ACKNOWLEDGEMENTS

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Special gratitude is extended to the Population Council for providing technical and financial support for developing this Guide. Finally, we would like to take this opportunity to thank all the institutions and individuals whose efforts have resulted in the production of the National Mentorship Guidelines. Please see the List of Contributors in the Annex for a full list of contributors.

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<td>Acquired Immune Deficiency Syndrome</td>
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<tr>
<td>ANC</td>
<td>Antenatal Care</td>
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<tr>
<td>ART</td>
<td>Anti Retroviral Therapy</td>
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<tr>
<td>ARV</td>
<td>Anti Retroviral</td>
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<tr>
<td>BCC</td>
<td>Behaviour Change and Communication</td>
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<tr>
<td>BCS</td>
<td>Balanced Counselling Strategy</td>
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<td>Counselling and Testing</td>
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<tr>
<td>CBO</td>
<td>Community-Based Organisations</td>
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<tr>
<td>CCC</td>
<td>Comprehensive Care Centre</td>
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<tr>
<td>CD4</td>
<td>Cluster of Differentiation 4</td>
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<tr>
<td>COC</td>
<td>Combine Oral Contraceptives</td>
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<td>CT</td>
<td>Counselling and Testing</td>
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<tr>
<td>DBS</td>
<td>Dried Blood Spot</td>
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<tr>
<td>DMPA</td>
<td>Depot Medroxy Progesterone Acetate</td>
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<tr>
<td>DRH</td>
<td>Division of Reproductive Health</td>
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<tr>
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<tr>
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<td>ECP</td>
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<td>FBO</td>
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<td>Family Planning</td>
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<td>FSH</td>
<td>Follicle Stimulating Hormones</td>
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<tr>
<td>GUD</td>
<td>Genital Ulcer Disease</td>
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<tr>
<td>HAART</td>
<td>Highly Active Anti-Retroviral Treatment</td>
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<tr>
<td>HCW</td>
<td>Health Care Workers</td>
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<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
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<tr>
<td>HLD</td>
<td>High High-Level Disinfection</td>
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<tr>
<td>HPV</td>
<td>Human Papilloma Virus</td>
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<tr>
<td>HTC</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>HTSP</td>
<td>Healthy Timing and Spacing of Pregnancy</td>
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<td>IDUs</td>
<td>Injecting Drug Users</td>
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<tr>
<td>IEC</td>
<td>Information, Education, Communication</td>
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<tr>
<td>IPC</td>
<td>Infection Prevention and Control</td>
</tr>
<tr>
<td>IPCC</td>
<td>Interpersonal Communication and Counselling</td>
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<tr>
<td>IUD</td>
<td>Intrauterine Device</td>
</tr>
<tr>
<td>LAM</td>
<td>Lactation Amenorrhea Method</td>
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<tr>
<td>LBW</td>
<td>Low Birth Weight</td>
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<tr>
<td>LH</td>
<td>Luteinizing Hormone Release</td>
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<tr>
<td>MEC</td>
<td>Medical Eligibility Criteria</td>
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<tr>
<td>MDGs</td>
<td>Millennium Development Goals</td>
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<tr>
<td>MCH</td>
<td>Maternal and Child Health</td>
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<tr>
<td>MOH</td>
<td>Ministry of Health</td>
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<tr>
<td>MOMS</td>
<td>Ministry of Medical Services</td>
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<tr>
<td>MOPHS</td>
<td>Ministry of Public Health and Sanitation</td>
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<tr>
<td>NASCOP</td>
<td>National AIDS and STI Control Program</td>
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<tr>
<td>NET-EN</td>
<td>Norethisterone enanthate</td>
</tr>
<tr>
<td>PCR</td>
<td>Polymerase Chain Reaction</td>
</tr>
<tr>
<td>PE</td>
<td>Physical Examination</td>
</tr>
<tr>
<td>PEP</td>
<td>Post-Exposure Prophylaxis</td>
</tr>
<tr>
<td>PITC</td>
<td>Provider-Initiated HIV Testing and Counselling</td>
</tr>
<tr>
<td>PMTCT</td>
<td>Prevention of Mother-to-Child Transmission</td>
</tr>
<tr>
<td>PNC</td>
<td>Postnatal Care</td>
</tr>
<tr>
<td>POPs</td>
<td>Progestin Only Pills</td>
</tr>
<tr>
<td>PPC</td>
<td>Post Partum Care</td>
</tr>
<tr>
<td>PPE</td>
<td>Personal Protective Equipment</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>RTI/s</td>
<td>Reproductive Tract Infection/S</td>
</tr>
<tr>
<td>SDM</td>
<td>Standard Days Method</td>
</tr>
<tr>
<td>SDP</td>
<td>Service Delivery Points</td>
</tr>
<tr>
<td>SRH</td>
<td>Sexual and Reproductive Health</td>
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<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>TB</td>
<td>Tuberculosis</td>
</tr>
<tr>
<td>VCT</td>
<td>Voluntary Counselling and Testing</td>
</tr>
<tr>
<td>VE</td>
<td>Vaginal Examination</td>
</tr>
<tr>
<td>VIA</td>
<td>Visual Inspection with Acetic Acid</td>
</tr>
<tr>
<td>VILI</td>
<td>Visual Inspection with Lugols Iodine</td>
</tr>
<tr>
<td>WHO</td>
<td>World Health Organization</td>
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</table>
Operational research and scientific evidence demonstrate that integration of HIV and Sexual and Reproductive Health (SRH) services improves access to and quality of the two individual services. However, this process requires additional knowledge and skills to maximise service provision. Although a number of approaches, such as off-site training workshops, have been applied to improve knowledge and skills of health workers in Kenya, capacity-building remains a challenge within our larger Reproductive Health Plan. The cost of off-site training is often prohibitive and scarce human resources also make it difficult for health workers to leave their facilities to attend training workshops.

Evidence through operational research has demonstrated that mentoring is one feasible strategy for provider training and is acceptable among health service providers and managers at different levels of healthcare. This Mentor’s Guide operationalizes the National Mentorship Guidelines which respond to the objectives of the National Reproductive Health and HIV Integration Strategy. The Mentor’s Guide aims to strengthen the human resources capacity for providing integrated RH and HIV services at all levels and increasing demand for high-quality RH and HIV services. The guide also responds to the need for health providers to be equipped with the necessary skills that are critical for successful RH/HIV integration.

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Integration of healthcare services provides an unparalleled opportunity to expand access to a wide range of care for women and their families, including family planning, HIV testing and counselling, and other health services including cervical cancer screening and physical exams. This effort is driven by the fact that many clients have the need for several services simultaneously and offering them all in the same venue and through the same provider reduces the number of missed opportunities. Capacity-building for integrated RH/HIV services is a key strategy for improving the uptake of these integrated services among women in Kenya. In this process, healthcare workers must become familiar with a broader range of skills and gain competencies in the clinical application of all types of services.

The mentorship approach is one methodology of training that allows providers to enhance their knowledge and skills in broad areas of content without moving outside of the work station for theoretical and practical instruction. With mentorship, their place of employment is their classroom. This capacity-building strategy lends to a greater continuity of care for the patients while providers continue to practice and expand their clinical skills.

Mentoring has a particular place in Kenya’s health services as the National Reproductive Health Training Plan 2007–2012 emphasizes the use of participatory training processes and solidifying the link between theory and practice, in order to improve the use and performance of its health personnel1. After development and pilot trials, Kenya’s Division of Reproductive Health (DRH) and National AIDS & STI Control Programme (NASCOP) worked closely with a technical working group of experts to compile the Mentorship Guidelines. This Mentor’s Guide accompanies the National Mentorship Guidelines to orient mentors and mentees through a structured Mentorship Programme and to strengthen the capacity of healthcare workers providing integrated RH/HIV services.

**PURPOSE**

This package of documents is for programme managers and healthcare workers interested in implementing a mentorship programme for capacity-building for RH/HIV integrated services. There are three components to the larger package.

The Mentorship Guidelines summarizes the development and organization of the mentorship programme and outlines requirements for its proper implementation. Programme managers, policy decision makers, and facility and county health directors may use this document to understand the set-up and purpose of a mentorship programme. They may also use this document in advocacy meetings and public events to increase awareness of and garner support for the mentorship approach.

The Mentor’s Guide provides an overview of the programme and serves as the primary document for a mentor to use during the Mentor’s Induction Workshop and Mentorship Programme. The Guide is divided into two sections. Section 1 outlines content for mentoring exercises and lessons in the Mentor’s Induction Workshop. Section 2 walks mentors through classroom and practical lessons included in both the Mentor’s Induction Workshop and the Mentorship Programme. Tools and references, including relevant national RH/HIV guidelines, are outlined in each training session.

The Mentee’s Guide serves as the primary resource for mentees during the Mentorship Programme. Course content for each lesson and exercise is clearly written out in each training session as well as references to guidelines for relevant RH/HIV clinical skills. Mentees should refer to this document during the Mentorship Programme and may find it useful to reference even after the programme is complete.

This manual is complementary to existing national documents, including the National Family Planning Guidelines for Service Providers (MOH, 2010), the National Guidelines for HIV Testing and Counselling in Kenya (MOH, 2010), and the Balanced Counselling Strategy Plus: A Toolkit for Family Planning Service Providers Working in High HIV/STI Prevalent Settings (MOH and Population Council, 2011). Additional national guidelines and provider handbooks referenced throughout the programme are listed in the National Training Materials and Guidelines section of this Guide.

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The mentorship programme is based on a flexible model that allows providers to learn while continuing to provide the much-needed RH/HIV services in their respective health facilities.

Upon deciding that a hospital or province will initiate a Mentorship Programme, experienced nurses and healthcare workers in HIV/FP/PNC are selected to be mentors. This selection is based on characteristics including the candidate’s experience with integrated services and using the Balanced Counselling Strategy, his/her enthusiasm for mentoring, and attitudes about training others. Mentors are trained during a five-day induction workshop to ensure that their skills are standardized and comprehensive in all areas of integrated services.

After the Mentor’s Induction Workshop, mentors return to their facilities to work directly with about five mentees for three to six months in the Mentorship Programme. During the programme, mentors and mentees establish a professional relationship where the mentor teaches the mentee important RH/HIV integration skills. A total of 14 theoretical and practical lessons are included in the programme. Lesson topics include physical exams, family planning, HIV testing and counselling, and referrals among others. Content for each lesson is based on existing national and international trainings/guidelines. Mentors should make these documents available during the Mentorship Programme.

Mentors observe mentees practice lessons and clinical skills in their facility and provide guidance and correction when appropriate. Mentees graduate the Mentorship Programme when they are considered competent and able to complete each task individually. A final evaluation of each mentee is hosted by national authorities from DRH and NASCOP. County Reproductive Health and HIV coordinators and trainers may also carry out the mentee’s final assessment in consultation with DRH and NASCOP.

Sequence of National Mentorship Programme Implementation

1. Development of Mentorship Programme
   - Need identified for Integrated RH/HIV and Capacity-Building Programme
   - Advocacy meetings held; financial and political support garnered
   - Situation analysis
   - Materials, tools, supplies developed and collected

2. Mentorship Programme implementation
   - Mentors selected
   - Mentor Induction Workshop 5 days
   - Mentorship Programme with mentees 3 to 6 months
   - Facility managers support and supervise

3. Mentorship Programme assessment and evaluation
   - Mentee–mentor internal evaluation
   - Mentee assessment and certification
   - Programme evaluation
   - Dissemination of results
Once a facility or district has decided to implement a mentorship program, mentors will be selected, trained, and oriented. In order to ensure that mentors are properly selected and prepared to implement the National Mentorship Guidelines, processes and expectations must be clearly outlined. Additionally, facilities must provide certain resources and meet expectations to facilitate programme implementation.

**Mentor Selection**

Facility managers should identify mentors who are experienced clinical officers trained in reproductive or Nurse Midwives working in HIV, family planning, PNC/PPC and who have received previous clinical skills training in RH/ HIV integration. Selected mentors must also demonstrate good teaching potential as well as interest, willingness, and commitment to mentoring.

**Mentor’s Induction Workshop**

The Mentor’s Induction Workshop is an opportunity for skills standardization among all providers selected to be mentors and orientation to the mentorship process. The goal of the Mentor’s Induction Workshop is to ensure mentor’s competency in all RH- and HIV-integrated service areas and prepare them to conduct effective mentoring sessions.

**Mentorship Programme**

During the Mentorship Programme, one to four mentees are partnered with one mentor and they work together throughout the programme. Mentees are healthcare workers without extensive experience in RH/HIV integration yet interested in expanding their knowledge and skill level in these service areas. Upon completing the programme, mentees are considered proficient in important RH/HIV clinical services, expanding their means to provide proper integrated care and increasing the quality of healthcare services in their facility.

The Mentorship Programme may last from 12 to 16 weeks. The programme begins with an initial assessment of the mentee’s skills. Findings from this initial evaluation frame the topic areas of focus for the curriculum and the amount of time spent on each lesson. After establishing a professional rapport and introducing the concepts of mentoring, mentors lead mentees through theoretical and practical lessons which are reviewed and practiced until the mentee demonstrates competency in completing the skills him/herself.

Evaluation of the mentee’s skill acquisition is conducted throughout the Mentorship Programme, at the completion of each lesson. Individual evaluations may take the form of verbal questions and answers from mentors during mentoring sessions, self-evaluations, role play, and skills demonstration. While in the clinical setting, mentors evaluate the mentee’s competency using the Skills Assessment Checklist. Mentees also document completion of clinical activities using the Mentee’s Log Book. Here, mentees are assigned a certain number of clients/meetings that must be completed related to each lesson topic. Mentors provide evaluation and assessment of each skill and sign off on the competency once the mentee has completed the exercise a predetermined number of times.

A final assessment of the mentee’s competency is conducted once the mentee has completed all the required knowledge and skills competencies. This comprehensive assessment entails successful demonstration of all RH/HIV skills of the Mentorship Programme. Mentees are evaluated by DRH and NASCOP national officials using the same Skills Assessment Checklist used throughout the programme. Mentees must score at least 85% based on competency training to be certified.

**Session Outline and Hours for Mentorship Programme Lessons**

Below are the approximate hours for the initial portion of each lesson. Additional time will be required for the mentee to practice skills obtained during these initial lessons and to apply lessons in a clinic setting. The amount of additional time will depend on the skill level of each mentee.

<table>
<thead>
<tr>
<th>Lesson Number</th>
<th>Lesson Title</th>
<th>Hours</th>
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<tbody>
<tr>
<td>1.1</td>
<td>Basic Concepts in Mentoring</td>
<td>1</td>
</tr>
<tr>
<td>2.1</td>
<td>RH/HIV Integration</td>
<td>1</td>
</tr>
<tr>
<td>2.2</td>
<td>Infection Prevention</td>
<td>4</td>
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<tr>
<td>2.3</td>
<td>Normal Anatomy &amp; Physiology of the Reproductive System</td>
<td>3</td>
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<tr>
<td>2.4</td>
<td>Physical Exam</td>
<td>2</td>
</tr>
<tr>
<td>2.5</td>
<td>Pelvic Exam</td>
<td>2</td>
</tr>
<tr>
<td>2.6</td>
<td>Cervical Cancer Screening</td>
<td>4</td>
</tr>
<tr>
<td>2.7</td>
<td>STI Prevention and Management</td>
<td>2</td>
</tr>
<tr>
<td>2.8</td>
<td>Postnatal/Postpartum Care</td>
<td>3</td>
</tr>
<tr>
<td>2.9</td>
<td>Family Planning and Healthy Timing and Spacing of Pregnancy</td>
<td>16</td>
</tr>
<tr>
<td>2.10</td>
<td>Balanced Counselling Strategy Plus</td>
<td>1</td>
</tr>
<tr>
<td>2.11</td>
<td>HIV Testing and Counselling</td>
<td>2</td>
</tr>
<tr>
<td>2.12</td>
<td>Referral and Service Linkages</td>
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</tr>
<tr>
<td>2.13</td>
<td>Documentation and Recordkeeping</td>
<td>3</td>
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Components and Tools of the Mentorship Guidelines Package

<table>
<thead>
<tr>
<th>GUIDELINES and MANUALS</th>
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<tbody>
<tr>
<td><strong>National Mentorship Guidelines to Strengthen Integrated RH/HIV Services</strong></td>
</tr>
<tr>
<td><strong>Mentor’s Guide</strong></td>
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<tr>
<td><strong>Mentee’s Guide</strong></td>
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<tr>
<th>TOOLS</th>
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<tbody>
<tr>
<td><strong>Mentee’s Initial Assessment Form</strong></td>
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</table>
| **Mentee’s Skills Assessment Checklist** | Checklist used at three occasions:  
1) Completed by mentor evaluating mentee’s performance throughout the programme.  
2) Completed by mentor to evaluate mentee’s overall performance over the entire programme and his/her preparedness for national accreditation.  
3) Completed by DRH and NASCOP national officials to evaluate mentee at completion of the programme. A score of 85% indicates that the mentee is eligible for certification. |
| **Mentee’s Log Book** | Patient log book for mentee to document each time he/she completes a clinical activity. Logs to be turned in to mentor for evaluation purposes. |
| **Evaluation Form** | Form completed by mentees at completion of the mentorship programme to evaluate performance of the mentor, and quality of reference materials and programme overall. |

National Training Materials and Guidelines to be used in the Mentorship Programme

Mentorship documents do not intend to be stand-alone training documents, yet serve to outline specific lessons to include in the Mentorship Programme. Content of each lesson is taken from existing national guidelines and documents. Using these documents during the programme will ensure that the most up-to-date, accurate, and relevant information is imparted.


**Integrating the Management of STIs/RTIs into Reproductive Health Services Pocket Handbook for Providers**, Ministry of Public Health & Sanitation and Ministry of Medical Services, Republic of Kenya, 2010

**Medical Eligibility Criteria for Contraceptive Use**, 4th Ed. World Health Organization, 2009


**National Family Planning Guidelines for Service Providers**, Division of Reproductive Health in the Ministry of Public Health and Sanitation, Kenya, 2010


**National Guidelines for Quality Obstetrics and Perinatal Care**, Ministry of Public Health & Sanitation and Ministry of Medical Services, Kenya, 2012


**Sexually Transmitted and Other Reproductive Tract Infections: A Guide to Essential Practice**, World Health Organization, 2005

**PROGRAMME CONTENT**

The course content in this Menteer’s Guide includes Lesson 1.1, an introduction to the concepts of mentoring, and Section 2, a compilation of all RH/HIV-integrated service lesson content.
LESSON 1.1 Basic Concepts in Mentoring

Objectives
By the end of the session, the participant will be able to:

1. Define mentoring, mentor and mentee
2. Describe the rationale and purpose of mentoring
3. Discuss roles and characteristics of successful mentors and mentees
4. List the guiding principles of a mentorship
5. List the four stages of the mentoring process
6. Distinguish between mentoring, on-the-job training, and supportive supervision
7. Introduce and describe the general format of the Mentorship Programme

Tools and Reference Documents

- National Mentorship Guidelines
- Mentee’s Guide

Lesson Content

Definition of Mentoring, Mentor, and Mentee

**Mentoring** is a one-on-one relationship between a more experienced individual and a novice, which fosters individual growth and development.

A **mentor** is someone who helps another person through an important transition, e.g., career development, personal growth, or coping with a new situation. A mentor facilitates the professional development of his/her mentee by adopting the role of a counsellor and a confidant(e).

A **mentee** is someone who seeks assistance with their professional development or personal growth from a more experience colleague, peer, or expert.

Rationale and Purpose of Mentoring

Rationale for Mentoring

a. Where there is a proficient/expert staff and a novice
b. Where removing staff from the workplace interrupts continuity in service provision
c. Appropriate for complex technical skills that may not be easy to comprehend in theory sessions only
d. Where experiential learning is required – learning through practice

Purpose of Mentoring

a. Influences behaviour, habits, performance, and progress of the less-experienced person (protégé)
b. Is about doing “things right” and not doing “the right things”
c. Is about creating a culture that develops and enables
d. Aims to establish a climate where capacity-building is recognized as a valued activity
e. Preserves, shares, and passes on professional protocol, knowledge, techniques, and skills
f. Integrates the functioning of coaching, advocacy, nurturing, and tutoring
g. Combines efficiency, efficacy and effectiveness

Effective mentoring relationships require clearly defined expectations, a support system, honest communication, mutual respect and acceptance, as well as encouragement.

Roles and Characteristics of Successful Mentors and Mentees

A mentor’s role

1. A mentor is the model of the learner’s experience.
2. A mentor motivates a mentee to take charge of their learning needs, to envision their pathway and career development, and to create learning objectives.
3. A mentor helps a mentee achieve competency and mastery of skills while developing decision making, problem-solving, and critical-thinking skills.

4. A mentor addresses a mentee’s strengths and limitations appropriately and constructively.

5. A mentor assists a mentee in establishing relevant healthcare contacts and networks for further career development.

Characteristics of a successful mentor
a. Is approachable, friendly, trustworthy, and honest
b. Displays professional competence and confidence
c. Able to maintain confidentiality of mentee and of patients
d. Able to discern mentee’s learning needs and provide constructive criticism in a respectful and motivational way
e. Is active in Continuous Professional Development (CPD) activities at their facility

A mentee’s role
1. A mentee is expected to have self-directed experiential learning.
2. A mentee is able to maintain confidentiality of patients.
3. A mentee is actively involved in the learning environment.

Characteristics of a successful mentee
a. Is interested in learning
b. Aspires to improve her/his job performance through improved knowledge and skill
c. Is comfortable asking questions and admitting when he/she does not understand
d. Is willing to commit extensive time and practice to clinical skills and competencies

Guiding Principles for Mentorship
These are principles that both the mentor and the mentee should abide by throughout the mentorship programme. They encapsulate concepts of ethics and professionalism. Following these principles will facilitate a successful and fruitful mentorship as well as maintain an appropriate professional environment for learning.

Guiding principles for mentors and mentees
1. Demonstrate professionalism
2. Respect clients’ rights
3. Ensure accurate documentation and complete recordkeeping
4. Adhere to policies and guidelines
5. Complete and submit timely reporting
6. Use appropriate referral protocols and forms
7. Ensure clinical decisionmaking is applied in all clinical practice situations

Four Stages of the Mentoring Process
A mentoring relationship cannot simply start from scratch. The relationship must evolve—develop—through stages in order to be successful.

The four stages of the mentoring process
1. Establishing rapport
2. Setting direction
3. Making progress
4. Closing

Establishing rapport: A time when the mentor and mentee spell out their common interests, share their values and their future goals, and explore the goals and objectives of the mentorship.

Setting direction: During this stage, mentor and mentee will prioritize objectives of the mentorship and establish a work plan which consists of tangible activities and achievements. This is the stage where the skills-transfer activities officially begin.

Making progress: This is the longest stage of the mentorship relationship and is when the mentor and mentee work together on all laid-out activities and objectives. Mentors demonstrate skills, mentees emulate and practice skills, and mentors provide constructive feedback and instruction for improvement. When challenges arise, they are handled.

