . . .”

- Maintain a written record of the ideas and suggestions on a flip chart or writing board. This will prevent repetition and keep learners focused on the topic. In addition, this written record is useful when it is time to discuss each item.

- Involve the learners and provide positive feedback in order to encourage more input.

- Review written ideas and suggestions periodically to stimulate additional ideas.

- Conclude brainstorming by reviewing all of the suggestions and clarifying those that are acceptable.

**Facilitating Small Group Activities**

There are many times during training that the learners will be divided into several small groups, which usually consist of four to six learners. Examples of small group activities include the following:

- Reacting to a case study, which may be presented in writing or orally by the trainer, or introduced through video or slides

- Preparing a role play within the small group and presenting it to the entire group. Dealing with a clinical situation/scenario, such as in a clinical simulation, which has been presented by the trainer or another learner

- Practicing a skill that has been demonstrated by the trainer using anatomic models

Small group activities offer many advantages, including:

- Providing learners an opportunity to learn from each other,

- Involving all learners,

- Creating a sense of teamwork among members as they get to know each other, and

- Providing for a variety of viewpoints.

When small group activities are being conducted, it is important that learners are not in the same group every time. The trainer can create small groups in different ways, such as:
- **Assigning** learners to groups,
- Asking learners to **count off** (“1, 2, 3,” etc.) and having all learners with the same number in a group together,
- Asking learners to **form their own groups,** or
- Asking learners to **draw a group number** (or group name).

The room(s) used for small group activities should be large enough to allow different arrangements of tables, chairs, and teaching aids (models, equipment) so that individual groups can work without disturbing one another. The trainer should be able to move easily about the room to visit each group. If smaller rooms are available near the primary training room, consider having small groups go to them to work on their problem-solving activity, case studies, clinical simulations, or role plays. Note that it will be difficult to conduct more than one clinical simulation at the same time in the same room/area.

Activities assigned to small groups should be **challenging, interesting, and relevant**; should require **only a short time to complete**; and should be **appropriate for the backgrounds of the learners.** The small groups may be working on the same activity, or each group may be taking on a different problem, case study, clinical simulation, or role play. Regardless of the type of activity, there is usually a time limit. When this is the case, inform groups when there are 5 minutes left and when their time is up.

Instructions may be presented to the groups in several ways:
- On a hand-out
- On a flip chart
- On a transparency
- Verbally by the trainer

Instructions for small group activities typically include:
- **Directions**
- **Time limit**
- **A situation or problem** to discuss, resolve, or role play
- **Learner roles** (if a role play)
- **Questions for group discussion**

Once the groups have completed their activity, the clinical training trainer will **bring them together** as a large group to discuss the activity. The discussion might involve:
- **Reports** from each group,
- **Responses** to questions,
- **Role plays** developed in each group and presented by learners in the small groups,
- **Recommendations** from each group, and/or
- **Discussion of the experience** (if a clinical simulation).

The trainer should provide an effective summary discussion after small group activities. This provides closure and ensures that learners understand the point of the activity.

**Conducting an Effective Clinical Demonstration**

When a new clinical skill is being introduced, a variety of methods can be used to demonstrate the procedure. For example:

- Show **slides** or a **video** in which the steps and their sequence are demonstrated in accordance with the accepted performance standards.
- Use **anatomic models** such as the postpartum IUD clinical simulator to demonstrate the procedure and skills.
- Perform **role plays** in which a learner or surrogate client simulates a client and responds as a real client would.
- Demonstrate the procedure with clients in the clinical setting (clinic or hospital).

Whatever methods are used to demonstrate the procedure, the trainer should set up the activities using the “whole-part-whole” approach.

- Demonstrate the whole procedure from beginning to end to give the learner a visual image of the entire procedure or activity.
- Isolate or break down the procedure into activities (e.g., preoperative counseling, getting the client ready, preoperative tasks, performing the procedure, etc.) and allow practice of the individual activities of the procedure.
- Demonstrate the whole procedure again and then allow learners to practice the procedure from beginning to end.

