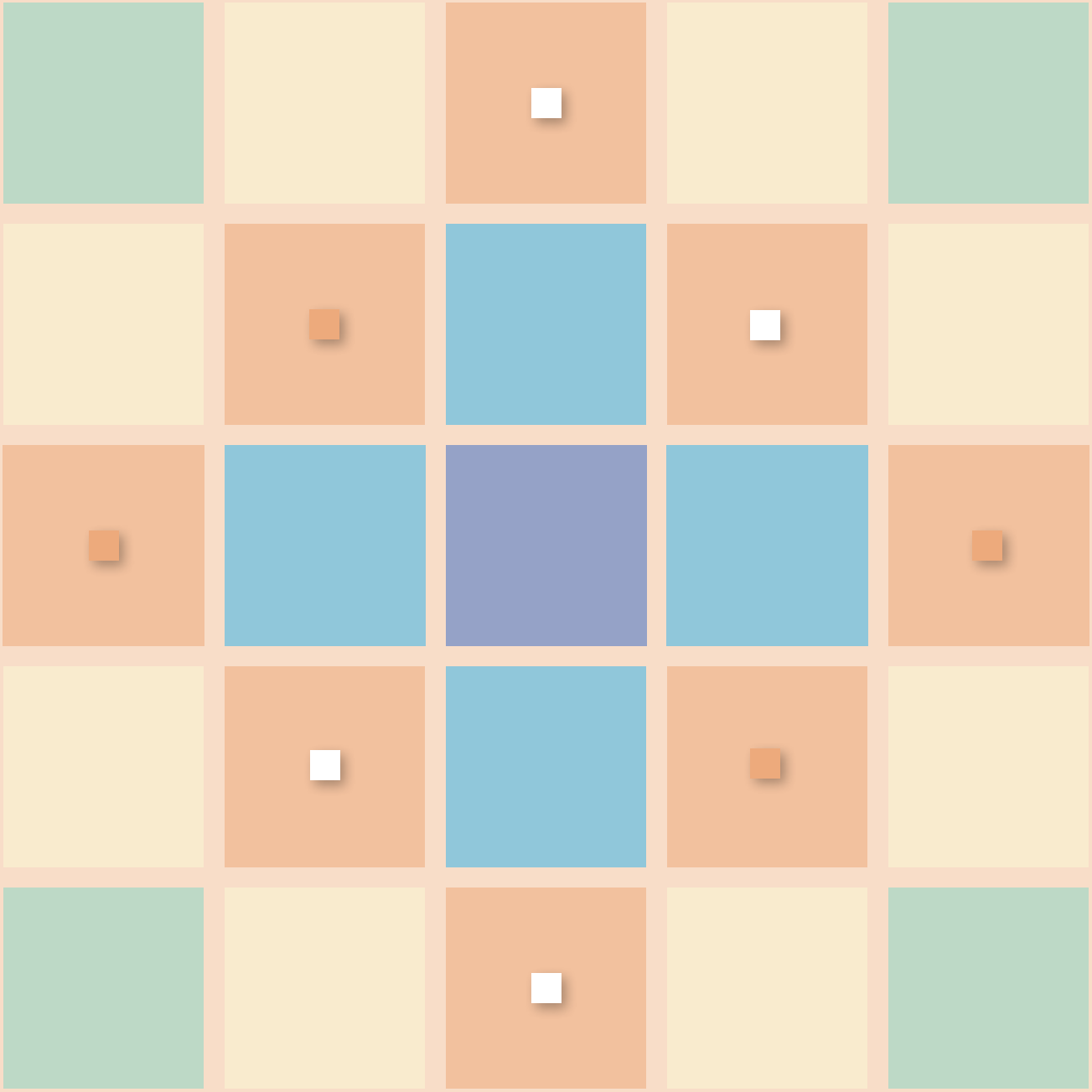
Training and Reference Guide for a Screening Checklist to Initiate Use of Contraceptive Implants



Second edition

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fhi Family Health International

This second edition of the *Training and Reference Guide for a Screening Checklist to Initiate Use of Contraceptive Implants* is consistent with the 2008 revisions to the World Health Organization's *Medical Eligibility Criteria for Contraceptive Use*. Family Health International (FHI) developed this guide, along with other similar guides, to provide training and reference materials in support of the FHI checklists. Each of these guides has been published under FHI's Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) program, which is supported by the U.S. Agency for International Development (USAID) under the terms of Cooperative Agreement No. GPO-A-00-05-00022-00. The contents of this series of publications do not necessarily reflect the views of USAID.

FHI is a public health and development organization working to improve the lives of the world's most vulnerable people. FHI conducts research and implements programs that advance public health and build local capacity to address development problems. FHI has been a global leader in family planning and reproductive health since 1971 and in the worldwide response to HIV/AIDS since 1986. Our research and programs also address malaria, tuberculosis, and other infectious and chronic diseases.

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Introduction

This training and reference guide was developed for family planning service providers interested in using the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants*, commonly referred to as the "Implant Checklist." Designed to serve as both a training and reference tool, the guide is composed of two parts: a training module and a collection of essential, up-to-date reference materials on contraceptive implants. This guide is part of a series to train on other checklists, namely the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives*, the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN)*, the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD,* and the checklist entitled *How to Be Reasonably Sure a Client Is Not Pregnant*.

The Implant Checklist was developed to assist service providers in screening clients who have already been counseled about contraceptive options and who have made an informed decision to use implants. This simple job aid is based on the technical guidance provided by the World Health Organization (WHO) in its *Medical Eligibility Criteria for Contraceptive Use* (2004, updated 2008). The checklist supports the application of these guidelines—known as the WHO MEC—into service delivery practice.

Contraceptive implants are matchstick-sized rods that contain the hormone progestin. Inserted beneath the skin of a woman's upper arm, implants release progestin very slowly, over 3 to 5 years. The most common contraceptive implants are *Jadelle*, which has 2 rods and provides effective contraception for 5 years, *Implanon*, which has 1 rod and is effective for 3 years, *Norplant*, which is composed of 6 capsules and is effective for at least 5 years, and *Sino-implant (II)*—branded as Zarin in Kenya—which has 2 rods and is effective for 4 years.

Research findings have established that contraceptive implants are safe and effective for use by most women, including those who have not given birth and those living with or at risk of HIV infection. However, for some women with certain medical conditions—such as breast cancer or most types of liver tumors—implants are not recommended. The Implant Checklist provides a series of questions designed to screen for these medical conditions and thereby to determine if a woman is medically eligible for implant insertion.

The Implant Checklist also includes a series of questions to rule out pregnancy. This is a required practice prior to implant insertion, because women who are pregnant do not need contraception. Pregnancy can be reliably determined with a pregnancy test, but in many areas of the world these tests often are either unavailable or unaffordable. In such cases, clients who are not menstruating at the time of their visit (occasionally referred to in this guide as "nonmenstruating women," for the sake of simplicity) are often denied contraception by providers who rely on the presence of menses as an indicator that a woman is not pregnant. Usually, these women are required to wait for their menses to return before they can initiate a contraceptive method, thus putting them at risk of an unwanted pregnancy. The pregnancy-related questions on the Implant Checklist are taken from the checklist entitled *How to Be Reasonably Sure a Client Is Not Pregnant*. This checklist, referred to as the "Pregnancy Checklist," has been shown to be 99 percent effective in ruling out pregnancy.

Purpose of the Training and Reference Guide

This publication is intended to provide program managers, administrators, trainers, and service providers with

- a training module on how to use the Implant Checklist;
- an overview of the Implant Checklist and guidance for adapting it for local use;
- current, essential, evidence-based information on implants;
- information on the most current research regarding the validity, effectiveness, and use of the Pregnancy Checklist.

Intended Users of This Guide

This guide can be used by

- trainers, facilitators, program managers, and administrators responsible for training service providers to use the Implant Checklist;
- service providers who need to apply the Implant Checklist in their practices and are responsible for learning how to use it;
- policy-makers and program managers interested in introducing the Implant Checklist for use in their communities.

Note: This guide focuses exclusively on how to use the Implant Checklist. In order to provide quality services, providers who offer or plan to offer implants to their clients may also need training or information on additional topics, such as implant insertion techniques, details on various contraceptive methods, and family planning counseling techniques.

For more comprehensive, evidence-based information on implants, please visit http://www.infoforhealth.org/implants/index.shtml.

Intended Participants of the Training

Training on the Implant Checklist would benefit both clinical and non-clinical service providers who may either counsel clients about using implants or provide this contraceptive method. Some examples of appropriate participants would be

- family planning providers;
- providers who are appropriately trained to safely insert and remove implants, such as physicians, midwives, clinical officers, nurses, or auxiliary nurses;
- non-clinical health workers, such as counselors or assistants, who complete the checklist, and appropriately trained health care providers, who perform the insertions.

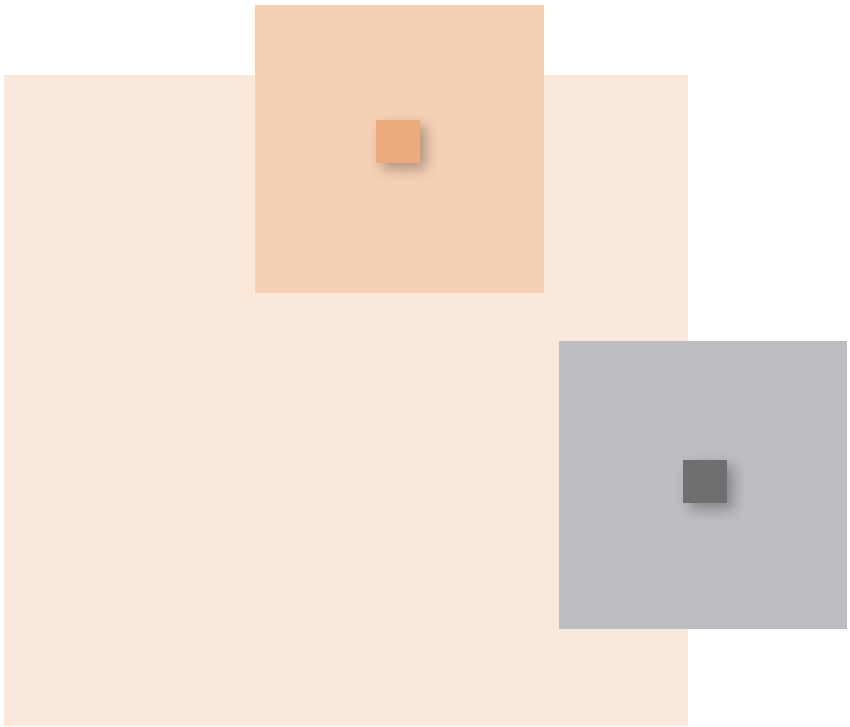
How to Use This Guide

Using the guide as a training tool

This guide provides a curriculum for training service providers to use the Implant Checklist. Training on the Implant Checklist can be completed in approximately five hours. Facilitators are free to adapt the training to serve the needs of their particular audience and may add or delete activities or use the information provided to create their own training. Additional tools that may assist the facilitator in preparing or adapting the training have been assembled in the section entitled Collateral Materials. They are described on page 9. Training schedules for different types of audiences are also available and may be found in the section entitled Supplementary Training Schedules, page 69.

Using the guide as a reference tool

This guide also provides reference information that supplements the training. This information includes recommendations on adapting the checklist to the local context, basic evidence-based information on implants, and an annotated bibliography.



Learning Objectives

By the end of the training, participants will have learned or become familiar with

- the rationale, purpose, and design of the Implant Checklist;
- the medical eligibility criteria to screen clients for initiating implant use;
- proper use of the checklist.

Number of Participants

No more than 30 people are recommended per training.

Time

A minimum of five hours is required to complete all sessions. This includes the Optional Session, but does not include breaks.

Structure of the Module

Session	Time	Topic	Training Method
1	30 minutes	**Welcome and Introductions** Exercise A: Peel the Cabbage	Large group activity; group discussion
2	20 minutes	**Rationale and Purpose of the Implant Checklist**	Facilitator presentation
	30 minutes	Exercise B: Review of the WHO Medical Eligibility Criteria	Small group activity
	10 minutes	Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist	Large group activity
3	40 minutes	**Design of and Instructions for Using the Implant Checklist**	Facilitator presentation
	140 minutes	Exercise D: Practice Using the Implant Checklist	Small group activity
4	15 minutes	**Wrap-Up**	Group discussion
Optional Session	15 minutes	**Summary of Research Findings**	Facilitator presentation

Each training session has four components:

- **Objective—**a short description of the purpose and learning objective(s) for the session
- **Time—**anticipated length of the session
- **Training Steps—**basic steps that guide the trainer through the activities
- **Facilitator's Resource—**detailed information to convey to participants, as indicated in the training steps

Training Materials

Facilitators will need the following materials:

- flip-chart paper
- tape
- markers
- colored pencils for all participants (red and green are recommended)
- training handouts:
  - the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants*
  - two versions of the Quick Reference Chart (one with the categories colored in and one with no color)
  - Scenario Exercises for Participants
  - Answer Guide to Scenarios

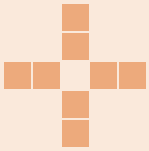
* The training handouts can be found on pages 35-50. They are also available as separate, printable PDF files in the section entitled Collateral Materials (see page 9).

Preparation for Facilitators

In order to understand the purpose, content, and approach of the training, we recommend that facilitators master the information contained in this guide. Facilitators should also be very familiar with the training handouts used in conjunction with the participant exercises, with the source documents for the technical guidance, and with the presentations. (All handouts, source documents, and presentations are accessible from the Collateral Materials section.) Some sessions require advance preparation, such as photocopying, preparing flip charts, or preparing components for exercises. Facilitators should know their audience and adapt the training accordingly.

Due to the technical nature of the subject matter, it is highly likely that questions about implants will arise that are beyond the scope of the information provided in the training portion of this guide. The information provided in the reference guide or in the collateral materials may help facilitators to address some of these questions. As this guide does not aim to comprehensively answer all questions around implant provision, additional training may be required. In those limited cases where the facilitator does not have a clinical background, it is recommended that someone with a clinical background be present to answer technical questions.

Key information for the facilitator is noted throughout the training module with the following symbol.



Collateral Materials

Following is the list of the collateral materials accompanying this training and reference guide, which have been assembled to help facilitators prepare their training sessions. These materials, which may be accessed by clicking this link, will also be useful when adapting the content for different audiences or participant groups. The source documents for the technical guidance and the training handouts, in PDF format, are printable. There are also *Powerpoint* presentations with speaker notes, as well as agendas and certificates in Microsoft *Word*, which are editable.

1. Participant agenda for a combined training on all five checklists

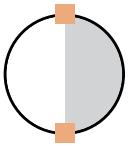
2. *PowerPoint* presentations for orienting different audiences to the checklists
- *PowerPoint* presentation A (for facilitators):
  How to Use Screening Checklists to Initiate Use of Contraceptives
- *PowerPoint* presentation B (for policy-makers and program managers):
  Screening Checklists to Initiate Use of Contraceptives—Tools for Service Providers

3. Handouts for participants:
- Scenario Exercises for Participants
- Answer Guide to Scenarios
- Quick Reference Charts
- Five Screening Checklists
- Certificate of Attendance (sample)

4. Electronic versions of all five training and reference guides

5. Basic, essential, evidence-based information on combined oral contraceptives (COCs), depot-medroxyprogesterone acetate (DMPA), intrauterine devices (IUDs), and implants:
- *Medical Eligibility Criteria for Contraceptive Use*, WHO 2004
- Revisions to the *Medical Eligibility Criteria for Contraceptive Use,* WHO 2008
- *Selected Practice Recommendations for Contraceptive Use*, WHO 2004
- Revisions to the *Selected Practice Recommendations for Contraceptive Use*, WHO 2008
- *PowerPoint* presentation C: Overview of COCs
- *PowerPoint* presentation D: Overview of Injectables—DMPA and NET-EN
- *PowerPoint* presentation E: Overview of the IUD
- *PowerPoint* presentation F: Overview of Implants
- *PowerPoint* presentation G: Hormonal Contraceptives—Considerations for Women with HIV and AIDS

Session One: Welcome and Introductions



30 minutes

Objectives: To present the learning objectives of the training

To facilitate introductions among participants and facilitator(s)

To develop a common understanding of training expectations and group norms

To "break the ice" and help participants become engaged in the training

Training Steps:

1. Welcome the participants and introduce yourself and any other facilitators. Provide an opportunity for participants to introduce themselves, as well. You may choose to do this by asking the participants to state their names and areas of expertise, or by using the icebreaker activity in the shaded box below. The icebreaker activity will help you understand your audience better.

2. Ask participants to state what they expect to learn from the workshop. Write their expectations on flip-chart paper and save them until the end of the workshop. These expectations will be valuable at the end of the workshop as an evaluation tool.

3. Ask participants to suggest guidelines, or norms, to be followed by the group during the training session. Group norms could include: switching off mobile phones, respecting others' right to speak, etc.

4. Launch the training by discussing the title of the Implant Checklist and the learning objectives of the training. Highlight any relevant expectations that were previously expressed by participants.