Closing: The end of the mentorship relationship is where each participant reviews his/her accomplishments and identifies shortcomings and areas for improvement. The mentor and mentee discuss the way forward, establish useful contacts for further professional development, and also create a plan for follow-up and evaluation.

Distinguish between Mentoring, On-the-job Training, and Supportive/Facilitative Supervision

Mentoring: A one-on-one relationship between a more experienced individual and a novice, which fosters individual growth and development.

On-the-job training: Professional training provided at and created by one specific institution to advance the skills and knowledge of its employees. On-the-job training is often a component of new-employee orientation and entails a variety of training techniques, including mentoring, coaching, practical, and supportive.

Supportive/Facilitative supervision: A management approach used in systems improvement and/or quality-of-care improvement of a healthcare facility. This type of supervision is hierarchical yet supportive, whereby the supervisor/manager serves as a liaison between the staff and external support in efforts to improve the level of skills and knowledge among staff members.
SECTION 2 RH/HIV Integrated Services Content

Section 2 includes lessons on RH/HIV clinical skills and competencies that should be mastered in order to complete the programme. These lessons include theory and clinical skills necessary to properly implement RH/HIV integrated services. During the Mentorship Programme, mentors will host in-depth instructional and practical lessons with their mentees until knowledge and competency are achieved. This may take multiple sessions of instruction, demonstration, and reviews of materials, depending on the mentee’s skill level. During the Mentorship Programme, all lessons in Section 2 will take place in a clinical setting, with access to a quiet area for more focused review of material when needed.

MENTEE’S INITIAL ASSESSMENT SHOULD BE ADMINISTERED AT THIS TIME (AVAILABLE IN ANNEX 1)

LESSON 2.1 RH/HIV Integration

Schedule and Timing
This lesson requires approximately 1 hour.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction of the session</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Discuss the objectives</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Discuss the mentee’s expectations for the session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss the tools and reference materials accompanying this lesson</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Review RH/HIV integration lesson content</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Agree on next meeting based on the mentor and mentee’s availability</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Ask the mentee to prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.2 Infection Prevention</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, the participant will be able to:
1. Define RH/HIV service integration
2. State the major objectives for service integration
3. Identify the main models of service integration in Kenya
4. Understand the role of health workers in providing integrated services

Tools and Reference Documents
- National Reproductive Health and HIV and AIDS Integration Strategy, MOH 2009
- Minimum Package for Reproductive Health & HIV Integrated Services, MOH 2012
- Fact Sheet: RH-HIV Integration in Kenya (reference in Annex)
- Mentees’ Initial Assessment Form (in Annex)

Lesson Content

Definitions

RH-HIV Integration is the reorganization and reorientation of health systems to ensure delivery of multiple (related) services during the same hours. It may entail offering HIV and AIDS services within RH services or RH services within HIV and AIDS services. Providers encourage clients/patients of one service to take up the other within the facility or community-based setting, or through a facilitated referral (from National Reproductive Health and HIV and AIDS Integration Strategy, 2009)

Reproductive Health refers to programs and policies related to and including family planning, maternal and newborn health, sexually transmitted infections, reproductive tract infections, sexual health, prevention and management of gender-based violence, prevention of unsafe abortion, and post-abortion care.

Linkages versus Integration
Linkages are the bi-directional synergies in policy, programmes, services, and advocacy between SRH and HIV. A linkage refers to broader human rights–based approach, of which service integration is a subset.
Integration refers specifically to how different kinds of reproductive health and HIV services or operational pro-
grammes can be joined together to ensure and maximize collective outcomes.

**RH/HIV Minimum Package** is a set of recommendations for different types of RH/HIV integrated services that are feasible for integration by level of care. For each type of service, a minimum level of service is defined and a set of basic requirements for each type of integration service is listed using the following categories: infrastructure; human resources, skills set and training materials; equipment; commodities and supplies; and documentation including M&E. With limited resources and a high demand for quality services, implementers must consider the possible synergies in each particular context and plan services to reach as many of the target population as possible (from *Minimum Package for Integrated RH & HIV Services*, 2012).

The goal of implementing the Minimum Package of Integrated Services is to:
- Outline a basic set of RH/HIV services to be integrated at various levels
- Provide guidance on basic service requirements for integrated services
- Standardize the provision of integrated RH/HIV services
- Increase access to and uptake of integrated services

### Objectives and Benefits of Service Integration

#### Reasons for RH/HIV Integration:
- Enhances access to quality and sustained RH and HIV services
- Risk factors for sexually transmitted infections (including HIV) and unintended pregnancies are addressed together
- Enhances efficiency, as both services require similar skills and equipment
- Meets the needs of clients who demand or need both services; e.g., women living with HIV/AIDS have a high unmet need for family planning
- Ensures equitable access to high-quality reproductive healthcare services
- Reduces stigma and discrimination of vulnerable populations
- Strengthens the evaluation and reporting systems for effective tracing, assessment and delivery of high-quality integrated services

#### Benefits of RH/HIV Integration
Integrating RH and HIV services has the potential to:
- Increase number of clients using services
- Enhance productive use of scarce resources
- Shorten clients’ waiting time and improve quality of services
- Enhance ability to prevent new incidences of HIV, especially among infants and youth through a wider range of services, e.g., PMTCT
- Provide greater support for dual protection
- Overcome stigma related to HIV/AIDS

### Models of RH/HIV Service Integration

#### On-site Approach
- May be a one-stop shop (kiosk) where RH/HIV integrated services are offered by one service provider in one room during the same consultation.
- May be a one-shop approach (supermarket) where the services are offered by more than one service provider within one facility during the same visit.
- Internal referral could take place within the same facility.

#### Off-site Approach
- A client accesses one type of service and receives the other service outside the facility/site through a referral.

#### Mixed-Model Approach
- May be where services are initiated in one facility but are provided in another.
- May be where some services are offered in one facility while others are offered in a different facility.
- For example, HIV services are provided at a Comprehensive Care Clinic where the client is also counselled on family planning, yet, the client must visit another facility to receive the method.

### Examples of Integrated Services Provided at Various Levels of Care

#### Community level
- Condoms and oral contraceptive pills
- Information, education, and communication (IEC) on ART and FP
- Counselling and testing for HIV
- Behaviour change communication (BCC) and referral for FP and HTC among other services

#### Maternal Child Health /Family Planning Clinic
- C&T for HIV and antenatal care (PMTCT)
- C&T for HIV and postpartum care
- STI screening and ARV prophylaxis

#### VCT Centre
- FP and C&T for HIV
- STI screening and condoms
- BCC and FP

#### Comprehensive Care Centres (CCCs)
- TB Screening and ART
- FP and ART
- STI screening and BCC

### Role of Health Workers in Providing Integrated Services
Each health worker should:
- Be trained to provide multiple services
- Support comprehensive care within the health centre team
- Be flexible
- Minimize queuing and minimize clinic visits
- Consider the family unit

### Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
- Read *Fact Sheet: RH/HIV Integration in Kenya* (reference available in Additional Resources section of Annex)
- Review Mentee’s Skills Assessment Checklist (in Annex)

### Mentee’s Evaluation
This lesson is evaluated through question-and-answer sessions.
LESSON 2.2 Infection Prevention

Schedule and Timing
This lesson requires approximately 2 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss general principles/guidelines of infection prevention</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss importance and rationale for infection control guidelines</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Discuss the levels of infection prevention and control</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Hand washing demonstration</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Personal Protective Equipment demonstration</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Demonstrate preparation of chlorine 0.5% decontamination solution</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate sterilization and high-level disinfection procedures</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Discuss hospital waste segregation and disposal</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss and demonstrate use/disposal of sharps</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.3 Normal Anatomy &amp; Physiology of Reproductive System</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Subsequent mentoring sessions on this topic will require approximately 2 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the last session including lesson content</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Demonstrate infection prevention practices and ask for a return demonstration</td>
<td>60 minutes</td>
</tr>
<tr>
<td>• Hand washing</td>
<td></td>
</tr>
<tr>
<td>• Personal protective equipment donning and removal</td>
<td></td>
</tr>
<tr>
<td>• Decontamination of used instruments</td>
<td></td>
</tr>
<tr>
<td>• Handling of sharps</td>
<td></td>
</tr>
<tr>
<td>• Sterilization of equipment</td>
<td></td>
</tr>
<tr>
<td>• Segregation of waste and proper disposal</td>
<td></td>
</tr>
<tr>
<td>Clarification and practice skills</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Agree on the next meeting based on the mentor and mentee’s availability</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.3 Normal Anatomy &amp; Physiology of Reproductive System</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, the participant will be able to:
1. Outline the main infection prevention and control guidelines in Kenya
2. Explain the rationale for infection prevention and control guidelines
3. State the levels of infection prevention and control
4. Describe basic infection prevention methods
5. Outline and demonstrate main principles of hand hygiene
6. Demonstrate proper use of personal protective equipment
7. Explain different decontamination procedures for contaminated equipment, instruments, and work spaces
8. Discuss general principles of waste segregation and disposal, including sharps
9. Demonstrate various infection-prevention skills during provision of various integrated RH/HIV services to clients

Tools and Reference Documents
• Facility's Infection Prevention Standards/Guidelines
• Facility's Hand Hygiene Guidelines
• Mentee’s Skills Assessment Checklist
Lesson Content

The content of this lesson is from the National Infection Prevention and Control Guidelines for Health Care Services in Kenya, 2010. Please refer to that document for further detail and instruction, if necessary.

Principles and Guidelines of Infection Prevention

Infection Prevention

Infections in healthcare facilities can occur through the transmission of infective agents from healthcare workers to patients, from patients to healthcare workers, from patient to patient, or among healthcare workers (HCWs). The risk of transmitting infections is higher if basic infection-control practices are not maintained.

In order to identify, prevent, monitor, and control the spread of infections in healthcare facilities, all-inclusive infection prevention and control (IPC) practices are required. The consistent use of IPC policies and guidelines ensures that IPC practices are carried out in a standard way across all healthcare facilities in Kenya. The practices and activities include:

- Using scientifically sound measures for preventing and controlling infections
- Monitoring healthcare practices
- Surveillance of infection in healthcare facilities
- Reporting IPC activities
- Providing adequate infrastructure, such as sinks and ventilation, and appropriate supplies and equipment
- Educating and training staff about IPC principles
- Educating patients, families, and members of the community in disease causation, prevention, and control
- Effectively managing IPC programs
- Periodically evaluating IPC policies and guidelines

Improving the health infrastructure by establishing and adhering to infection prevention and control practices is the most cost-effective way to improve health outcomes, prevent morbidity and mortality, decrease healthcare costs, and avoid possible litigation that could arise from hospital acquired infections.

Rationale for Infection Prevention

The purpose of infection prevention is to:

- Reduce the incidence of preventable infections in patients and staff, and to safely care for patients with infections
- Promote good practices through a better understanding of infection prevention and control practices
- Guide the health sector in the development of safe, effective, and appropriate procedures
- Promote a greater awareness of potential infection hazards for health care workers

Levels of Infection Prevention and Control

Preventing and controlling infection in a healthcare facility involves two approaches:

1. **Standard Precautions** are taken to reduce the risk of transmitting blood-borne micro-organisms and pathogens.
   - Should be used in care of all patients, as a minimum, regardless of diagnosis or presumed infection status
   - Is the primary strategy for successful hospital infection control

2. **Additional (transmission-based) Precautions** are designed for patients documented as (or suspected to be) infected with transmissible pathogens for which additional precautions are needed.
   - Precautions are beyond standard precautions to interrupt transmission
   - Level of precaution and personal protective equipment donned depend on mode of infection transmission
   - May be airborne, droplet, or contact precautions; precautions may also be combined in cases where there are multiple routes of transmission.

Patients may also be assigned an additional category of isolation precaution, depending on their clinical situation.

Hand hygiene

Washing hands using plain soap, water, and friction removes 99% of the transient micro-organisms and bacteria from our hands. After hand washing, dry hands either by air, with a personal hand towel, or use an electric drying machine. Avoid using a communal towel.

**Steps for hand washing**

1. Remove all jewellery.
2. Thoroughly wet hands with running water. Do not dip hands into a basin that contains standing water, even with the addition of an antiseptic agent, because micro-organisms can survive and multiply in these solutions. Use a comfortable water temperature. Washing your hands in hot water increases the risk of skin irritation and does not remove more micro-organisms.
3. Apply a hand-washing agent (plain soap or detergent). Washing hands with plain water without soap is not effective.
4. Rub all areas of the hands and fingers vigorously for 10 to 15 seconds, paying close attention to fingernails and areas between the fingers. Don't forget the wrists. Repeat each action five times.
5. Remove debris from under the fingernails.
6. Rinse hands thoroughly with clean running water for 10 to 15 seconds.
7. Use a paper towel when turning off the water if the tap is hand-operated.

8. Dry hands with paper towels or air dry them. Avoid using common or shared towels, which might harbour micro-organisms and contaminate hands even after proper hand washing or hand rubbing. To avoid sharing towels, use disposable paper, or single-use hand towels. Do not dry hands on personal clothes or on wet and soiled towels.

Personal protective equipment (PPE)

Protective barriers and clothing are referred to as personal protective equipment, which protect clients and healthcare workers from micro-organisms in the healthcare setting.

- PPE provides a physical barrier between micro-organisms and the wearer, preventing contamination of hands, eyes, clothing, hair, and shoes.
- PPE prevents transmission of micro-organisms to other patients and staff.
- Standard infection prevention must still apply when using PPE.
- PPE must be used effectively, correctly, and whenever there is a risk of contact with blood and body fluids.
- Making PPE available and training HCWs to use it properly is essential.

Healthcare workers should follow these guidelines for using PPE:

- Assess the risk of exposure to blood, body fluids, excretions, or secretions and choose items of PPE accordingly.
- Use the right PPE for the right purpose.
- Avoid any contact between contaminated (used) PPE and surfaces, clothing, or people outside the patient care area.
- Discard used PPE appropriately in designated disposal bags.
- Do not share PPE.
- Change PPE completely and thoroughly wash your hands each time you leave a patient to attend to another patient or another duty.

The following individuals should use PPE:

- HCWs who provide direct care to patients and who may have contact with blood, body fluids, excretions, or secretions.
- Laboratory staff who handle patient specimens.
- Family members who provide care to patients and could come in contact with blood, body fluids, excretions, or secretions.

Decontamination Procedures

Figure 3 outlines the basic infection prevention processes recommended for reducing disease transmission from soiled instruments and reusable items, including decontamination, cleaning, sterilization, or high-level disinfection (HLD).
### Figure 2: Types and recommended use of personal protective equipment

<table>
<thead>
<tr>
<th>Type of PPE</th>
<th>Recommended Uses</th>
<th>Primarily Protects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Gloves</td>
<td>• When there is a reasonable chance of hands coming in contact with blood or other body fluids, mucous membranes, or broken skin&lt;br&gt;• Before performing invasive medical procedures&lt;br&gt;• When inserting vascular devices such as peripheral venous lines&lt;br&gt;• Before handling contaminated waste items or touching contaminated surfaces</td>
<td>Healthcare workers</td>
</tr>
<tr>
<td>Caps, gowns, scrub suits, aprons</td>
<td>• When performing invasive procedures during which tissue beneath the skin is exposed&lt;br&gt;• When handling patients with infectious disease&lt;br&gt;• When handling contaminated waste</td>
<td>Healthcare workers and patients</td>
</tr>
<tr>
<td>Masks</td>
<td>• When performing invasive procedures&lt;br&gt;• When handling patients with airborne or droplet infections&lt;br&gt;• When handling medical waste</td>
<td>Healthcare workers, patients, incinerator operators, and visitors</td>
</tr>
<tr>
<td>Goggles or glasses</td>
<td>• Situations in which splashing of blood, body fluids, secretions, or excretions is likely</td>
<td>Healthcare workers</td>
</tr>
<tr>
<td>Mackintoshes, plastic or rubber aprons</td>
<td>• Situations in which splashing or spillage of blood, body fluids, secretions, or excretions is likely&lt;br&gt;• Contaminated waste</td>
<td>Healthcare workers</td>
</tr>
<tr>
<td>Closed boots or shoes</td>
<td>• Situations in which sharp instruments are used or in which spillage of infectious agents is likely&lt;br&gt;• In the nursery</td>
<td>Healthcare workers and patients</td>
</tr>
<tr>
<td>Sterile drapes</td>
<td>• Major or minor surgical procedures</td>
<td>Patients</td>
</tr>
</tbody>
</table>

(From the National Infection Prevention and Control Guidelines for Health Care Services in Kenya, 2010)

### Figure 3: Key steps in processing contaminated instruments, gloves, and other items
Decontamination is the first step in handling used instruments and equipment.

The recommended decontamination agent is 0.5% chlorine (bleach) solution and can be made from chlorine tablets/powder or liquid chlorine. Make a fresh solution every morning, or after eight hours.

Immediately after use, place all instruments in disinfectant (such as 0.5% chlorine solution) for 10 minutes to inactivate most organisms. After removal, immediately rinse them in cool water to remove residual chlorine before cleaning them. Once instruments have been decontaminated, they can be cleaned and sterilized or high-level disinfected.

Formula for preparing a 0.5% chlorine solution using chlorine tablets/powder

\[
\frac{\text{% chlorine desired}}{\text{% chlorine in bleach powder}} \times 1,000 = \text{Grams of powder for each litre of water}
\]

Example: To make a 0.5% chlorine solution from calcium hypochlorite powder containing 35% active chlorine:

\[
\frac{0.5\%}{35\%} \times 1,000 = 14.3
\]

• Therefore, you must dissolve 14.3 grams of calcium hypochlorite powder in each liter of water used to make a 0.5% chlorine solution.

• The resulting chlorine solution is likely to be cloudy.

Formula for preparing a 0.5% chlorine solution using liquid chlorine

\[
\frac{\text{% chlorine liquid bleach}}{\text{% chlorine desired}} - 1 = \text{parts of water per part of bleach}
\]

Examples: To make a 0.5% chlorine solution from 3.5% bleach:

\[
\frac{3.5\%}{0.5\%} - 1 = [7] - 1 = 6 \text{ parts water for each part bleach}
\]

• Therefore, you must add 1 part bleach to 6 parts water to make a 0.5% chlorine solution

Cleaning of instruments must take place after decontamination and prior to disinfection or sterilization. Sterilization and HLD may not be effective without proper cleaning.

To manually clean instruments, follow this procedure:
1. Wear PPE (plastic apron, rubber gloves, eye protection, mask or face shield)
2. Take instruments apart, immerse all parts in warm water with detergent
3. Scrub vigorously with a brush, detergent, and water
4. Rinse in clean water
5. Dry instrument in cabinet or using a clean lint-free cloth; inspect instrument to ensure that it is clean

Sterilization Techniques eliminate all micro-organisms, including endospores and are recommended when items will come in contact with a patient’s bloodstream or tissues under the skin. Three types of sterilization exist:

Dry-heat sterilization
• Includes temperatures of 170°C for one hour or 160°C for two hours
• It is not necessary to open/disassemble items

Steam sterilization (autoclave)
• Includes temperatures of 121°C and pressure of 106kPa
• Procedure takes 20 minutes if instruments are unwrapped and 30 minutes if instruments are wrapped
• If instruments are unwrapped, they should be stored in a sterile (or HLD) container with a tight-fitting lid after sterilization

Chemical sterilization
• Soak instruments in one of the two chemical solutions:
  - 2%–4% Glutaraldehyde for a minimum of 10 hours
  - 8% Formaldehyde for a minimum of 24 hours
• After soaking, rinse instruments with boiled water and air dry
• Store sterile instruments in a sterile (or HLD) container with a tight-fitting lid

High-Level Disinfection is used to destroy micro-organisms on delicate or heat-sensitive instruments that cannot be sterilized. HLD is not sterilization but may be used if sterilization is not available or suitable. HLD can be achieved by boiling or using chemical disinfectants.

Boil instruments for 20 minutes in a cooking pot with a lid. Disassemble instruments before completely immersing them in boiling water. Do not add anything else to the pot after boiling begins. Allow water to boil for 20 minutes. Upon safely removing instruments with forceps, transfer them to a dry HLD container. Allow items to air dry. Use items within one week.

Chemical High-Level Disinfection entails soaking instruments for 20 minutes in 0.5% chlorine solution that has been prepared using clean water, 2%–4% glutaraldehyde, or 6% hydrogen peroxide. HCW should be wearing PPE when working with chemicals. Disassemble instruments before completely immersing them in the disinfectant. Remove items using HLD forceps and wear sterile gloves. Rinse items well with sterile (or boiled or filtered) water three times and allow them to air dry in HLD container. Use items within one week.

Waste segregation and disposal

Healthcare waste is a potential reservoir of pathogens and requires appropriate, safe, and reliable handling. The purpose of proper waste management is to:
• Minimize spread of infection
• Reduce risk of accidental injury (from handling waste)
• Reduce likelihood of contaminating soil, ground water, and environment
• Reduce attraction of insects and rodents
• Reduce odours
General (non-infectious) waste includes paper, trash, boxes, bottles, and plastic containers. Approximately 85% of waste generated in hospitals is non-infectious.

Infectious (contaminated) waste is potentially infectious or toxic if not disposed of properly and includes: blood, body fluids, secretions; sharps or other items that have come in contact with blood or body fluids; and, medicines or supplies that might be toxic.

Hazardous chemical waste includes chemicals or medicines that are potentially toxic.

Waste segregation is when contaminated and no contaminated waste is segregated at the point of generation. When segregating waste be sure to:

- Use appropriately colour-coded separate containers. If colour-coded bins are not available, label the containers used.
- Do not fill containers more than three-quarters full.
- Never sort through contaminated wastes. Do not try to separate wastes after they have been combined. Never put hands into containers.
- Keep containers in convenient places.

The main risk of infection is associated with sharps contaminated with blood. Sharps include all objects that pose a risk because of their puncture/cutting properties and include syringes with needles, blades, wires, broken glass, etc.

Guidelines for Disposal of Sharps and Sharps Containers

- Disposable syringes and needles should be discarded immediately.
- Do not try to recap or remove needle from a syringe before disposing.
- Place sharps in safety box resistant to punctures and leakages which is marked “Danger Contaminated Sharps” with a biohazard symbol.
- Sharps box should be closed and disposed of when three-quarters full.
- Destroy sharps together with hazardous healthcare wastes
- Do not, under any circumstances, dispose of used syringes, needles, or safety boxes in normal garbage or dump them without prior treatment.

When handling waste, use appropriate PPE, including heavy-duty utility gloves. Handle wastes carefully to avoid spills or splashes. Always wash your hands after removing gloves and handling contaminated wastes.

When disposing of waste, incineration is the preferred method. If incineration is not possible, burial of waste is an alternative.

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:

- Review the Mentee’s Skills Assessment Checklist (available in Annex). Take note of the infection prevention and control related activities in each section.
- Review National Infection Prevention and Control Guidelines for Health Care Services in Kenya if further instruction or clarification are needed.
- Practice the above activities in the facility setting throughout actual clinical experiences during the Mentorship Programme.