When planning and giving a demonstration of a clinical procedure, either using anatomic models or with clients, if appropriate, the trainer should use the following guidelines:

- Before beginning, state the objectives of the demonstration and point out what the learners should do (e.g., interrupt with questions, observe carefully, etc.).
- Make sure that everyone can see the steps involved.
- Never demonstrate the skill or activity incorrectly.
- Demonstrate the procedure in as realistic a manner as possible, using instruments and materials in a simulated clinical setting.
• Include all steps of the procedure in the proper sequence, according to the approved performance standards. This includes demonstrating “nonclinical” steps such as pre- and postoperative counseling, communication with the client during surgery, use of recommended infection prevention practices, and so on.

• During the demonstration, explain to learners what is being done, especially any difficult or hard-to-observe steps.

• Ask questions of learners to keep them involved. Example: “What should I do next?” “What would happen if . . . ?”

• Encourage questions and suggestions.

• Take enough time so that each step can be observed and understood. Remember that the objective of the demonstration is for learners to learn the skills, not for the trainer to show her/his dexterity and speed.

• Use equipment and instruments properly and make sure learners clearly see how they are handled.

In addition, when observing the trainer’s performance during the initial demonstration, learners should use a clinical skills checklist developed specifically for the clinical procedure. Doing this:

• Familiarizes the learner with the use of competency-based clinical skills checklists;

• Reinforces the standard way of performing the procedure; and

• Communicates to learners that the trainer, although very experienced, is not absolutely perfect and can accept constructive feedback on her/his performance.

As the role model the learners will follow, the trainer must practice what she/he demonstrates (i.e., the approved standard method as detailed in the learning guide). Therefore, it is essential that the trainer use the standard method. During the demonstration, the trainer should also provide supportive behavior and cordial, effective communication with the client and staff to reinforce the desired outcome.

Managing Clinical Practice

Getting the most out of clinical practice requires that the trainer be well acquainted with the clinical practice sites. Ideally, the trainers should be staff from the hospital or clinic where the clinical practice for the training will take place. If that is not the case, then being very familiar with the health care facility before training begins will enable the trainer to develop a relationship with the staff, address any inadequacies in the situation, and prepare for the best possible learning experience for learners. Even the best planning, however, is not always enough to ensure a successful clinical practice experience. In the classroom, the trainer is able to control the schedule and activities to a large extent, but in the clinic the trainer must always be alert to unplanned learning opportunities that may arise at any time and be ready to modify the schedule accordingly.
Performing Clinical Procedures with Clients

The final stage of clinical skills development involves practicing procedures with clients. Anatomic models, no matter how realistic, cannot substitute entirely for the reality of performing the procedure with a living, breathing, feeling, and reacting human being. The disadvantages of using real clients during clinical skills training are obvious: Clients may be subjected to increased discomfort or even increased risk of complications when procedures are performed by unskilled clinicians. When possible and appropriate, learners should be allowed to work with clients only after they have correctly and consistently demonstrated the skills on an anatomic model or in a simulated situation. In this implants course, the learners are provided the opportunity to learn implant insertion techniques on Day 1. All learners should practice and be qualified in the procedure before they proceed to the clinical areas.

The rights of clients should be considered at all times during a clinical training course. The following practices will help ensure that clients’ rights are routinely protected during clinical training:

- The right to bodily privacy must be respected whenever a client is undergoing a physical examination or procedure. The client should be draped appropriately for all examinations and procedures.

- The confidentiality of any client information obtained during counseling, history taking, physical examinations, or procedures must be strictly observed. Clients should be reassured of this confidentiality. Confidentiality can be difficult to maintain when actual cases are used in learning exercises such as case studies and clinical meetings. Such discussions always should take place in a private area where other staff and clients cannot overhear and should be conducted without reference to the client by name.

- When receiving counseling, undergoing a physical examination, or receiving postpartum family planning services, the client should be informed of the role of each person involved (e.g., trainers, individuals undergoing training, and support staff).

- The client’s permission should be obtained before having a clinician-in-training observe, assist with, or perform any procedures. Understanding the right to refuse care from a clinician-in-training is important for every client. Furthermore, care should not be rescheduled or denied if the client does not permit a clinician-in-training to be present or provide services. In such cases, the trainer or other staff member should perform the procedure.

- The trainer should be present during any client contact in a training situation and the client should be made aware of the trainer’s role. Furthermore, the trainer should be ready to intervene if the client’s safety is in jeopardy or if the client is experiencing severe discomfort.