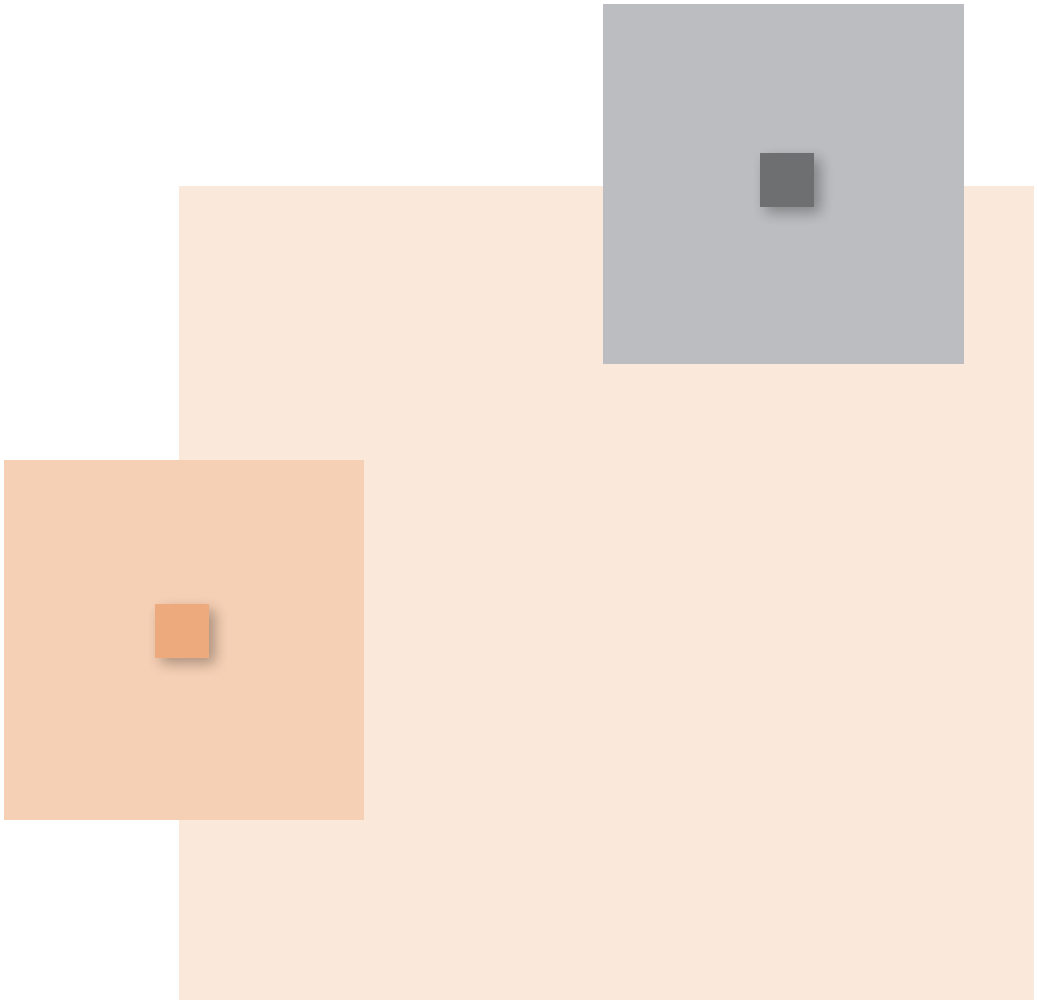
5. Conduct Exercise A (page 12) to engage participants in an introductory discussion of their current practices for screening women who wish to start using implants.

Icebreaker Activity

Each participant talks to the person next to them for five minutes to find out: a) their name, b) the name of their organization and the nature of their work, and c) why they are attending the training today. Participants should then present this information back to the group.

6. Explain that the *Checklist for Screening Clients Who Want to Initiate Contraceptive Implants,* which we will often refer to as the "Implant Checklist," was developed to help providers correctly determine if a woman has any conditions that would prevent her from receiving implants safely.

7. Explain that participants will review the Implant Checklist and will practice using it later in the training. In so doing, they will discover the answers to the following questions:
   - Why was the Implant Checklist developed?
   - How should service providers use the Implant Checklist?
   - What is the basis for the Implant Checklist?
   - How does the Implant Checklist work?



Exercise A: Peel the Cabbage

Preparation

Prior to the training, write the following three questions at least four times, each on a different piece of paper. You should have at least 12 pieces of paper. Mix the pages up and then layer and crumple them so that they resemble a cabbage. Include additional questions on additional pieces of paper, as appropriate. Also write each of these three questions on a different flip-chart page, and tape up each page for all to see.

> ***Name one practice that you follow to determine if a woman can safely receive implants.***
>
> ***Name one approach to ruling out pregnancy prior to inserting implants.***
>
> ***Name one health condition that prevents women from having implants inserted.***

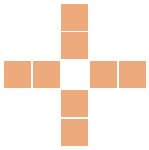
Objective: Participants will discuss their current practices for screening women who wish to start using implants

1. Toss "the cabbage" to one of the participants. The person who catches the cabbage must peel off the top "layer," read the question aloud, and answer it. After answering the question, the participant "tosses the cabbage" to another participant, who answers the next question. If a question is repeated, participants must come up with a different response. Continue tossing the cabbage until all the questions are answered. **Possible answers are given below.**

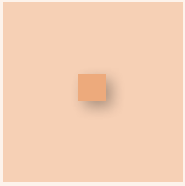
> ***Name one practice that you follow to determine if a woman can safely receive implants.***
>
> Take the client's medical history, ask questions about the presence of certain symptoms, require laboratory tests, use the Implant Checklist, etc.
>
> ***Name one approach to ruling out pregnancy prior to inserting implants.***
>
> Administer a pregnancy test, check for the presence of menses, perform a pelvic exam, use the Pregnancy Checklist, etc.
>
> ***Name one health condition that prevents women from having implants inserted.***
>
> Breast cancer, serious liver disease, etc.

2. If appropriate for your audience, you may chose to make the exercise fun by having the group give some form of mild "penalty" to participants who cannot answer their questions. This might be raising one hand, bending their heads to one side, or standing on one foot, until the cabbage is completely peeled. Let the participants be creative!

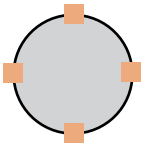
3. Conclude the exercise by telling participants they will have the opportunity to see whether their answers were correct or not at the end of Exercises B and C in Session Two.



Participants may already have extensive knowledge and practical experience in family planning. Make an effort to incorporate participants' questions, knowledge, and experience into your training session, as appropriate.



Session Two: Rationale and Purpose of the Implant Checklist

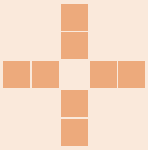


60 minutes

Objective: To learn why and how the checklist was developed

Training Steps:

1. Hold up a copy of the Implant Checklist to show participants, **but do not distribute it until later in the session, at the end of Exercise B.** Check to see if the participants are familiar with the checklist, by asking the following questions:
   - How many of you already use the Implant Checklist to decide if a woman can safely initiate use of contraceptive implants?
   - For those of you who use this checklist, do you find it useful in your work? How?
2. Explain what the Implant Checklist is and why it was developed. If appropriate for your audience, and if needed, you may also choose to discuss the research on the rationale for the Pregnancy Checklist (see Optional Session, page 32).
3. Engage participants in a discussion of how service providers should use the Implant Checklist. Ask participants the following question to emphasize the use of this job aid to improve efficiency in their daily work:
   - In your daily work, how easy is it to use your national guidelines/protocols to determine if it is safe for a woman to have implants inserted?
4. Discuss the basis for the two sets of questions on the Implant Checklist.
   - First, introduce the WHO MEC and explain its purpose.
   - Then perform Exercise B (page 15) to help participants understand how the four MEC categories work in relation to the use of implants.
   - Next, explain the concept of the Pregnancy Checklist questions, what they are, and why they were developed.
   - Perform Exercise C (page 17) to help participants understand the usefulness of the Pregnancy Checklist questions for ruling out pregnancy among women who are not menstruating at the time of their visit.

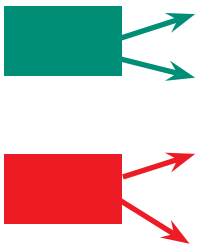


If there are national guidelines or protocols for the provision of family planning, it is important to link the checklists to these documents to promote utilization of the checklist.

Exercise B: Review of the WHO Medical Eligibility Criteria

Preparation

- Prior to the training, make photocopies of both Quick Reference Charts (pages 45-46) and the Implant Checklist (pages 47-50) to distribute to each participant.
- You will also need green and red pens or markers for each participant.
- In addition, you may want to prepare a flip-chart page containing the information in the box below.



Category 1: No restrictions for use.

Category 2: Generally use; some follow-up may be needed.

Category 3: Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

Category 4: Should not be used.

Objective: Participants will review the Quick Reference Chart to become familiar with relevant conditions that have been studied and determined to be safe, or not safe, for implant insertion and use

1. Give each participant a blank copy of the Quick Reference Chart, along with a green and a red pencil or marker.

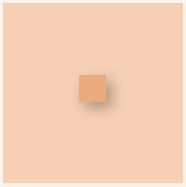
2. Present the information in the box above, illustrating that the four MEC categories may be simplified into two categories: GREEN (representing categories 1 and 2) indicates that the method may be used and RED (representing categories 3 and 4) indicates that the woman is not medically eligible to use the method.

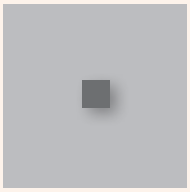
3. Ask participants to use the green and red pencils or markers to color in the rectangles to the right of the conditions listed on the chart. Choose a maximum of four conditions, such as diabetes, high blood pressure, HIV/AIDS, and endometrial cancer. Have participants use GREEN if they think the condition falls under category 1 or 2 and RED if they believe the condition falls under category 3 or 4. They should choose the color based on their knowledge, assumptions or best guess. At your discretion, participants can work individually, in pairs, or as a group. Allow 10 minutes to complete this task. (If no colored pencils or markers are available, have participants write a "G" for green or a "R" for red in the rectangles.)

4. Now, distribute copies of the color version of the Quick Reference Chart and ask the participants to compare their own answers to it. Allow about 10 minutes for them to assess whether their answers were correct or incorrect. **Note that the color version has four colors, one for each category. To make this activity simpler, only two colors are being used instead of four. Explain to participants that light red/pink is RED and light green is GREEN.**

5. Ask volunteers to share which color or category they assigned to each condition. Correct any misinformation as you go along.

6. Distribute a copy of the Implant Checklist. Ask participants to compare the first six questions on the checklist to the conditions colored in red on the Quick Reference Chart. Participants will quickly see that the checklist only asks about category 3 and 4 conditions (red categories). Explain that the checklist questions were designed to identify women who should not have implants inserted or who will require additional evaluation by a higher-level provider before implants may be inserted. Category 1 and 2 conditions (green categories) are not addressed on the checklist, because research shows that women with these conditions can have implants inserted safely.





Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist

Preparation

In advance of the training, write each of the following statements on a separate piece of paper. The statements represent six circumstances that prevent a woman from becoming pregnant and one that does not.

- **Client 1:** "I've not had sexual intercourse since my last menstrual period."
- **Client 2:** "I always use condoms during intercourse, but I want to start using something else."
- **Client 3:** "I just started my menses six days ago."
- **Client 4:** "I have a 3-week-old baby."
- **Client 5:** "Five days ago, I had a miscarriage."
- **Client 6:** "I am fully breastfeeding my 5-month-old baby. Since having my baby, I have not had my menstrual period."
- **Client 7:** "It has been two weeks since I had my last menstrual period."

Objective: Participants will gain a better understanding of the benefits of using the Pregnancy Checklist by visually comparing the number of women who would potentially receive contraception at the time of their visit when providers do and do not use the checklist. This exercise is based on studies of the Pregnancy Checklist done in Kenya, Guatemala, Mali, Senegal, and Egypt.

1. Ask seven participants to come to the front of the room. They will represent seven female clients who are seeking implants and who are not menstruating at the time of their visit.

2. Tell the rest of the participants they will act as providers. They will need to rule out pregnancy before providing contraception to these women and are to rely on their current practices to make their determinations. Ask them to explain how they would respond to these clients. Participants might say that these clients should be
   - sent home with condoms and asked to return when menstruating, or to return four weeks later for an exam if still not menstruating (whichever comes first);
   - given pregnancy tests;
   - given pelvic or abdominal exams;
   - asked more questions.

3. Now distribute your prepared statements, one to each volunteer "client". Have the first client read the first statement out loud. Then ask the group acting as providers if pregnancy can be ruled out for this particular client, since she has been abstinent since her last menstrual period. Require participants to explain their answers.

4. Repeat the exercise for each of the remaining six clients. Correct any misinformation as you go along.

5. Conclude the exercise by explaining that clients 1-6 represent the six questions on the Pregnancy Checklist that allow pregnancy to be ruled out. Emphasize that if these questions were not asked, these clients would not be able to receive implants right away. Point out that the Pregnancy Checklist prompts providers to inquire about all six of these conditions when facing a client. Explain that, for client 7, pregnancy has not been ruled out. Since it has been two weeks since her last menstrual period, there is a possibility she is pregnant. However, the Pregnancy Checklist cannot diagnose pregnancy, so another approach will be needed to determine whether this woman is, in fact, pregnant.

Facilitator's Resource:

Why Was the Implant Checklist Developed?

- The Implant Checklist was developed to help family planning providers screen women for certain medical conditions in order to determine quickly and with confidence whether a client may safely have implants inserted as her contraceptive method of choice.
- Screening is necessary, because some medical conditions preclude safe use of implants. **Most** women who want to initiate use of implants can safely and effectively do so. **Some** women need further evaluation and/or treatment before having implants inserted. For example, a woman who has blood clots in her legs or lungs should not have implants inserted unless it is determined through further evaluation that she is on an established anticoagulant therapy. A **few** women, such as those who have breast cancer, should not have implants inserted under any circumstance.
- Screening for initiating use of implants should also include ruling out pregnancy, because women who are already pregnant do not require contraception.
- Training on the Implant Checklist would benefit both clinical and non-clinical service providers who either counsel clients about implants or provide this contraceptive method. Such providers might be
    - family planning providers;
    - providers who are appropriately trained to safely insert and remove implants, such as physicians, midwives, clinical officers, nurses, or auxiliary nurses;
    - non-clinical health workers, such as counselors or assistants, who complete the checklist, and appropriately trained health care providers, who perform the insertions.

How Should Service Providers Use the Implant Checklist?

- As a screening/decision-making tool
    - The Implant Checklist can be used as a screening tool to help a provider determine whether a woman (1) is a good candidate for implant use, (2) will need further evaluation, or (3) should choose another family planning method. The checklist screens for **known** conditions only. It is **not** a diagnostic tool, such as a blood test, which can determine whether a woman has a particular disease or condition.

- The checklist is not a counseling tool, and should only be used after counseling has been completed and the woman has made an informed decision to have implants inserted. In order to make an informed decision, each woman should be counseled about her contraceptive options by a provider who is properly trained in counseling techniques and in providing information on various contraceptive methods.

- As a job aid for using resources more efficiently
  - The Implant Checklist can save time for both providers and clients by giving providers simple questions to rule out pregnancy, thus eliminating the need for most nonmenstruating clients to make another appointment.
  - Evidence-based practice guidelines can be lengthy and complicated. Use of the Implant Checklist provides a way to apply these same guidelines in a simple, efficient, and timely manner.

What Is the Basis for the Implant Checklist?

- The Implant Checklist is composed of two sets of questions:
  - Questions 1-6 are designed to determine if the client is medically eligible to use implants (*i.e.*, that she has no known conditions which would preclude safe implant use)
  - Questions 7-12 allow providers to be reasonably sure the client is not pregnant

First we will discuss the questions related to medical eligibility, and then we will discuss the questions designed to rule out pregnancy.

- **Medical Eligibility Questions (Questions 1-6)**
  - The first set of questions on the Implant Checklist is based on WHO's *Medical Eligibility Criteria for Contraceptive Use* (2004, updated 2008), which is commonly known as the WHO MEC. The WHO MEC is a set of recommendations to support the development of national guidelines for the safe provision of contraceptives. It is updated by a WHO expert working-group every five years (or as needed), in order to reflect the latest clinical and epidemiological data. The Quick Reference Chart on page 46 is a condensed version of the information contained in the WHO MEC.
  - The WHO MEC considers various individual characteristics (e.g., age, breastfeeding status) or health conditions (e.g., diabetes, hypertension) that may or may not affect eligibility for the use of each contraceptive method and classifies them into one of the following four categories.

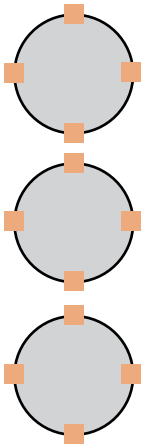
Category	Recommendation
1	No restriction for use of method
2	Advantage of using method outweighs theoretical or proven risk: method generally can be used, but follow-up may be required
3	Theoretical or proven risk outweighs the advantages of using method: method not recommended except if other more appropriate methods are not available/acceptable
4	Method should not be used

- The Implant Checklist poses questions related to categories 3 and 4 only. These two categories cover conditions for which the method is not recommended or should not be used. Category 1 and 2 conditions are not addressed by the checklist, because research shows that women with these conditions can have implants inserted safely.

Pregnancy-Related Questions (Questions 7-12)

- The second set of questions on the Implant Checklist is taken from another checklist entitled *How to Be Reasonably Sure a Client Is Not Pregnant* (Pregnancy Checklist). The pregnancy-related questions were added to the Implant Checklist in order to address a medical barrier that women often encounter when seeking implants at a time when they are not menstruating. In countries where resources are limited and pregnancy tests are often unavailable or unaffordable, many providers worry that these women may be pregnant (unless they are within four weeks postpartum). Many of these clients are sent home, often without contraception, to await menses. Those who are unable to return—often because of time and money constraints—risk unintended pregnancy.
- The questions from the Pregnancy Checklist enable providers to be reasonably sure a woman is not pregnant or to decide that another approach is required to rule out pregnancy. Each question describes a situation that effectively **prevents** a woman from getting pregnant. **The checklist is <u>not</u> a diagnostic tool for determining if a woman <u>is</u> pregnant**. (Note: In the event that pregnancy is not ruled out by questions 7-12, this still does not *necessarily* mean that the woman is pregnant. It only means that another approach will be needed to make a definitive determination.)

Session Three: Design of and Instructions for Using the Implant Checklist



3 hours

Objectives: To understand the design of the Implant Checklist

To practice using the Implant Checklist in different scenarios to ensure that participants are comfortable using it

Training Steps:

1. Discuss the checklist's design and explain how to use the checklist.

2. Ask participants if they have any questions, and clarify anything they did not understand.

2. Conduct Exercise D to allow everyone in the group to practice administering the checklist.

Exercise D: Practice Using the Implant Checklist

Preparation

Prior to the training:

- Photocopy the Scenario Exercises for Participants (pages 35-36).
- Make sure you are familiar with the information provided in the Answer Guide to Scenarios (pages 37-43).
- Make photocopies, if desired, of the Answer Guide to distribute at the end of the session.
- Prepare a flip-chart page containing the following questions:
  - Is this client a good candidate for implant insertion during today's visit?
  - Why or why not?
  - What course of action would you take next? (For example: counsel, refer, provide implants, send client home with condoms to await menses, administer a pregnancy test, etc.)
  - Did you experience any problems applying the checklist to your scenarios?