Mentee’s Evaluation

This lesson is evaluated through the mentee’s competency and correct application of the content while conducting all practical sessions of the Mentorship Programme. The mentee must demonstrate competency in all steps of the Infection Prevention section in the Skills Assessment Checklist. These skills will be evaluated by her/ his mentor and then by final external evaluators upon completion of programme.

![Figure 4: Waste segregation](From the National Infection Prevention and Control Guidelines for Health Care Services in Kenya, 2010)
LESSON 2.3 Normal Anatomy & Physiology of the Reproductive System

Schedule and Timing
This lesson requires approximately 3 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the general overview of the reproductive system</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Host small group exercise to learn anatomy &amp; physiology of the female</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Present information on and discuss the menstrual cycle</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Present information on anatomy &amp; physiology of the male</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Discuss the process of conception</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Discuss methods to educate clients about anatomy &amp; physiology</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.4 Physical Exam</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, the participant will be able to:

1. Define the meaning of anatomy and physiology of the reproductive system.
2. Outline the importance of knowing the anatomy and physiology of the reproductive system and conception.
3. Name the female reproductive organs and state their functions.
4. Describe the physiology of the menstrual cycle.
5. Name the male reproductive organs and state their functions.
6. Describe the conception process.
7. Discuss why women are more vulnerable to HIV infection.

Tools and Reference Documents

- Mentee’s Skills Assessment Checklist
- National Training Manual on Integrating Counselling and Testing for HIV into Family Planning Services, MOH 2008
Lesson Content

The content of this lesson is from the National Training Manual on Integrating Counselling and Testing for HIV into Family Planning Services, MOH 2008. Please refer to that document for further detail and instruction, if necessary.

Anatomy & Physiology of Reproductive System – Definition and Importance

Definition of anatomy and physiology of the reproductive system
In the context of this manual, the term anatomy refers to the structure, composition, make-up or frame of the reproductive system while physiology refers to the functioning or working of the bodily processes pertaining to the reproductive system and conception.

Importance of anatomy and physiology of reproductive system and conception

Knowledge of anatomy and physiology helps health providers to:
• Advise and counsel clients seeking various reproductive health services
• Advise clients on effective contraceptive methods
• Discuss the mode of transmission of HIV/STIs/RTIs and strategies for prevention.
• Understand how various contraceptive methods work including natural family planning methods
• Better advise clients about the changes that take place in their bodies during the menstrual cycle
• Explain the hormonal changes that take place among males and females from puberty to adulthood and old age

Female Reproductive System
Label and state the functions of the various parts of the female genitalia

Figure 5: The female genitalia (external)
• **Clitoris** – this is the penile analogue in the female. It is located at the top meeting of the folds of the lips of the vagina and serves as the erotic organ for sexual arousal.

• **Vagina** – this is the lower part of the female reproductive tract, a moist canal that extends from the labia minora to the cervix, an elastic-like passage that receives the penis during coitus and expands to allow the passage of a fetus during delivery. It also acts as a passage for menstrual flow.

• **Cervix** – this is the narrow outer end of the uterus opening into the vagina. It has two openings, the internal and external os. It allows passage of sperm from the vagina into the uterus. Its competency maintains the pregnancy till term and it dilates to allow expulsion of the fetus during labour. After conception, the cervix prevents infection from ascending into the uterus.

• **Uterus** – this is a pear-shaped organ at the upper end of the vagina with the capacity to stretch to accommodate more than 4.5 kilograms. It is made up of three layers, the endometrium, the myometrium, and the perimetrium. The uterus protects and nourishes the fetus during pregnancy and its contractions expel the baby during delivery. It has three main parts – the fundus, the body, and the cervix.

• **Fallopian tubes** – these are thin tubes about 11 cm long on either side of the uterus. They both have a pathway through which the released ova travel from the ovary to the uterus. In addition, this is where fertilization occurs. It is a passage for both sperm and ova and has four parts – the isthmus, the interstitial part, the ampulla, and fimbriae.

• **Ovaries** – these are two almond-shaped glandular organs and are the primary sex gland of a woman which produce ova during the reproductive phase. They are located in the pelvis and are attached to the uterus by the ovarian ligaments.

• **Ovum** – is the female sex cell.
Key points
• The menstrual cycle is influenced by changing levels of hormones in the brain.
• Day 1 of the menstrual cycle is the first day of menstrual bleeding. Levels of progesterone and oestrogen are low on Day 1.
• As the menstrual cycle continues, an ovum matures in the ovary, called a follicle, and it produces oestrogen. When the ovum is mature, a burst of progesterone is excreted.
• Oestrogen signals the uterine lining to thicken.
• Hormone levels peak at ovulation, approximately Day 14, and this begins the second half of ovulation.
• Progesterone secreted in the second half of the cycle prepares the uterus for nourishing an ovum (if it is fertilized).
• If the ovum is fertilized, hormones are secreted to maintain pregnancy.
• If the ovum is not fertilized, hormones are no longer secreted and the uterine lining begins to shed (menstruation).

Question and Answer
1. What event takes place on Day 1 of the menstrual cycle?
2. What do follicle stimulating hormones (FSH) do during the first half of the menstrual cycle?
3. What do the ovarian follicles produce?
4. What does oestrogen do to the uterus?
5. What main event does the peak in luteinizing hormone release (LH) cause?
6. When does ovulation occur in the menstrual cycle?
7. What happens to the ovarian follicle after the ovum comes out of it?
8. What does the corpus luteum secrete?
9. What do the corpus luteum’s secretions do?
10. What happens to the corpus luteum if fertilization does not take place?
11. What happens to the levels of oestrogen and progesterone if fertilization does not take place?
12. What happens to the uterine lining if fertilization does not take place?

Male Reproductive System

Functions of major organs of the male genitalia
The main organs of the male genitalia include: cowper’s gland, testicles, scrotum, epididymis, seminal vesicle, prostate gland, vas deferens, penis, sperm, and urethra.

Label and state the functions of the various parts of the male genitalia.
• **Penis**: The male organ for sexual relations and elimination of urine and semen. It normally becomes erect at arousal.

• **Scrotum**: A skin sac in which the main sex glands (testicles) reside.

• **Testicles**: The main sex glands (2) on the man that produce sex cells and the hormone testosterone.

• **Urethra**: The pathway running the length of the male organ for elimination of urine and semen.

• **Cowper's gland**: Gland responsible for providing lubricating fluid that keeps the urethra moist.

• **Prostate gland**: The gland that secretes a clear fluid into the urethra under sexual stimulation, mixing with sperm and contributing to the volume of semen.

• **Epididymis**: A tubular, coiled organ that is responsible for maturing sperm.

• **Seminal vesicle**: The organ that produces a sticky fluid in which the sperm moves and feeds.

• **Vas deferens**: The tubes that lead from the epididymis to the seminal vesicles and prostate gland. They contract rhythmically during ejaculation to push out the sperm.

• **Sperm**: The male sex cell with a big oval head and a long tail.
Conception Process

**Key points**

- A mature ovum comes out of the ovary during ovulation. If it meets spermatozoa within 24 hours of ovulation, it can be fertilized.
- Contractions in the fallopian tube move the ovum along to the uterus.
- Sexual intercourse with ejaculation in the vagina sends the sperm into the vagina.
- Spermatozoa enter the cervix due to its thin mucus. About half the spermatozoa die in the acidic conditions of the vagina.
- Spermatozoa travel quickly up into the uterus. Approximately 1 hour after ejaculation there is only about 10% of the original number of spermatozoa left.
- Spermatozoa travel quickly along the fallopian tubes. About half of the remaining spermatozoa have gone into the tube without an ovum.
- A couple of hundred sperm complete the journey into the outer third of the fallopian tube where they meet the ovum and fertilization takes place. If conditions are favourable, spermatozoa can live for up to five days in the woman’s genital tract. As a result, spermatozoa can wait for a newly developed ovum to arrive.
- If the sperm meet an ovum in the outer third of the fallopian tube, fertilization can take place. Ovulation takes place approximately 14 days before the next menstrual period, +/– 2 days. However, it can only be fertilized within 24 hours of ovulation.

Incorporating Reproductive Anatomy and Physiology into Services

**Key questions**

- Do you currently educate your clients about sexual anatomy and physiology? Please share some examples.
- What are some strategies for educating clients about sexual and reproductive anatomy, the menstrual cycle, and the conception process?
- What are some of the challenges to educating clients about sexual and reproductive anatomy and physiology?
- Are there any common beliefs or myths about the menstrual cycle or the process of conception that may need to be corrected with your clients?

Vulnerability of Women to HIV Infection

There are many factors that make women more vulnerable to HIV. Broadly these may be grouped as follows:

- **Biological**
  
  HIV prevalence is much higher among females aged 14–19 compared to boys of the same age group. This could be attributed to the underdeveloped genital tract, earlier engagement in sexual activities, and also the fact that women are often asymptomatic with regard to STI/RTI infection.

  Poor management of post-abortion care coupled with lack of or poor condom use are additional risk factors for HIV infection.

- **Epidemiological and health factors**

  A majority of women do not have ready access to health facilities to diagnose/treat STIs and RTIs. Cervical erosion and ulceration are predisposing factors for HIV infection among women. Poor obstetric care may also predispose some women to HIV infection.

- **Socioeconomic factors among others**

  Low literacy means knowledge of modes of HIV transmission may be correspondingly low. Negative religious and cultural beliefs as well as low status of women (including gender-based violence) may be contributing to women’s high vulnerability to HIV infection.

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:

- Review the Mentee’s Skills Assessment Checklist (available in Annex). Take note of where the anatomy & physiology lesson and activities can be applied.
- Review *National Training Manual on Integrating Counselling and Testing for HIV into Family Planning Services* if further instruction or clarification are needed.

Mentee’s Evaluation

This lesson is evaluated through question-and-answer sessions as well as the mentee’s competency and correct application of the content in all practical sessions of the Mentorship Programme. Successful completion of this lesson is assessed and documented by the mentor.
Lesson 2.4  Physical Exam

Schedule and Timing
This lesson requires approximately 2 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the general overview of a physical exam including rationale</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Discuss and demonstrate a full physical examination</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Return demonstration and correct where necessary</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Briefly discuss areas that need improvement or more practice</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.5 Pelvic Exam</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Subsequent mentoring sessions require approximately 4 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentee to conduct a physical examination under the supervision of the mentor and seek clarification/assistance where needed</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Mentee evaluation and feedback on performance</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.5 Pelvic Exam</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Mentee continues to practice competency skills on at least 10 clients until next meeting.

Objectives
By the end of the session, the participant will be able to:
1. State the purpose for conducting a complete physical examination on a FP/PNC client
2. Discuss the components of a complete physical examination
3. Correctly demonstrate a complete physical examination on a minimum of 10 clients

Tools and Reference Documents
- Fundamentals of Nursing textbook/e-book
- Physical examination handout
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book

Lesson Content

Definition and Purpose of a Physical Exam
A full physical exam is defined as an organized process of examining a patient’s body head-to-toe, collecting health history, or assessing a general systems examination. The exam covers most of the body systems including: the cardiac, respiratory, digestive, and neurological systems.

The purposes of a physical exam are:
- To obtain baseline physical and mental data on the patient.
- To supplement, confirm, or question data obtained in the nursing history.
- To obtain data that will help the nurse establish nursing diagnoses and plan patient care.

Components of a Physical Exam
A physical examination should encompass a general examination (head to toe) and include vital signs and weight among other components. The systemic examination of the thyroid, heart, breasts, abdomen, pelvis, and other relevant systems will be based on the history obtained from the woman. If there is concern about specific systems, further assessment may be undertaken.

Physical exam techniques
- **Inspection**: when the provider looks at different parts of the patient’s body. It should begin with general observation of the patient and then move on to specific body areas.
- **Palpation**: when the provider uses his or her hands to examine the patient. It is used to determine the consistency of tissue directly or indirectly with the palms.
of the hands or finger pads, alignment and intactness of structures such as the extremities, symmetry of body parts and movement, as well as areas of warmth and tenderness.

- **Percussion**: when the provider places one hand on the patient and then taps a finger on that hand, with the index finger of the other hand. Solid and hollow areas generate different vibrations and the examiner can therefore determine whether or not various organs (heart, liver, etc.) are enlarged, whether there is fluid present where it should be absent (e.g., abdominal and chest cavities), or if there is a mass.

- **Auscultation**: when the provider listens over body cavities to determine presence and quality of heart, lung, and bowel sounds. A stethoscope is usually used for auscultation.

**A physical assessment includes**

1) a comprehensive health history and
2) a physical exam.

A comprehensive health history may include
- Biographical data such as name, age, marital status and occupation
- Reason for seeking care (i.e., “chief complaint”)
- Present health or history of present illness, which entails a short statement as well as current medications and diagnoses
- Past health history including any related illnesses, accidents, hospitalizations
- An obstetric history including pregnancy wastage, previous preterm deliveries, and STI/RTI
- Family history of immediate relatives and any hereditary conditions
- A Review of Systems where the patient reports functioning of specific systems
- Psychosocial and Lifestyle Factors (includes social, cultural, spiritual, mental health, violence, sexual history)

Physical Exam components include:
- General overall health state
- Skin, hair, nails
- Head, neck, eyes, ears, nose, and sinuses
- Mouth and throat
- Breast and axillae
- Respiratory system
- Cardiovascular system
- Peripheral vascular system
- Gastrointestinal system
- Urinary system
- Male and female genital systems
- Sexual health
- Musculoskeletal system
- Neurological system
- Hematologic system
- Endocrine system

**Demonstration of Physical Examination**

**Key points**
- Establish a positive health worker/patient rapport. Always greet the client in a friendly nonthreatening manner. This will decrease the client’s anxiety and enhance more cooperation.
- Explain the purpose for the physical assessment. The health worker needs to inform the patient that the purpose of the assessment is to gather information about the patient’s health in order to plan individualized care.
- Obtain an informed, verbal consent for the assessment. Patients often appreciate being asked for their consent to be examined in full.
- Ensure confidentiality of all data. The client should be examined in a private room where others cannot overhear or see the patient. Explain what information is needed and how it will be used. It is also important to convey where the data will be recorded and who will see it.
- Provide privacy from unnecessary exposure. Assure as much privacy as possible by using drapes appropriately and closing doors.
- Communicate special instructions to the patient. As you proceed with the examination, inform the patient of what you intend to do and how he/she can help, especially when you anticipate possible embarrassment or discomfort.
- Follow a Systematic Assessment Flow. The patient’s condition often dictates what area is covered first in the assessment; however, one should still systematically examine every body system to avoid excluding important assessment areas.

**With the patient sitting up, the following systems are reviewed:**
- **Skin**: Exposed areas of the skin are observed; the size and shape of any lesions are noted.
- **Head**: Hair, scalp, skull, and face are examined.
- **Eyes**: External structures are observed. Internal structures can be observed using an ophthalmoscope (a lighted instrument) in a darkened room.
- **Ears**: External structures are inspected. A lighted instrument called an otoscope is used to inspect internal structures.
- **Nose and sinuses**: External nose is examined. The nasal mucosa and internal structures are observed using a penlight and a nasal speculum.
- **Mouth and pharynx**: Lips, gums, teeth, roof of the mouth, tongue, and pharynx are inspected.
- **Neck**: Lymph nodes on both sides of the neck and the thyroid gland are palpated.
- **Back**: Spine and muscles are palpated and checked for tenderness. A stethoscope is used to listen for breath sounds on the back.
• **Breasts and armpits:** A woman’s breasts are inspected with the arms relaxed and then raised. In both men and women, the lymph nodes in the armpits are palpated. While the patient is still sitting, movement of the joints in the hands, arms, shoulders, neck, and jaw can be checked.

• **Musculoskeletal system:** As client/patient stands, the straightness of the spine and the alignment of the legs and feet are noted.

**While the patient is lying down on the examining table, the examination includes:**

• **Heart:** A stethoscope is used to listen to the heart’s rate and rhythm. The blood vessels in the neck are observed and palpated.

• **Front of chest and lungs:** A stethoscope is used to listen to the internal breath sounds.

• **Breasts:** Palpated and inspected for lumps.

• **Abdomen:** Light and deep palpation to feel the outlines of organs including the liver, spleen, kidneys, and aorta.

• **Rectum and anus:** While lying on the left side, the outside areas are observed. An internal digital examination (using a finger) is usually done if the patient is over 40 years old. In men, the prostate gland is also palpated.

• **Reproductive organs:** External sex organs and surrounding area are inspected and examined for hernias. In men, the scrotum is palpated.

• **Legs:** Inspected for swelling. Pulses in the knee, thigh, and foot area are found. The joints and muscles are observed.

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**Mentee’s Assignment**

Upon completion of this lesson, the mentee should complete the following assignment:

- Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 2 on Physical Examination.
- Review *Fundamentals of Nursing* textbook/e-book or follow-up with mentor if further instruction or clarification are needed on physical examination steps.
- Practice the above lesson in the facility setting with at least 10 clients.

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**Mentee’s Evaluation**

The mentee’s competency in this lesson is evaluated using two methods. First, the mentee must demonstrate competency in all steps of the Physical Examination section in the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Second, the mentee must conduct physical examinations on a minimum of 10 patients in the facility setting to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
LESSON 2.5 Pelvic Exam

Schedule and Timing
This lesson requires approximately 2 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the general overview and rationale of a pelvic examination</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Demonstrate external examination and ask the mentee for a return demonstration</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Demonstrate a speculum examination and ask for a return demonstration</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Demonstrate bimanual examination and ask for a return demonstration</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Demonstrate recto-vaginal examination and ask for a return demonstration</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.6 Cervical Cancer Screening</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Subsequent mentoring sessions require approximately 6 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mentee conducts pelvic examination under the supervision of a mentor and seeks clarification/assistance where needed</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Mentee evaluation and feedback on performance</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.6 Cervical Cancer Screening</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Mentee continues to practice competency skills on at least 10 clients until next meeting.

Objectives
By the end of this session, participants will be able to:
1. Define and state the purpose of a pelvic examination on a FP/PNC client
2. Discuss all the components of a pelvic examination
3. Demonstrate competency in each step entailed in conducting a pelvic examination
4. Conduct pelvic examinations on at least 10 clients

Tools and Reference Documents
- Fundamentals of Nursing textbook/e-book
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book
- Sexually Transmitted and Other Reproductive Tract Infections: Guide to Essential Practices, WHO 2005
- Course in Visual Methods for Cervical Cancer Screening: Visual Inspection with Acetic Acid and Lugol’s Iodine, PATH 2004

Lesson Content
The content of this lesson is from Sexually Transmitted and Other Reproductive Tract Infections: A Guide to Essential Practices, WHO 2005. Please refer to that document for further detail and instruction, if necessary.

Definitions and Purpose of Pelvic Examination
A pelvic examination is a complete physical exam of a woman’s reproductive organs. This is an important element of preventive healthcare for all adult women and helps a healthcare worker evaluate the size and position of the vagina, cervix, uterus, and ovaries.

A pelvic exam is done to help detect certain cancers in their early stages, infections, sexually transmitted infections (STIs), or other reproductive system problems.

Patients should be examined in the same condition of privacy as those in which the history was taken. Patients should feel comfortable that no one will walk into the room while they are undressing or lying on the examination table. When examining a patient of the opposite sex, it is usually advisable to have an assistant of the same sex as the patient present.

Components of a Pelvic Examination
A pelvic examination includes the following four components:

1. External examination is an inspection and palpation of the external genitals, including the perineum and anus, looking for lumps, swelling, unusual discharge, sores, tears, and scars around the genitals and in between the folds of the vulva.

2. Speculum examination is conducted to examine the cervix for bleeding, discharge, abnormal growths, or signs of infection, and also is necessary for a cervical cancer screening.
3. **Bimanual pelvic examination** entails the HCW placing her/his fingers inside the patient’s vagina and allows for greater examination of abdomen and pelvic area in order to identify any tenderness and pain, abnormal growths, signs of infection, or signs of pregnancy.

4. **Recto-vaginal examination** is an internal inspection and palpation of the rectal and vaginal areas to examine the walls of the rectum, palpate the posterior aspect of the uterus and identify any fistulas, nodules, tears, or lesions.

**Demonstration of a Pelvic Examination**

Before starting a pelvic examination, be sure you have privacy. Ask the woman to pass urine. Have her lie on her back, with her heels close to her bottom and knees up. Explain what you are about to do. Don a clean glove on the hand that you will be inserting inside the vagina or rectum.

**Procedures**

**External Genitalia Examination**
- Examine the external areas of the genital region and anus for lumps, swelling, unusual discharge, sores, tears, and scars around the genitals.

**Speculum Examination**
- Be sure the speculum has been properly disinfected/sterilized before you use it.
- Insert the first finger of gloved hand into the vagina. Push gently downward on the muscle and you wait for the woman to relax her muscles. Hold speculum sideways with other hand and slip it into vagina.
- When the speculum is halfway in, turn it so the handle is down (or up). Gently open blades and look for the cervix. Gently move the speculum until the cervix is between the blades. Tighten the screws to keep the speculum in place.
- Cervix should be pink, round, and smooth. Additional normal findings include small yellow cysts, areas of redness at os, or clear mucoid discharge.
- Signs of infection include yellowish discharge or easy bleeding when cervix is touched with swab. Note any abnormal growths or sores.
- Note if cervical os is open or closed and any discharge or bleeding.
- To remove the speculum, gently pull it until the blades are clear of cervix, bring blades together and turn the speculum to look at the walls of the vagina.

**Bimanual Pelvic Examination**
- Place gloved pointing and middle finger inside the vagina with palm up.
- Feel the cervix to see if it is firm and round. Put one finger on either side of the cervix and move the cervix gently while watching the woman’s facial expression. If this movement causes pain, she may have an infection of the uterus, tubes, or ovaries. If her cervix feels soft, she may be pregnant.
- Feel the uterus by gently pushing on her lower abdomen with the outside hand. Feel for its size and shape by moving your inside fingers to sides of cervix and “around” the uterus.
  - A normal uterus feels firm, smooth, and smaller than a lemon. If the uterus is soft and large, the woman may be pregnant. If the uterus feels lumpy and hard, she may have a fibroid or other growth. If it hurts when you touch it, she may have an infection inside. If the uterus does not move freely, she may have scars from an old infection.
  - Feel the tubes and ovaries using the hand inside the vagina and outside pushing on the lower abdomen. If these are normal, they will be hard to feel. Any abnormalities, including pain or lumps bigger than an almond, require further evaluation.
  - Move finger along the inside of the vagina looking for any lumps, tears, or sores.

**Recto-vaginal Examination**
- If completing recto-vaginal examination after bi-manual examination, use a new glove. Tell patient what you are about to do and encourage her to relax.
- After applying lubrication to your pointing and middle fingers on one hand, insert the middle finger into the anus slowly and afterwards place the pointing finger inside the vagina.
- Feel the uterus and the surrounding structures by gently pushing on the woman’s lower abdomen with the outside hand. Feel for its size and shape.
- Feel for any lumps, tears, or sores on the posterior vaginal wall and along the inside of the rectal wall.

When finished with the procedure, clean and disinfect your glove if it will be reused. Help the patient to a sitting position. Wash your hands well with soap and water.