- The trainer must give coaching and feedback carefully during practice with clients. Corrective feedback in the presence of a client should be limited to errors that could harm or cause discomfort to the client. Excessive negative feedback can create anxiety for both the client and the clinician-in-training.

- Clients should be chosen carefully to ensure that they are appropriate for clinical training purposes. For example, learners should not practice with “difficult” clients until they are proficient in performing the procedure.
Creating Opportunities for Learning

Planning for Learning

The trainer should develop a plan for each day spent in the health care facility. The plan will provide a daily focus that is consistent with the learning objectives and help to ensure that all required skills will be adequately addressed. When preparing the plan, the trainer should consider the following points:

- Clinical practice should progress from basic to more complex skills. This not only helps ensure the safety and quality of care provided by learners, but also allows them to gain self-confidence as they demonstrate competency in the basic skills.

- To maximize these opportunities, the trainer should consider the following strategies:
  - Discuss with staff weeks before the training that there will be providers training in implant services and note the dates on which implant services will be available at no charge to clients.
  - Consider several clinic sites that have busy family planning clinics and ensure that transportation is available to take learners to various clinics.

In addition to daily practice of specific clinical skills, the trainer’s plan should include other areas of focus, such as infection prevention, facility logistics, and client flow. Although these topics may not be directly assessed with a checklist or other tool, they play an important role in the provision of high-quality implant services. To make sure that learners give adequate attention to these topics, the trainer should design and develop activities such as the following:

- Observing the infection prevention practices used in the facility. Which recommended practices are being used, and which are not? Are they being used consistently and correctly? Why or why not?

- Reviewing facility-based records for the past several months to identify the types of family planning clients seen. Additional information could be obtained, such as the most common complications and side effects and how to manage them.

In the Health Care Facility

As has been mentioned, planning alone is not sufficient to guarantee a successful clinical practice. There are several strategies that a trainer can use in the health care facility to increase the likelihood of success.

- The trainer must actively monitor the skills each learner is able to practice, and with what frequency, so that each learner has adequate opportunities to develop competency.

- The learners also should be encouraged to watch for such learning opportunities. The trainer may then decide which, and how many, of the learners will be assigned to a particular client. The trainer and learners should remember that clinical experiences need to be shared equally.
To take advantage of opportunities as they occur may require that the trainer modify the plan for that day and subsequent days, but with as little disruption as possible in the provision of services. Learners should be notified of any changes as early as possible so that they can be well prepared for each clinical day.

In some training situations, all learners might not have the opportunity to work with all types of clients. The trainer will need to supplement the work with clients with additional work on anatomic models and discussions. The trainer will need to determine if a learner can be qualified as competent to provide implant services if she/he has not completed all the skills that are central to the objectives of the course.

Conducting Pre- and Post-Clinical Practice Meetings
Health care facilities do not always have meeting rooms, so the trainer must make every effort to find a space that:

- Allows free discussion, small group work, and practice on models; and
- Is away from the client care area if possible, so as to not interfere with efficient client care or other staff duties.

Pre-Clinical Practice Meetings
The trainer and learners should meet at the beginning of each clinical practice session. The meeting should be brief. The following items should be covered:

- The learning objectives for that day
- Any scheduling changes that may be needed
- Learners’ roles and responsibilities for that day, including the work assignments and rotation schedule, if applicable
- Special assignments to be completed that day
- The topic for the post-clinical practice meeting, so that the learners can take special note of anything that happens during the day that would contribute to the discussion
- Questions related to that day’s activities or from previous days, if they can be answered concisely; if not, they should be deferred until the post-clinical practice meeting

Post-Clinical Practice Meetings
The trainer should end each clinical practice day with a meeting to review the day’s events and build on them as learning experiences. A minimum of 30 minutes is recommended. These meetings are used to:

- Review the day’s learning objectives and assess progress toward their completion;
- Present cases seen that day, particularly those that were interesting, unusual, or difficult;
- Respond to questions concerning situations and clients in the health care facility or information in the reference manual;
- Plan for the next clinical session, making changes in the schedule as necessary; and
- Conduct additional practice with models if needed.

**The Trainer as Supervisor**

In the role of supervisor, the trainer must monitor learner activities in the health care facility so that:

- Each learner receives appropriate and adequate opportunities for skills practice;
- Learners do not disrupt the efficient provision of services within the facility or interfere with staff and their duties; and
- The care provided by each learner does not harm clients or place them in an unsafe situation.