Objective: To help participants become comfortable using the Implant Checklist

1. Introduce the scenario exercises and explain that participants will be grouped in pairs. Each pair will receive two scenarios. Within each pair, one participant will play the role of the client and the other will play the provider administering the checklist. Participants will then switch roles for the second scenario and repeat the process. This way, everyone will have a chance to practice using the checklist and to experience both roles.

2. Explain that after they role-play their scenarios, each pair should discuss and be able to answer the questions on the flip chart.

3. Divide the participants into pairs and distribute two scenarios to each pair. Participants will have 10 minutes to role-play each scenario and 10 minutes to answer the questions on the flip chart (40 minutes total). Give the following instructions, according to the role the participants will play:

For participants acting as providers

- Make sure you have read and understood the checklist questions and explanations before administering the checklist to the client.
- Ask the client the checklist questions and follow instructions to determine if the client can receive implants.
- Trust the client's response.

- Base your decisions on the checklist questions only, and not on any assumptions about the client. Making assumptions could lead you to the wrong conclusion and cause you to deny your client access to contraception unnecessarily.
- You may answer questions or define terms, if necessary. However, do not make substantive changes to the checklist questions. For example, do not separate one question into two questions or combine two questions into one.

For participants acting as clients

- Read the scenario carefully and answer the checklist questions based on the situation outlined in the scenario.
- If a situation is not specifically described in your assigned scenario, you should answer "NO." For example, if the scenario does not specify that the woman's last menstrual period started within the past seven days, you, as the client, should answer "NO" to that question.

4. Reconvene the group and discuss each scenario with the whole group. Depending on the number of participant pairs, this part of the exercise may take between one and a half to two hours. For each scenario, ask a participant pair to share their answers to the flip-chart questions. If they do not answer questions 1 or 2 correctly, or if additional possibilities exist in answer to question 3, solicit responses from the other participants, or provide it from the answer guide.

5. For each checklist question, discuss any concerns participants have about its phrasing or clarity. Help the group find ways to explain or rephrase the question without changing its meaning. **Be familiar with the information in the section of this guide entitled Adapting the Checklist to the Local Context, page 53.**

6. When discussing a scenario in which pregnancy cannot be ruled out, emphasize that the client should be told she is not **necessarily** pregnant, but that, in light of her responses, another approach will be needed to rule out pregnancy (either a pregnancy test, a pelvic exam, or awaiting her next menses). If she has to wait to rule out pregnancy, always provide her with some interim form of protection against pregnancy, such as condoms.

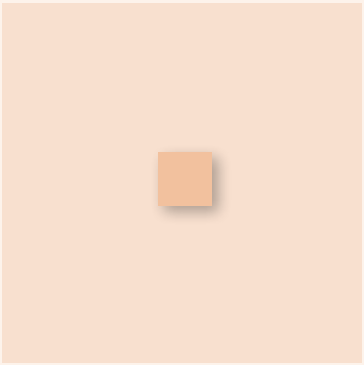
7. After all the scenarios have been discussed, the Answer Guide to Scenarios (pages 37-43) may be distributed to the participants for their future reference.

8. A course of action has been outlined for each scenario. However, if any adaptations are made to the scenarios and/or checklist, it should be recognized that the course of action may change somewhat, as well.

9. The scenarios have been designed to work with any provider training group. To further adapt the training to meet the needs of a specific audience, scenarios may be modified by the facilitator or by another qualified person. Additional scenarios may also be created.

Optional Approaches for Conducting Scenarios

- Ask one or more of the participant pairs to role-play in front of the larger group. Have the whole group discuss each scenario before going on to the next one.
- Instead of role-playing in pairs, ask participants to work individually, each one developing a response to his/her scenario(s). Then have some participants present their responses to the larger group.
- Ask participants to work individually and then find two or three people who had the same scenario. They should discuss their responses and see how they differ. These small groups could then share with the larger group.

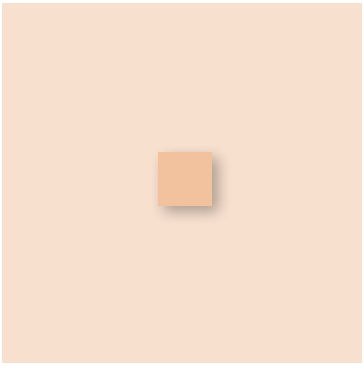


Facilitator's Resource:

How Does the Implant Checklist Work?

- The Implant Checklist is designed to use the provider's time as efficiently as possible. **Notice that instructions for both sets of questions on the checklist state: "As soon as the client answers YES to *any question*, stop, and follow the instructions after question 6 (or after question 12)."** This means that if the client answers "YES" to any question, the provider is finished with that set of questions. Therefore, depending on the client's responses, the questioning may proceed question by question, OR the provider may discover the woman is not a good candidate early in the questioning.
- The Implant Checklist consists of 12 questions, as well as instructions for providers based on a woman's responses. The first set of questions is meant to determine if the woman has no known conditions that could preclude safe insertion of implants (questions 1-6, related to medical eligibility). The second set of questions is meant to identify women who are not pregnant and to determine if they can have implants inserted right away (questions 7-12, related to pregnancy). Each of the checklist questions is explained in more detail on the reverse side of the checklist. Providers should refer to these explanations to understand the intent of the questions.
- **Medical Eligibility Questions**
  - **"Yes" response**—If a woman answers "YES" to any **one** of these questions, she is not medically eligible for implant insertion; *however*, some of these women may become medically eligible after further evaluation. See the instruction box at the bottom of this set of questions and follow the guidance provided there.
  - **"No" response**—If a woman answers "NO" to **all** questions, the client is medically eligible to receive implants. However, pregnancy must be ruled out first. Proceed to the pregnancy-related questions.
- **Pregnancy-Related Questions**
  - **"Yes" response**—If a woman answers "YES" to any **one** question and is free from signs and symptoms of pregnancy, providers can be 99 percent sure she is not pregnant. Proceed with implant insertion.
  - **"No" response**—If a woman answers "NO" to **all** questions, she has not been protected from pregnancy. To rule out pregnancy in these women, the provider will need to do a pregnancy test, conduct a pelvic exam, or have the woman return when she is menstruating. If the client is sent home to await her menses, always provide her with condoms to use in the meantime.

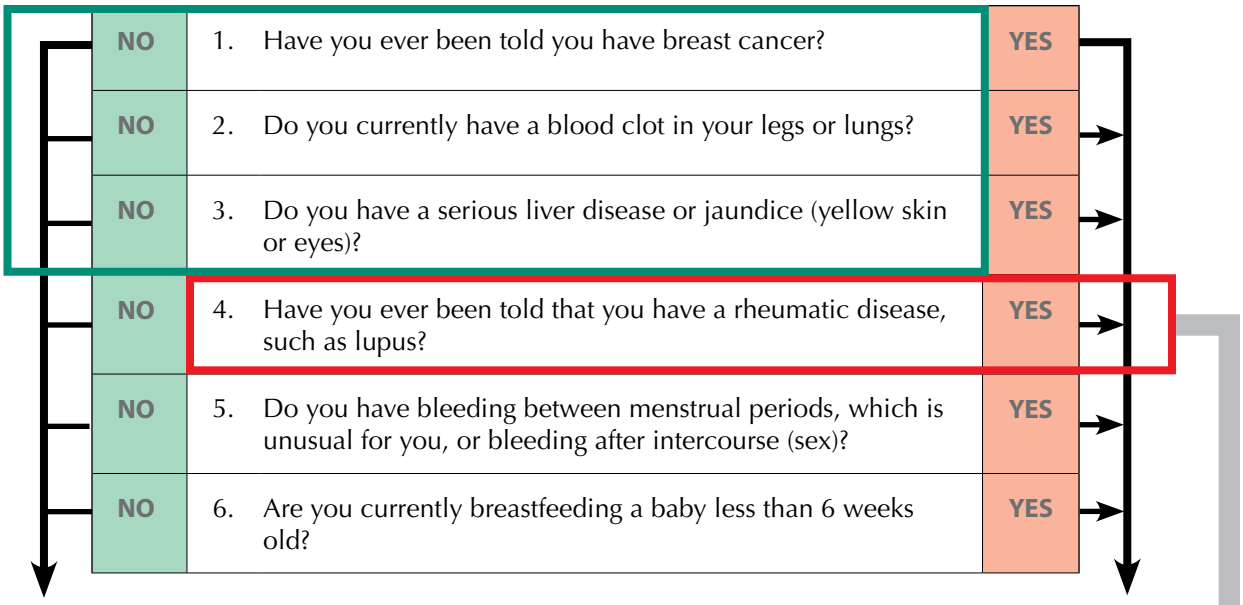
- When asking women questions from the checklist, providers should not confuse or replace diseases and conditions with signs and symptoms.
    - One symptom can indicate several possible conditions. Also, many symptoms are not accurate indicators, so their presence could unnecessarily prevent a woman from receiving implants. For example, if the original question asks a woman if she has ever had lupus, it should not be changed to ask instead if she has achy joints or high fever. These symptoms may have many causes and do not necessarily indicate a history of lupus. Also the checklist is designed to screen for conditions the woman **knows** she has (medical history), not to diagnose new conditions.
- Generally, conditions asked about on the checklist are serious enough that a woman would know if she has them, because she would have had to seek medical attention for them. This is why several of the questions begin, "Have you ever been told …," "Do you have…," and "Have you ever had…." If a woman has not been told she has a condition, providers should assume she does not have it.
- Providers should make an effort to build trusting relationships with clients before administering the Implant Checklist. For example, the provider might wish to convey to the client the necessity of answering as accurately and as honestly as possible, in order to avoid possible complications from implant use. The majority of women will answer honestly to the best of their ability.



Example for Medical Eligibility Questions

Suppose that a woman answers "NO" to questions 1, 2 and 3 but then she answers "YES" to question 4, because she has lupus. At this point, the provider should stop asking questions and read the instructions in the red box after question 6. The instruction is that implants cannot be inserted without further evaluation of her condition. She should be evaluated or referred, as appropriate, and given condoms to use in the meantime.

To determine if the client is medically eligible to use implants, ask questions 1-6. As soon as the client answers YES *to any question*, **stop and follow the instructions after question 6.**



If the client answered **NO** to ***all of questions 1–6,*** she can use implants. Proceed to questions 7–12.

If the client answered **YES** to ***question 1,*** she is not a good candidate for implants. Counsel about other available methods or refer.

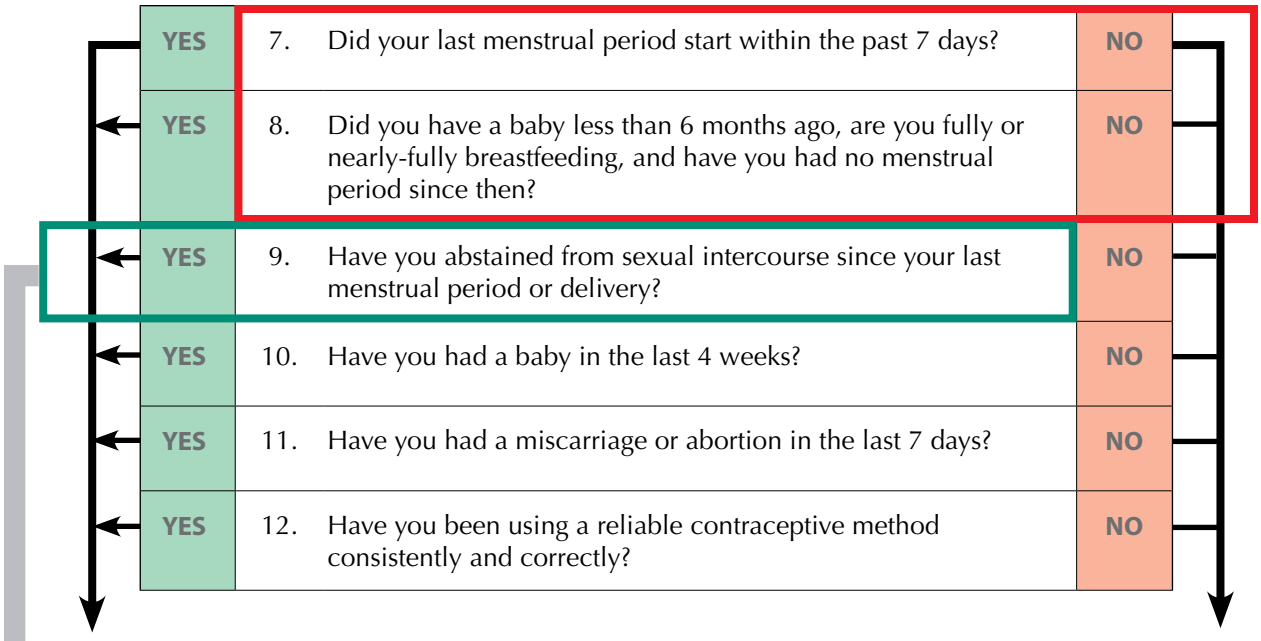
If the client answered **YES** to ***any of questions 2–5,*** implants cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to ***question 6***, instruct her to return for implant insertion as soon as possible after the baby is six weeks old.

Example for Pregnancy-Related Questions

Suppose that a woman answers "NO" to questions 7 and 8, but then answers "YES" to question 9, because she has abstained from sexual intercourse since her last menstrual period. At this point, the provider should stop asking questions, because a "YES" response to any of the questions indicates a circumstance under which it is highly unlikely that a woman could be pregnant.

Ask questions 7-12 to be reasonably sure that the client is not pregnant. As soon as the client answers YES *to any question*, **stop, and follow the instructions after question 12.**



If the client answered **YES** to ***at least one of the questions 7–12*** and she is free from signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can have implants inserted now.

If the client began her last menstual period ***within the past 7 days (5 days for Implanon),*** she can have implants inserted now. No additional contraceptive protection is needed.

If the client began her last menstrual period ***more than 7 days ago (5 days for Implanon),*** she can ***have implants inserted now,*** but instruct her that she must ***use condoms or abstain from sex for the next 7 days.*** Give her condoms to use for the next 7 days.

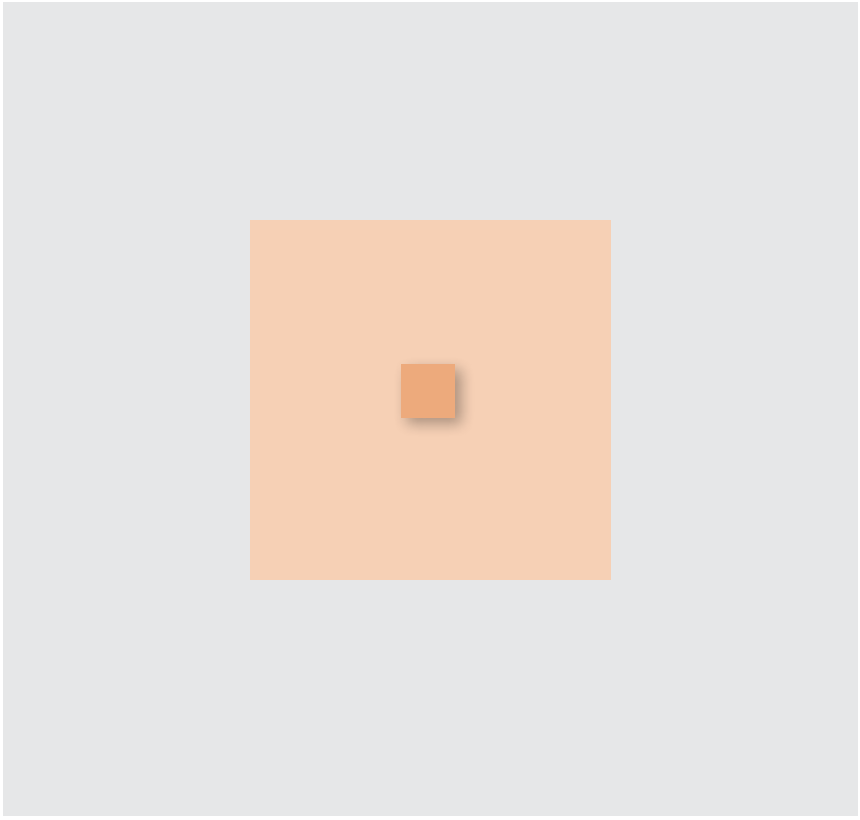
If the client answered **NO** to ***all of questions 7–12,*** pregnancy cannot be ruled out.

She must use a pregnancy test or wait until her next menstrual period to have implants inserted.

Give her condoms to use in the meantime.

Optional information: Participants may inquire about the design elements of the checklist, such as arrows and colors. An explanation is provided below for your use in addressing these questions. It is important to note that while these design elements provide visual cues, they are **secondary** to the written instructions on the checklist, which participants **must** follow.

- The arrows next to the "YES" responses and the straight lines next to the "NO" responses offer cues as to how to proceed through the questions. The arrows indicate the provider should end the questioning and jump directly to the instruction box below that set of questions. The straight lines indicate the provider must proceed to the next question.
- Generally, if the client's response falls in the GREEN boxes, she is a good candidate, and if her response falls in the RED box, she is probably not a good candidate. However, for the eligibility questions, ALL of the client's answers must fall in the green boxes for the woman to be a good candidate, whereas for the pregnancy questions ONE answer in the green boxes is sufficient for her to be a good candidate.

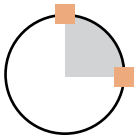


Session Four: Wrap-Up

Objectives: To summarize what was accomplished during the training session

To address any remaining issues

To thank participants for their attention and participation



15 minutes

Training Steps:

1. Briefly summarize the objectives and accomplishments of the training.

2. Show participants the flip-chart page containing the expectations they expressed at the beginning of the training. Ask participants if these expectations have been met.