**Mentee’s Assignment**

Upon completion of this lesson, the mentee should complete the following assignment:
- Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 3 on Pelvic Examination.
- Review *Fundamentals of Nursing* textbook/e-book or follow up with mentor if further instruction or clarification is needed on pelvic examination skills.
- Practice the above lesson in the facility setting with at least five clients.

**Mentee’s Evaluation**

The mentee’s competency in this lesson is evaluated using two methods. First, the mentee must demonstrate competency in all steps of the Pelvic Examination section in the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Second, the mentee must conduct pelvic examinations on a minimum of five patients in the facility setting to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
LESSON 2.6  Cervical Cancer Screening

Schedule and Timing
This lesson requires approximately 4 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present causes and progression of cervical cancer; presentation of cervical cancer; and screening methods to identify the abnormal vaginal and cervical findings</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Host a presentation of case studies and interactive discussion</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Discuss means for preventing cervical cancer</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate cancer screening tests, including counselling, follow-up, and education</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Mentee provides a return demonstration</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>2 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.7 STI Prevention and Management</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Mentee continues to practice competency skills on at least five clients until next meeting.

Objectives
By the end of this session, participants will be able to:
1. Outline the progression, presentation, and causes of cervical cancer
2. Describe the purpose of screening for cervical cancer and indications for screening
3. List the different methods of cervical cancer screening
4. Demonstrate cervical cancer screening methods, including visual inspection with acetic acid (VIA), visual inspection with Lugol’s iodine (VILI), and pap smear
5. Demonstrate proper counselling, follow-up, and education associated with cervical cancer screening methods
6. Describe the HPV vaccination and other means of prevention of cervical cancer

Tools and Reference Documents
- Facility/organizational procedural guidelines on cervical cancer screening
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book
- Course in Visual Methods for Cervical Cancer Screening: Visual Inspection with Acetic Acid and Lugol’s Iodine, PATH 2004

Lesson Content
The content of this lesson is from the Course in Visual Methods for Cervical Cancer Screening: Visual Inspection with Acetic Acid and Lugol’s Iodine, PATH 2004. Please refer to that document for the complete curriculum and detailed instruction.

Cervical Cancer: Cause, Progression, and Presentation
The cause of cervical cancer is a virus called Human Papilloma Virus (HPV), a common sexually transmitted infection. HPV lives in the skin (squamous cells) covering the pubic area (vulva and shaft of the penis), as well as the interior lining of the vagina and cervix in women and the urethra and anus in both sexes.

Risk of Cervical Cancer
Almost all women (estimates of 70% to 80%) will be infected with carcinogenic (cancer-causing) types of human papilloma virus (HPV). However, not all develop cervical cancer. Some women have additional risk factors for infection or expression of disease, but almost all face the risk of being exposed to a cancer-causing type of HPV. The risks of exposure to HPV include:
- Early onset of sexual contact
- Multiple sexual partners
• Sexually transmitted infections
• HIV/AIDS and those on highly active anti-retroviral treatment (HAART)
• Other immunosuppressive states like organ transplant and continuous use of certain medications

More than 100 types of HPV have been identified, with some types more closely linked to cervical cancer. HPV types 16 and 18 have been strongly implicated in cervical and other anogenital cancers.

Progression and Presentation of Cervical Cancer
Cancer of the cervix is painless and progresses slowly. After an initial infection with HPV, a precursor lesion may result (in fewer than 10% of cases), but the lesion rarely progresses to cervical cancer. When it does, progression takes 10–15 years.

In advanced stages, the signs and symptoms include painful sexual intercourse, bleeding after sex, lower abdominal and back pain, and a foul vaginal smell. Yet, because HPV is usually asymptomatic and most sexually active women have already been infected, all sexually active women should be considered at risk.

Screening for Cervical Cancer
Screening for cervical cancer is recommended for all women 25 to 49 years of age, once every five years. Screening is especially important for women with HIV as their risk is increased, and should be conducted every six months for the first year and then annually thereafter (MPHS 2012).

Screening is not advised if:
• Client is pregnant, especially within first three months of pregnancy
• Client is postpartum, up to six weeks
• Client is using intra-vaginal medication
• Gross lesions are observed upon visual inspection

Screening can be done at any point in the menstrual cycle (it may be difficult to see if menstrual flow is heavy—in such cases, you may need to re-examine).

Pre-cancerous lesions may appear on the cervix and can be identified by screening methods. As part of a pelvic exam using the speculum, three cervical cancer screening methods are possible:

1. visual inspection with acetic acid (VIA)
2. visual inspection with Lugols iodine (VILI)
3. pap smear

Lesions detected in their early stages through these visual procedures (VIA and VILI) can be treated immediately on an outpatient basis. If lesions are identified as in more advanced stages, clients are referred for specialized treatment.

Visual inspection with acetic acid
• Involves looking at the cervix after swabbing it with 3%-5% acetic acid
• Abnormal areas will have a distinct white appearance commonly referred to as acetowhite change.
• VIA has a sensitivity of 74% and a specificity of 69%
• Results are available immediately

Visual inspection with Lugols iodine
• Involves looking at the cervix after swabbing it with Lugols iodine
• Normal cells take up the iodine while abnormal areas appear a bright yellow (like mustard or banana) color
• VILI has a sensitivity of 92% and a specificity of 85%
• Should be used as a confirmatory test if VIA is positive
• Results are available immediately

Pap smear
• Involves scraping the cervix using a uterine cervical brush and rotating around the cervix entirely three times in order to collect exfoliating cells
• Specimen is scraped on glass slide, “fixed” in place with alcohol, and sent to a laboratory for examination
• Slide is analyzed by a specially trained cytologist, and therefore results are not available immediately
• Limitations to pap smear include its requirement for a microscope and laboratory equipment as well as a trained specialist; it may miss pre-cancerous and cancerous cells; and may induce unpleasant side effects

Screening for HPV infection involves these physical procedures. If any are positive, the client should be treated immediately. Follow-up is advised for the following:

• Screening should be repeated every five years if cervix is normal
• If treated for lesion, screening should be repeated every year
• If living with HIV and on ARV treatment, screening should be repeated every 6 to 12 months

Prevention of Cervical Cancer
It is unclear whether standard STI precautions really protect women from getting HPV. Condoms do not cover all the areas where HPV can be transmitted.

The HPV vaccine is now available for prevention of cervical cancer by minimizing incidence of HPV infection. This vaccine is indicated for females 10 to 25 years old and comes in three doses. Currently, it is only available in high-resource settings.
Case Studies and Interactive Discussion
Refer to Course in Visual Methods for Cervical Cancer Screening: Visual Inspection with Acetic Acid and Lugol’s Iodine (PATH 2004) for case presentation and discussion questions.

Demonstration Using Pelvic Model

Procedures
- Prepare the environment properly, with regard to privacy and lighting.
- Explain how to prepare the client for the procedure, i.e., greeting the client, explaining the procedure, warning about slight discomfort, proper positioning of the client (lithotomy) on the examination table, and ensuring that client has emptied her bladder.
- Ensure proper hand washing and the donning of sterile gloves.
- Clearly explain how to inspect the external genitalia for anomalies before properly swabbing the vulva and inserting the speculum appropriately.
- Explain proper application of acetic acid (for VIA) and Lugol’s iodine (for VIILI) to the cervix and inspecting the transformation zone for any discoulouration.
- Emphasize the proper disposal of used equipment.
- Ensure proper hand washing after procedure.

Key points for counselling and education
- Screening should take place in a private and comfortable environment.
- Women have the right to make an informed decision about whether or not they want to be tested.
- Women have the right to fully understand all procedures associated with cervical cancer screening and an opportunity to ask questions
- After the screening, allow the woman to get dressed in private before you discuss her results with her.
- If the woman is VIA or VIILI negative, explain the meaning of the test results and tell her to return for another screening in five years.
- If the screening tests are abnormal, discuss referral for further management in a nonthreatening manner and using words the woman can understand.

Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
- Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 4 on Cervical Cancer Screening.
- Review Course in Visual Methods for Cervical Cancer Screening: Visual Inspection with Acetic Acid and Lugol’s Iodine or follow up with mentor if further instruction or clarification are needed on steps and skills.
- Practice the above lesson in the facility setting with at least five clients.

Mentee’s Evaluation
The mentee’s competency in this lesson is evaluated using three methods. First, quizzes and question-and-answer sessions hosted are during the training session. Second, the mentee must demonstrate competency in all steps of the Cervical Cancer Screening section in the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Last, the mentee must conduct screenings on a minimum of five patients in the facility to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
Lesson Content


Sexually Transmitted Infections and Reproductive Tract Infections

Reproductive tract infections (RTIs) are infections of the genital tract and are caused by organisms normally present in the reproductive tract, or introduced from the outside. RTIs affect both men and women and some (such as syphilis and gonorrhoea) are sexually transmitted. RTI is a broad term that includes sexually transmitted infections and other infections of the reproductive tract not transmitted through sex.

Sexually transmitted infections (STIs) refer to the way that many infections are transmitted. STIs in most cases have more severe health consequences than other RTIs and STIs/RTIs are the most important causes of maternal and perinatal morbidity and mortality.

Not all sexually transmitted infections are reproductive tract infections; and not all reproductive tract infections are sexually transmitted

Categories of STIs

- **BACTERIAL**: syphilis, gonorrhoea
- **Fungal**: candidiasis
- **Protozoa**: Chlamydia, trichomoniasis
- **Viral**: hepatitis, genital herpes simplex, HIV, genital warts

Prevention and control of STIs

Control of STIs requires effort in four main areas:

- Improved counselling that helps people make better choices
- Contact tracing
- Compliance with treatment programmes, and
- Increased use of condoms
Prevention of STIs can be primary, secondary, or tertiary.

- **Primary prevention** entails prevention of an infection in the first place and includes the following measures: abstinence, mutual monogamy, correct and consistent use of condoms, and safer sex practices.

- **Secondary prevention** entails prompt early detection, treatment, and contact tracing of any patient with an STI/RTI. The following activities are considered secondary prevention: Prompt and correct treatment, increasing access to health care, notifying and treating partners; and screening for cases.

- **Tertiary prevention** is treatment of the infection and management of any complications. This level of prevention entails comprehensive management of the condition, including health education, patient counselling, laboratory evaluation, and providing appropriate treatment regimen. Training and research also are included under tertiary prevention.

**Partner notification**
Notifying sexual partners of a client infected with an STI/RTI is extremely important in the control and prevention of further STI/RTI transmission. Partner notification entails locating and treating people who have potentially been exposed to an STI and may even be asymptomatic. All patients with an STI/RTI are encouraged to talk with their sexual partners and ask them to seek STI evaluation and treatment.

Partner notification prevents the spread of the STI, prevents potential re-infection of the client, and prevents potential complications entailed in a long-standing unidentified and untreated STI.

Partner notification may be done by:
1. The patient (via partner slips, cards, or a simple conversation)
2. The provider (where the clinic staff directly contact the patient’s partners)
3. A combination of both the patient and the provider (which may be necessary if there is reluctance by the patient to disclose information to his/her partners)

As part of all partner notification and STI/RTI screening and treatment procedures, HIV testing should be encouraged!

**HIV and STIs**
It is now well established that the presence of other sexually transmitted infections greatly facilitates the transmission and acquisition of HIV between sexual partners. Ulcerative STIs, like genital warts, and non-ulcerative STIs may increase HIV transmission three- to fivefold.

Co-infection of HIV and STIs can prolong or augment the infectiousness of individuals with STIs and, therefore, the two infections “amplify” one another. RTIs may also increase the risk of HIV transmission, particularly if they cause inflammation or lesions in the genital tract.

For this reason, an STI control programme is an essential component of HIV prevention strategies. In addition, treating people with STIs provides a valuable opportunity for health workers to reach those at particularly high risk of acquiring HIV.

**Facts about the association between STIs and HIV**
1. STIs/RTIs primarily disrupt the integrity of the skin (mucosal barrier), enabling HIV easy access to the body
2. STIs/RTIs that cause inflammation, such as gonorrhea, trichomoniasis, and Chlamydia, weaken the skin barrier
3. The presence of genital ulcers increases the risk of HIV transmission 10 to 100 times
4. People living with HIV who also have STIs/RTIs have increased HIV viral shedding in their genital fluids, increasing the virus’s potential of being transmitted
5. STI/RTI treatment has been demonstrated to significantly reduce HIV viral shedding

**Education and Counselling on STI Prevention**
Health education is the provision of essential information related to the prevention or treatment of STI/RTI and need not take much time.

Counselling requires time to establish trust, assess the person’s individual situation, and relate prevention information directly to the person’s life.

Health education and counselling about STI prevention should address the following main points:

- Correct and consistent condom use
- Reducing the number of sexual partners or delaying sexual activity
- Recognizing symptoms and early use of health services

Counselling should always be flexible, be adapted to the needs and circumstances of each patient, and take into account barriers to behaviour change.

**Counselling guidelines for STI management:**
1. Advise client to contact all partners, especially latest contact
2. Offer HIV counselling and testing
3. Provide health education and counselling on possible complications, even if the client is asymptomatic
4. Encourage couples counselling as much as possible
5. Advise clients that transmission is possible even without symptoms
6. Educate clients on the risks of prenatal transmission
7. Emphasize partner notification and partner treatment to prevent re-infection
General skills for education and counselling:
• Welcome your patient warmly by name and introduce yourself
• Assure your patient that privacy and confidentiality will be respected
• Sit close enough to be able to talk comfortably and privately
• Make eye contact and look at the patient as she speaks
• Use language that the patient understands
• Listen to the patient and take note of body language. Try to understand feelings, experiences, and points of view
• Be encouraging; nod or say, “Tell me more about that”
• Use open-ended questions
• Provide relevant information
• Try to identify the patient’s real concerns
• Suggest various options to the patient
• Respect the patient’s choices
• Always verify that the client has understood what has been discussed by having her repeat the most important information

Do not:
• Keep moving about the room
• Encourage other providers to interrupt
• Write notes continuously as the patient is speaking
• Make judgemental comments or negative facial expressions

(from Sexually Transmitted and Other Reproductive Tract Infections: A Guide to Essential Practice, WHO 2005)

Role-play activity
The patient is a 19-year-old woman who has come to the facility crying and upset. She is reluctant to explain what is wrong because she is embarrassed and scared and does not know what’s going on “down there.” She has had multiple partners but has been with one man for six months. They do not use condoms and she does not know the signs and symptoms of STIs.

Signs, Symptoms, and Management of STIs
Early identification of STIs is not always possible and some infections often have no noticeable signs or symptoms in women. To help detect STIs early, a healthcare worker can:
• Ask whether the client or the client’s partner has any genital sores or unusual discharge
• Look for signs of STIs when doing a pelvic or genital examination
• Know how to advise a client who may have an STI/RTI
• Promptly diagnose and treat a client with signs and symptoms, or refer for appropriate care
• Advise clients to notice any genital sores, warts, or unusual discharge in themselves or their sexual partners (from Family Planning: Global Handbook for Providers, WHO/JHU 2011)

Common STI/RTI signs and symptoms include:
• Urethral discharge
• Genital ulcer disease (GUD)
• Lower abdominal pain
• Abnormal vaginal discharge
• Ophthalmia neonatorum (conjunctiva infection of neonates)

Figure 10: Common signs and symptoms that may suggest an STI include

<table>
<thead>
<tr>
<th>Symptom</th>
<th>Possible Cause</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discharge from the penis – pus, clear or yellow-green drip</td>
<td>Commonly: Chlamydia, gonorrhoea Sometimes: Trichomoniasis</td>
</tr>
<tr>
<td>Abnormal vaginal bleeding or bleeding after sex</td>
<td>Chlamydia, gonorrhoea, pelvic inflammatory disease</td>
</tr>
<tr>
<td>Burning or pain during urination</td>
<td>Chlamydia, gonorrhoea, herpes</td>
</tr>
<tr>
<td>Lower abdominal pain or pain during sex</td>
<td>Chlamydia, gonorrhoea, pelvic inflammatory disease</td>
</tr>
<tr>
<td>Swollen and/or painful testicles</td>
<td>Chlamydia, gonorrhoea</td>
</tr>
<tr>
<td>Itching or tingling in the genital area</td>
<td>Commonly: Trichomoniasis Sometimes: Herpes</td>
</tr>
<tr>
<td>Blisters or sores on the genitals, anus, surrounding areas, or mouth</td>
<td>Herpes, syphilis, chancre</td>
</tr>
<tr>
<td>Unusual vaginal discharge – changes from normal vaginal discharge in colour, consistency, amount, and/or odour</td>
<td>Most commonly: Bacterial vaginosis, candidiases (not STIs) Commonly: Trichomoniasis Sometimes: Chlamydia, gonorrhoea</td>
</tr>
</tbody>
</table>

When a patient has been identified in your facility as having an STI/RTI
• Treat the STI according to the diagnosis
• Advise the patient to abstain from sex during treatment and also when symptoms of STI (such as lesions) are present
• Offer patient HIV testing if status is unknown
• Provide information on STIs and the methods of STI prevention for the future
• Conduct patient-centred risk reduction discussion and planning
• Remind and demonstrate how to use condoms correctly and consistently
• Provide condoms
• Encourage patient to notify his/her partner to seek testing and treatment
• Treat all female partners whether or not they are symptomatic
Male condom demonstration
1. Use a new condom for each act of sex
2. Before any act of contact, place the condom on the tip of erect penis with the rolled side down; squeeze the air out of the tip of the condom
3. Unroll the condom all the way to the base of penis
4. After ejaculation, hold the rim of condom in place and withdraw penis while it is still erect
5. Dispose of the condom safely

Female condom demonstration
1. Use a new female condom for each act of sex
2. Before any physical contact, insert the condom in the vagina. Can be inserted in any comfortable position – squat, raise one leg, sit, lie down
3. Grasp ring at the closed end and squeeze it so it becomes long and narrow. Use the other hand to separate the outer labia and locate the opening of the vagina
4. Gently push inner ring into vagina as far as it will go. Insert a finger into the condom to push it into place (about 2–3 cm will remain outside the vagina)
5. Ensure that the penis enters the condom and stays inside the condom during intercourse
6. To remove the condom, after the man withdraws his penis, hold the outer ring of the condom, twist to seal in fluids, and gently pull it out of the vagina
7. Dispose of condom safely

Key points about condom use
- If used consistently and correctly, condoms provide good protection against STIs/RTIs, HIV, and unwanted pregnancy
- Do not use the male and female condom together
- Do not reuse condoms
- Dispose of used condoms by placing them in a waste container, in latrine, or burying. Do not flush condoms down the toilet.

Health service providers should use every opportunity to talk to HIV clients especially about condoms because:
1. Condoms help stop transmission of HIV in discordant couples
2. Condoms protect against re-infection with other HIV strains
3. People living with HIV are at increased risk for acquiring other STIs
4. Condoms protect from unwanted pregnancy
5. Condoms prevent acquiring additional “viral load”—more HIV virus that can make symptoms and the disease progression worse

Community STI Prevention Activities

Key points
- Health workers can have the greatest impact on STI/RTI prevention measures if their educational efforts go beyond the health facility where they work.
- Most people are unable to recognize the signs and symptoms of STIs and also do not know what to do when they experience signs and symptoms.
- Reaching community members who do not visit your health facility will assist in preventing the spread of STIs/RTIs in your community.
- Possible ways to reach the community include:
  - Giving brochures or pamphlets to your clients and asking them to share them with others;
  - Posting posters and signs with health messages about STI prevention throughout your community; and
  - Organizing community education events such as film shows, group talks, drama presentations, or broadcast messages on the radio, TV, or in newspapers.

Key messages to use in community STI education and prevention activities
STIs and RTIs can be avoided by being mutually faithful to your partner, by abstaining from sex, or by using condoms correctly every time.

Most and STIs and RTIs can be treated if you take your medications as instructed, even when you feel better.

After treatment of an STI, be sure to return to the health facility to be sure you are free of the infection

Use condoms correctly every time.

Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
- Review all tools and reference materials listed, or follow up with mentor if further instruction or clarification are needed on steps and skills.

Mentee’s Evaluation
Mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session. This forum is used to gauge the mentee’s understanding of the information and its application in a clinical setting. The mentee must also demonstrate competency in the steps of condom use and STI counselling documented in the Skills Assessment Checklist. These competencies will be evaluated by her/his mentor and then by final external evaluators upon completion of programme.
LESSON 2.8  Postnatal/Postpartum Care

Schedule and Timing
This lesson requires approximately three hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Discuss the importance of services included in postnatal care to mother and baby, including special needs for high-risk populations</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Explain and demonstrate a full postpartum physical examination</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Explain and demonstrate obtaining a health history from the mother</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Mentee provides a return demonstration of a physical exam and health history. Mentor teaches/corrects when necessary.</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Explain and demonstrate a full physical examination on the newborn</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Mentee provides return demonstration of newborn physical exam</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.9Family Planning</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Mentee continues to practice competency skills on at least five mother/baby dyads until next meeting.

Objectives
By the end of this session, participants will be able to:
1. Outline essential routine postnatal care for mothers
2. Outline essential routine postnatal care for newborns
3. Discuss the extra care provided to high-risk babies, e.g., those with low birth weight and those born to mothers living with HIV/AIDS
4. List postnatal/postpartum danger signs requiring detection and management/referral
5. Discuss means to strengthen postnatal care services in Kenya
6. Explain the role of community health workers in postnatal care
7. Discuss promotion of male involvement in postnatal care

Tools and Reference Documents
- Facility/organizational procedural guidelines on postnatal care
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book
- National Guidelines for Quality Obstetrics and Perinatal Care, MOH 2012
- National Orientation Package for Targeted Postnatal Care: Orientation Manual for Health Providers, PowerPoint, MOH 2011
- Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice, WHO 2006

Lesson Content
The content of this lesson is from the National Guidelines for Quality Obstetrics and Perinatal Care, MOH 2012; Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice, WHO 2006; and Counselling for Maternal and Newborn Healthcare: A Handbook for Building Skills, WHO 2010. Please refer to those documents for further guidelines on postpartum/postnatal care.

Definitions
Postpartum/Postnatal care is the care provided to a mother and her newborn during the period immediately following the birth up to six weeks post-delivery. The initial phase of the postpartum period begins after delivery and care are provided, most often in the birthing room or in a recovery room.

The healthcare worker should assess the mother’s condition every 15 minutes for the first hour after delivery, and every 30 minutes for the second hour. Thereafter, the mother and her baby should be assessed every 4 to
8 hours depending on the policy at the healthcare facility.

Counselling during this period is an interactive process between the health worker and a woman and her family, during which information is exchanged and support is provided so that the woman and her family can make decisions, design a plan, and take action to improve their health.

Services in Postpartum Care for Mother

During the postpartum period, the healthcare worker should provide a physical assessment and exam of the mother. The main components of this physical exam are as follows:

- Vital signs (temperature, blood pressure, pulse rate)
- Pain assessment
- Assessment of uterine tone and location (is it midline?)
- Fundal height
- Presence of lochia and/or vaginal discharge
- Amount and consistency of bleeding
- Condition of perineum
- Function of and possible distension of bladder
- Bowel function
- Physical comfort

Postpartum advice and counselling are important for the mother and her baby during the initial postpartum period. The following main points should be addressed and discussed during the postpartum period.