**The trainer must always be with learners when they are working with clients**, especially when they are performing clinical procedures. Trainers might have more than one or two learners to supervise. Because the trainer cannot be with all of them at the same time, other methods of supervision must be used.

- Learners must understand what they can do independently and what requires trainer supervision, so that they can keep busy when the trainer is working with other learners. Learners should take responsibility for ensuring that they are supervised when necessary. However, the trainer holds the ultimate responsibility.
- Additional activities that require no direct supervision will give learners the opportunity to be actively engaged in learning when they are not with clients.
- Clinical staff also can act as supervisors if the trainer is confident of their clinical skills and ability to provide appropriate feedback. The possibility of having clinical staff supervise learners is another reason for the trainer to get to know the staff before training begins. During clinical site preparation, the trainer can observe the skills of the staff members and verify that they are competent, if not proficient, service providers. The trainer might also have the opportunity to assess staff members’ coaching skills and even to work with staff members to improve their skills so that they can serve as role models and support learners.
- The more learners there are in a facility, the more the trainer relies upon the staff to act as trainers. The trainer has the ultimate responsibility for each learner, including final assessment of skill competency. For this reason, if multiple clinical sites are used during a course, a trainer must be assigned to each site.
- Because clinical staff usually are not involved in the classroom portion of a course, they do not get to know the learners and their abilities before the learners arrive at the facility. It is a good idea to share such information with the clinical staff if they will take over a large part of the learner supervision. Clinical staff should also be encouraged to do an initial assessment of learners’ skills before allowing them to work with clients, so that they can feel confident that the learners are well prepared.
Clinical staff should also be aware of the feedback the trainer would like to receive about learners.

- Will it be oral, written, or both? If written feedback is needed, the trainer should design an instrument or form to guide the clinical staff. The trainer should develop a form that staff members can complete quickly and easily, should instruct the staff in its use, and should furnish enough copies of the form for staff to use.
- How frequently will feedback be provided?
- Should both positive and corrective feedback be provided?
- Are there appropriate administrative channels through which the feedback should be transmitted? In some clinics, staff members provide their feedback to the individual in charge of the health care facility who then prepares a report for the trainer.

When designing the feedback system, the trainer should keep in mind the time required to prepare and provide feedback. This will be extra work for the clinical staff, who already have a very busy schedule. It is best to keep the feedback system as simple and easy to use as possible.

The Trainer as Coach

One of the most difficult tasks for the trainer, and one with which even experienced trainers struggle, is to be a good coach and provide feedback in the clinical setting. No matter how comfortable a trainer is giving feedback in the classroom or while working with models, the situation changes in the facility. The clients, staff, and other learners are nearby, and the facility’s emergency services need to keep running smoothly and efficiently. The trainer often feels pressured to keep things moving because other clients need to be seen. The trainer also needs to be available to all the learners. Spending too much time with any one client or learner has an impact on everyone.

Feedback Sessions

Feedback sessions before and after practice are often skipped in an effort to save time. However, these sessions are very important to the continued development of the learner’s psychomotor or decision-making skills. Without adequate feedback and coaching, the learner might miss an important learning opportunity and take longer to achieve competency. Keep in mind that by this time the learner has already demonstrated competency on a model and may not need extensive feedback. To minimize disruption of services, the pre- and post-practice feedback sessions can take place in just a few minutes in a location away from the client care areas.

- The structure of the feedback session is essentially the same regardless of whether the session takes place before or after practice, and whether it is for a learner’s performance with models or with clients.
- The learner should first identify personal strengths and the areas where improvement is needed.
- Next, the trainer should provide specific, descriptive feedback that includes suggestions of not only what to improve, but also how to improve.
- Finally, the learner and the trainer should agree on the focus of the practice session, including how they will interact while they are with the client. For example, they may agree that if the trainer places a hand on the learner’s shoulder, it is a signal to stop and wait for further instructions.
The feedback session before practice should be given before the trainer and learner enter the room to work with the client. The feedback session after practice can be delayed until the client’s care has been completed or the client is in stable condition and no longer needs continuous care. The trainer should try not to delay feedback any longer than necessary. Feedback is always more effective when given as soon after care as possible. This will also allow the learner to use the feedback with the next client for whom services are provided, if appropriate.