3. Engage participants in a wrap-up discussion, by asking the following questions:

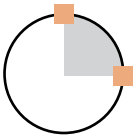
- How easy or difficult was it to use the Implant Checklist?
- How easy or difficult was it to explain questions to the client?
- What problems did you encounter while using the checklist?
- Do you foresee any barriers to using the checklist in your work? How could these barriers be overcome?
- What would help you to use the checklist in your work?
- Do you have any suggestions for improving the checklist or for getting more providers to use it?
- What did you find helpful about the training?
- Could the training be improved in any way? If so, how?

This is a good way to end the training, because it allows you to address any issues or concerns that participants may have. Also, FHI requests that you compile these responses and forward them to our staff at publications@fhi.org for future improvements to this guide.

4. Thank the participants for their time and energy. Tell them whom they should contact for more information or materials.

5. Distribute certificates of attendance to each participant.

Optional Session: Summary of Research Findings



15 minutes

Objective: To understand the research surrounding the need for and the effectiveness of the Pregnancy Checklist

Training Steps:

1. Summarize the research on the rationale for the Pregnancy Checklist.

2. Summarize the research validating the Pregnancy Checklist.

Facilitator's Resource:

Research on the Rationale for the Pregnancy Checklist

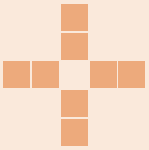
- The Pregnancy Checklist was developed to reduce barriers to contraception for women who are not menstruating at the time of their visit. Research on menstruation requirements has been done in several countries.
  - Kenya—an estimated one-third of all new clients were sent home without a contraceptive method because of a menstruation requirement (Stanback et al. 1999).
  - Ghana—76 percent of health care providers said they would send a client home if she was not menstruating at the time of her visit (Twum-Baah and Stanback 1995).
  - Cameroon—only one-third of nonmenstruating clients received hormonal contraceptive methods, because providers were unsure of clients' pregnancy status (Nkwi et al. 1995).
  - Jamaica—92 percent of clients were required to be menstruating or to have a negative pregnancy test at the time contraceptives were provided (McFarlane et al. 1996).
- Additional research evaluated whether using the Pregnancy Checklist reduced the number of women denied contraceptives because they were not menstruating at the time of their visits.
  - In Guatemala, 16 percent of nonmenstruating women were denied their contraceptive choice when no checklist was used. After providers began using the checklist, only 2 percent of women were denied (Stanback et al. 2005).
  - In Senegal, the situation was similar. Fewer women were denied their contraceptive method of choice after providers were introduced to the checklist—11 percent were denied without the checklist versus 6 percent when the checklist was available (Stanback et al. 2005).

Research on the Validity of the Pregnancy Checklist

- The Pregnancy Checklist has been extensively tested to ensure that it is valid and that women identified by the checklist as not pregnant truly are not pregnant. Research has been done in Kenya, Guatemala, Mali, Senegal, and Egypt. Those studies posed several questions to determine the checklist's validity.

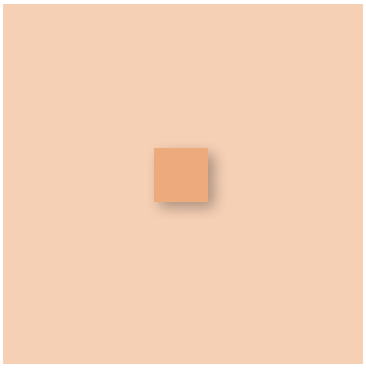
  Does the checklist accurately predict that a woman is <u>not</u> pregnant?
  Yes—Researchers compared results obtained with the checklist to pregnancy tests and found that more than 99 percent of the time the checklist was correct in ruling out pregnancy. In the very rare cases where the checklist ruled out pregnancy but the client was actually pregnant, the reasons for this were contraceptive failure or inaccurate answers given by the client.

  Can the checklist predict that a woman <u>is</u> pregnant?
  No—Most women who are identified as possibly pregnant are, in fact, not pregnant. Researchers gave pregnancy tests to women who answered "No" to all questions and found that fewer than 15 percent were actually pregnant. If pregnancy is not ruled out by the checklist, the woman should be referred for additional evaluation or a pregnancy test, or should await menses.



Emphasize that the checklist was developed to RULE OUT *pregnancy and to minimize barriers women face in seeking contraception. The checklist* CANNOT *be used to diagnose pregnancy.*

Optional information: The end of the Pregnancy Checklist states, "If the client answered **YES** to **at least one of the questions** and she is free of signs or symptoms of pregnancy, provide client with desired method." Research shows that the six questions are much more reliable in determining whether a woman is not pregnant than are signs and symptoms. If a provider is trained to do so, signs and symptoms should be assessed in addition to, but not instead of, administering the checklist. If a provider is not trained to assess signs and symptoms of pregnancy, the provider should feel confident that pregnancy has been ruled out, based on answers to the questions alone. Symptoms may include nausea, mood changes, and missed menstrual period(s), and signs may be uterine softness and breast tenderness.



Scenario Exercises for Participants

1 **Implant Scenario**

You are a 24-year-old woman who gave birth to your first child five months ago. You are fully breastfeeding and have not had a menstrual period since childbirth, but you need to return to work full-time in two weeks. Returning to work will make it impossible to keep up your breastfeeding schedule, so you plan to switch to formula and other supplementary foods as soon as you return to work.

2 **Implant Scenario**

You are a 30-year-old woman who is married, monogamous, and has three children. You know that you are HIV positive, but have had no symptoms and feel healthy. You have been using condoms consistently and correctly, but often worry that the condom may break or slip and you will get pregnant.

3 **Implant Scenario**

You are a 32-year-old woman who wants no more children. You and your husband are mutually monogamous. You report recently having had unexplained bleeding after intercourse with your husband. Your last menstrual period started four days ago.

4 **Implant Scenario**

You are a 31-year-old woman in a monogamous marriage. You are currently being treated for viral hepatitis.

5 **Implant Scenario**

You are a 39-year-old woman with five children. Recently, you were admitted to the hospital with severe chest pain and shortness of breath. You were diagnosed with a blood clot in one of your lungs. You are feeling well now, but are still on anticoagulant therapy (blood thinners). You haven't had sex since your last menses.

6 **Implant Scenario**

You are a 29-year-old woman who started having joint pain about a year ago and who was diagnosed with lupus. You were prescribed treatment, but can't name the drugs you are taking. You still have some occasional joint pain. You and your husband want to wait at least two or three years before having another baby.

7 **Implant Scenario**

You are a 28-year-old divorced woman who has two children. You had surgery two years ago to remove a breast cancer tumor.

8 **Implant Scenario**

You are a 33-year-old married woman with three children. You do not want to risk getting pregnant again, as you were recently diagnosed with diabetes. You have abstained from sexual intercourse since your last menstrual period.

9 **Implant Scenario**

You are a 25-year-old woman who has been in a serious relationship for the past year. You and your boyfriend have agreed to be mutually monogamous and have decided to get tested for sexually transmitted infections, including HIV. You have also decided that, assuming you are both healthy, you would like to start using contraception other than condoms. Your doctor diagnosed you with chlamydia. Your boyfriend's test for chlamydia also came back positive. You just started your period yesterday.

10 **Implant Scenario**

You are a 26-year-old woman who has been diagnosed with AIDS and you do not want to have any children and pass on your disease. You are not taking antiretroviral treatments. You have been using contraceptive pills consistently and correctly, but you are afraid you may forget to take a pill and want to switch to another method that is easier to use.

11 **Implant Scenario**

You are a 21-year-old married woman with no children. You and your husband do not want any children right now, but you are nervous, because you are not using contraception. You are menstruating at the time of your visit.

12 **Implant Scenario**

You are a 37-year-old woman with four children and are requesting implant insertion. Your doctor told you on two occasions that your blood pressure was elevated but that you didn't need to take any medication yet to control it. Your husband has been away from home for the past two weeks and you haven't had sex since your last menstrual period.

Implant Scenario 1

You are a 24-year-old woman who gave birth to your first child five months ago. You are fully breastfeeding and have not had a menstrual period since childbirth, but you need to return to work full-time in two weeks. Returning to work will make it impossible to keep up your breastfeeding schedule, so you plan to switch to formula and other supplementary foods as soon as you return to work.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   The explanation for question 6 on the Implant Checklist states that a breastfeeding woman can begin implant use six weeks after her baby is born. Also, the provider can be reasonably sure this woman is not pregnant, since she is still protected by the lactational amenorrhea method, or LAM. (See explanation for question 8.)

3. ***What course of action would you take next?***
   Proceed with implant insertion.

Implant Scenario 2

You are a 30-year-old woman who is married, monogamous, and has three children. You know that you are HIV positive, but have had no symptoms and feel healthy. You have been using condoms consistently and correctly, but often worry that the condom may break or slip and you will get pregnant.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   HIV infection is not a contraindication for implant insertion or continuing use of implants. Women who are infected with HIV, who have AIDS, or who are on antiretroviral therapy can safely use implants. Also, the provider can be reasonably sure this woman is not pregnant, because she has been using condoms consistently and correctly.

3. ***What course of action would you take next?***
   Proceed with implant insertion.

Implant Scenario 3

You are a 32-year-old woman who wants no more children. You and your husband are mutually monogamous. You report recently having had unexplained bleeding after intercourse with your husband. Your last menstrual period started four days ago.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   No.

2. ***Why or why not?***
   The explanation for question 5 indicates that unexplained vaginal bleeding could be a sign of an underlying pathological condition, such as malignancy (cancer), or an infection.

3. ***What course of action would you take next?***
   Implants should not be inserted until the client's condition has been evaluated further. Implant use does not adversely affect such conditions. However, it may cause changes to bleeding patterns, which could mask symptoms of a serious underlying condition, delaying diagnosis.

   If you do not have the capacity to rule out infection or a malignancy, the client should be referred to a higher-level provider or specialist for evaluation and diagnosis, and implant use should be delayed until the condition has been evaluated. The woman should also be provided with a contraceptive method, such as condoms, to use in the meantime.

Implant Scenario 4

You are a 31-year-old woman in a monogamous marriage. You are currently being treated for viral hepatitis.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   No.

2. ***Why or why not?***
   Although she answered "YES" to question 3 (*Do you have a serious liver disease or jaundice [yellow skin or eyes]?*), she is medically eligible for implant insertion, since women with active or chronic

hepatitis can use implants safely. *Only those* women with current serious liver disease such as severe cirrhosis, malignant liver tumors, or benign liver tumors (with the exception of focal nodular hyperplasia) should not use implants, because the hormones in implants are processed by the liver and their use may further compromise liver function that is already weakened by the disease. However, she answered "NO" to all pregnancy questions, which means pregnancy cannot be not ruled out.

3. ***What course of action would you take next?***
   Administer a pregnancy test or ask the client to wait until her next menstrual period to have implants inserted. Provide condoms to use in the meantime.

Implant Scenario 5

You are a 39-year-old woman with five children. Recently, you were admitted to the hospital with severe chest pain and shortness of breath. You were diagnosed with a blood clot in one of your lungs. You are feeling well now, but are still on anticoagulant therapy (blood thinners). You haven't had sex since your last menses.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   The explanation for question 2 indicates that a woman with known blood clots in legs or lungs is not a good candidate for implants, unless she is on established anticoagulant therapy. Because this woman receives anticoagulant treatment, she can have an implant inserted. Also, the provider can be reasonably sure she is not pregnant, since she hasn't had sex since her last menses.

3. ***What course of action would you take next?***
   Proceed with implant insertion.

Implant Scenario 6

You are a 29-year-old woman who started having joint pain about a year ago and who was diagnosed with lupus. You were prescribed treatment, but can't name the drugs you are taking. You still have some occasional joint pain. You and your husband want to wait at least two or three years before having another baby.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   No.

2. ***Why or why not?***
   She is not medically eligible, since she answered "YES" to question 4 (*Have you ever been told that you have a rheumatic disease, such as lupus?*). Women who have systemic lupus disease and who are not on immunosuppressive treatment should not use implants, due to concerns about possible risk of thrombosis. Since the provider can't be sure what type of treatment this client receives, implants should not be inserted at this time.

3. ***What course of action would you take next?***
   Counsel the woman on available nonhormonal contraceptive options, such as an IUD or condoms, for which lupus is not a contraindication. If she still wants to use implants and you can confirm that her treatment includes immunosuppressant drugs, she may have implants inserted then. Provide her with condoms to use in the meantime.

Implant Scenario 7

You are a 28-year-old divorced woman with two children. You had surgery two years ago to remove a breast cancer tumor.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   No.

2. ***Why or why not?***
   She is not medically eligible since she answered "YES" to question 1 (*Have you ever been told you have breast cancer?*). Women with a history of breast cancer, or those who have current breast cancer, should not have implants inserted. This is because breast cancer is a hormone-sensitive tumor, and use of implants could adversely affect the course of the disease.

3. ***What course of action would you take next?***
   Counsel the woman on available nonhormonal contraceptive options, such as an IUD, condoms, or sterilization. Breast cancer is not a contraindication for these methods.

Implant Scenario 8

You are a 33-year-old married woman with three children. You do not want to risk getting pregnant again, as you were recently diagnosed with diabetes. You have abstained from sexual intercourse since your last menstrual period.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   Women with diabetes can generally use implants safely. Also, the provider can be reasonably sure this woman is not pregnant, since she has not had sex since her last menses.

3. ***What course of action would you take next?***
   Proceed with implant insertion.

Implant Scenario 9

You are a 25-year-old woman who has been in a serious relationship for the past year. You and your boyfriend have agreed to be mutually monogamous and have decided to get tested for sexually transmitted infections, including HIV. You have also decided that, assuming you are both healthy, you would like to start using contraception other than condoms. Your doctor diagnosed you with chlamydia. Your boyfriend's test for chlamydia also came back positive. You just started your period yesterday.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   Chlamydia is not a contraindication for implant insertion. Also, since this client just started her period, the provider can be reasonably sure she is not pregnant.

3. ***What course of action would you take next?***
   Proceed with implant insertion. The provider should also treat her and her partner for chlamydial infection and counsel them to abstain from sex or use condoms until both are cured.

Implant Scenario 10

You are a 26-year-old woman who has been diagnosed with AIDS and you do not want to have any children and pass on your disease. You are not taking antiretroviral treatments. You have been using contraceptive pills consistently and correctly, but you are afraid you may forget to take a pill and want to switch to another method that is easier to use.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   Women who are infected with HIV, who have AIDS, or who are on ARV therapy can safely use implants. Also, because the client has been using contraceptive pills consistently and correctly, the provider can be reasonably sure she is not pregnant.

3. ***What course of action would you take next?***
   Proceed with implant insertion. The provider should also counsel this client about using condoms along with implants, in order to prevent transmission of HIV to others.

Implant Scenario 11

You are a 21-year-old married woman with no children. You and your husband do not want any children right now, but you are nervous, because you are not using contraception. You are menstruating at the time of your visit.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   Neither youth nor absence of children is a contraindication for implant insertion. Since the client is menstruating at the time of her visit, the provider can be reasonably sure she is not pregnant.

3. ***What course of action would you take next?***
   Proceed with implant insertion.

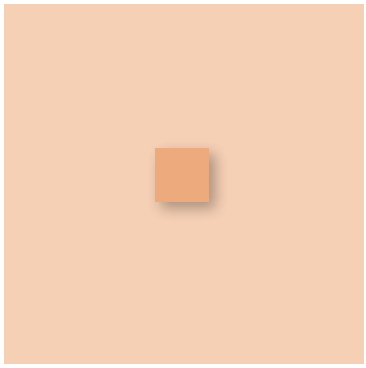
Implant Scenario 12

You are a 37-year-old woman with four children and are requesting implant insertion. Your doctor told you on two occasions that your blood pressure was elevated, but that you didn't need to take any medication yet to control it. Your husband has been away from home for the past two weeks and you haven't had sex since your last menstrual period.

1. ***Is this client a good candidate for implant insertion during today's visit?***
   Yes.

2. ***Why or why not?***
   She is medically eligible, because elevated blood pressure is not a contraindication for implant insertion. Also, since this client hasn't had sex since her last menstrual period, the provider can be reasonably sure she is not pregnant.

3. ***What course of action would you take next?***
   Proceed with implant insertion.



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)

CONDITION		COC	DMPA	Implants	Cu-IUD
Pregnancy		NA	NA	NA	
Breastfeeding	Less than 6 weeks postpartum				NC
	6 weeks to < 6 months postpartum				
	6 months postpartum or more				
Postpartum	Less than 21days, non-breastfeeding				NC
	< 48 hours including immediate post-placental	NC	NC	NC	
	≥ 48 hours to less than 4 weeks				
	Puerperal sepsis				
Postabortion	Immediate post-septic				
Smoking	Age ≥ 35 years, < 15 cigarettes/day				
	Age ≥ 35 years, ≥ 15 cigarettes/day				
Multiple risk factors for cardiovascular disease					
Hypertension	History of (where BP cannot be evaluated)				
	BP is controlled and can be evaluated				
	Elevated BP (systolic 140 - 159 or diastolic 90 - 99)				
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
	Vascular disease				
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE				
	Acute DVT/PE				
	DVT/PE, established on anticoagulant therapy				
	Major surgery with prolonged immobilization				
Known thrombogenic mutations					
Ischemic heart disease (current or history of) **or stroke** (history of)					
Known hyperlipidemias					
Complicated valvular heart disease					
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies				
	Severe thrombocytopenia				
	Immunosuppressive treatment				
Headaches	Non-migrainous (mild or severe)				
	Migraine without aura (age < 35 years)				
	Migraine without aura (age ≥ 35 years)				
	Migraines with aura (at any age)				
Vaginal bleeding patterns	Irregular without heavy bleeding				
	Heavy or prolonged, regular and irregular				
	Unexplained bleeding (prior to evaluation)				

CONDITION		COC	DMPA	Implants	Cu-IUD
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels				
	Persistently elevated β-hCG levels or malignant disease				
Cancers	Cervical (awaiting treatment)				
	Endometrial				
	Ovarian				
Breast disease	Undiagnosed mass	*	*	*	
	Current cancer				
	Past w/ no evidence of current disease for 5 yrs				
Uterine distortion due to fibroids or anatomical abnormalities					
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				
	Vaginitis				
	Current pelvic inflammatory disease (PID)				
	Other STIs (excluding HIV/hepatitis)				
	Increased risk of STIs				
	Very high individual risk of exposure to STIs				
Pelvic tuberculosis					
Diabetes	Non-vascular disease				
	Vascular disease or diabetes for > 20 years				
Symptomatic gall bladder disease (current or medically treated)					
Cholestasis (history of)	Related to pregnancy				
	Related to oral contraceptives				
Hepatitis	Acute or flare				
	Chronic or client is a carrier				
Cirrhosis	Mild				
	Severe				
Liver tumors (hepatocellular adenoma and malignant hepatoma)					
HIV	High risk of HIV or HIV-infected				
AIDS	No antiretroviral therapy (ARV)				
	Clinically well on ARV therapy	see drug interactions			
	Not clinically well on ARV therapy	see drug interactions			
Drug interactions, including use of:	Nucleoside reverse transcriptase inhibitors				
	Non-nucleoside reverse transcriptase inhibitors				
	Ritonavir, ritonavir-boosted protease inhibitors				
	Rifampicin or rifabutin				
	Anticonvulsant therapy**				

Source: Adapted from *Medical Eligibility Criteria for Contraceptive Use*. Geneva: World Health Organization, updated 2008.
Available: http://www.who.int/reproductive-health/family_planning/guidelines.htm

☐ **Category 1** There are no restrictions for use.