- Ensure that someone is always nearby for the first 24 hours after birth, in case there are any prompt changes in the new mother’s condition
- Avoid inserting anything into the vagina
- Avoid sexual intercourse until the perineal area is healed
- Empty the bladder regularly
- Ensure enough rest and sleep
- Washing hands before handling the baby is important to prevent infection
- Change perineal pads every 4 to 6 hours, or more frequently if experiencing heavy lochia
- Wash perineum daily and after bowel movement. Ensure wiping front to back

Nutrition and food can, at times, be an issue of concern for mothers and their families. Emphasize the following points when discussing nutrition related to breastfeeding, newborns, and recovering after birth:

- Eat a variety of healthy foods, including meat, fish, oils, nuts, seeds, cereals, beans, vegetables, and milk.
- Normal foods will not harm the breastfeeding baby
- Thin women and adolescents require additional nutritional counselling to ensure their healthy recoveries
- Misconceptions and taboos about particular foods and their effects on the mother and baby should be addressed
- Family members, including the father and mother-in-law, should encourage the new mother to eat enough and to avoid physical labour

Healthcare workers should also be sure to facilitate an environment where mothers feel comfortable asking questions about their experience, taking care of their newborn, vocalizing any concerns, and/or asking for assistance.

Refer to National Guidelines for Quality Obstetrics and Perinatal Care (MOH, 2012) for information about targeted postnatal care. Topics for mother include:

- Health promotion using health messages and counselling (e.g., on nutrition and resumption of sexual activity)
- Assisting the mother and her family to develop a personalised PNC plan
- Provision of essential postpartum care by a skilled attendant
- Early detection of danger signs and treatment of problems
- Prevention of mother-to-child transmission of HIV (PMTCT)
- Emergency preparedness and complication readiness
- Counselling and service provision for postpartum FP/healthy timing and spacing of pregnancy
- Screening for other conditions, e.g., cervical cancer, breast cancer, STI/RTIs

Services in Postnatal Care for Newborn

During the immediate postnatal period, the healthcare worker should provide a physical assessment and exam of the newborn. The main components of this exam are as follows:

- Vital signs (temperature, pulse rate, and respiratory rate)
- Weight and length
- Heart and breath sounds
- Head circumference
- Danger signs, including chest retractions, wheezing
- Rashes or abnormal skin presentations, such as redness or jaundice
- Umbilical cord care

In addition to the exam, services in the immediate postnatal period should include:

- Assessment for danger signs
- Assessment of feeding method and support for optimal feeding practices
- Promotion of hygiene and good skin and eye care
• Demonstration of correct cord care of the umbilical cord area
• Identification of any superficial skin infections, including pus draining from umbilicus, redness extending from umbilicus, swelling, redness, hardness of skin
• Ensuring the baby's warmth via skin-to-skin care
• Delay of baby's first bath until 24 hours after birth
• Encouragement and facilitation of birth registration
• Referring mother and baby to immunization clinic

Refer to National Guidelines for Quality Obstetrics and Perinatal Care (MOH, 2012) for information about targeted postnatal care. Topics for newborn include:
• Provision of essential care to the newborn
• Counselling on infant and young child feeding
• Early detection of danger signs and treatment of problems
• Immunisation

High-risk Considerations during Postpartum/Postnatal Period

Specific groups of mothers and babies may be at particularly high risk for complications in the postpartum/postnatal period. Additional services and care may need to be provided to ensure their health.

Additional considerations for mothers with HIV/AIDS
• Determine what the woman has told her partner and/or her family about her HIV status before mentioning anything related to it. RESPECT THIS CONFIDENTIALITY.
• Be sensitive to special concerns and fears related to transmission of the virus, life expectancy, providing care, or any others.
• Use standard precautions.
• Advise the woman that she is more prone to infections and should seek medical advice if experiencing: fever, persistent diarrhoea, respiratory infection, burning upon urination, vaginal itching or foul-smelling discharge/lochia.
• Advise that lochia may cause infection in others and therefore she should safely dispose of stained perineal pads.
• Provide counselling on family planning.
• Encourage exclusive breastfeeding and provide extra support for feeding.

The majority of newborn deaths occur among those of low birth weight (LBW) and pre-term (born before 37 weeks gestation).

Babies with low birth weight, small for gestational age, or born to mothers living with HIV/AIDS
• Be sure to identify LBW and small-for-gestational-age babies using national guidelines on weight and approximate gestational age

• Ensure a full newborn assessment on newborns that are considered high-risk
• Assess for existing danger signs and refer/manage as appropriate
• Provide extra support for breastfeeding, including expressing milk or using a cup to feed if necessary
• Emphasize the importance of warmth and promote skin-to-skin care
• Quickly identify those babies who are unable to breastfeed and refer for additional services

Danger signs for Postpartum/Postnatal Emergencies

The early identification of danger signs and appropriate and immediate referral for their proper management is essential to save the lives of mothers and babies. Prompt detection of and attention to these following danger signs will help prevent life-threatening complications.

Danger signs for mother
• Excessive bleeding (more than one perineal pad per hour)
• Foul smelling vaginal discharge
• Fever with or without chills
• Severe abdominal pain
• Excessive tiredness or breathlessness
• Swollen hands, face, legs with severe headache or blurred vision
• Painful, engorged breasts with sore, cracked, bleeding nipples

Danger signs for newborn
• Convulsions
• Limited movement or movement only when stimulated
• Poor feeding
• Rapid breathing (more than 60 breaths per minute)
• Grunting or chest retractions (chest drawing in)
• Temperature above 38°C or below 35.5°C
• Weight less than 1500 grams
• Born more than 2 months early (gestational age under 32 weeks)

Strengthening Postpartum/Postnatal Care in Kenya

To strengthen postpartum/postnatal services, the Kenyan MOH increased the number of visits recommended, to include a check-up within 48 hours, at two weeks, and six weeks. (from DRH Safe Motherhood and Neonatal Health Program)

Other aspects of postpartum/postnatal care that HCWs can emphasize include:
• Increase knowledge about the postpartum/postnatal period
• Increase delivery of counselling on the benefits of postpartum care to mothers after delivery
• Increase knowledge about return to fertility
• Increase counselling on family planning, emphasizing lactation amenorrhea method (LAM) and transitions to other modern methods after delivery
• Increase linkages between postpartum family planning and other MCH consultations including immunization services and well-baby checks.

Community Health and Postpartum/Postnatal Care Services

Community health workers can also positively affect postpartum and postnatal services for women and children. With proper training and support, the community can support postnatal care initiatives by:

1. Promoting health behaviours, including exclusive breastfeeding, ensuring warmth, and following hygienic practices.
2. Ensuring that extra care and attention is provided to low-birth-weight babies
3. Early identification and management of newborn cases of pneumonia when referral is not possible
4. Providing information and family planning services
5. Providing vitamin A supplements to mothers
6. Identifying danger signs for mothers and newborns
7. Promoting the use of newborn and child services like birth registration and immunization

Male Involvement

Men’s participation in postnatal/postpartum programs has positive effects and outcomes on health and on education. When men participate in these services and decisions associated with postpartum/postnatal health, there is an increase in their understanding of the activities, and greater utilization of services.

Healthcare workers can play a big part in increasing men’s involvement in postnatal/postpartum care. Some methods include:

• Inviting husbands and male partners to participate.
• Initiating partner notification when a female patient has a sexually transmitted infection (STI).
• Establishing community mobilization strategies whereby men who have participated in postnatal/postpartum care activities inform their peers of their experiences in a structured activity, such as a peer-to-peer discussion.
• Community sensitization which entails a collaboration between healthcare workers and the community where, together, plans to include and encourage men are developed and implemented. Methods could include community outreach, public meetings, and use of incentives.

Demonstrate Postpartum Physical Exam

Key components

• Weight and height
• Pelvic exam (perineal healing/vaginal discharge/pelvic support)
• Breast exam
• Abdominal exam

Refer to Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice (WHO 2006). Normal findings include:

• General condition: Ensure that the patient is feeling well and relaxed, has no signs of anaemia or jaundice, the vital signs are within normal range, and the uterus is well contracted. While the mother should be encouraged to rest adequately, early ambulation and exercise should be encouraged.
• Lochia: The colour of the lochia varies with involution of the uterus. Referred to as Rubra- red (Day 0–3), Serosa- yellow (Day 3–7) Alba- white (Day 7–14). Normal lochia does not have an offensive odour.
• Perineum: Initially there may be vulval oedema. Signs of infection include redness, persistent swelling, presence of pus, and severe pain. Ensure that the episiotomy or any tears/lacerations are repaired and healing. Note that delayed healing may be a sign of infection. The mother needs to be counselled on hygienic perineal toilet and safe disposal of sanitary wear.
• Breast: Usually the breasts are soft on palpation during the first 24 hours post-delivery; there may or may not be any colostrum at this time. By Day 3 breasts normally become swollen, warm, and increased vascularity is demonstrated. From Day 2–4, milk secretion is established in most cases. It is important that the mother be shown the correct technique for proper positioning of baby and attachment to avoid cracking of the nipples.
• Appetite: Usually good; may be reduced around Day 3 if the mother is constipated.
• Excretion: Urine output, urination, and passage of motions is usually normal; they need to be monitored and the mother encouraged to void regularly.

Demonstrate Health History

Subjective data

• Diet and exercise habits
• Use of prenatal vitamins and iron supplements
• Cultural conditions related to diet
• Status of breastfeeding
• Alcohol consumption
• Exercises for pelvic and abdominal muscles
• Possible postpartum depression symptoms
• Sleeping patterns and current level of fatigue
• Resources and family support available
• Relationship with spouse/partner and support provided
• Knowledge of and interest in family planning methods
• Sibling adjustment among other children

Refer to Counselling for Maternal and Newborn Healthcare: A Handbook for Building Skills (WHO 2010) for instruction on all the steps included in a complete postpartum physical exam.

Demonstrate Newborn Physical Exam

**Key components**

• Weight
• Breath sounds, respiratory rate, grunting, and retractions
• Skin rashes, infections, or abnormal presentation
• Sucking and feeding ability

Refer to Pregnancy, Childbirth, Postpartum and Newborn Care: A Guide for Essential Practice (WHO 2006) for instruction on all the steps included in a complete postpartum physical exam.

**Mentee’s Assignment**

Upon completion of this lesson, the mentee should complete the following assignment:

• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 5 on Postpartum/Postnatal Care
• Review National Guidelines for Quality Obstetrics and Perinatal Care (MOH, 2012); Pregnancy, Childbirth, Postpartum and Newborn care: A Guide for Essential Practice (WHO 2006); and Counselling for Maternal and Newborn Healthcare: A Handbook for Building Skills (WHO 2010) or follow up with the mentor if further instruction or clarification are needed on steps and skills.

• Conduct postnatal exam and counselling in the facility setting with at least five mother/baby dyads.

**Mentee’s Evaluation**

The mentee’s competency in this lesson is evaluated using three methods. First, question-and-answer sections hosted during the training session are used to gauge the mentee’s understanding of information and its application in a clinical setting. Second, the mentee must demonstrate competency in all steps of the Postpartum/Postnatal section of the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Last, the mentee must conduct postnatal exams and counselling on a minimum of five mother/baby dyads in the facility setting to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
There are nine modules within this lesson, each focusing on a different contraceptive category. These modules can be covered together in one lesson or can be covered individually over a number of days. An overview of the schedule and timing is below.

Each individual module includes its own schedule, set of objectives, lecture content, mentee assignment, and mentee evaluation.

**Schedule and Timing**
This lesson requires a total of 16 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Overview of family planning and healthy timing and spacing</td>
<td>2 hours</td>
</tr>
<tr>
<td>Contraceptive pills including combined oral contraceptives and progestin-only pills</td>
<td>1 hour</td>
</tr>
<tr>
<td>Emergency contraception pills</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Injectables, classroom and practical sessions</td>
<td>2 hours</td>
</tr>
<tr>
<td>Implants, classroom and practical sessions</td>
<td>3 hours</td>
</tr>
<tr>
<td>Intrauterine contraceptive devices, classroom and practical sessions</td>
<td>3 hours</td>
</tr>
<tr>
<td>Permanent methods including tubal ligation and vasectomy</td>
<td>90 minutes</td>
</tr>
<tr>
<td>Condoms, male and female</td>
<td>80 minutes</td>
</tr>
<tr>
<td>Natural family planning methods, including fertility awareness methods and lactational amenorrhea</td>
<td>2 hours</td>
</tr>
</tbody>
</table>

**Tools and Reference Documents**
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book
- *National Family Planning Guidelines for Service Providers*, MOH 2010
- National Orientation Packages for HIV Service Providers
MODULE 2.9.1 Overview of Family Planning and Healthy Timing and Spacing of Pregnancy

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 2 hours.

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce topic and definition of related terms</td>
<td>10 min</td>
</tr>
<tr>
<td>Interactive discussion to review all family planning methods</td>
<td>20 min</td>
</tr>
<tr>
<td>Present dual protection concept and benefits</td>
<td>15 min</td>
</tr>
<tr>
<td>Discuss WHO Medical Eligibility Criteria</td>
<td>35 min</td>
</tr>
<tr>
<td>Present important aspects of counselling and education on family planning methods</td>
<td>30 min</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 min</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.2 Contraceptive Pills</td>
<td>3 min</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, participants will be able to:
1. Define family planning and healthy timing and spacing of pregnancy
2. Name and classify different methods of family planning
3. Define and explain dual protection
4. Define and correctly use the WHO Medical Eligibility Criteria
5. Discuss key principles of counselling and education on family planning

Lesson Content
Definitions and Importance of Family Planning
Family planning (FP) is not only a key intervention for improving health; it is also a key strategy for the achievement of national and international development goals, including the Millennium Development Goals (MDGs).

A rights-based approach to the provision of contraceptives assumes a holistic view of clients, which includes taking into account clients’ sexual and RH care needs and considering all appropriate eligibility criteria and practice recommendations in helping clients choose and use an FP method.

Healthy timing and spacing of pregnancy (HTSP) is an approach to family planning that helps women and families delay, space, or limit their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children. HTSP works within the context of free and informed contraceptive choice and takes into account fertility intentions and desired family size.

Classification of Family Planning Methods

Contraceptive method classifications
- Hormonal methods
- Barrier methods
- Short-term methods
- Long-term methods
- Permanent methods

Dual Protection

Key points
- Dual protection is protection against STIs (including HIV/AIDS) and unplanned pregnancy
- It can be achieved either by the consistent and correct use of condoms, or the use of one method to protect against unplanned pregnancy and a second method to protect against STIs and HIV (e.g., condom)
- Dual protection is also implied in the avoidance of risky sex (i.e., in mutual monogamy between uninfected partners combined with a contraceptive method for those wanting to avoid pregnancy)
• Male involvement is crucial to the success of dual protection
• All FP clients should receive counselling about dual protection
• FP service providers must adopt a more positive attitude towards the condom as an effective method of contraception
• Condoms must be available, affordable, and of good quality.

WHO Medical Eligibility Criteria (MEC)

The Medical Eligibility Criteria offers guidance on the safety of the use of different methods for women and men with specific characteristics or known medical conditions. The recommendations are based on systematic reviews of available clinical and epidemiological research.

Purpose of the Medical Eligibility Criteria:
1. To base guidelines for family planning practices on the best available evidence
2. To address misconceptions regarding who can and cannot safely use contraception
3. To reduce medical barriers
4. To improve access and quality of care in family planning

Classification of categories
Each condition was defined as representing either an individual’s characteristics (e.g., age, history of pregnancy) or a known pre-existing medical/pathological condition (e.g., diabetes, hypertension). It is expected that national and institutional health and service delivery environments will decide the most suitable means for screening for conditions according to their public health importance. Client history will often be the most appropriate approach.

The conditions affecting eligibility for the use of each contraceptive method were classified under one of the following three categories:

<table>
<thead>
<tr>
<th>Classification</th>
<th>With Clinical Judgement</th>
<th>With Limited Clinical Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstance</td>
<td>Yes Use the method</td>
</tr>
<tr>
<td>2</td>
<td>Generally use: Advantages outweigh risks</td>
<td>No: Do not use the method</td>
</tr>
<tr>
<td>3</td>
<td>Generally do not use: risks outweigh advantages</td>
<td>Method not to be used</td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td></td>
</tr>
</tbody>
</table>

Key Principles to Family Planning Counselling

Good counselling helps clients choose and use family planning methods that suit them. Clients differ, their situations differ, and they need different kinds of help. The best counselling is tailored to the individual client.

Tips for successful counselling
• Show every client respect, and help each client feel at ease
• Encourage the client to explain needs, express concerns, ask questions
• Let the client’s wishes and needs guide the discussion
• Be alert to related needs such as protection from STIs and support condom use
• Listen carefully
• Use words the client knows
• Respect and support the client’s informed decisions
• Check the client’s understanding
• Invite the client to come back any time for any reason (from Family Planning: A Global Handbook, WHO and JHU 2011)

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:
• Review National Family Planning Guidelines for Service Providers (MOH 2010) or follow up with mentor if further instruction or clarification are needed.

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session.
MODULE 2.9.2  Contraceptive Pills

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 1 hour.

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce hormonal contraceptives</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss combined oral contraceptive pills</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Discuss progestin-only oral contraceptive pills</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.3 Emergency Contraception</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, participants will be able to:
1. List all hormonal contraceptive methods
2. List and explain the types of contraceptive pills
3. Describe the mechanism of action of combined oral contraceptives and progestin-only oral contraceptives, as well as their effectiveness
4. List and explain the limitations of the different types of contraceptive pills, including women who cannot use these methods
5. List common side effects
6. Highlight key points about oral contraceptives

Lesson Content
The content of this lesson is from *Family Planning: A Global Handbook for Providers*, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Hormonal Contraceptive Methods
- Hormonal methods contain synthetic hormones (oestrogen, progestin, or a combination), which primarily work through preventing ovulation or by making the cervical mucus too thick for sperm to penetrate.
- These methods are very effective but vary in levels/types of side effects.
- Oestrogen-based methods should not be used by breastfeeding women, or among women who have risk factors for cardiovascular disease.
- Progestin-only methods should be delayed up to six weeks postpartum.
- Hormonal methods do not protect against STIs.

Contraceptive Pills
*Combined Oral Contraceptives* include low doses of oestrogen and progestin.
- Brand names include Eugynon and Microgynon

Mechanism of action: work primarily by preventing the release of eggs from the ovaries.

Effectiveness
- When COCs are used consistently and correctly, less than 1 pregnancy per 100 women occurs over the first year
- When COCs are commonly used, about 8 pregnancies per 100 women occur over the first year
- Risk of pregnancy is greatest when a woman starts a new pill pack three or more days late, or misses 3+ pills

Limitations
- Some health risks are very rare, including blood clots in deep veins of the legs or lungs. Other risks that are extremely rare include stroke and heart attack.
- Postpartum women may not take until six months after giving birth.
- If woman is older than 35 years old and smokes, choose another method.
- If woman misses one or more pills, she should follow instructions available in Family Planning Global Handbook for Providers.
Side effects and their management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular bleeding</td>
<td>• Reassure her that it is not harmful</td>
</tr>
<tr>
<td></td>
<td>• Urge her to take pill at same time every day</td>
</tr>
<tr>
<td></td>
<td>• Consider 800mg ibuprofen 3 times a day</td>
</tr>
<tr>
<td></td>
<td>• Consider a different formulation</td>
</tr>
<tr>
<td>Headaches</td>
<td>• Suggest aspirin, ibuprofen, paracetamol, or other pain reliever</td>
</tr>
<tr>
<td>Nausea or dizziness</td>
<td>• Suggest taking pills at bedtime</td>
</tr>
<tr>
<td></td>
<td>• Consider local available remedies</td>
</tr>
<tr>
<td>Mood changes</td>
<td>• Give support as appropriate</td>
</tr>
<tr>
<td></td>
<td>• Refer for care if necessary</td>
</tr>
<tr>
<td>Migraine headaches</td>
<td>• Require stopping use of COCs and assistance choosing another method</td>
</tr>
</tbody>
</table>

Managing missed Combined Oral Contraceptive pills

Key messages:
• Take a missed pill as soon as possible
• Keep taking pills as usual, one each day (may take two pills at same time or on the same day)

If she missed 1 or 2 pills
• Take a pill as soon as possible
• Little to no risk of pregnancy

If she missed three or more pills in a row in the first two weeks of the packet
• Take a pill as soon as possible
• Use back-up method for next seven days
• Consider emergency contraception if she had sex in past five days

If she missed three or more pills in a row in the third week of a packet
• Take a pill as soon as possible
• Finish all the hormonal pills. Throw away the seven non-hormonal (placebo) pills and start a new packet immediately
• Use a back-up method for seven days

Key points
• Take one pill every day
• Bleeding changes are common but not harmful
• Take any missed pill as soon as possible
• Can be given to women at any time to start later
• Woman does not need a pelvic exam in order to start

Progestin-only oral contraceptives include low doses of progestin only
• Brand names include Postinor-2 and Mini Pill
• Progestin-only pills can be started six weeks after giving birth

Mechanism of Action: POPs work primarily by thickening the cervical mucus and disrupting the menstrual cycle, including the prevention of eggs released from the ovaries.

Effectiveness
• When POPs are used consistently and correctly, less than 1 pregnancy per 100 women occurs over the first year
• When POPs are commonly used, about 1 pregnancy per 100 women occurs over the first year
• Risk of pregnancy is greatest if pills are taken late or missed
• Less effective for women who are not breastfeeding

Limitations
• Some women cannot take progestin-only pills, including those with acute blood clots, or those who have breast cancer
• Postpartum women may not take POPs until six weeks after giving birth
• If a woman misses one or more pills, she should follow instructions available in Family Planning Global Handbook for Providers.

Side effects and their management (same as above, Combined Oral Contraceptives)

Managing missed progestin-only pills
• Take a missed pill as soon as possible
• Keep taking pills as usual. The woman may take two pills at same time or on the same day
• If she has regular monthly bleeding, use a back-up method for two days and consider emergency contraception if she has had sex in past five days

Key Points
• Take one pill every day
• Safe for breastfeeding women and their babies six week after giving birth
• Adds to the contraceptive effectiveness of breastfeeding
• Bleeding changes are common but not harmful
• Can be given to a woman at any time to start later
• Woman does not need a pelvic exam in order to start

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:
• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus
• Review National Family Planning Guidelines for Service Providers (MOH 2010) and Family Planning: A Global Handbook for Providers (WHO and JHU, 2011) or follow up with mentor if further instruction is needed.