**Feedback during a Procedure**

Be sure the client knows that the learner, although already a service provider, is also still a learner. Reassure the client that the learner has had extensive practice and mastered the skill on models. The client should expect to hear the trainer talk to the learner and understand that it does not mean that something is wrong. Finally, the client should clearly understand that the trainer is a proficient service provider and is there to ensure that the procedure is completed safely and without delay.

**Positive Feedback**

Positive feedback is often easy to give and can be provided in the presence of the client. Trainers often think that hearing feedback, even positive feedback, will disturb the client. Many clients, however, find it comforting to hear the trainer give the learner positive feedback.

- Keep the feedback restrained and low-key; overly exuberant praise can be as worrisome to the client as hearing negative comments. Too much praise may cause the client to wonder, “What is being hidden?” “Why is it so surprising that this person is doing a good job?”

- Positive feedback can be conveyed by facial expression and tone of voice, rather than words, and still be highly effective.

At the same time, the absence of feedback of any kind can be disturbing to the learner. By this phase of skill development the learner is expected to do a good job, even with the first client, and is accustomed to hearing positive comments. To maintain the learner’s confidence, continue to give positive feedback.

**Corrective Feedback**

Corrective feedback is difficult to give under any circumstances, but particularly when a client is present. It is important to keep such feedback low-key and restrained. There are a number of techniques that will make it easier.

- Often a look or hand gesture (e.g., a touch on the shoulder) can be as effective as words and less worrisome to the client.

- Simple suggestions to facilitate the procedure can be made in a quiet, direct manner. Do not go into lengthy explanations of why you are making the suggestion or offering an observation; save that for the post-practice feedback session.
To help a learner avoid making a mistake, the trainer can calmly ask a simple, straightforward question about the procedure itself. If a step in a procedure is about to be missed, for example, asking the learner to name the next step before doing anything further could help avoid an error. This is not the time to ask hypothetical questions about potential side effects and complications, as this may distract the learner and alarm the client.

Sometimes, even though they have had extensive practice on models, learners make mistakes that can potentially harm the client. In these instances, the trainer must be prepared to step in and take over the procedure at a moment’s notice. This should be done calmly and with complete control to avoid unnecessarily alarming the client.

Where Practice Meets Reality
Practicing in simulation (or in a classroom) is necessary preparation for gaining practical experience in the clinical setting—but the “practicing,” as such, continues. True skills competency can be achieved only by practicing with actual clients. This is because part of being competent is being able to provide high-quality services in real-life situations with living, breathing people—despite difficult emotions, unexpected findings, and other unanticipated occurrences. So, although trainers and learners will continue to use many of the tools and methods they became familiar with in the classroom, building on what they already know, no one knows what will actually happen in the clinical setting . . . not even the trainer. Ensuring that learners can practice and finally demonstrate the desired competencies in this “uncharted territory” requires careful planning, clear communication, flexibility, and a firm commitment to protecting the safety and rights of clients—on the parts of everyone involved: the trainer(s), learners, and clinical staff.
Appendix 3: Using the Reproductive Implant Training Arm (RITA) Correctly

To practice LARC insertion and removal, learners should use the training model as if it were an actual client. Follow all insertion and removal steps in the training manual. During insertion training, the trocar should pass between the skin tube and the foam core (muscle tissue). If resistance is felt, the trocar probably has cut into the foam core because it was inserted at too deep an angle.

Immediately after insertion practice, learners can practice the removal techniques. If they inserted some of the implants too deep, they will have difficulty removing them, just as would occur with an actual client.

How to Care for the Training Model:

- If the skin tube becomes sticky and dirty, it may be washed, dried, and recoated inside with powder.
- Rotate the skin tube each time you use it to make it last longer. Avoid making incisions close together.
- Do not store the model with more than one tension block in place. If more than one block is left in place, the rods will imprint the foam core, making removal of implants very difficult.
- To ensure that the tension of the skin tube remains uniform during insertion practice, insertions should be initiated from the middle of the model’s surface and directed toward either end of the model.