☐ **Category 2** Generally use; some follow-up may be needed.

☐ **Category 3** Usually not recommended; clinical judgment and continuing access to clinical services are required for use.

☐ **Category 4** The method should not be used.

Unlike previous versions of the MEC Quick Reference Chart, this version includes a complete list of all conditions classified as Category 3 and 4 by WHO.

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

NA (not applicable): Women who are pregnant do not require contraception.

NC (not classified): The condition is not part of the WHO classification for this method.

* Evaluation of an undiagnosed mass should be pursued as soon as possible.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

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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)

CONDITION		COC	DMPA	Implants	Cu-IUD
Pregnancy		NA	NA	NA	
Breastfeeding	Less than 6 weeks postpartum				NC
	6 weeks to < 6 months postpartum				
	6 months postpartum or more				
Postpartum	Less than 21 days, non-breastfeeding				NC
	< 48 hours including immediate post-placental	NC	NC	NC	
	≥ 48 hours to less than 4 weeks				
	Puerperal sepsis				
Postabortion	Immediate post-septic				
Smoking	Age ≥ 35 years, < 15 cigarettes/day				
	Age ≥ 35 years, ≥ 15 cigarettes/day				
Multiple risk factors for cardiovascular disease					
Hypertension	History of (where BP cannot be evaluated)				
	BP is controlled and can be evaluated				
	Elevated BP (systolic 140 - 159 or diastolic 90 - 99)				
	Elevated BP (systolic ≥ 160 or diastolic ≥ 100)				
	Vascular disease				
Deep venous thrombosis (DVT) and pulmonary embolism (PE)	History of DVT/PE				
	Acute DVT/PE				
	DVT/PE, established on anticoagulant therapy				
	Major surgery with prolonged immobilization				
Known thrombogenic mutations					
Ischemic heart disease (current or history of) **or stroke** (history of)				I C	
Known hyperlipidemias					
Complicated valvular heart disease					
Systemic lupus erythematosus	Positive or unknown antiphospholipid antibodies				
	Severe thrombocytopenia		I C		I C
	Immunosuppressive treatment				I C
Headaches	Non-migrainous (mild or severe)	I C			
	Migraine without aura (age < 35 years)	I C			
	Migraine without aura (age ≥ 35 years)	I C			
	Migraines with aura (at any age)		I C	I C	
Vaginal bleeding patterns	Irregular without heavy bleeding				
	Heavy or prolonged, regular and irregular				
	Unexplained bleeding (prior to evaluation)				I C

CONDITION		COC	DMPA	Implants	Cu-IUD
Gestational trophoblastic disease	Regressing or undetectable β-hCG levels				
	Persistently elevated β-hCG levels or malignant disease				
Cancers	Cervical (awaiting treatment)				I C
	Endometrial				I C
	Ovarian				I C
Breast disease	Undiagnosed mass	*	*	*	
	Current cancer				
	Past w/ no evidence of current disease for 5 yrs				
Uterine distortion due to fibroids or anatomical abnormalities					
STIs/PID	Current purulent cervicitis, chlamydia, gonorrhea				I C
	Vaginitis				
	Current pelvic inflammatory disease (PID)				I C
	Other STIs (excluding HIV/hepatitis)				
	Increased risk of STIs				
	Very high individual risk of exposure to STIs				I C
Pelvic tuberculosis					I C
Diabetes	Non-vascular disease				
	Vascular disease or diabetes for > 20 years				
Symptomatic gall bladder disease (current or medically treated)					
Cholestasis (history of)	Related to pregnancy				
	Related to oral contraceptives				
Hepatitis	Acute or flare	I C			
	Chronic or client is a carrier				
Cirrhosis	Mild				
	Severe				
Liver tumors (hepatocellular adenoma and malignant hepatoma)					
HIV	High risk of HIV or HIV-infected				
AIDS	No antiretroviral therapy (ARV)				I C
	Clinically well on ARV therapy	see drug interactions			
	Not clinically well on ARV therapy	see drug interactions			I C
Drug interactions, including use of:	Nucleoside reverse transcriptase inhibitors				
	Non-nucleoside reverse transcriptase inhibitors				
	Ritonavir, ritonavir-boosted protease inhibitors				
	Rifampicin or rifabutin				
	Anticonvulsant therapy**				

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NA (not applicable): Women who are pregnant do not require contraception.

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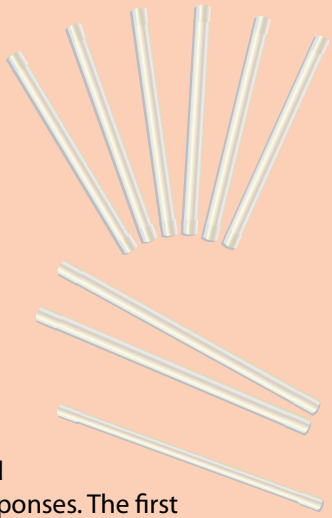
* Evaluation of an undiagnosed mass should be pursued as soon as possible.

** Anticonvulsants include: phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine, and lamotrigine. Lamotrigine is a category 1 for implants.

Family Health International

Checklist for Screening Clients Who Want to Initiate Contraceptive Implants



Contraceptive implants, such as Norplant, Jadelle, Sinoplant, and Implanon, are safe and effective for use by most women, including those who are at risk of cardiovascular disease, sexually transmitted infections (STIs) and HIV infection, or those living with HIV. For some women, implants are generally not recommended because of the presence of certain medical conditions, such as breast cancer or most types of liver tumors. Women who desire to use implants must therefore be screened for certain medical conditions to determine if they are appropriate candidates.

Family Health International (FHI), with support from the U.S. Agency for International Development (USAID), has developed a simple checklist (see center spread) to help health care providers screen clients who have been counseled about contraceptive options and who have made an informed decision to use implants. The checklist is based on recommendations included in the *Medical Eligibility Criteria for Contraceptive Use* (WHO, updated 2008). It consists of 12 questions and provides guidance based on clients' responses. The first six questions are designed to identify medical conditions that would prevent safe use of implants or require further evaluation. Clients who are ruled out because of their response to some of the medical eligibility questions may still be good candidates for implants if the suspected condition can be excluded through appropriate evaluation. The last six questions enable providers to determine with reasonable certainty that a woman is not pregnant before initiating the method.

A health care provider should complete the checklist before inserting the implant(s). In some settings the responsibility for initiating implants may be shared — by a counselor who completes the checklist and an appropriately trained health care provider who performs the insertion. Providers trained to perform insertions may include nurses, nurse-midwives, nurse-practitioners, midwives, physicians, and, depending on educational and professional standards in each country, physician's assistants and associates.

This checklist is part of a series of provider checklists for reproductive health services. The other checklists include the *Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives,* the *Checklist for Screening Clients Who Want to Initiate DMPA (or NET-EN),* the *Checklist for Screening Clients Who Want to Initiate Use of the Copper IUD,* and the checklist entitled, *How to be Reasonably Sure a Client is Not Pregnant.* For more information about the provider checklists, please visit www.fhi.org.

Assessing Medical Eligibility for Implants

1. Have you ever been told you have breast cancer?

This question is intended to identify women who know they have had or currently have breast cancer. These women are not good candidates for implants because breast cancer is a hormone-sensitive tumor, and implant use may adversely affect the course of the disease.

2. Do you currently have a blood clot in your legs or lungs?

This question is intended to identify women with known blood clots, not to determine whether a woman might have an undiagnosed blood clot. Women with blood clots in their legs or lungs usually experience acute symptoms that prompt them to seek health care. For this reason, they would likely be aware of the condition and would answer "yes." Because implant use may make these conditions worse, answering "yes" to the question means that the woman is not a good candidate for contraceptive implants. However, women on established anticoagulant therapy generally can use implants.

Continued on page 50

Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

To determine if the client is medically eligible to use implants, ask questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 6.

NO	1. Have you ever been told you have breast cancer?	YES
NO	2. Do you currently have a blood clot in your legs or lungs?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Have you ever been told that you have a rheumatic disease, such as lupus?	YES
NO	5. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES
NO	6. Are you currently breastfeeding a baby less than 6 weeks old?	YES

If the client answered **NO** to ***all of questions 1–6,*** she can use implants. Proceed to questions 7–12.

If the client answered **YES** to ***question 1,*** she is not a good candidate for implants. Counsel about other available methods or refer.

If the client answered **YES** to ***any of questions 2–5,*** implants cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to ***question 6,*** instruct her to return for implant insertion as soon as possible after the baby is six weeks old.

Ask questions 7–12 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 12.

YES	7. Did your last menstrual period start within the past 7 days?	NO
YES	8. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	9. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	10. Have you had a baby in the last 4 weeks?	NO
YES	11. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	12. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to ***at least one of questions 7–12*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can have implants inserted now.

If the client began her last menstrual period ***within the past 7 days (5 days for Implanon),*** she can have implants inserted now. No additional contraceptive protection is needed.

If the client began her last menstrual period ***more than 7 days ago (5 days for Implanon),*** she can ***have implants inserted now,*** but instruct her that she must ***use condoms or abstain from sex for the next 7 days.*** Give her condoms to use for the next 7 days.

If the client answered **NO** to ***all of questions 7–12,*** pregnancy cannot be ruled out.

She must use a pregnancy test or wait until her next menstrual period to have implants inserted.

Give her condoms to use in the meantime.

Continued from page 47

3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?

This question is intended to identify women who know that they currently have a serious liver disease such as severe cirrhosis; malignant liver tumors; or benign liver tumors, with the exception of focal nodular hyperplasia (a tumor that consists of scar tissue and normal liver cells). Women with these conditions should not use implants, because the hormones used in implants are processed by the liver and may further compromise liver function. Women with other liver problems, such as acute or chronic hepatitis, can use implants safely.

4. Have you ever been told that you have a rheumatic disease, such as lupus?

This question is intended to identify women who have been diagnosed with systemic lupus disease. Women who have systemic lupus disease and who are not on immunosuppressive treatment should not use implants, due to concerns about a possible increased risk of thrombosis.

5. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?

This question is intended to identify women who may have an underlying pathological condition. While these conditions are not directly affected by implants, changes in bleeding patterns which are common among implant users, could make such conditions harder to diagnose. Unusual, unexplained bleeding changes may indicate infection or cancer that should be evaluated without delay or treated by a higher-level health care provider. Implant use should be postponed until the condition can be evaluated. In contrast, women for whom heavy, prolonged, or irregular bleeding constitutes their usual bleeding pattern may initiate and use implants safely.

6. Are you currently breastfeeding a baby less than six weeks old?

This question is included because of the theoretical concern that hormones in breast milk may have an adverse effect on a newborn during the first six weeks after birth. A breastfeeding woman can begin implant use six weeks after her baby is born.

Determining Current Pregnancy

Questions 7–12 are intended to help a provider determine, with reasonable certainty, whether a client is not pregnant. If a client answers "yes" to any of these questions and has no signs or symptoms of pregnancy, it is highly likely that she is not pregnant. The client can have implants inserted now.

If the client is within 7 days of the start of her menstrual bleeding (5 days for Implanon), she can start the method immediately. No back-up method is needed.

If it has been more than 7 days since her first day of bleeding (more than 5 days for Implanon), she can start the method immediately, but must use a back-up method (i.e., using a condom or abstaining from sex) for 7 days to ensure adequate time for the implants to become effective.

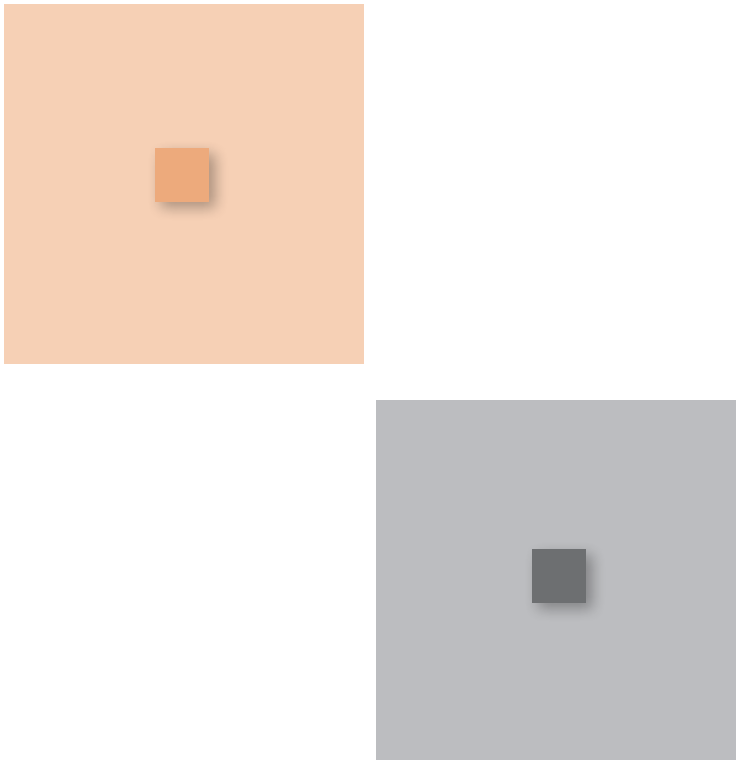
If you cannot determine with reasonable certainty that the woman is not pregnant (using the checklist), and if you do not have access to a pregnancy test, then she needs to wait until her next menstrual period begins before having implants inserted. She should be given condoms to use in the meantime.

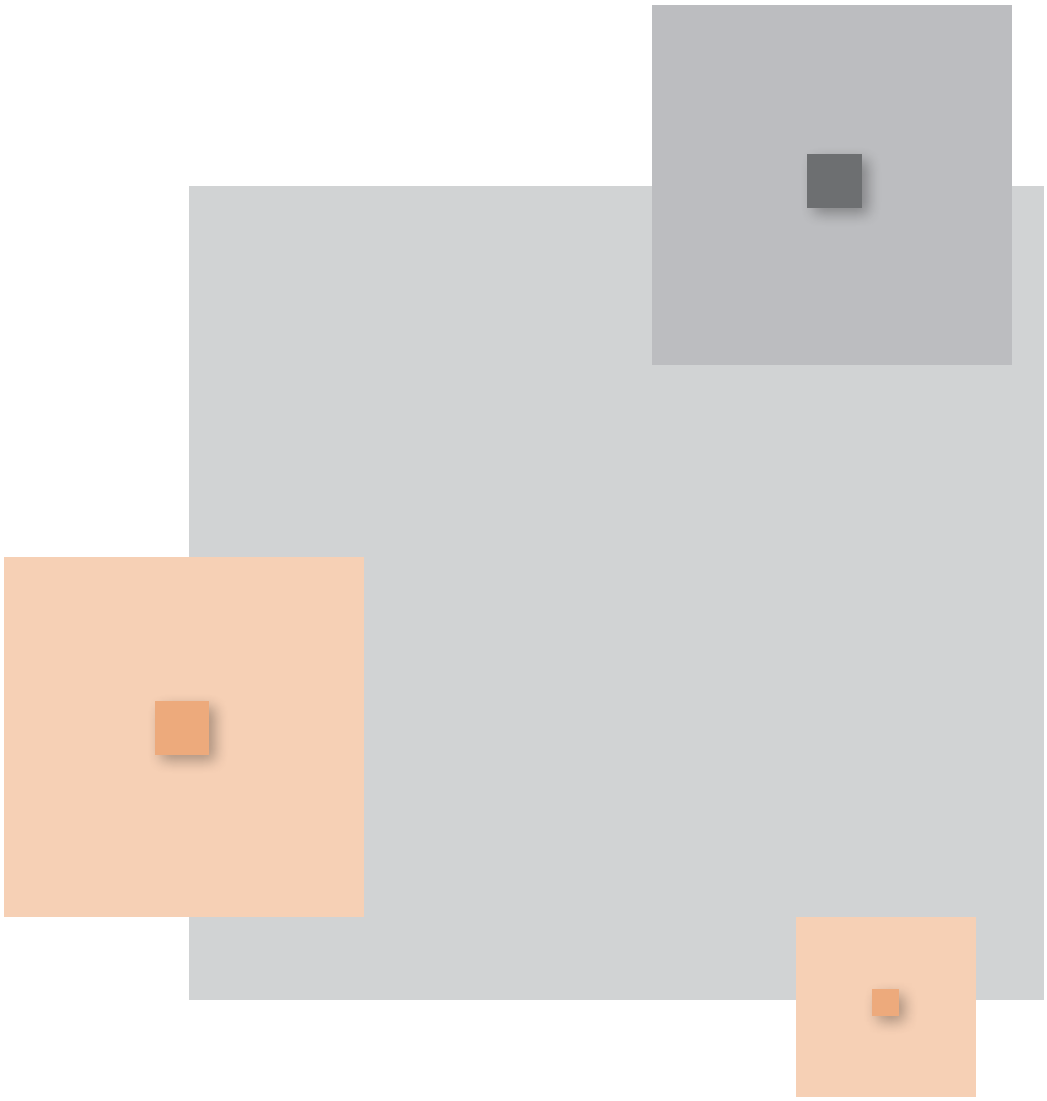
Reference Guide

The purpose of this reference guide is to provide essential information that supplements the training module. The reference guide provides

- recommendations on adapting the checklist to the local context;
- basic evidence-based information on implants;
- an annotated bibliography.