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session.
MODULE 2.9.3 Emergency Contraceptive Pills

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 40 minutes

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and define emergency contraception</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss emergency contraception</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Host an interactive discussion on advantages and disadvantages of emergency</td>
<td>15 minutes</td>
</tr>
<tr>
<td>contraception</td>
<td></td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>
| Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.4 Injectable | 3 minutes  

Objectives
By the end of this session, participants will be able to:
1. List and explain the types of emergency contraception
2. Describe the mechanism of action and effectiveness of emergency contraception methods
3. List and explain the limitations of emergency contraception, including women who cannot use these methods
4. List common side effects
5. Highlight key points about emergency contraception

Lesson Content
The content of this lesson is from the Family Planning: A Global Handbook for Providers, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Emergency Contraception (EC)
Emergency contraception works by preventing pregnancy following unprotected intercourse. Pills contain progestin alone, or a progestin and an oestrogen together.
- Sometimes called “morning after” pills
- Includes:
  - Levonorgestrel-only dedicated product
  - Oestrogen-progestin dedicated product
  - Progestin-only oral contraceptives
  - Combined oral contraceptives
  - Ulipristate acetate dedicated product

Mechanism of action: ECPs work primarily by preventing or delaying the release of eggs from the ovaries. They do not work if a woman is already pregnant.

Effectiveness
- If 100 women used EC, 1 to 2 women would likely become pregnant
- EC pills should be taken as soon as possible after unprotected sex. The sooner they are taken, the better they prevent pregnancy.

Benefits
- Offer a second chance at preventing pregnancy
- Are controlled by the woman
- Reduce seeking out abortion in case of contraceptive error or non-use
- No delay in return to fertility
- Safe and suitable for all women

Limitations
- EC should not be used on a regular basis
- Only effective within 72 hours of unprotected intercourse (some are effective up to five days)
- Does not protect against STIs/HIV
- May cause nausea
- Frequently repeated EC pill use may be harmful for women with conditions classified as “use with care” (MEC category 2) and “should not use” (MEC categories 3 and 4)
- EC should not be given to women who are known to be pregnant, although there is no known harm to the woman, her pregnancy, or the fetus
Side effects and their management

### Key points
- Help to prevent pregnancy up to five days after unprotected sex
- Do not disrupt an existing pregnancy
- Safe for all women
- Provide an opportunity for women to begin an ongoing contraceptive
- Dedicated products, progestin-only pills, and combined oral contraceptives all can act as emergency contraceptives
- Provide or refer woman for treatment or prophylaxis against STIs/HIV, especially in cases of rape or violence

### Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
- Review National Family Planning Guidelines for Service Providers (MOH 2010) and Family Planning: A Global Handbook for Providers (WHO and JHU, 2011) or follow up with mentor if further instruction or clarification are needed.

### Mentee’s Evaluation
Mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session.

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular bleeding</td>
<td>• Will stop without treatment</td>
</tr>
<tr>
<td></td>
<td>• Assure the woman that it is not a sign of illness or pregnancy</td>
</tr>
<tr>
<td>Change in timing of next monthly</td>
<td>• Assure the woman that it is not a sign of illness or pregnancy</td>
</tr>
<tr>
<td>bleeding</td>
<td>• If more than a week later than expected, assess for pregnancy.</td>
</tr>
<tr>
<td>Nausea and vomiting</td>
<td>• An anti-emetic may be used before using COC or POP as emergency contraception</td>
</tr>
<tr>
<td></td>
<td>• If vomiting occurs within two hours of administration, repeat ECP dose as soon as possible. If vomiting occurs again, consider placing vaginally</td>
</tr>
</tbody>
</table>
MODULE 2.9.4 Injectables

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 2 hours

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and define injectables</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss different types and dosing of injectables</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Host interactive discussion on advantages and disadvantages of injectables</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Discuss side effects and key points related to injectable use</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate administration of injectables following national guidelines</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Mentee to provide return demonstration</td>
<td>25 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.5 Implants</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, participants will be able to:
1. List and explain the types of injectables
2. Describe the mechanism of action as well as the effectiveness of injectables
3. List and explain the limitations of injectables, including women who cannot use them
4. List common side effects of injectables
5. Highlight key points about injectables
6. Demonstrate administration of injectables

Lesson Content
The content of this lesson is from Family Planning: A Global Handbook for Providers, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Injectables
Injectables are hormonal contraceptive methods that prevent pregnancy by preventing ovulation
- Progestin-only injectables include depot medroxyprogesterone acetate (DMPA) and norethisterone enanthate (NET-EN) which contain progestin only.
- DMPA is the most widely used progestin-only injectable known as “the jab,” “the shot,” Depo, Depo-Provera, Megesteron, and Petogen
- NET-EN is also known as Noristerat and Syngestal
- Monthly injectables contain a progestin and an oestrogen and are also called combined injectable contraceptives

- Medroxyprogesterone acetate/estradiol cypionate is also known as Ciclofen, Ciclofenina, Cyclo-Provera, Lunella and others
- Norethisterone enanthate/estradiol valerate is marketed under the trade names Mesigyna and Norigynon

Mechanism of Action: work primarily by preventing the release of eggs from the ovaries.

Effectiveness
- Progestin Only Injectables
  - When given on time, less than 1 pregnancy per 100 women occur over the first year
  - When commonly used, about 3 pregnancies per 100 women occur over the first year

- Monthly Injectables
  - When given on time, less than 1 pregnancy per 100 women occur over the first year
  - When commonly used, about 3 pregnancies per 100 women occur over the first year
Return to fertility requires a few months (up to 4 months with DMPA) compared with most other methods.

Benefits
- Do not require daily action
- Do not interfere with sex
- Pelvic exam is not required to initiate use
- Are private (no one else can tell that a woman is using contraception)
- Progestin-only injectables cause no monthly bleeding (for many women)
- Are good for spacing births

Limitations
- Return to fertility may be delayed up to four months after discontinuation.
- Does not protect against STIs/HIV.
- Monthly injectables cannot be used while fully breastfeeding less than six weeks postpartum.
- A woman should not use progestin-only injectables if she has high blood pressure (over 160 systolic or 100 diastolic), diabetes for more than 20 years, heart disease, unexplained vaginal bleeding, or breast cancer.
- A woman should not use monthly injectables if she is less than six weeks postpartum (only if she is not breastfeeding), is more than 35 years old and smokes, has severe liver disease, has high blood pressure (over 140 systolic or 90 diastolic), diabetes for more than 20 years, heart disease, unexplained vaginal bleeding, breast cancer, or migraines aura.

Key Points
- Bleeding changes are common but not harmful. Stopping monthly bleeding is not harmful.
- Clients must return for injections regularly and on time. Every three months (13 weeks) for DMPA, every two months for NET-EN, and every four weeks for monthly injectables.
- Late or missed injections can be managed and may be safe. Refer to existing guidelines for proper management and client education.
- Gradual weight gain is common.
- Return to fertility is often delayed (and may take several months).

Key Points of Demonstration
1. Obtain one dose of the injectable, needle, and syringe
2. Wash hands and the injection site.
3. Prepare the vial (according to specific injectable instructions)
4. Fill the syringe with proper dose.
5. Inject the contents of the syringe (into hip, upper arm, buttocks, or outer thigh). Do not massage the injection site.
6. Dispose of disposable syringes and needles safely.

Assure every client that she is welcome to come back any time for any reason.

Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
- Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus
- Review National Family Planning Guidelines for Service Providers (MOH 2010) and Family Planning: A Global Handbook for Providers (WHO and JHU, 2011) or follow-up with mentor if further instruction or clarification are needed.

Mentee’s Evaluation
The mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session as well as a return demonstration of injection administration. The mentee must also demonstrate competency in all steps of injection administration as outlined in the section of the Skills Assessment Checklist. These skills will be evaluated by her/his mentor and then by final external evaluators upon completion of the programme.
MODULE 2.9.5  Implants

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 3 hours.

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and define implants</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss different types of implants</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Host an interactive discussion on advantages and disadvantages of implants</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Discuss side effects and key points related to implant use</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate administration of two-rod implants following national guidelines. Include demonstration of proper counselling and instruction. Mentee to provide a return demonstration</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Demonstrate removal of two-rod implants following national guidelines. Mentee to provide a return demonstration</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Provide feedback, correction, and evaluation of the mentee using the Assessment Checklist to measure performance</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.6 Intrauterine Devices</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Mentee will practice implant insertion and implant removal skills with at least 10 clients during the Mentorship Programme.

Objectives
By the end of the session, participants will be able to:
1. List and explain the types of implants
2. Describe the mechanism of action as well as the effectiveness of implants
3. List and explain the limitations of implants
4. List common side effects of implants
5. Highlight key points about implants
6. Demonstrate insertion and removal of implants
7. Discuss counselling and education topics related to implant insertion and removal

Lesson Content

The content of this lesson is from *Family Planning: A Global Handbook for Providers*, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Implants

Implants are small hormone-bearing capsules or rods which, when inserted under the skin of a woman’s upper arm, release hormones slowly over a long period of time to prevent pregnancy. They contain only progesterone and do not contain any oestrogen. Therefore, they are free from the side effects associated with oestrogen-containing methods

- **Norplant** is a 6-capsule implant with a 5–7 year duration of effectiveness
- **Jadelle** is a 2-rod implant with a five-year duration of effectiveness
- **Implanon** is a 1-rod implant with a three-year duration of effectiveness
- **Sino-Implant (II)** is a 2-rod implant with a four-year duration of effectiveness

All implants use the progestin hormone levonorgestrel.

Mechanism of action: implants work by

- Thickening cervical mucus to prevent sperm from passing
- Suppressing ovulation
- Thinning the endometrium to inhibit implantation from taking place
- Reducing sperm transportation through the fallopian tubes

Effectiveness

- Less than 1 woman per 100 will become pregnant using implants over the first year
- Small risks of pregnancy remain beyond the first year, around 1 pregnancy per 100 women using implants
• Jadelle, Sino-Implant, and Norplant begin to lose effectiveness sooner for heavier women

Benefits
• Do not require any attention once they are inserted
• Prevent pregnancy very effectively
• Are long-lasting
• Do not interfere with sex
• Pelvic exam is not required to initiate use
• Are private (no one else can tell that a woman is using contraception)

Limitations
• Return to fertility may be delayed up to four months after discontinuation
• Does not protect against STIs/HIV
• Monthly injectables cannot be used while fully breastfeeding less than six weeks postpartum
• A woman should not use progestin-only injectables if she has high blood pressure (over 160 systolic or 100 diastolic), diabetes for more than 20 years, heart disease, unexplained vaginal bleeding, or breast cancer
• A woman should not use monthly injectables if she is less than six weeks postpartum (only if she is not breastfeeding), is more than 35 years old and smokes, has severe liver disease, has high blood pressure (over 140 systolic or 90 diastolic), diabetes for more than 20 years, heart disease, unexplained vaginal bleeding, breast cancer, or migraine auras.

Key points
• Provide long-term pregnancy protection
• Require specifically trained provider to insert and remove
• Little required of the client once implants are in place
• Bleeding changes are common but even stopping monthly bleeding entirely is not harmful
• Gradual weight gain is common

Implant insertion demonstration procedure
1. Explain the procedure to the client.
2. Be sure to have proper equipment:
   • Sterile surgical cloths, sterile tray, sterile gloves, antiseptic solution
   • Local anaesthetic, needle, and syringe
   • Scalpel with blade, trocar, tweezers
   • Skin closure, gauze, and compress
3. Have patient lie down and extend no dominant arm.
4. Clean the upper arm with antiseptic solution and cover with sterile drapes.
5. Open a sterile implant package and drop onto sterile drapes. Always use sterile gloves or forceps when handling the rods. If rods fall outside of the sterile drapes, do not use them. Open a new package.
6. After asking the client about allergies, inject local anaesthetic to area.
7. Make a 2 mm incision with a scalpel or insert the trocar directly without incision.
8. Marks on the trocar indicate how far it should be introduced under the skin before loading the implant. Orient the trocar with bevel up.
9. Once the tip of the trocar is inserted, point it upwards to keep the rods in a superficial plane. Keep the trocar subdermal by tenting the skin. Advance the trocar about 5.5 cm from the incision to the mark. Do not force—if you feel resistance, try another direction.
10. Remove the plunger when the trocar is advanced completely to the mark. Load the first implant with tweezers or forceps.
11. Push the implant gently with plunger to the tip of the trocar until you feel resistance. Hold the plunger steady and pull back on the trocar. Do not remove the trocar completely until both rods have been placed.

Side effects and their management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
</table>
| Changes in bleeding patterns | • Rule out pregnancy, abortion, pelvic inflammatory disease, or other gynaecological conditions  
• Assure client that irregular or no bleeding does not require any treatment  
• If client sees bleeding changes as a problem, help client choose another method  
• Suggest iron supplements and eating foods high in iron (meats, fish, green leafy vegetables) if evidence of anaemia |
| Headaches | • Suggest aspirin, ibuprofen, paracetamol, or other pain reliever  
• Check blood pressure, and if normal with persisting headaches, discontinue method and help her choose another method. If elevated, do not give injection |
| Weight change | • Review diet and counsel as needed  
• If unacceptable, help client choose another method |
| Acne | • Wash face regularly  
• If unacceptable, help client choose another method such as COCs which may help improve acne |
| Breast tenderness | • Suggest wearing a supportive bra  
• Suggest hot or cold compresses  
• Suggest aspirin, ibuprofen, paracetamol, or other pain reliever |
12. When you can see the mark near the tip of the trocar in the incision, the implant has been released and will remain in place beneath the skin. This can be checked with palpation.

13. Insert the second implant at the side of the first one, to form a V shape. Check positioning by cautious palpation of the insertion area.

14. After removing the trocar, close the incision with a sterile skin closure. No need for suturing the area. Cover with a compress and wrap enough gauze around the arm to ensure hemostasis.

15. Observe the patient for a few minutes for signs of bleeding from the incision site.

Implant insertion key points
• A woman who has chosen implants needs to know what will happen during insertion.
• Implant insertion must be completed by a trained health professional and is a minor surgical procedure. Training and practice under direct supervision are very important to correct insertion.
• Insertion should preferably be performed during the first few days of menstrual bleeding and not later than the seventh day after menses.
• Insertion-related complications are rare and depend on the skill of the provider.
• Assure every client that she is welcome to come back any time for any reason.

Implant removal demonstration procedure
1. Explain the procedure to the client.
2. Be sure to have proper equipment:
   • Local anaesthetic, needle and syringe
   • Scalpel
   • Forceps or tweezers
   • Skin closure, gauze and compress
3. Locate the implants using palpation. Inject anaesthetic under the implants on the end where they are closer to one another.
4. Make a 4 mm incision close to the ends of the implants.
5. Push each implant with fingers gently towards the incision. When visible through the incision, grasp it with the forceps or tweezers. Use a scalpel to very gently open the tissue around the implant.
7. Measure the length of the removed implants (Jadelle are 43 mm).
8. Close and bandage the incision. Tell client to keep her arm dry for a few days.

Implant removal key points
• Implant removal must be completed by a trained health professional and is a minor surgical procedure.

Training and practice under direct supervision are very important to correct insertion.
• Clients have every right to request removal of implants and their decision should not be challenged.
• Implants may sometimes be nicked, cut, or broken during removal. If the procedure proves difficult, close the incision, bandage the wound and have the client return for another attempt. A nonhormonal method of contraception should be used until both implants have been removed.
• Following removal, pregnancy may occur at any time.
• Assure every client that she is welcome to come back any time for any reason.

Counselling and education key points
• Listen to clients’ concerns and questions
• Assure confidentiality in provision of care
• Inform client of side effects that she may experience and ways to manage them
• Advise client that a return visit is not necessary until she wants to remove the implants
• Provide client with a “reminder card” for when her implant must be removed or replaced

Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus and Section 7 on Implant Insertion and Removal.
• Review National Family Planning Guidelines for Service Providers (MOH 2010) and Family Planning: A Global Handbook for Providers (WHO and JHU, 2011) or follow up with mentor if further instruction is needed.
• Practice implant insertion and removal on 10 clients in clinical setting during the Mentorship Programme.

Mentee’s Evaluation
The mentee’s competency in this lesson is evaluated using three methods. First, quizzes and question-and-answer sessions hosted during the training session are used to gauge the mentee’s understanding of the information and its application in a clinical setting. Second, the mentee must demonstrate competency in implant insertion, counselling, and removal, outlined in relevant section of the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Last, the mentee must conduct implant insertions and removals on 10 clients in the facility setting to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
MODULE 2.9.6  Intrauterine Contraceptive Devices (IUDs)

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 3 hours.

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and define intrauterine contraceptive devices (IUDs)</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss different types of IUDs</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Host interactive discussion on advantages and disadvantages of IUDs</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Discuss side effects and key points related to IUDs</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate administration of IUDs following national guidelines. Mentee to provide a return demonstration.</td>
<td>60 minutes</td>
</tr>
<tr>
<td>Role-play exercise to practice instructions and guidance associated with IUD insertion and removal</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Demonstrate removal of IUD following national guidelines. Mentee to provide a return demonstration</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Provide feedback, correction, and evaluation of mentee using Assessment Checklist to measure performance</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.7 Permanent Surgical Methods</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Mentee will practice IUD insertion and IUD removal skills with at least 10 clients during the Mentorship Programme.

Objectives
By the end of the session, participants will be able to:
1. List and explain the types of IUDs
2. Describe the mechanism of action as well as the effectiveness of IUDs
3. List and explain the limitations of IUDs
4. List common side effects of IUDs and their management
5. Highlight key points about IUDs
6. Demonstrate insertion and removal procedures of IUDs
7. Discuss counselling and education topics related to IUD insertion and removal

Lesson Content
The content of this lesson is from the Family Planning: A Global Handbook for Providers, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Intrauterine Contraceptive Devices

An Intrauterine Contraceptive Device (IUD) is a small flexible device inserted into the uterine cavity by a trained healthcare worker. There are a few types of IUDs, yet the copper-bearing IUD is the most widely available in Kenya.

- **Copper IUD** is made of plastic with copper sleeves on the arms and copper wire wound around the stem.
  - Copper T 380A is effective for up to 12 years
  - NOVA T is effective for up to five years
  - Copper T220 is effective for up to three years
- **Hormone-releasing IUD** is made of plastic and steadily releases small amounts of a progestin hormone that serves to prevent pregnancy.
  - Mirena, LNG IUS, and Progestasert are effective up to five years

Almost all brands of IUDs have two strings tied to the lower end. The strings hang through the opening of the cervix into the vagina.
Mechanism of action:
The copper IUD prevents pregnancy by preventing sperm from fertilizing the egg by changing the environment in the uterine cavity. IUDs do not cause an abortion.

The hormone-releasing IUD prevents pregnancy via its hormonal activity, suppressing ovulation, thinning the uterine lining to inhibit implantation, and decreasing sperm transportation in the fallopian tubes.

Effectiveness

Copper IUD
- Less than 1 pregnancy will occur per 100 women using a copper IUD over the first year (6 to 8 per 1,000 women)
- About 2 pregnancies per 100 women occur over the remaining 10 years of its duration

Hormonal IUD
- Less than 1 pregnancy will occur per 100 women using a hormonal IUD over the first year (2 per 1,000 women)
- Less than 1 pregnancy per 100 women occur over the remaining five years of its duration (5 to 8 per 1,000 women)

The IUD is comparable in safety and effectiveness to sterilization

NOTE: As copper IUDs are the primary IUD available in Kenya, the majority of the below content refers to that method. More detailed information about the hormonal IUD is available in the listed resources.

Benefits
- Do not require any attention once they are inserted
- Prevent pregnancy very effectively
- Are long-lasting
- Have immediate effectiveness
- Insertion of a copper IUD can serve as emergency contraception within five days of unprotected intercourse
- Have immediate return to fertility when removed

Limitations
- Requires appropriate infection prevention practices during insertion and removal. Requires a pelvic examination before insertion to assess eligibility for IUD.
- Copper IUD may increase menstrual bleeding and cause cramping during the first few months of use.
- If client already has an STI at the time of insertion or the provider does not maintain sterility upon insertion, there is a small increased risk of pelvic infection in the first three weeks after insertion.
- Does not protect against STIs/HIV.
- Women with the following conditions should not use IUDs:
  - Increased risk of STIs (with multiple sex partners or with partners who have multiple sexual partners)
  - Pregnant
  - Certain gynaecologic or obstetric conditions, such as pelvic tuberculosis among others
  - Septic abortion (within the past three months)
- Current or recent or recurrent PID
- Living with AIDS and unwell

Side effects of copper IUDs and their management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
</table>
| Changes in bleeding patterns | • Rule out pregnancy, abortion, pelvic inflammatory disease, or other gynaecological conditions  
• If pregnant, advise removal of IUD when the pregnancy is less than 13 weeks and strings are visible. Advise client of increased risk of spontaneous abortion and infection if IUD cannot be removed.  
• Suggest iron supplements and eating foods high in iron (meats, fish, green leafy vegetables) if evidence of anaemia. Consider iron supplements.  
• If the client sees bleeding changes as a problem, help her choose another method |
| Abdominal cramps | • Rule out partial expulsion of IUD, perforation, ectopic pregnancy, pelvic inflammatory disease |
| Missing string | • Inquire whether client noticed strings/IUD expelled  
• Explore cervical canal after the next menstrual period. If strings cannot be felt in the cervical canal, refer for ultrasound or x-ray. Advise to use barrier method until resolved. |
| Suspected PID/cervical discharge | • Examine for STI and PID. If present, treat appropriately.  
• IUD can be retained if treatment is successful. Otherwise, help client choose another method |

Key points
- Provides long-term pregnancy protection
- Requires specifically trained provider to insert and remove
- Little required of the client once in place
- Bleeding changes are common but not harmful; even stopping monthly bleeding entirely is not harmful
- Can be inserted postpartum, immediately after placenta delivered, or within 48 hours of placenta expulsion
- Does not suppress milk production in breastfeeding women
- Does not cause pelvic inflammatory disease (PID)
- Does not increase risk of infertility
- Is safe for women who have not been pregnant before
- Is a safe and good contraceptive choice for healthy women living with HIV
- Does not increase risk of STIs if not infected at time of insertion
**IUD insertion demonstration procedure**

1. **Before insertion procedure, provider should**
   - Screen the woman to ensure she is eligible for IUD use at this time.
   - Provide proper education and counselling about the procedure and give time for the client to ask questions or vocalize concerns.
   - Ask the woman to wash her perineum with soap and water.
   - Place the speculum and sound the uterus to ensure high fundal placement of the IUD (procedure available in IUD Guidelines for Service Providers, JHPIEGO 2005).

2. Put new/clean examination surgical gloves on both hands (if taken off to load the IUD).

3. Prepare the client by giving her a brief overview of the procedure and encourage her to ask questions. Provide reassurance as needed.

4. Remind the client to let you know if she feels pain.

5. Gently grasp the tenaculum and apply gentle traction. Hold the loaded IUD so that the blue depth-gauge is in the horizontal position in one hand, while grasping the tenaculum with the other hand and gently pulling outward and downward. This will help straighten the cervical canal for easier insertion.

6. Carefully insert the loaded IUD into the vaginal canal and gently push it through the cervical os and into the uterine cavity at the appropriate angle. Be careful not to touch the walls of the vagina or the speculum blades with the tip of the loaded IUD.

7. Gently advance the loaded IUD into the uterine cavity and stop when the blue depth gauge comes in contact with the cervix or slight resistance is felt. Do not use force at any stage of this procedure.

8. Hold the tenaculum and white plunger rod stationary, gently pull the insertion tube towards yourself (with your free hand) until it touches the circular thumb grip of the white plunger rod. This will release the IUD in the woman’s uterus.