Instructions for Using a Zoe Gynecologic Simulator

A ZOE Gynecologic Simulator is a model of a full-sized, adult female lower torso (abdomen and pelvis). It is a versatile training tool developed to help health professionals teach the processes and skills needed to perform many gynecologic procedures. ZOE models are ideal for demonstrating and practicing the following procedures:

- Bimanual pelvic examination, including palpation of normal and pregnant uteri
- Vaginal speculum examination
- Visual recognition of normal cervixes and abnormal cervixes
- Uterine sounding
- IUD insertion and removal
- Diaphragm sizing and fitting
- Laparoscopic inspection and occlusion of fallopian tubes (Falope rings or other clips)
- Minilaparotomy (both interval and postpartum tubal occlusion)
- Treatment of incomplete abortion using manual vacuum aspiration (MVA)

Contents of the Original Zoe Model

There are several models of ZOE Gynecologic Simulators now available, including an interval model and postpartum kit, so specific parts and accessories will vary. The original ZOE Gynecological Simulator kit includes the following:

<table>
<thead>
<tr>
<th>Item</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Normal ante- and retroverted uteri with clear tops, attachments for round and ovarian ligaments as well as fallopian tubes, and normal patent cervical os for pelvic examination and IUD insertion</td>
<td>2</td>
</tr>
<tr>
<td>6–8 week uterus with dilated (open) cervical os, which allows passage of a 5 or 6 mm flexible cannula</td>
<td>1</td>
</tr>
<tr>
<td>10–12 week uterus with dilated (open) cervical os, which allows passage of a 10 or 12 mm flexible cannula</td>
<td>1</td>
</tr>
<tr>
<td>Postpartum uterus (20 week size) with attached fallopian tubes for practicing postpartum tubal occlusion by minilaparotomy</td>
<td>1</td>
</tr>
<tr>
<td>Cervixes (not open) for use in visual recognition:</td>
<td></td>
</tr>
<tr>
<td>- Normal cervix</td>
<td>1</td>
</tr>
<tr>
<td>- Cervix with proliferation of columnar epithelium (ectropion)</td>
<td>1</td>
</tr>
<tr>
<td>- Cervix with inclusion (nabothian) cyst and endocervical polyp</td>
<td>1</td>
</tr>
<tr>
<td>- Cervix with lesion (cancer)</td>
<td>1</td>
</tr>
<tr>
<td>Normal cervixes with open os for IUD insertion/removal</td>
<td>5</td>
</tr>
<tr>
<td>Cervixes for 6–8 week and 10–12 week uterus (2 of each size)</td>
<td>4</td>
</tr>
<tr>
<td>Normal tubal fimbriae and ovaries (2 of each)</td>
<td>4</td>
</tr>
<tr>
<td>Fallopian tubes for tubal occlusion</td>
<td>8</td>
</tr>
<tr>
<td>Simulated round and ovarian ligaments (set of 2 each)</td>
<td>4</td>
</tr>
<tr>
<td>Extra thin cervical locking rings</td>
<td>3</td>
</tr>
<tr>
<td>Flashlight with batteries</td>
<td>1</td>
</tr>
<tr>
<td>Soft nylon carrying bag</td>
<td>1</td>
</tr>
</tbody>
</table>

Outer Skin

The outer skin of the model is foam-backed in order to simulate the feel of the anterior pelvic wall. The entire outer skin is removable to allow the model to be used for demonstration purposes (e.g., performing IUD insertion).

The 3 cm incision (reinforced at each end) located just below the umbilicus can be used to insert a laparoscope to look at the uterus, round ligaments, ovaries, and fallopian tubes, and to practice laparoscopic tubal occlusion. This incision also can be used for practicing postpartum tubal ligation by minilaparotomy.
The 3 cm incision located a few centimeters above the symphysis pubis is used for practicing interval minilaparotomy. This incision also is reinforced, which allows the skin to be retracted to facilitate demonstration of the minilaparotomy technique.

**Cervixes**

The normal cervixes have a centrally located, oval-shaped os, which permits insertion of a uterine sound, uterine elevator, or IUD. The abnormal cervixes are not open and can be used for demonstration only.

Each of the cervixes for treatment of incomplete abortion has a centrally located, oval-shaped os, which is dilated to allow passage of a 5 or 6 mm or 10 or 12 mm flexible cannula, respectively.

The normal cervixes and interchangeable uteri feature the patented “screw” design for fast and easy changing.