The facilitator should anticipate—and be prepared to answer—questions that are likely to arise and that are beyond the scope of the Implant Checklist. The checklist is intended solely to help providers decide if clients may or may not safely initiate use of implants. However, participants are likely to inquire about such issues as side effects of implant use by specific client populations, or women who are at risk of HIV or who are living with AIDS, etc. This guide does not attempt to provide comprehensive information about implants, and trainers should consult other resources, as needed. It is recommended that a clinician with experience in implant insertion cofacilitate the training, if possible.





Adapting the Checklist to the Local Context

The Implant Checklist can be adapted to meet the specific needs of a local area or program, or to align with national guidelines that may apply. However, before the adapted version is finalized and put into use, we strongly recommend that any changes be reviewed by an expert who understands the medical basis for the checklist. If the checklist is adapted, the corresponding training module should also be adjusted to reflect any changes. The intent of each question is explained on the reverse side of the checklist to help with these adaptations. The following are examples of situations in which adaptation may be needed.

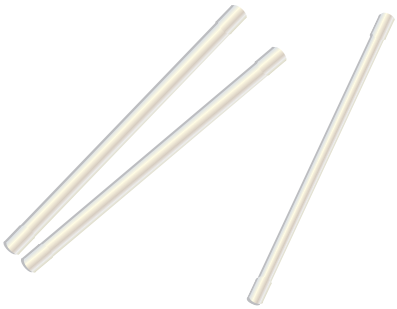
- **Adapting the checklist to the local language and style**
  Whenever necessary, the checklist should be translated and the style adapted to meet the cultural and linguistic needs of the intended users of the checklist and their clients. In addition to English, the checklist has been produced in French, Spanish, Kiswahili and several other languages. These checklists are available on FHI's web site, www.fhi.org.
- **Adapting for local culture**
  Some of the questions on the checklist deal with personal issues and may need to be asked in a sensitive manner. For example, question 11 asks about miscarriage and abortion. To help ensure that the client feels safe and comfortable answering honestly, it may be useful to ask instead: "Have you lost a pregnancy in the last seven days?"
- **Adapting the checklist for comprehension**
  Adaptations may also be made if the questions are too technical to be understood. Be careful, however, not to inadvertently change the intent of the question, because even small changes in wording can cause significant changes in meaning. For audiences with low literacy levels, it may be helpful to develop materials that convey key messages through illustrations with simple captions. Illustrations also should be appropriate for the local target audience.

The purpose of the Implant Checklist is to allow more women to receive this contraceptive method safely. Poor adaptations of the checklist questions could prevent eligible women from receiving implants. The following are examples of poorly adapted **checklist questions.**

Original Question	Poorly Adapted Question	Reason
Changes to the approach/structure of the question		
Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	Are you fully or nearly fully breastfeeding and have you had no menstrual period since you gave birth?	The structure of the question is changed in this example. The original question identifies women who are experiencing lactational amenorrhea, which is defined by the three criteria in the question, and can be used to effectively prevent unintended pregnancy. Removing "Did you have a baby less than 6 months ago?" removes one of the criteria, so this question can no longer be used to identify women with lactational amenorrhea.
Have you ever been told you have breast cancer?	Do you have or have you ever had a breast lump?	The original question intends to identify women with a history of breast cancer. It does not intend to diagnose breast cancer. Implant use is contraindicated for women with a history of breast cancer, but not for women who have an undiagnosed mass or benign breast disease (although evaluation is recommended after these women initiate implants).

FACT SHEET: Implants

Progestin-only implants consist of hormone-filled capsules or rods that are inserted under the skin in a woman's upper arm. The Norplant implant system is a set of six thin, flexible capsules made of silicone that is effective for five years. Jadelle was designed to deliver the same daily dose of levonorgestrel that Norplant delivers but has only two rods instead of six and is effective for five years. Sino-implant (II) is identical to Jadelle. Implanon—a single-rod system—continually releases a low, steady dose of the progestin etonogestrel for a period of up to three years.



Primary mechanisms of action

- Thicken cervical mucus (make it difficult for sperm to penetrate)
- Partially prevent ovulation (in about half of menstrual cycles)

Characteristics of progestin-only injectables

- Highly effective
- Easy to use
- Long-acting pregnancy protection, but easily reversible
- Do not interfere with intercourse; private
- Have no affect on quality or quantity of breast milk
- Have beneficial non-contraceptive effects (help prevent ectopic pregnancy and iron deficiency anemia)
- Substantially reduce the risk of ectopic pregnancy
- Have common side effects
- Insertion involves minor surgical procedure and some discomfort for a day or two
- Cannot be initiated or discontinued without a provider
- Provide no protection from sexually transmitted infections, including HIV

Possible side effects *(generally not signs of a health problem)*

- Light spotting or bleeding between monthly periods
- Prolonged bleeding (less common)
- Amenorrhea
- Weight change
- Headaches, nausea, and breast tenderness (less common than with COC)
- Rapid disappearance of side effects upon implant removal

Who can use progestin-only implants

Women of any parity or reproductive age who:

- want to use this method of contraception
- have no contraindications

Who should not use progestin-only implants *(for a complete list, see WHO eligibility criteria)*

Women who have the following conditions (contraindications):

- Breastfeeding while less than six weeks postpartum
- Acute deep venous thrombosis (unless on established anticoagulant therapy)
- Unexplained vaginal bleeding (before evaluation)
- History of or current breast cancer
- Severe cirrhosis, malignant liver tumors, or benign liver tumors, with the exception of focal nodular hyperplasia (which is a tumor that consists of scar tissue and normal liver cells).

Use of progestin-only implants by women with HIV and AIDS

- Women with HIV and AIDS who do not take antiretroviral drugs (ARVs) can use progestin-only implants without restrictions.
- Women with AIDS on antiretroviral drugs (ARVs) generally can use progestin-only implants but should be counseled about dual method use and consider using condoms in addition to implants. Besides preventing the spread of HIV, condoms may be especially beneficial to women on ARVs, because condoms provide additional protection from pregnancy in the event that ARVs reduce the effectiveness of the implant.

Provide follow-up and counseling for

- Any client concerns or questions
- Common side effects, especially irregular bleeding or spotting or amenorrhea
- Any signs of complications. Counsel the woman to come back immediately if any of the following symptoms develop:
  - unusually heavy or prolonged bleeding
  - severe pain in the lower abdomen (ectopic pregnancy)
  - infection at the insertion site
  - very bad headaches that start or become worse after initiation
  - unusually yellow skin or eyes

Explain to the client that implants can be removed any time for any reason.

Dispelling myths regarding progestin-only implants

Progestin-only implants **do not**:

- Break and move around within a woman's body
- Cause birth defects
- Cause cancer

No More Waiting!

Using a Checklist to Rule Out Pregnancy is an Effective Way to Increase Access to Contraceptives

Summary

Nonmenstruating women need not wait for the onset of their menses to initiate their contraceptive method of choice. Several research studies conducted in various countries show that a simple checklist developed to help providers rule out pregnancy among such clients is correct 99 percent of the time and is effective in reducing the proportion of clients denied contraceptive services. Using this checklist offers an effective and inexpensive alternative to laboratory tests and increases women's access to essential family planning services.

Family planning providers are required to determine whether a woman might already be pregnant before initiating use of her contraceptive method of choice. When pregnancy tests are unavailable or unaffordable, health providers often rely on the presence of menstruation as an indicator to rule out pregnancy. When women do not present with menses at the time of their visit, they are sent home—often without any contraception—to await the onset of menses. This is because providers fear that contraception can harm an unrecognized pregnancy. Data analyzed from family planning programs in Cameroon, Ghana, Jamaica, Kenya and Senegal have found that a significant proportion of new, nonmenstruating clients (25 percent to 50 percent) are denied their desired method as a result of their menstrual status.[1] Clients sent home because of such menstruation requirements risk unplanned pregnancies, if they are unable to return because of time and financial constraints.

How to Be Reasonably Sure a Client Is Not Pregnant

Ask the client questions 1-6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions.

NO	1. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	YES
NO	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3. Have you had a baby in the last 4 weeks?	YES
NO	4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	5. Have you had a miscarriage or abortion in the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	6. Have you been using a reliable contraceptive method consistently and correctly?	YES

If the client answered **NO** to ***all of the questions,*** pregnancy cannot be ruled out. Client should await menses or use a pregnancy test.

If the client answered **YES** to ***at least one of the questions*** and she is free of signs or symptoms of pregnancy, provide client with desired method.

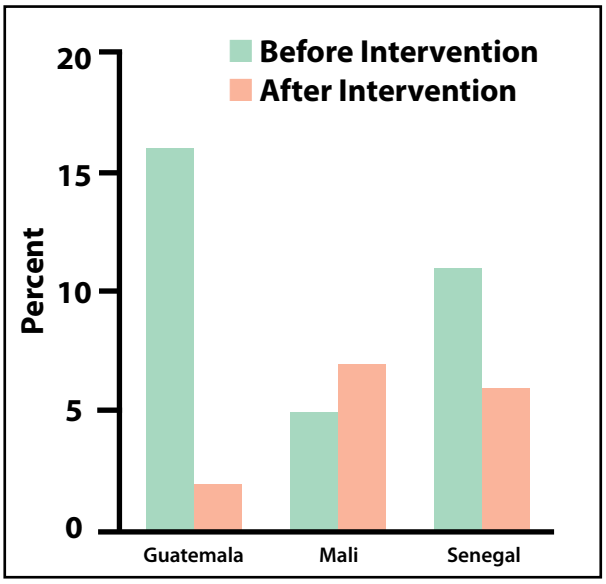
Figure 1

Family Health International (FHI) developed a simple checklist to rule out pregnancy among such clients with a reasonable degree of certainty. The checklist consists of six questions that providers ask clients while taking their medical history. If the client answers "yes" to any of these questions, and there are no signs or symptoms of pregnancy, then a provider can be reasonably sure that the woman is not pregnant. (See Figure 1.) The six questions are based on criteria established by the World Health Organization (WHO) that indicate conditions that effectively prevent a woman from getting pregnant.

Checklist Correctly Rules Out Pregnancy

A study to test the validity of the checklist against a standard pregnancy test was first conducted in Kenya[2] in 1999 and later repeated in Egypt in 2005. In both studies, the checklist correctly ruled out pregnancy 99 percent of the time. In addition, each of the six individual questions indicated a high predictive value in ruling out pregnancy. As a result, both studies concluded that in low resource settings, where pregnancy tests are not available, nonmenstruating women should not leave a family planning clinic without an effective method, given that providers can be reasonably sure a woman is not pregnant as determined by a "yes" response to any of the six questions on the checklist.

Figure 2
Percentage of all new family planning clients denied their desired method as a result of their menstrual status, before and after the checklist intervention, in Guatemala, Mali, and Senegal, 2001-03



1. Stanback J, Thompson A, Hardee K, Janowitz B. Menstruation requirements: a significant barrier to contraceptive access in developing countries. *Stud Fam Plann* 1997;28(3):245-50.

2. Stanback J, Qureshi Z, Sekadde-Kigondu C, Gonzalez B, Nutley T. Checklist for ruling out pregnancy among family planning clients in primary care. *Lancet* 1999;354(9178):566.

3 Stanback J, Diabate F, Dieng T, Duarte de Morales T, Cummings S, Traoré M. Ruling out pregnancy among family planning clients: the impact of a checklist in three countries. *Stud Fam Plann* 2005;36(4):311-15.

Checklist Allows Signficantly More Women Access to Contraceptives

An operations research study was conducted in Guatemala, Mali, and Senegal from 2001 to 2003 to determine the impact of the checklist on family planning services.[3] The study results showed that where denial of services to nonmenstruating family planning clients was a problem, introduction of the pregnancy checklist significantly reduced denial rates and improved access to contraceptive services.

Among new family planning clients, denial of the desired method due to menstrual status decreased significantly—from 16 percent to 2 percent in Guatemala and from 11 percent to 6 percent in Senegal. Denial rates in Mali, which were low from the start, increased slightly. However, this increase was not statistically significant. (See Figure 2.)

Uses of the Pregnancy Checklist Beyond Family Planning

Although originally developed as a tool for family planning providers, the pregnancy checklist may prove useful to other health providers in low-resource settings who also need to rule out pregnancy. For example, providers who prescribe and pharmacists who dispense medications that should be avoided during pregnancy, including certain antibiotics or anti-seizure drugs, can adapt the pregnancy checklist for use in their settings.

Contraceptive Implants: Safe, Effective, Long-acting, Reversible

- Implants provide highly effective, long-acting pregnancy protection (3 to 5 years)
- Although insertion and removal require a trained provider, both procedures are done quickly
- Contraceptive protection is immediately reversible upon implant removal; implants have no impact on long-term fertility

Background

Contraceptive implants are matchstick-sized rods that contain progestin. Implanted beneath the skin of a woman's upper arm, the progestin is slowly released over 3 to 5 years. Implants interrupt fertility by thickening cervical mucus (mechanically preventing the sperm from accessing the ovum) and through hormonal effects that prevent ovulation in about half of menstrual cycles. Family planning programs are introducing the new one- or two-rod implant systems, Implanon, Jadelle, and—in some countries—Sino-Implant (II). As of 2008, Norplant, the six-capsule implant system, will no longer be manufactured.

Implant types. The most common contraceptive implants include:

- ***Jadelle:*** 2 rods, provides contraception for 5 years
- ***Implanon:*** 1 rod, provides contraception for 3 years
- ***Norplant:*** 6 capsules, provides contraception for 5-7 years
- ***Sino-Implant (II):*** 2 rods, provides contraception for 4 years

Method characteristics. Contraceptive implants are highly effective at preventing pregnancy, long-acting, totally user-independent, and completely and immediately reversible upon removal. Unlike some other hormonal forms of contraception, implants can be used by cigarette smokers, women who have risk factors for cardiovascular disease (including high blood pressure), and women who are breastfeeding (after 6 weeks postpartum).

Insertion requires a minor surgical procedure by a trained practitioner using appropriate aseptic technique in a sterile surgical environment. As with other hormonal contraceptive methods, some women experience side effects such as headaches, breast tenderness, mood changes, nausea, and unpredictable vaginal bleeding—all of which usually decrease over time. Unpredictable vaginal bleeding associated with the use of implants sometimes leads users to have the implants removed, so appropriate counseling is essential to reduce discontinuation.

Health benefits. Unlike some other hormonal forms of contraception, implants do not contain estrogen, so women can safely breastfeed with an implant in place. Because implants may cause menstrual bleeding to be lighter, less frequent, or absent, some users may have a decreased risk of iron-deficiency anemia. Users also gain protection against health risks associated with pregnancy, pelvic inflammatory disease, and ectopic pregnancy. Implants have no effect on sexual function.

Conditions that may make use of implants unsafe. In most cases, women with the following conditions should be advised to use a different form of contraception:

- Serious liver disease, such as liver tumor, severe cirrhosis, or active hepatitis
- Current deep venous thrombosis or pulmonary embolus
- Unexplained or unusual vaginal bleeding that requires evaluation
- Current use of antiseizure drugs (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or rifampicin
- Breast cancer (currently or in the past)

In most cases, breastfeeding women who are fewer than six weeks postpartum should delay initiation of contraceptive implant use.

Sexually transmitted infections and HIV/AIDS. Implants provide no protection against STIs and HIV/AIDS. A male or female condom should be used to decrease the risk of transmission. Women with HIV/AIDS can use implants, but should also use a barrier method to decrease the risk of disease transmission.

Special considerations. Contraceptive efficacy of Norplant and Jadelle is reduced more quickly in women who are overweight. For women weighing 80 kg or more, Jadelle and Norplant become less effective after four years of use. For women weighing 70–79 kg, Norplant becomes less effective after five years of use. These women should have their implants replaced sooner.

Programmatic Considerations

Offering implants as a contraceptive choice requires that trained practitioners perform the minor procedures necessary to insert or remove the device in a reliably aseptic environment. Counseling should also be made available to potential recipients, so that they clearly understand implant insertion and removal procedures and the risks and benefits of implant use, as well as what to expect in terms of side effects, particularly bleeding changes.

Depending on pricing structures, contraceptive implants can be cost effective when used long term. Jadelle and Implanon have come down in price by about 25 percent since 2006 (to around US$20), which has stimulated demand at the

program level. The price of Sino-Implant (II) is expected to be between US$5-$8 and, its low cost will further improve the availability of implants.

Lessons Learned

The following points increase the likelihood of success in a program offering implants as a contraceptive choice.

- Prior to offering implants, the program should carefully assess its ability to sustainably provide:
  - Adequate pre-insertion counseling to potential users, so clients can make an informed decision about implants
  - Trained providers who are available for both insertion and removal of implants
  - An aseptic environment in which insertion and removal can take place
  - All of the equipment necessary for implant insertion and removal
  - A database and information system that will allow users to be located and contacted towards the end of the implant's lifespan, so that removal occurs on time
  - A steady supply of implants
  - Reliable access to removal services
- Community groups should be involved in the addition of implants to the program's menu of contraceptive choices, and information should be available in the community's language for potential practitioners, users, and community groups.
- Cultural context and acceptability of the device and its side effects should be considered.
- Providers offering contraceptive implants should be supervised and programs evaluated on an ongoing basis.