9. Remove the white plunger rod, while holding the insertion tube stationary.

10. Once the plunger rod has been removed, very gently and carefully push the insertion tube upward again, towards the fundus of the uterus, until you feel slight resistance. This step ensures that the arms of the T are as high as possible in the uterus.

11. Partially withdraw the insertion tube from the cervical canal until the strings can be seen extending from the cervix and use Mayo scissors to cut the strings at 3–4 cm from the cervical opening.

12. Gently remove the tenaculum.

13. Examine the woman’s cervix for bleeding. If there is bleeding, use high-level disinfected (or sterile) forceps to place cotton/gauze on affected tissue and apply pressure for 30–60 seconds.


15. Place the tube, speculum, and the instruments in 0.5% chlorine solution for 10 minutes for decontamination.

16. Allow woman to rest. Advise her to remain on the exam table until she feels ready to get dressed.

(from IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual, JHPIEGO, 2005)

**Figure 11: Inserting the loaded IUD**

**Figure 12: Advancing and withdrawing the IUD, then pushing the IUD high in the uterus**

**IUD insertion key points**

- A woman who has chosen an IUD needs to know what will happen during insertion.
- IUD insertion must be completed by a trained health professional. Training and practice under direct supervision are very important to correct insertion.
• Insertion should preferably be performed during the first few days of menstrual bleeding and not later than the seventh day after menses.
• Insertion-related complications are rare yet include puncture of uterine wall.
• Assure every client that she is welcome to come back any time for any reason.

IUD removal demonstration procedure
1. Prepare the client by giving her an overview of the procedure, encouraging her to ask questions, and providing reassurance as needed.
2. Remind her to let you know if she feels any pain.
3. Put new/clean gloves on both hands.
4. Insert sterile speculum and visualize cervix and IUD strings
5. Cleanse the cervix and vagina with antiseptic (iodine or chlorohexidine).
6. Alert the woman immediately before removing the IUD. Ask her to take slow, deep breaths and relax. Inform her that she may feel cramping which is normal.
7. Grasp the IUD strings with high-level disinfected (or sterile) forceps. Apply steady but gentle traction, pulling on strings towards you.
8. If removal is difficult, do not use excessive force. Seek guidance on managing difficult IUD removals, or refer to specially trained provider to dilate cervix.
9. Show the woman the IUD.
10. Place the IUD in 0.5% chlorine solution for 10 minutes for decontamination. If the woman is not having a new IUD inserted, remove speculum and place all instruments in decontamination solution.
11. If woman is experiencing any negative symptoms (nausea, pain/cramping, dizziness), allow her to remain on the exam table to rest until she feels better (from IUD Guidelines for Family Planning Service Programs: A Problem-Solving Reference Manual, JHPIEGO, 2005)

IUD removal key points
• The woman has the right to discontinue her IUD use at any time, regardless of the reason.
• If a woman no longer wants to use the IUD, assist her with selecting another contraceptive method, if so desired.
• IUD removal is usually uncomplicated and relatively painless.
• A new IUD can be inserted immediately after removing an old one if the client so desires (unless removal is for a medical reason).
• Pre- and post-procedures for removal are similar to those of insertion.
• Inform the client that she can get pregnant as soon as the IUD is removed.

Role-play activity questions
• How effective are IUDs?
• How do IUDs work?
• Who can use IUDs?
• What is entailed in the procedure?
• What are the potential side effects? How can side effects be managed?
• What are the benefits of IUDs?
• When can the IUD be removed?
• Will the IUD make me infertile?

Role-play activity key points
• Describe the most common side effects to the client before insertion. Explain about these side effects.
• Talk with clients before the IUD insertion procedure, show her the tools that will be used, and ask her to tell you any time she feels pain or discomfort.
• Talk with the client during the insertion procedure; ask her if she is feeling pain.
• Encourage the client to check the strings occasionally, especially in first few months.
• Discuss with the client how to remember the date to return and the length of pregnancy protection. Consider providing an IUD reminder card.

Mentee’s Assignment
Upon completion of this lesson, the mentee should complete the following assignment:
• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus, and Section 8 on IUD Insertion and Removal.
• Practice IUD insertion and removal on 10 clients in a clinical setting during the Mentorship Programme.

Mentee’s Evaluation
The mentee’s competency in this lesson is evaluated using three methods. First, question-and-answer sessions hosted during the training session are used to gauge the mentee’s understanding of information and its application in a clinical setting. Second, the mentee must demonstrate competency in all steps of IUD insertion, counselling, and removal, outlined in relevant section of the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Lastly the mentee must conduct IUD insertions and removals on 10 clients in the facility setting to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
MODULE 2.9.7 Permanent Surgical Methods

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 90 minutes

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review male and female reproductive systems</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Introduce and define voluntary surgical contraception</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Describe female tubal ligation, including effectiveness, benefits and limitations, side effects, and key points</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Describe male vasectomy, including effectiveness, benefits and limitations, side effects, and key points</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Role-play exercise to practice counselling and education related to permanent surgical contraception</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.8 Condoms</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

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

1. Explain the two types of surgical permanent contraception, tubal ligation and vasectomy
2. List and explain the limitations of surgical contraception
3. List common side effects of surgical contraception
4. Highlight key points about surgical contraception
5. Discuss counselling and education topics related to surgical contraception and where to refer clients for procedures

Lesson Content
The content of this lesson is from *Family Planning: A Global Handbook for Providers*, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Permanent Surgical Contraceptive Methods

Permanent Surgical Contraceptive Methods include female sterilization and male sterilization, surgical procedures undertaken to permanently and most effectively prevent pregnancy. These are contraceptive options for women and men who will not want more children.

- **Tubal ligation** is also called tubal sterilization, female sterilization, voluntary surgical contraception, tubectomy, tying the tubes, and “the operation.”

  Through a small incision in the abdomen (or inserting a long, thin tube with a lens into the abdomen through a small incision), the fallopian tubes are cut or blocked. Eggs released from the ovaries cannot move down the tubes to meet the sperm.

- **Vasectomy** is also called male sterilization and male surgical contraception.

  Through a puncture or small incision in the scrotum, the vas deferens (2 tubes that carry sperm to the penis) are cut or blocked. By closing off each vas deferens, sperm is kept out of semen.

**Mechanism of action:**
Both surgical contraceptive methods block the contact of eggs and sperm and therefore prevent pregnancy. Tubal ligation blocks transport of eggs down the fallopian tubes. Vasectomy blocks transport of sperm into semen, keeping it out of ejaculatory fluid.

**Effectiveness**
- **Tubal ligation is one of the most effective contraceptive methods**

  Less than 1 pregnancy per 100 women occurs over the first year after having the tubal ligation procedure (5 per 1,000 women)
A small risk of pregnancy remains after the first year of use. Over 10 years about 2 pregnancies per 100 women become pregnant.

**Vasectomy is one of the most effective contraceptive methods**

Less than 1 pregnancy per 100 women occurs over the first year after their partners have vasectomies (2 per 1,000 women)

**Benefits**

- Do not require any attention once procedures have taken place
- Are the most effective methods of contraception
- Are permanent
- Have immediate effectiveness
- Are safe, with few medical restrictions
- Most women and men who receive surgical contraception do not regret their decisions
- Tubal ligation can safely be provided post-partum, post-abortion, or as an interval procedure; vasectomy can be performed any time
- Does not require routine follow-up

**Limitations**

- Generally, surgical contraception cannot be reversed
- Surgical procedures sometimes fail and women become pregnant
- Women with gynaecologic issues such as infection or cancer may not be eligible for tubal ligation.
- Women with cardiovascular conditions, such as heart problems, high blood pressure, or diabetes may not be eligible
- Men with infection, swelling, injuries, or lumps on their genitals may not be eligible for vasectomy
- Men with diabetes, heart disease, or young age should use caution when electing a vasectomy
- Partners of men with vasectomy should use another contraceptive method for the first three months to avoid pregnancy

**Side effects of tubal ligation and their management**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Infection at incision site (very rare)</td>
<td>Clean the infected area with soap and water or anti-septic. Give oral antibiotics for 7–10 days. Ask the client to return if the infection has not cleared</td>
</tr>
<tr>
<td>Abscess (very rare)</td>
<td>Clean the area with antiseptic. Cut open and drain the abscess. Treat the wound. Give oral antibiotics for 7–10 days. Ask the client to return after taking the antibiotics if she has heat, redness, pain or drainage</td>
</tr>
</tbody>
</table>

**Side effects of vasectomy and their management**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bleeding or blood clots</td>
<td>Reassure client that minor bleeding and small clots go away without treatment</td>
</tr>
<tr>
<td>Infection at incision site (very rare)</td>
<td>Clean the infected area with soap and water or anti-septic. Give oral antibiotics for 7–10 days. Ask the client to return if the infection has not cleared</td>
</tr>
<tr>
<td>Abscess</td>
<td>Clean the area with antiseptic. Cut open and drain the abscess. Treat the wound. Give oral antibiotics for 7–10 days. Ask the client to return after taking the antibiotics if she has heat, redness, pain or drainage</td>
</tr>
</tbody>
</table>

**Key points**

- Pre-sterilization counselling is crucial, as method is permanent
- Involves a physical examination and a safe, simple, surgical procedure done by a specifically trained provider
- Is safe for women/men with HIV/AIDS to receive this method
- No one should be coerced or pressured into having a sterilization procedure
- Provides long-term pregnancy protection
- Vasectomy does not affect male sexual performance

_Each couple must decide which method is best for them. If both tubal ligation and vasectomy are acceptable, vasectomy would be preferable because it is simpler, safer, easier, and less expensive than tubal ligation._

If you suspect pregnancy, assess for pregnancy including ectopic pregnancy (symptoms include unusual abdominal pain, abnormal vaginal bleeding, light-headedness, and fainting). _Ectopic pregnancy is a life-threatening emergency condition requiring immediate surgery._
Key points of counselling and education

• Sterilization is intended to be permanent
• Alternative methods are available and effective if permanent contraception is not something client is sure about
• Assess client’s reasons for his/her choice, as younger women/men may need extra time to consider future life goals as well as longer-term reversible contraceptive methods such as implants or IUD
• Screen each client for risk indicators of regret: these include younger age, marital instability, decision made in absence of other long-term contraceptive methods, or decision made under pressure
• Include supportive partners in discussion
• There is no need for spousal consent in order to receive surgical contraception
• Provide details of procedure and recovery
• Discuss the need to use condoms to prevent transmission of STIs and HIV
• Review and discuss informed consent and authorization process and forms

Six points of informed consent

1. Temporary contraceptives are also available to the client
2. Voluntary sterilization is a surgical procedure
3. There are certain risks of the procedure as well as benefits
4. If successful, the procedure will prevent the client from having children
5. The procedure probably cannot be reversed
6. The client can decide against the procedure at any time before it takes place (without losing rights to other medical or health services/benefits)

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:

• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus and Section 9 on Referral and Service Linkages

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session. The mentee must demonstrate the ability to appropriately refer clients seeking permanent contraceptive methods. This skill will be assessed using the Skills Assessment Checklist Section 9 on Referral and Skills Assessment.
MODULE 2.9.8 Condoms

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 80 minutes.

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and define female and male condoms</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss different types of condoms</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Host an interactive discussion on advantages and disadvantages of condoms</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss side effects and key points related to condoms</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate use of male and female condom. Mentee to provide return demonstration</td>
<td>40 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.9.9 Natural Family Planning Methods</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, participants will be able to:
1. Explain the two types of condoms
2. List and explain the limitations of condoms
3. List common side effects of condoms
4. Highlight key points about condoms
5. Demonstrate use of male and female condoms

Lesson Content
The content of this lesson is from the Family Planning: A Global Handbook for Providers, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Condoms

Condoms are barrier contraceptive methods. Condoms come in different sizes, shapes, colours, and texture. They help prevent pregnancy and some STIs including HIV.

- **Male condom** is a sheath, or covering, made to fit a man’s erect penis during sexual intercourse. Most are made of thin latex rubber. Some are coated with lubricant or spermicide.

- **Female condom** is a pouch made of polyurethane that fits into the woman’s vagina during sexual intercourse.

**Mechanism of action:** Both types of condoms work by forming a barrier that keeps sperm from getting into the vagina. They also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

**Effectiveness**

- **Male Condom**
  - When used correctly with every act of sex, about 2 pregnancies occur per 100 women whose partners use male condoms over the first year

- **Female Condom**
  - When used correctly with every act of intercourse, about 5 pregnancies occur per 100 women using female condoms over the first year.
  - As commonly used, about 21 pregnancies occur per 100 women using female condoms.

Effectiveness depends on the user. Risk of pregnancy or STI is greatest when condoms are not used with every act of sex.

**When used consistently and correctly, condoms significantly reduce the risk of becoming infected or infecting a partner with an STI.**

- Condoms prevent 80% to 95% of HIV transmission that would have occurred without a condom
- Condoms protect against STIs that are spread by discharge as well as those spread skin-to-skin

**Benefits**

- Have immediate effectiveness
- Are safe, with few medical restrictions
- Offer contraception only when needed (require no daily intake)
• Easy to obtain; can be used without seeing a heath-care provider
• Highly effective protection against STIs including HIV
• Easy to use, with little practice
• No health risks associated with use (unless allergic to latex)
• Female condom is woman-controlled

Limitations
• Have higher failure rate if not used consistently and correctly; use with spermicides does not increase condom efficacy
• May reduce sensitivity of male
• A new condom must be worn for each act of sexual intercourse
• Male condom may cause itching for those who are allergic to latex
• Female condom must be inserted before sexual intercourse
• Female condoms are expensive and cannot be reused
• Couples who want highly effective protection against pregnancy (e.g., woman has a condition that makes pregnancy dangerous) should consider a more reliable method

Male condoms should not be used with non–water soluble lubricants or jellies (such as petroleum or oil) as they lead to rapid degeneration and may reduce effectiveness in preventing pregnancy and STIs.

Female condoms come lubricated with a silicone-based lubricant and also can be used with any type of lubricant.

Male and female condoms should NOT be used at the same time.

Side effects of condoms and their management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
</table>
| Allergy/irritation   | • In case of latex allergy, advise client to use another method. If it is a lubricant that causes the irritation, suggest using water as a lubricant.  
• Clients at risk of STIs and HIV should be counselled to continue condom use despite irritation. |

Key points
• Condoms are the only contraceptive method that can protect against pregnancy and STIs, including HIV.
• Require correct use with every act of sex for greatest effectiveness.
• Require both male and female partner’s cooperation. Talking about condom use before sex can improve the chances one will be used.
• Male condoms may dull the sensation of sex for some men. Discussion between partners can overcome this objection, or use a female condom.
• A woman can initiate use of a female condom, although partner cooperation is necessary.
• Inserting and removing female condoms may require some practice and becomes easier with experience.

Demonstration key points
• Ensure that the clients understand the correct use. Ask them to teach back the method or demonstrate use on a model.
• Give plenty of condoms to clients and tell them where they can buy them, if needed.
• Explain why using a condom with every act of sex is important.
• Explain about emergency contraception use in case of errors to help prevent pregnancy.
• Discuss ways in which a partner can bring up condom use with his/her partner. This includes:
  • Emphasizing that use of condoms is for pregnancy prevention rather than STI prevention.
  • Taking an uncompromising stance, e.g., “I cannot have sex with you unless we use a condom.”
  • Suggesting a different type of condom (male or female).
  • Suggesting that the couple come together to the clinic for counselling on the importance of condom use.

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:
• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management and Balanced Counselling Strategy Plus

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session. The mentee must demonstrate competency in condom use and counselling outlined in Section 6 of the Skills Assessment Checklist on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy. These skills will be evaluated by her/his mentor and then by final external evaluators upon completion of programme.
MODULE 2.9.9 Natural Family Planning methods

Schedule and Timing
As part of Lesson 2.9, this module requires approximately 2 hours

<table>
<thead>
<tr>
<th>Module Content</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce and define natural family planning</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss and define the different types of natural family planning</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Host interactive discussion on advantages and disadvantages, side effects, and key points related to natural family planning methods</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Highlight key points to be included in client education and counselling with regard to natural family planning</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Module 2.10 Balanced Counselling Strategy Plus</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Objectives
By the end of the session, participants will be able to:
1. Explain the types of Natural FP methods
2. List and explain the benefits and limitations of natural family planning methods
3. Highlight key points about natural family planning
4. Discuss counselling and education topics related to natural family planning

Lesson Content
The content of this lesson is from Family Planning: A Global Handbook for Providers, WHO and JHU, 2011. Please refer to that document for further detail and instruction.

Natural family planning, also called fertility awareness or periodic abstinence, is the practice of abstaining from intercourse (or using condoms) during the fertile period of the menstrual cycle. The fertile period is recognized through various ways such as checking temperature and changes in cervical mucus.

Lactational Amenorrhea Method (LAM) is a temporary family planning method based on the natural effect of breastfeeding on fertility. It requires three conditions:
1. The mother’s monthly bleeding has not returned
2. The baby is fully breastfed and is fed often, day and night
3. The baby is less than six months old

Mechanism of action:
Works primarily by preventing the release of eggs from the ovaries and prevents the release of natural hormones that cause ovulation.

Effectiveness:
• When used correctly less than 1 pregnancy occurs per 100 women using LAM in the first six months after childbirth
• When commonly used, about 2 pregnancies occur per 100 women using LAM in the first six months after childbirth

Withdrawal is when the man withdraws his penis from his partner's vagina and ejaculates outside the vagina, keeping his semen away from her external genitalia. This is also known as “pulling out” or coitus interruptus.

Mechanism of action:
Works by keeping the sperm out of the woman’s body

Effectiveness:
• When used correctly with every act of sex, about 4 pregnancies occur per 100 women whose partners use withdrawal
• When commonly used, about 27 pregnancies occur per 100 women

Cervical Mucus or Billings Ovulation Method: Woman identifies the fertile time with increasing amounts of cervical mucus.
**Basal Body Temperature:** Woman identifies the fertile time by taking her temperature every morning (at the same time) before getting out of bed. Temperature readings are recorded on a graph.

**Sympto-thermal Method:** A combination of cervical mucus and basal body temperature methods as well as other signs of ovulation, including abdominal pain, cervical changes, and breast tenderness.

**Calendar/Rhythm Method:** The woman uses a calendar to track her fertile “window” and avoids unprotected sex during those days.

**Cycle-Beads, Standard Days Method:** A method using colour-coded string of beads to track fertile and infertile days of the menstrual cycle and monitor her cycle length. A woman keeps track of her menstrual cycle with the first day of menses being Day 1. Woman avoids unprotected intercourse on cycle Days 8–19. The woman can have unprotected intercourse on all other days of the cycle, moving to Day 1 again on the first day of the next menses.

**Effectiveness of Fertility-Based Methods:**

With consistent and correct use, effectiveness of natural family planning varies.

<table>
<thead>
<tr>
<th>Method</th>
<th>Pregnancies per 100 women in first year of use</th>
</tr>
</thead>
<tbody>
<tr>
<td>Standard days method</td>
<td>5</td>
</tr>
<tr>
<td>Calendar rhythm method</td>
<td>9</td>
</tr>
<tr>
<td>Basal body temperature method</td>
<td>1</td>
</tr>
<tr>
<td>Ovulation (cervical mucus) method</td>
<td>3</td>
</tr>
<tr>
<td>Sympto-thermal method</td>
<td>2</td>
</tr>
</tbody>
</table>

**Benefits**

- No health risks or physical side effects are associated with use
- Free
- No need for prescriptions from healthcare workers
- Improved knowledge of reproductive system and possible closer relationship between couples

**Limitations**

- Low effectiveness and high failure rate
- Many require daily recordkeeping
- Long periods of training are required
- Requires varied periods of abstinence
- Requires cooperation of both partners
- Couples who want highly effective protection against pregnancy (e.g., woman has a condition that makes pregnancy dangerous) should consider a more reliable method

**Counselling and education associated with fertility-based methods**

- Ask clients how they are doing with the method and if they have any questions
- Ask if they are having difficulty identifying fertile days or trouble avoiding unprotected intercourse on the fertile days
- Check whether couple is using method correctly
- Ask client about any life changes that may affect her needs, particularly those related to having children and STI/HIV risk
- Suggest client use alternative method of contraception if challenges or changes are inhibiting correct and consistent use of fertility-based method

**Counselling and education associated with use of LAM**

- Breastfeed often. An ideal pattern is feeding on demand, at least 10 to 12 times a day in the first few weeks and 8 to 10 times a day thereafter
- Babies that do not want to feed more than 4 hours apart may need gentle encouragement to breastfeed more often, even at night
- Plan for the next FP visit while LAM criteria still apply so the client can choose another method as soon as any one of the three LAM criteria no longer applies
- Women living with HIV can use LAM. There is a chance, however, that a woman will transmit HIV to her infant. Details about LAM for mothers living with HIV is available in *Guidelines for the Prevention of Mother-to-Child Transmission (PMTCT) of HIV/AIDS in Kenya* (NASCOP, 2009)

**Counselling and education associated with withdrawal**

- Suggest that the couple also use another method until the man feels he can use withdrawal correctly with every act of sex
- Men who cannot sense consistently when ejaculation is about to occur or men who ejaculate prematurely should not use withdrawal
- ECP and alternative methods of family planning are available

**Mentee’s Assignment**

Upon completion of this lesson, the mentee should complete the following assignment:


**Mentee’s Evaluation**

The mentee’s competency in this lesson is evaluated using question-and-answer sessions hosted during the training session.
LESSON 2.10 Balanced Counselling Strategy Plus (BCS+)

Schedule and Timing
This lesson requires approximately 1 hour.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduce the BCS+ toolkit, including definition and contents</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Describe the main components of the toolkit and their application</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Describe the application of the BCS+ algorithm</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Describe the application of BCS+ job aids</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.11 HIV Testing &amp; Counselling</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Subsequent mentoring sessions may include the following activities

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review of the last session including lesson content</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate BCS+ procedure and ask for return demonstration</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Evaluate mentee using checklist provide feedback on performance</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Practice skills</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Agree on the next meeting based on mentor and mentee’s availability</td>
<td>2 minutes</td>
</tr>
</tbody>
</table>

Mentee continues to practice competency skills on at least 10 clients during the Mentorship Programme.

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

1. Define the Balanced Counselling Strategy Plus
2. Introduce the purpose and role of each BCS+ component
3. Describe the application of the BCS+
4. Demonstrate use of the BCS+ in family planning and/or HIV counselling and testing
5. Revise BCS+ algorithm as needed or appropriate according to setting and facility

Tools and Reference Documents
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book

Lesson Content
The content of this lesson is from the Balanced Counselling Strategy Plus Toolkit, MOH and Population Council 2011. Please refer to that document for further detail and instruction.

Definition and Contents of Balanced Counselling Strategy Plus (BCS+)
The Balanced Counselling Strategy (BCS) is a practical, interactive, client-friendly counselling strategy. The BCS+ toolkit, developed and tested in Kenya and South Africa, provides the information and materials needed for healthcare facility providers to provide complete and high-quality family planning counselling to clients who live in areas with high rates of HIV and STIs.