**Assembly of the Original Zoe Model**

To use the original ZOE pelvic model for demonstrations, or initially to learn how to change the parts (e.g., cervixes and uteri), you need to know how to remove the skin.

**Removing and Replacing the Detachable Skin and Foam Backing**

1. First, carefully remove the outer skin and its foam lining away from the rigid base at the “top” end of the model. (“Top” refers to the portion of ZOE nearest to the metal carrying handle located above the umbilicus.)
2. Lift the skin and foam up and over the legs, one leg at a time.
3. Be as gentle as possible. The detachable skin is made of material that approximates skin texture and it can tear.
4. If you wish to change the anteverted uterus and normal cervix that are shipped attached to the ZOE, first you must remove the uterus.
5. Start by pulling the round ligaments away from the wall.
6. Then grasp the uterus while turning the wide grey ring counterclockwise until the cervix and uterine body are separated.
7. To remove the cervix, turn the thin grey ring counterclockwise until it comes off.
8. You then can push the cervix out through the vagina.
9. To reassemble, simply reverse this process.
10. To replace the skin and foam lining, start by pulling them down over the legs.
11. Then make sure the rectal opening is aligned with the opening in the rigid base.
12. Pull the skin and foam over the top of the model.
13. Finally, make sure that both are pulled firmly down around the rigid base, and that the skin is smoothly fitted over the foam.
Once you understand how ZOE’s anatomic parts fit together, we suggest you change them through the opening at the top of the model. This will help to preserve ZOE’s outer shell as you will only have to remove it for demonstrations or to change the postpartum (20 week size) uterus.

The anteverted and retroverted uteri have transparent top halves and opaque lower halves for use in demonstrating IUD insertion. These uteri are supported by round ligaments attached to the pelvic wall. The round ligaments, ovaries, and fallopian tubes are removable.

To remove the uterus:
- Unscrew the wide locking ring attached to the uterus using a counterclockwise rotation.

To remove the cervix:
- Unscrew the thin locking ring immediately outside the apex of the vagina.
- The cervix should be pushed through the vagina and removed from the introitus.

To reassemble, proceed in reverse order.

Procedures with All Zoe Models

Speculum examination:
- Use a medium bivalve speculum.
- Prior to inserting the speculum, dip it into clean water containing a small amount of soap. (This makes inserting the speculum easier.)
- To see the cervix, fully insert the speculum, angle it posteriorly (as in the human, the vagina in the ZOE model is angled posteriorly), then open the blades fully.
- To increase the diameter of the opening, use the speculum thumb screw (Pederson or Graves speculum).

Passing instruments (uterine sound, uterine elevator, dilator, or cannula) through the cervical os:
- Apply a small amount of clean water containing a drop or two of soap solution to the cervix (just as you would apply it with antiseptic solution in a client). This will make passing the instrument through the cervical os easier.

Sounding the uterus, inserting an IUD, and interval minilaparotomy or laparoscopy:
- Use either the normal (nonpregnant) anteverted or retroverted uterus with a cervix having a patent os.

Postpartum minilaparotomy (tubal occlusion):
- Use the postpartum uterus (20 week size) with a cervix having a patent os.
Treatment of incomplete abortion using MVA:
- Use either the 6 to 8 week or the 10 to 12 week uterus (incomplete abortion) with the appropriate size cervix.

Care and Maintenance of All Zoe Models
The specific model of ZOE Gynecological Simulator will vary, depending on the location of the training site and the procedures being performed, but the care and maintenance are the same for all of these models.
- ZOE is constructed of material that approximates skin texture. Therefore, in handling the model, use the same gentle techniques you would use when working with a client.
- To avoid tearing ZOE’s skin when performing a pelvic exam, use a dilute soap solution to lubricate the instruments and your gloved fingers.
- Clean ZOE after every training session using a mild detergent solution; rinse with clean water.
- DO NOT write on ZOE with any type of marker or pen, as these marks may not wash off.
- DO NOT use alcohol, acetone, Betadine™, or any other antiseptic that contains iodine on ZOE. They will damage or stain the skin.
- Store ZOE in the carrying case and plastic bag provided with your kit.
- DO NOT wrap ZOE in other plastic bags, newspaper, plastic wrap, or any other kind of material, as these may discolor the skin.