Sivin I, Nash H, Waldman S. Jadelle® levonorgestrel rod implants: A summary of scientific data and lessons learned from programmatic experience. Available: http://www.popcouncil.org/pdfs/jadelle_monograph.pdf.

World Health Organization and Johns Hopkins Bloomberg School of Public Health/Center for Communication Programs/INFO Project. *Family Planning: A Global Handbook for Providers.* Available: http://www.infoforhealth.org/globalhandbook/handbook.pdf.

Source: The preceding Global Health Technical Brief is adapted from the MAQ website (Maximizing Access and Quality), a USAID initiative.

Comparison of Implants

Contraceptive implants are matchstick-sized rods that contain the hormone progestin. Inserted beneath the skin of a woman's upper arm, implants release progestin very slowly, over 3 to 5 years. The most common contraceptive implants are Jadelle, Implanon, Norplant, and Sino-implant (II). The table below presents a comparison of various characteristics of the different types of implants.

Comparison of Implants						
Common Trade Name	**Formulation**	**Labeled Length of Use**	**Average Insertion Time[1]**	**Average Removal Time[1]**	**Registration**	**Bulk Public Sector Price[2]**
Implanon, manufactured by Organon	1 rod, containing 68 mg etonogestrel	Up to 3 years	1.5 mintes	2.7 minutes	Registered in more than 40 countries.	US$19-25
Norplant	6 capsules, each containing 36 mg levonorgestrel	Up to 5 years	4.8 minutes	10 to 15 minutes	Registered in more than 60 countries, but unavailable after 2008.	US$23
Jadelle	2 rods, each containing 75 mg levonorgestrel	Up to 5 years	2.5 minutes	5. to 7.5 minutes	Registered in more than 50 countries.	US$21-27
Sino-implant (II), manufactured by Shanghai Dahua Pharmaceutical and currently branded as Zarin in much of Africa.	2 rods, each containing 75 mg levonorgestrel	Up to 4 years	Data not available	Data not available	Registered in China, Indonesia Kenya, and Sierra Leone. Registrations underway globally, coordinated by FHI.	About US $8, provided with disposable trocar

[1] As measured in clinical trials
[2] As of September 2007

Source: The preceding table has been excerpted and adapted from* Population Reports*, Series K, Number 7, Implants, the Next Generation. Available: http://www.infoforhealth.org/pr/k7/2.shtml#table1.

Hubacher D, Mavranezouli I, McGinn E. Unintended pregnancy in sub-Saharan Africa: magnitude of the problem and potential role of contraceptive implants to alleviate it. *Contraception* 2008;78(1):73-78.

Unintended pregnancies continue to burden many countries in sub-Saharan Africa. This study estimated the number of unintended pregnancies in 42 countries in mainland sub-Saharan Africa and modeled the impact of expanding use of contraceptive implants at the expense of short-term hormonal birth control methods. Using a decision-analytic model, the study estimated the potential impact of more widespread use of the contraceptive implant. Every year in sub-Saharan Africa, approximately 14 million unintended pregnancies occur and a sizeable proportion is due to poor use of short-term hormonal methods. If 20 percent of the 17.6 million women using oral contraceptives or injectables wanted long-term protection and switched to the contraceptive implant, over 1.8 million unintended pregnancies could be averted over a 5-year period. Poor patterns of short-term hormonal contraceptive use (high discontinuation rates and incorrect use) contribute significantly to the problem of unintended pregnancy in sub-Saharan Africa. More availability and widespread use of highly effective methods, such as the contraceptive implant, will improve reproductive health in the region.

Shelton J, Angle M, Jacobstein R. Medical barriers to access to family planning. *Lancet* 1992;340:1334-1335.

While well-intentioned and based partly on medical rationale, some service delivery practices are unnecessary and can prevent access to family planning services for women and men who could safely use methods. There are six types of medical barriers: inappropriate or out-of-date contraindications; too-stringent eligibility criteria; unnecessary physical exams and laboratory tests; provider biases; limiting contraception provision to physicians only; and government regulations that limit the types of contraceptives available. To reduce medical barriers, providers must work as a group to assess all service delivery practices, in order to determine whether they are essential to the provision of contraception. The medical community should develop standard guidelines on contraceptive use. Family planning should be viewed as less medical: Women and men should be seen as clients, not patients, and increased emphasis should be placed on delivery of methods through community-based, over-the-counter, and social marketing outlets. Additional research should be conducted to assess contraceptive risks and benefits, to evaluate ways to reduce unnecessary restrictions, and to understand clients' perceptions of family planning methods and services.

Stanback J, Diabate F, Dieng T, Duarte de Morales T, Cummings S, Traoré M. Ruling out pregnancy among family planning clients: the impact of a checklist in three countries. *Stud Fam Plann* 2005;36(4):311-315.

Women in many countries are often denied vital family planning services if they are not menstruating when they present at clinics, for fear that they might be pregnant. A simple checklist based on criteria approved by WHO has been developed to help providers rule out pregnancy among such clients, but its use is not yet widespread. Researchers in Guatemala, Mali, and Senegal conducted operations research to determine whether a simple, replicable introduction of this checklist improved access to contraceptive services by reducing the proportion of clients denied services. From 2001 to 2003, sociodemographic and service data were collected from 4,823 women from 16 clinics in the three countries. In each clinic, data were collected prior to introduction of the checklist and again three to six weeks after the intervention. Among new family planning clients, denial of the desired method due to menstrual status decreased significantly—from 16 percent to 2 percent in Guatemala and from 11 percent to 6 percent in Senegal. Multivariate analyses and bivariate analyses of changes within subgroups of nonmenstruating clients confirmed and reinforced these statistically significant findings. In Mali, denial rates, which were low from the start, increased slightly. However, this increase was statistically insignificant. Where denial of services to nonmenstruating family planning clients was a problem, introduction of the pregnancy checklist significantly reduced denial rates. This simple, inexpensive job aid improves women's access to essential family planning services.

Stanback J, Nakintu N, Qureshi Z, Nasution M. Does assessment of signs and symptoms add to the predictive value of an algorithm to rule out pregnancy? *J Fam Plann Reprod Health Care* 2006;32(1):27-29.

A WHO-endorsed "pregnancy checklist" has become a popular tool for ruling out pregnancy among family planning clients in developing countries. The checklist consists of six criteria excluding pregnancy, all conditional upon a seventh "master criterion" relating to signs or symptoms of pregnancy. Few data exist on the specificity of long-accepted signs and symptoms of pregnancy among family planning clients. A study based on a previous observational study in Kenya (n=1,852) found that signs and symptoms of pregnancy were rare (1.5 percent), as was pregnancy (1 percent). Signs and symptoms were more common (18.2 percent) among the 22 clients who tested positive for pregnancy than among the 1,830 clients (1.3 percent) who tested negative, but did not add significantly to their predictive value. Although the "signs and symptoms" criterion did not substantially

improve the ability of the checklist to exclude pregnant clients, several reasons (including use of the checklist for IUD clients) render it unlikely that the checklist will be changed.

Stanback J, Nutley T, Gitonga J, Qureshi Z. Menstruation requirements as a barrier to contraceptive access in Kenya. *East Afr Med J* 1999;76(3):124-126.

A study was conducted in Kenya in 1996 to determine whether menstruation requirements pose a barrier to new clients seeking family planning services. Data were collected from eight public-sector health centers and one hospital in two provinces. Health providers tracked the menstrual status of women using a simple tally sheet. Forty-five percent of the women seeking services were not menstruating. Among the 345 nonmenstruating women, 51 percent were breastfeeding and amenorrheic, while 49 percent were between menstrual periods. Providers considered nonmenstruating women pregnant unless they were within six weeks postpartum. Women were told to go home and await the onset of menses or to have a pregnancy test at another facility. Researchers estimated that 78 percent of nonmenstruating women were sent home without their chosen method, and that up to one-third of all women were turned away. In most cases, pregnancy could have been ruled out with a simple checklist. Policy-makers should consider adopting national guidelines that remove the unnecessary menstruation requirement.

Stanback J, Qureshi Z, Sekadde-Kigondu C, González B, Nutley T. Checklist for ruling out pregnancy among family-planning clients in primary care. *Lancet* 1999;354(9178):566.

Where pregnancy tests are unavailable, health providers, fearing possible harm to fetuses, often deny contraception to nonmenstruating clients. In Kenya, a trial (n=1,852) of a simple checklist to exclude pregnancy showed a negative predictive value of more than 99 percent. Use of this simple tool could improve access to services and reduce unwanted pregnancies and their sequelae.

Stanback J, Thompson A, Hardee K, Janowitz B. Menstruation requirements: a significant barrier to contraceptive access in developing countries. *Stud Fam Plann* 1997;28(3):245-250.

Some family planning clinics require women seeking hormonal contraception or IUDs to be menstruating before they can receive their chosen method. Studies in Ghana, Kenya, Cameroon, Senegal, and Jamaica have found that menstruation requirements negatively affect access to services for clients who

could safely use contraceptives. As many as one-fourth to one-half of new clients seeking contraceptive services are sent home to await the onset of menses. These clients risk an unplanned pregnancy, and many are unable to return to the clinic because of time and money constraints. Because pregnancy is a contraindication to contraceptive use, health providers have used menstruation as a proxy for expensive pregnancy tests. Another rationale for menstruation requirements is timing—hormonal methods are usually initiated and IUDs typically inserted during menses. In addition, some providers believe pregnant women may use contraceptives to induce abortion. While many providers believe that women know about menstruation requirements, data from Kenya and Cameroon show that clients do not. Denial of contraceptive methods to nonmenstruating women is a serious obstacle to services that could be reduced by using a simple checklist to rule out pregnancy.

World Health Organization. *Medical Eligibility Criteria for Contraceptive Use.* Third edition. Geneva, Switzerland: Reproductive Health and Research, 2004, updated 2008.

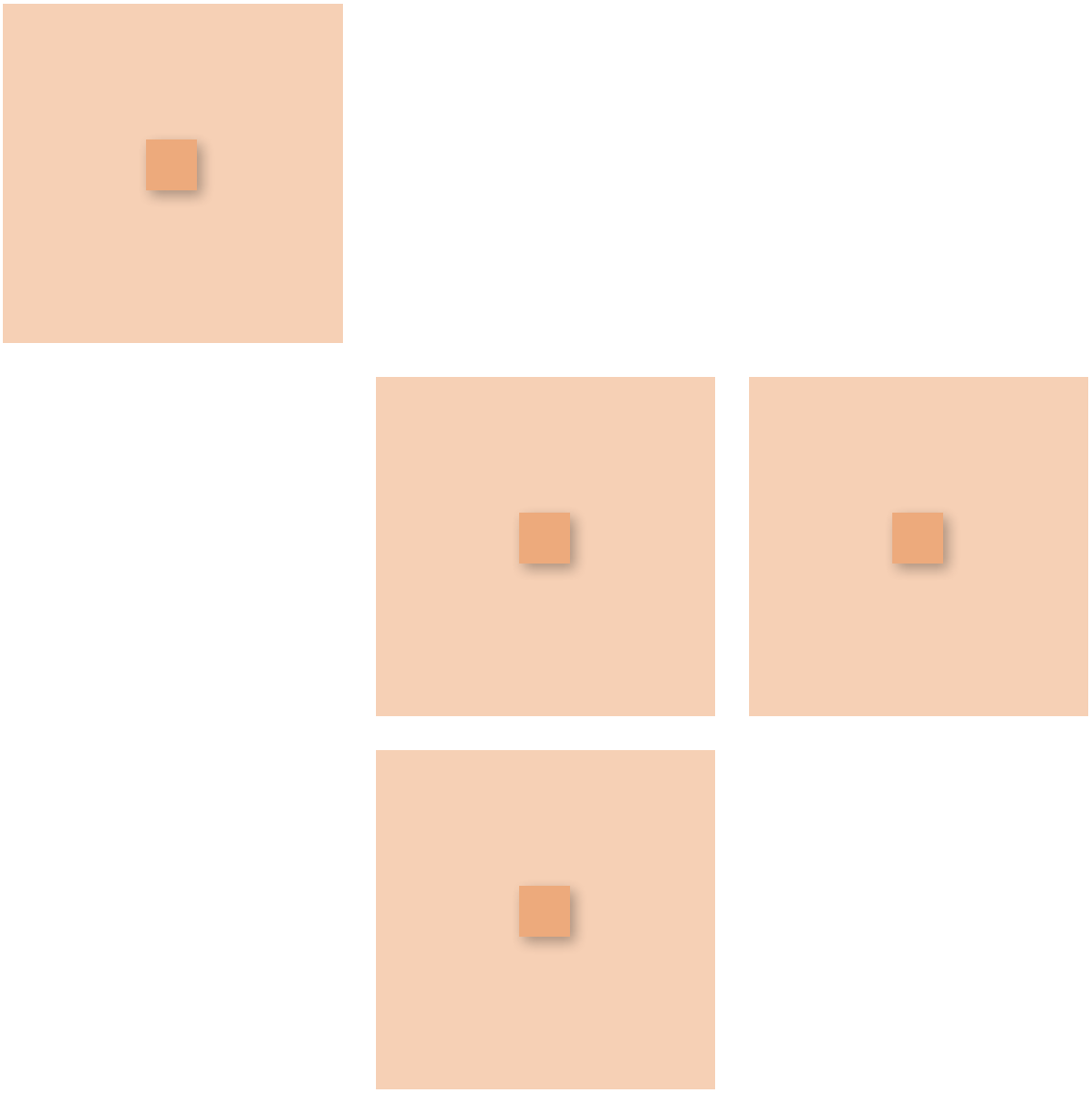
The 2004 document was developed by a WHO expert working-group that convened 36 participants from 18 countries, including representatives of many agencies and organizations. The document is important for improving access to quality care in family planning, as it reviews the medical eligibility criteria used for selecting appropriate methods of contraception for a variety of clients. The document provides guidelines for eligibility based on the latest clinical and epidemiological data and is intended for use by policy-makers, family planning program managers and the scientific community. It aims to provide guidance to national family planning and reproductive health programs in preparing guidelines for the service delivery of contraceptive methods.

In April 2008, WHO convened a follow-on working group to revise the third edition in response to newly published evidence, as well as to provide recommendations for additional medical conditions. The working group was comprised of 43 participants from 23 countries and included international experts in family planning (clinicians, epidemiologists, policy-makers, programme managers), in evidence identification and synthesis, and in pharmacology, as well as users of the guideline.

World Health Organization. *Selected Practice Recommendations for Contraceptive Use.* Second edition. Geneva, Switzerland: Reproductive Health and Research, Family and Community Health, 2004, updated 2008.

Selected Practice Recommendations for Contraceptive Use is a companion guideline to *Medical Eligibility Criteria for Contraceptive Use*, published by WHO. This document provides guidance for using contraceptive methods safely and effectively once they are deemed to be medically appropriate. It is intended to be used by policy-makers, program managers, and the scientific community and aims to support national programs in preparing service delivery guidelines.

In April 2008, WHO convened an expert working-group to revise the second edition, in response to newly published evidence and requests for clarification of specific recommendations from users of the guideline. The working-group was comprised of 43 participants from 23 countries and included international experts in family planning (clinicians, epidemiologists, policy-makers, and programme managers), in evidence identification and synthesis, and in pharmacology, as well as guideline users.

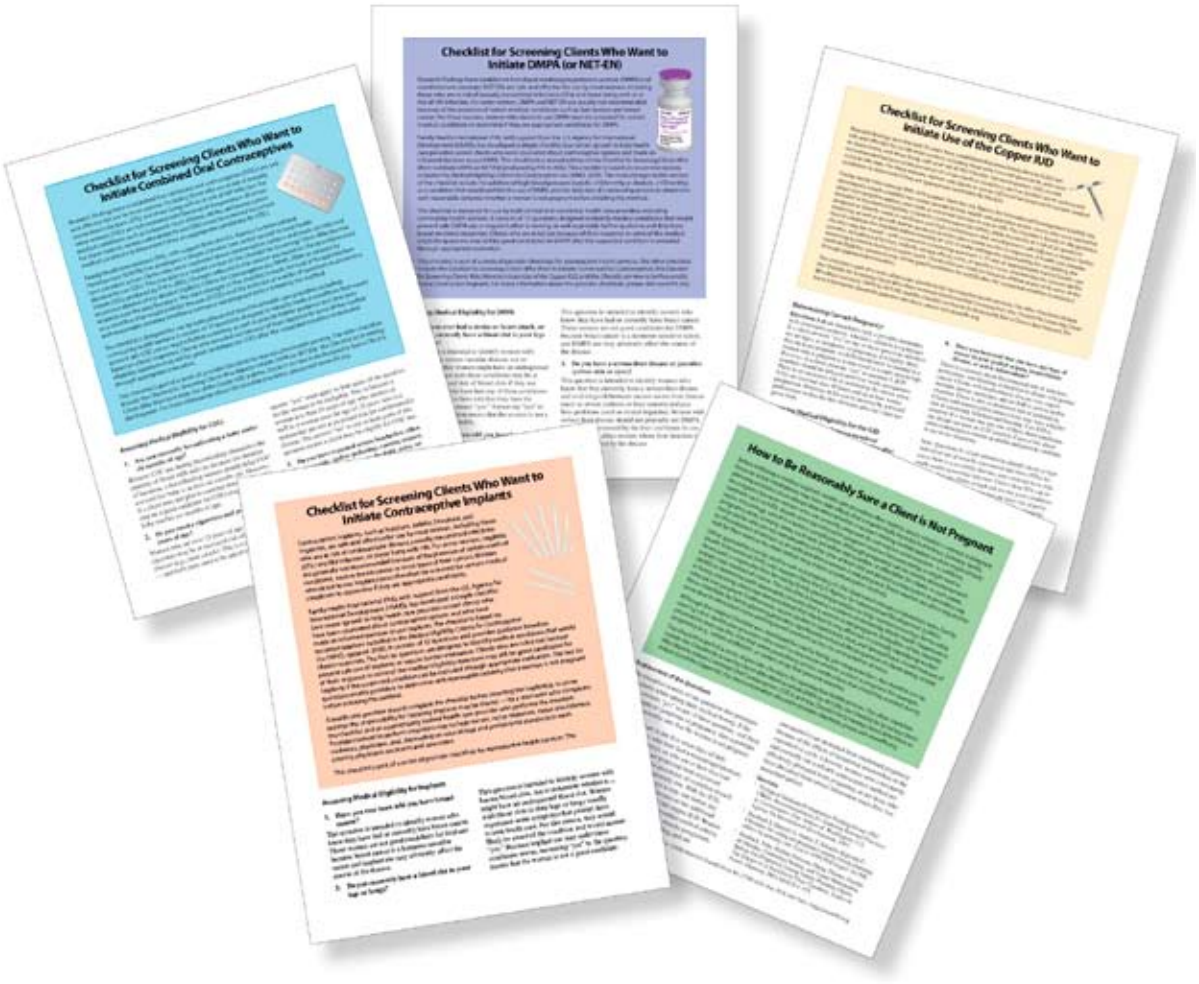


Supplementary Training Schedules

A. Combined Training on All Five Provider Checklists

FHI has produced a series of five easy-to-use checklists. Four of the checklists are designed to assist clinical and non-clinical family planning service providers in screening women who want to initiate use of COCs, DMPA/NET-EN, the copper IUD, or implants. The fifth checklist helps providers rule out pregnancy among nonmenstruating women seeking to initiate the contraceptive method of their choice. It is recommended that service providers be trained to use all five checklists, unless a particular checklist is not applicable to their scope of work.

A training and reference guide is available for each checklist. Familiarity with all five guides is necessary for conducting a combined training. The Suggested Schedule for a Combined Training and Overview of Sessions (provided on pages 70 and 71) follows the same structure used in the individual training guides. As always, facilitators who adapt the training should carefully consider the needs of their participants. The Notes section of the schedule will help determine what to include and how to adapt a session.

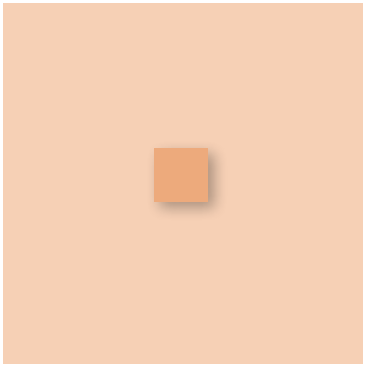


Suggested Schedule for a Combined Training and Overview of Sessions

Time: Approximately 9 hours

Session	Time	Topic	Notes
1	40 minutes	**Welcome and Introductions** Exercise A: Peel the Cabbage	Adapt from any of the checklist trainings. Use the questions: • What practice is currently used to determine if a woman is medically eligible to receive contraception? (Consider COCs, DMPA, IUDs, and implants.) • How is pregnancy ruled out? • Can you name some conditions that prevent women from using COCs, DMPA, IUDs or implants? (Create a separate list of conditions for each contraceptive method.)
2	20 minutes	**Rationale and Purpose of the Checklists**	Adapt from the COC, DMPA, IUD, or Implant Checklist trainings. • Show all five checklists, but do not distribute them to participants at this time. • Emphasize that all checklists were designed to help providers screen women for eligibility to use contraceptives safely and, therefore, to reduce barriers to contraception. The Pregnancy Checklist may have other purposes, as well. • Note that the checklists were designed for a variety of providers and can be used in a variety of settings. The IUD Checklist differs from the others in that it requires that one set of questions be administered by a provider trained to conduct a pelvic exam.
	80 minutes	Exercise B: Review of the WHO Medical Eligibility Criteria **Important Note:** The order of the exercises varies somewhat from one guide to another. In the IUD Guide, the order of the MEC Review and Pregnancy Exercises (B and C) is reversed from that of the COC, DMPA and Implants Guides. There is no MEC Exercise in the Pregnancy Guide.	• Follow steps 1-6 under Exercise B for COCs, DMPA, and implants, and under Exercise C for IUDs, with the following exceptions: **Step 3:** Choose a maximum of four conditions for each of the four contraceptive methods and allow a total of 30 minutes to complete the task. The following conditions are suggested for the exercise: *COCs, DMPA, and implants:* diabetes, high blood pressure, HIV/AIDS, and endometrial cancer *IUDs:* pregnancy, STIs/PID, HIV, and AIDS **Step 4:** Allow 30 minutes for participants to assess whether their answers were correct or incorrect. **Step 6:** Distribute a copy of the COC, DMPA, IUD, and Implant Checklists and complete the step. • Additional IUD discussion points should be brought up at this time (see Significant Issues Affecting Medical Eligibility, IUD Guide, Session 2, Facilitator's Resource).
	10 minutes	Exercise C: Demonstrating the Benefits of Using the Pregnancy Checklist	Additional detail on the research related to the Pregnancy Checklist can be found in the Optional Session.

Session	Time	Topic	Notes
3	30 minutes	**Design of and Instructions for Using the Checklists**	All of the checklists have the same basic design and instructions for use. Therefore, the training presented in this guide can be easily adapted to apply to all the checklists. Some notes: • The Pregnancy Checklist contains one set of questions; the COC, DMPA, and Implant Checklists contain two sets; the IUD Checklist contains three sets. • The Pregnancy Checklist contains no questions related to medical eligibility. • When administering the COC, DMPA, IUD or Implant Checklists, there is no need for providers to ***also*** administer the Pregnancy Checklist (since the Pregnancy Checklist questions are incorporated into each of the other checklists).
	3-6 hours	Exercise D: Practice Using the Five Checklists	Provide participants the opportunity to use the COC, DMPA, IUD, and Implant Checklists. The time needed to complete the exercise will vary, depending on the number of scenarios selected. **To save time, do not independently practice the Pregnancy Checklist, since it is included in the other checklists.** Review the optional approaches for conducting the scenarios as potential time-saving tools. The option chosen should be the most appropriate for the needs of the participants.
4	20 minutes	**Wrap-Up**	Modify as needed from this or any of the trainings.



B. Training Para-Professionals on the Implant Checklist

The term "para-professional" applies here to service providers working in facilities where implants are provided, but who have no training to perform implant insertion. Such para-professionals can be trained to screen for medical eligibility for implant insertion and to refer clients to appropriately trained health providers for the insertion procedure. For this audience, the training content should be simplified, lecture sessions avoided, and the training practical in nature to ensure para-professionals' understanding of the checklist and comfort in using it correctly. The outline below follows the same structure used in the individual training guides. As always, facilitators who adapt the training should carefully consider the needs of their participants. The Notes section will help determine what to include.

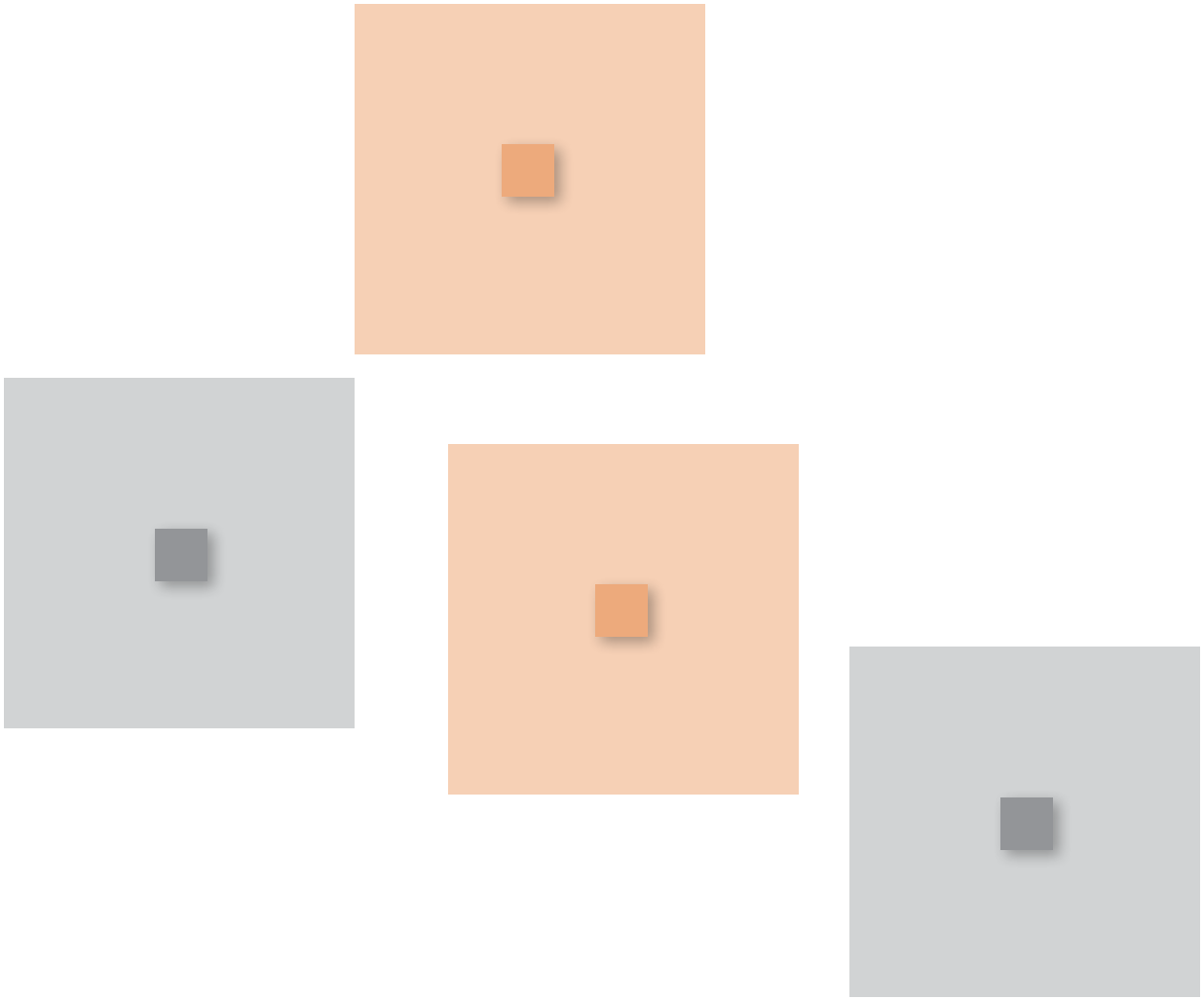
Suggested Schedule for Training Para-professionals and Overview of Sessions

Time: 2 hours

Session	Time	Topic	Notes
1	15 minutes	**Welcome and Introductions** Icebreaker Activity	Use Session 1 from this guide. **Do not perform Exercise A: Peel the Cabbage.**
2	20 minutes	**Rationale and Purpose of the Implant Checklist** Exercise B: Demonstrating the Benefits of Using the Pregnancy Checklist	Training Steps: • Distribute copies of the Implant Checklist and the Quick Reference Chart (color version only) to each participant. • Briefly and in simple language explain what the Implant Checklist is and why it was developed. Clearly explain that the third set of questions is intended for skilled providers. • Perform Exercise B: Demonstrating the Benefits of Using the Pregnancy Checklist to illustrate its effectiveness for ruling out the possibility of pregnancy in women who are not menstruating at the time they are seen by the para-professional. • Use the Quick Reference Chart to illustrate that many women, even those with certain medical conditions, can have implants inserted safely. Allow five minutes for participants to familiarize themselves with the Quick Reference Chart. **Do not perform Exercise C: Review of the WHO Medical Eligibility Criteria.**
3	20 minutes	**Design of and Instructions for Using the Implant Checklist**	• Briefly and simply explain the design of the Implant Checklist and go over instructions for using it. • Discuss with participants what is expected of them once the two sets of questions have been administered. For example, what should the next step be if the client is not eligible? If pregnancy is not ruled out? • After this, ask participants if they have any questions or need any items clarified.
	45 minutes	Exercise D: Practice Using the Implant Checklist	Review the optional approaches for conducting the scenarios as potential time-saving tools. The option chosen should be the most appropriate for the needs of the participants.
4	15 minutes	**Wrap-Up**	Modify as needed from this training.

C. Introducing Provider Checklists to Policy-makers and Program Managers

Policy-makers and program managers who are considering introducing the checklists in their service delivery settings will have different informational needs from those of providers. A slide presentation with speaker notes specifically tailored to this audience (*PowerPoint* presentation B) can be found in the collateral materials accompanying this guide. The presentation provides a broad overview of all five checklists, explains their rationale, and discusses general issues surrounding their use. Specific details on how to use the checklists have been excluded. Presenters may wish to address additional issues specific to local programs and are free to add slides and information, as necessary.



Sample Energizers

Energizers are highly recommended during training sessions, in particular during trainings involving lectures. In this training, an energizer is recommended between sessions two and three.

- **Coconut**
  The facilitator shows the group how to spell out C-O-C-O-N-U-T by using full movements of the arms and the body. All participants then try this together.

- **The sun shines on...**
  Participants sit or stand in a tight circle with one person in the middle. The person in the middle shouts "The sun shines on..." and names a color or articles of clothing that some in the group are wearing. For example, "The sun shines on all those wearing blue," or "The sun shines on all those wearing socks," or "The sun shines on all those with brown eyes." All participants who have that attribute must change places with one another. The person in the middle tries to take one of their places as they move, so that there is another person left in the middle without a place. The new person in the middle shouts "The sun shines on..." and names a different color or type of clothing.

- **Body writing**
  Ask participants to write their names in the air with a part of their bodies. They may choose to use an elbow, for example, or a leg. Continue in this way, until everyone has written his or her name with several body parts.

- **Football cheering**
  The group pretends that they are attending a football game. The facilitator assigns specific cheers to various sections of the circle, such as *Pass*, *Kick*, *Dribble* or *Header*. When the facilitator points at a section, that section shouts its cheer. When the facilitator raises his/her hands in the air, everyone shouts "Goal!"

Source: Adapted from International HIV/AIDS Alliance.* 100 ways to energise groups: games to use in workshops, meetings and the community. *Brighton, UK: International HIV/AIDS Alliance, 2002.

Sample Certificate of Attendance

Name of Sponsoring Organization

_____

certifies that

Name of Participant

_____

has successfully completed training on the

Checklist for Screening Clients Who Want to Initiate Contraceptive Implants

_____

(Date)

_____

(Place)

_____
Name of Person Issuing Certificate

_____
Title

_____
Sponsoring Organization

_____
Name of Person Issuing Certificate

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Title

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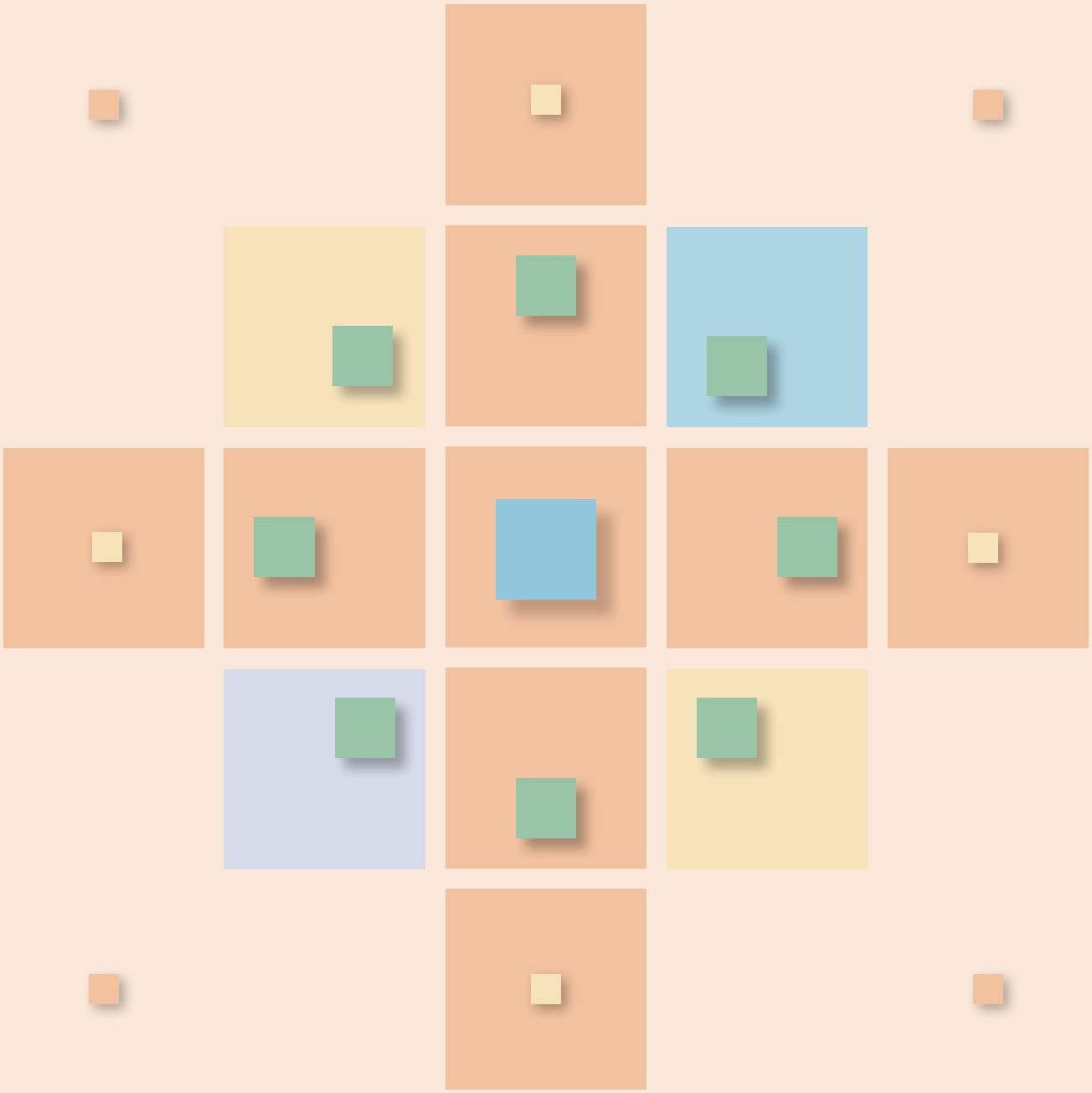
Sponsoring Organization



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