The BCS+ toolkit is designed to provide the information and tools needed for healthcare facility directors, supervisors, and service providers to implement the Balanced Counselling Strategy in their family planning services. This toolkit includes the following:

BCS+ Trainer’s Guide: Supervisors and others can use this to train healthcare facility directors and service providers on how to use the BCS+ for counselling family planning clients.
BCS+ User’s Guide: This guide focuses on how to implement the Balanced Counselling Strategy Plus. It can be distributed during training or used on its own with the BCS+ job aids.

BCS+ job aids comprising:
BCS+ algorithm that summarizes the 19 steps needed to implement the BCS+ during a family planning counselling session. These steps are organized into four stages: pre-choice, method choice, post-choice, and STI/HIV counselling.

BCS+ counselling cards that the provider uses during a counselling session. There are 26 counselling cards, the first of which contains six questions that the service provider asks to rule out the possibility that a client is pregnant. Each of the next 16 cards contains information about a different family planning method. The next three cards provide advice on pregnancy and the postpartum period. The last six cards provide essential information for counselling on preventing, detecting, and treating STIs and HIV.

BCS+ method brochures on each of the 16 methods represented by the counselling cards. The brochures provide counselling to clients on the method they have chosen and then are given to clients for later reference. This means clients do not have to rely on their recollection of what was discussed with the provider.

WHO Medical Eligibility Criteria Wheel guides providers through medical conditions and medications that may be contraindications to use of particular contraceptive methods.

Application and Demonstration of BCS+ Toolkit

Below are instructions on how to apply the BCS+ in a facility setting. These instructions are for healthcare workers interested in using the BCS+ toolkit in the provision of family planning and HIV integrated services and counselling.

• Read the entire BCS+ User’s Guide on how to implement the Balanced Counselling Strategy Plus.
• Refer to the BCS+ algorithm as a reminder of the steps needed for implementation. It is helpful to have the algorithm handy on your desk or hang it on a wall so that you can refer to it easily.
• Use the BCS+ counselling cards to help a client choose a method based on her/his reproductive intentions. Use the first counselling card to rule out if the client is pregnant. If she is not, use the remaining method cards to help the client choose a contraceptive method suited to her reproductive health intentions.
• Once the client has chosen a contraceptive method, review the corresponding BCS+ method brochure with the client. Use the brochure to reinforce information about the method chosen and to respond to questions. This helps to ensure that the client understands the method. Give the brochure to the client. S/he can refer to it at home or use it to talk to her/his partner.
• For mentors, use the BCS+ Trainer’s Guide to familiarize healthcare staff with this new counselling approach and to build the capacity of service providers. The trainer’s guide covers eight hours of training and includes over three hours of practice and role plays.
• The BCS+ User’s Guide, Trainer’s Guide, and all related tools are available on an electronic CD-ROM. Adapt these materials for use as needed.

Revised the BCS+ Algorithm

The BCS+ job aids are generic and can be revised based on a region’s/country’s needs and norms. Guidelines for adapting job aids are available in BCS+ User’s Guide.

• Conduct a technical review of family planning and NCT norms, which may include a meeting with the MOH, experts, and service providers.
• Decide together which aspects of the toolkit will be revised.
• Be sure to adjust all job aids accordingly so they are in sync and all updated accordingly.
• Adhere to the existing format of the BCS+ job aids as much as possible.
• If adding/revising steps to the algorithm, write the steps using action verbs. For example, “Ask the client whether she has had her monthly bleeding.”
• Pre-test (validate) the revised BCS+ job aids.
• Ask two to three less experienced service providers to use the revised BCS+ job aids and observe whether they were able to perform the tasks based on the instructions in the job aids. Revise the job aids accordingly.
• Incorporate the use of the job aids into existing training, or develop a short course to show service providers how to use the job aids.
Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:

• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus

• Review Balanced Counselling Strategy Plus (MOH &Population Council 2011) or follow-up with mentor if further instruction is needed

• Revise the BCS+ algorithm steps according to the needs of your position and/or facility

• Conduct integrated family planning and HIV counselling in the facility setting with at least 10 clients during Mentorship Programme.

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using three methods. First, question-and-answer sessions hosted during the training session are used to gauge the mentee’s understanding of the information and its application in a clinical setting. Second, the mentee must demonstrate competency in all steps of the Balanced Counselling Strategy Plus according to the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Last, the mentee must apply BCS+ during family planning counselling on a minimum of 10 clients to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
LESSON 2.11  HIV Testing and Counselling

Schedule and Timing
This lesson requires approximately 2 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Present information about HIV testing and counselling (HTC) and its importance</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Review the main components of an HTC session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss the types of HIV testing and counselling</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Discuss required HIV testing and counselling and its implications</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Host an interactive discussion on core principles of HTC</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Demonstrate a full HTC session; mentee to provide a return demonstration</td>
<td>50 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.12 Referral and Service Linkages</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

Subsequent mentoring sessions on this topic may include the following activities

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Review the last session including lesson content</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Mentee to demonstrate HTC procedure</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Evaluate mentee using checklist and provide feedback</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Practices skills</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Agree on next meeting based on the mentor and mentee’s availability</td>
<td>2 minutes</td>
</tr>
</tbody>
</table>

The mentee continues to practice competency skills and on at least 10 clients during the Mentorship Programme.

Objectives
By the end of this session participants will be able to:
1. Define HIV testing and counselling (HTC) and discuss its importance
2. Explain the components of an HTC session including pre-test, test, and post-test
3. List types of HIV testing and counselling
4. Describe intricacies of required HIV testing and counselling
5. List the core principles of HIV testing and counselling
6. Demonstrate an HTC session with a client

Tools and Reference Documents
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book
- Guidelines for HIV Testing and Counselling in Kenya, NASCOP 2010
- National Training Manual on Integrating Counselling and Testing for HIV into Family Planning Services, MOH 2008

Lesson Content
The content of this lesson is from the Guidelines for HIV Testing and Counselling in Kenya, NASCOP 2010. Please refer to that document for further detail and instruction, if necessary.

HIV testing and counselling (HTC) process
HIV testing and counselling (HTC) is the main entry point to prevention, care, and treatment of HIV. Kenya has adopted the UNAIDS concept of Universal Access. The achievement of these ambitious targets hinges on the successful expansion of HCT programs in the country. (from Guidelines for HIV Testing and Counselling in Kenya, NASCOP 2010)

Core principles of HCT
1. International and national policy and standards emphasize that all HTC services in Kenya should be conducted with the best interests of the clients.
2. HTC should never be coercive or mandatory.
3. Persons receiving HTC must give informed consent and is therefore voluntary.
4. HTC services are confidential, meaning the anything that is discussed between the healthcare worker and the client will not be disclosed anyone else.

5. HIV testing must be accompanied by pre-test information and post-test counselling, including referrals to appropriate services.

Components of an HTC session

The three primary components of HIV testing and counselling are the pre-test session, the HIV test, and the post-test session. These three elements make up the minimum service package of HTC.

Pre-test session

The pre-test session introduces basic HIV information to the client or patients wishing to receive an HIV test, and may be provided to an individual, a couple, or a group. This session includes information about:

- Benefits of knowing one’s HIV status
- Benefits of couples testing
- An explanation of the HIV testing process
- The need for consent for the HIV test
- A summarized version of risk assessment
- Referral for support, care, and treatment
- Importance of disclosure to partners and other family members

HIV testing

In a majority of settings, licensed rapid tests are done on the spot by the HTC service provider. Anyone receiving an HIV test should be encouraged to receive their HIV test results. In some instances at a health facility, patients or clients may be referred to another on-site HTC service provider or laboratory for the test; however, it is important to emphasize that clients should be offered their results, regardless of where the HIV test is conducted. All HIV positive test results must be confirmed by at least one other test.

Post-test session

After the HIV test is complete, the HTC service provider must offer post-test counselling to the client or patient based on the results. Risk reduction information and emotional support should be provided at this time based on the individual’s personal risk factors, and referrals to appropriate follow-up services should be given.

Other services that may be offered during the post-test session for either HIV-positive or HIV-negative clients, depending on their needs and the setting, include:

- Prevention counselling
- Partner testing and disclosure
- Emotional support
- Referral to additional prevention services as needed, e.g., male circumcision
- Needle exchange for injecting drug users (IDUs)
- Condoms education and distribution
- Post-exposure prophylaxis (PEP)
- Supported disclosure
- Family member testing
- Prevention with positives
- Maternal and child health services
- Family planning services

Types of HCT Delivery Models

Client-initiated HIV testing and counselling

This refers to a situation whereby an individual, couple, or group actively seeks out HIV testing and counselling at a site where these services are provided and accessible. Previously in Kenya this took place primarily in the context of voluntary counselling and testing (VCT); however HTC may be initiated by clients in settings other than VCT sites such as health facilities, mobile sites, or even in people’s homes.

Provider-initiated HIV testing and counselling (PITC)

This refers to a situation in which the service provider, who may be a healthcare worker or other type of HTC service provider, offers an HIV test to a client or patient regardless of their reason for attending the facility. It is important to note that PITC is significantly different from diagnostic testing and counselling (DTC). Whereas DTC targets patients with HIV-related signs and symptoms, PITC opens up HTC to all patients in the health facility. PITC therefore makes HTC part of routine care in health facilities in Kenya. Failure to offer HTC when symptoms or signs of HIV are present is substandard care and is not acceptable.

Self-testing for HIV

Recent advances in testing technologies have led to several non–blood-based HIV tests. Some common examples include oral fluid and urine-based testing. It is anticipated that other simple non-blood tests will become available in Kenya in the coming years.

Community and Health Facility Approaches

HIV testing and counselling approaches

Approaches to HTC have been diversified in Kenya in order to expand the options available to clients in order to cater to their interests and convenience.

Community-based approach is generally to strengthen the social elements of HTC for prevention, family level counselling, and links to support groups. Some examples of community-based sites are:

- Stand-alone HIV testing and counselling centres not attached to other specific health services, generally operated by nongovernmental organisations (NGOs), faith-based organisations (FBOs), or other community-based organisations (CBOs).
• **Outreach HIV testing** and counselling services offered outside of a fixed site, such as mobile or workplace HTC. Some of the current outreach means include vehicles, tents, churches, or in a workplace.

• **Home-based HIV testing** and counselling entails an HTC service provider physically going to the home of a client to offer HTC. In this setting, HTC is initiated by the service provider, but the client still has a right to refuse the test.

**Health facility approaches** are initiated at service delivery points in all sections of a hospital or health facility for any person. This approach generally requires the direct participation and engagement of the healthcare worker in providing the service and trained healthcare workers are encouraged to provide HTC to patients themselves, when possible, rather than referring the patient to the laboratory for testing.

**Required HIV testing and counselling**

HIV testing may be performed without specific consent in certain specific settings, such as during military recruitment and specialized employment, e.g., healthcare workers. HIV testing may also be ordered by a court of law.

In all cases of required testing, services must be confidential, and performed with adequate counselling. Persons receiving an HIV test in these situations shall be informed of the test and must have access to the results in an appropriate setting, in addition to being provided with the necessary referrals.

**Most HIV testing is voluntary and the client has the right to refuse testing.**

**Demonstration**

Use National Guidelines for HIV Testing and Counselling (NASCOP 2010) for reference or additional guidance

**Key points of HTC demonstration**

- Prepare the environment for an HCT session, e.g., privacy, seating arrangement
- Be sure materials are available for the client to take home, e.g., visual aids, information brochures
- Greet and speak to the client using simple language
- Establish the client’s reasons for visiting
- Assure the client of complete confidentiality
- Allow the client to voice current knowledge about HIV and concerns
- Conduct the HIV test properly
- Give results to the client, and only the client, and treat per the diagnosis
- Discuss any problems the client may have related to partner notification
- Give a return date to the client

**Role-play activity**

The patient is a 22-year-old man who has come to the facility confused and upset. He says that he has been with multiple partners recently, does not use condoms, and also occasionally uses IV drugs. He has a friend who was recently diagnosed with HIV and he does not know if he can be infected.

**Mentee’s Assignment**

Upon completion of this lesson, the mentee should complete the following assignment:

- Review the **Mentee’s Skills Assessment Checklist** (available in Annex) Section 6 on Family Planning, HIV Testing and Counselling, STI Prevention and Management, and Balanced Counselling Strategy Plus
- Review **Guidelines for HIV Testing and Counselling in Kenya** (NASCOP 2008) or follow up with mentor if further instruction is needed.
- Conduct HIV testing and counselling in the facility setting with at least 10 clients during the Mentorship Programme.

**Mentee’s Evaluation**

The mentee’s competency in this lesson is evaluated using two methods. First, the mentee must demonstrate competency in all steps of HIV Testing and Counselling according to the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Last, the mentee must apply HTC skills with a minimum of 10 clients to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
LESSON 2.12  Referral and Service Linkages

Schedule and Timing
This lesson requires approximately 1 hour.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and definitions</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Review the types of referrals and service linkages</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Explain the existing referral protocols and procedures in facility</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Discuss reasons for referral and methods to ensure effective referral</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Present referral policies, procedures, forms, and tools</td>
<td>15 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Plan for the next meeting</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Prepare for the next session by reviewing the lesson content, tools, and reference materials for Lesson 2.13 Documentation and Recordkeeping</td>
<td>3 minutes</td>
</tr>
</tbody>
</table>

The mentee continues to practice referral and service linkages skills with at least 10 clients seeking HIV and/or RH services during the Mentorship Programme.

Objectives
By the end of this session participants will be able to:
1. Define referral and service linkages
2. List types of service linkages
3. Name reasons for referrals and service linkages
4. Outline steps that can be made to ensure effective referral and service linkages
5. Locate and demonstrate use of the facility’s referral forms and procedures

Tools and Reference Documents
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book

Lesson Content
Definition and types of linkages
Service linkages refer to the relationship that the health facility or service delivery unit maintains with other facilities and organizations that provide services needed by patients/clients. These services are those not provided by the health facility or service delivery unit.

Types of service linkages
External: systematic and effective referral of patients/clients from one service to another within the district health system or network. This is designed to ensure that a patient/client receives all the services she/he requires at that point in time.

Internal: organized referral between service delivery points within a health facility, such as other healthcare workers, comprehensive care centres, pharmacy, laboratory, nutritionist, or other services.

Reasons for Referral
Patients/clients may need a referral for the following reasons:
- To seek specialized services, e.g., CD4 count for a woman with HIV seeking family planning services
- Providers do not have the correct training or skills to meet the client’s needs, e.g., trainers who have not been trained on VIA/VILI cannot provide cervical cancer screening
- Facilities do not have the infrastructure to support services, e.g., healthcare workers in the comprehensive care centre may not be able to provide family planning services
- Limited equipment and supplies in facilities for integrated service provision
- Clients choose to attend another service

Ensuring an Effective Referral
- Develop/make available operations manual for referral in all the service delivery points.
• Familiarize the staff with the referral procedures and protocols for RH and HIV services inside and outside the facility.
• Maintain a referral directory (list of services at receiving sites and their cost).
• Provide adequate referral tools and support the healthcare workers.
• Promote communication and feedback between the service delivery points/facilities in order to establish collaboration.
• Track referrals between the service delivery points.
• Document outcomes of referral.
• Consider employing and training lay people, such as mothers to increase referrals for other mothers.
• Make sure everyone understands the meaning of “shared confidentiality” in the continuum of care.
• Provide clinical back-up and support supervision to the service provider and facility managers of the receiving referrals.
• Host multi-disciplinary team member meetings for staff from all referral sites to evaluate and appraise the process. Consider including community health workers, laboratory staff, counsellors, and pharmacy staff.
• Review the referral system periodically to identify gaps in services and take steps to bridge them.

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:
• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 9 on Referral and Service Linkages
• Review facility’s referral policies and procedures or follow-up with mentor if further instruction or clarification is needed on steps and skills.
• Conduct referral in the facility setting with at least 10 clients during the Mentorship Programme.

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using three methods. First, question-and-answer sessions hosted during the training session are used to gauge the mentee’s understanding of information and its application in a clinical setting. Second, the mentee must demonstrate competency in all steps of Referral and Service Linkages according to the Skills Assessment Checklist, to be evaluated by her/his mentor and then by final external evaluators upon completion of programme. Last, the mentee must apply referral skills with a minimum of 10 clients to be documented in the Mentee’s Log Book and evaluated by her/his mentor during the Mentorship Programme.
Lesson Content

Importance of Documentation and Recordkeeping

Data are vital for reporting and decisionmaking. Therefore, clear documentation is needed in health care and so is timeliness in submission of relevant reports to the relevant authorities.

Recordkeeping involves recording and keeping information to facilitate future planning and reference.

Reports involve compiling specific information on forms for future use, evaluation, and documentation.

Recordkeeping and reporting are important because:
- Reports serve as the key procurement function at the district health facility
- The information collected is used for decisionmaking in management and supervision activities
- Client information should be accurate, clear, complete, and relevant

Documents and Forms used for Recordkeeping

Examples
- Daily activity register for HIV testing, blood safety, contraceptives, and STI drugs
- Consumption data report and request for blood safety commodities

Tools and Reference Documents
- Mentee’s Skills Assessment Checklist
- Mentee’s Log Book

Objectives

By the end of this session participants will be able to:
1. Discuss the importance of recordkeeping
2. List and identify the types of logistic records, registers, and related tools for capturing client information
3. Fill out records correctly
4. Explain the concept of data entry and data threats

Schedule and Timing

This lesson requires approximately 2 hours.

<table>
<thead>
<tr>
<th>Mentoring Activity</th>
<th>Allotted time</th>
</tr>
</thead>
<tbody>
<tr>
<td>Introduction and importance of recordkeeping</td>
<td>5 minutes</td>
</tr>
<tr>
<td>Review types of records</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Practice filling out logistic records</td>
<td>30 minutes</td>
</tr>
<tr>
<td>Discuss data entry and data threats</td>
<td>20 minutes</td>
</tr>
<tr>
<td>Practice documentation and submission</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Question-and-answer session</td>
<td>10 minutes</td>
</tr>
<tr>
<td>Plan for course evaluation</td>
<td>5 minutes</td>
</tr>
</tbody>
</table>

LESSON 2.13 Documentation and Recordkeeping

Service delivery Points (SDP) contraceptive consumption data report and request form
SDP STI drugs and related supplies consumption data report and request form
Counter requisition and issue voucher (S11)
Issue and receipt voucher (S12)

Categories of Forms
- Consumption records document data on clients attending service delivery points
- Stock-keeping records document information about commodities and supplies
- Transaction records document information about commodities being moved in and out of a facility
- Consumption records record information on commodities consumed in the SDP
- Reporting records document different reports submitted to different agencies, supervisors, and government entities.

Form review activity
- Name of the form
- Who completes it
- Where it is submitted (such as which government department)
- Its purpose
- One potential challenge in completing, submitting, or compiling these documents
Data Entry

When completing reports or records, it is extremely important that the data entered into the forms be correct, clear, and formatted appropriately. Many forms are completed by hand and the data are then entered into a computer for further analysis and review of all the data collected. This process is called data entry.

Errors in data entry can change the interpretation of the data which then misrepresents the actual picture. Some considerations to avoid the errors include:

• Person entering data needs to validate the information before data entry
• Person entering data needs to ensure that the number of forms logged in equals the actual number of forms received
• When compiling reports, pay attention in order to minimize errors such as incompleteness and inaccurate information, and submit reports in a timely and correct manner
• Quantities requested should not be rounded up
• Any losses and adjustments in data reported should be explained

Mentee’s Assignment

Upon completion of this lesson, the mentee should complete the following assignment:

• Review the Mentee’s Skills Assessment Checklist (available in Annex) Section 9 on Referral and Service Linkages
• Review the facility’s referral policies and procedures or follow up with the mentor if further instruction or clarification are needed on steps and skills.

Mentee’s Evaluation

The mentee’s competency in this lesson is evaluated using question-and-answer sessions during the lesson.

MENTORSHIP PROGRAMME COURSE EVALUATION AND CLOSING

Evaluation of Mentee

Once the mentee completes all the course sessions and achieves key competencies, he/she shall be evaluated for completion of the programme. This evaluation includes:

• A comprehensive review of progress and accomplishments by the mentor, highlighting specific areas of achievement and success.
• A post-test theoretical exam as well as practical skills evaluation, both hosted by the mentor using the Mentee’s Skills Assessment Checklist.
• A final evaluation of the mentee’s competencies by the national authority using the Mentee’s Skills Assessment Checklist. Performance assessments are completed for both theoretical and practical application of all RH/HIV lessons included in the Mentorship Programme. Upon satisfactory performance, DRH and NASCOP will award completion certificates to mentees.

Evaluation of the Mentorship Programme

Evaluation of the Mentorship Programme is conducted by the following means:

• Outcome of the mentees participating in the programme
• An evaluation form completed by mentees participating in the programme upon their completion (available in Annex 4)
• Feedback from mentees, mentors, and related staff associated with the programme

Course Closing and Follow-up Support

Upon closing the programme and receiving certification, the mentee and mentor bring their relationship to a close while establishing specific ties that they will carry through in the future. The mentor and mentee should discuss how to move skills further and useful contacts to make and maintain, and develop an action plan for meeting on a regular basis for further professional development.
ANNEX 1  Mentees Initial Assessment Form

This initial assessment form is to be completed by every new mentee before starting the Mentorship Programme. This form should be completed only once and submitted to the mentee’s mentor. A copy of this form should be submitted to the District RH Coordinator along with the Mentor’s Monthly Summary Sheet. The original form should remain with the facility where the mentee and the mentor are working.

1. NAME OF HEALTH FACILITY ____________________________________________________________

2. FACILITY TYPE ________________________________________________________________

3. DISTRICT _________________________ PROVINCE ________________________________

4. MENTEE NAME _______________________________________________________________

5. MENTEE’S UNIT OF DEPLOYMENT ____________________________________________ (E.G., E.G., MCH/FP OR CCC/ART)

6. DESIGNATION OF THE MENTEE (TICK THE APPROPRIATE DESIGNATION)
   (a) Enrolled Nurse/Midwife (Certificate) _____
   (b) Registered Nurse/Midwife (Diploma) ______
   (c) Degree Nurses (Degree) ______
   (d) Clinical Officers (Diploma) ______
   Others (Specify) ________________________________________________________________

7. YEARS OF EXPERIENCE IN THE SERVICE __________________________________________

8. MENTEE’S DURATION OF EXPERIENCE IN MCH/FP SERVICES
   ❑ ≤ 6 months     ❑ ≤ 1 year     ❑ ≤ 2 years     ❑ > 2 years

9. MENTEE’S DURATION OF EXPERIENCE IN HIV COUNSELLING & TESTING
   ❑ ≤ 6 months     ❑ ≤ 1 year     ❑ ≤ 2 years     ❑ > 2 years
### 10. MENTEE’S IN-SERVICE TRAINING

| Training /update                                      | Yes/No | Date of training | Duration of training | Mode of training e.g., OJT, workshop, CME | In your own opinion indicate your current level of skill
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<tbody>
<tr>
<td>Family planning</td>
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<td>0= no skills 1= not satisfactory 2= satisfactory</td>
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<tr>
<td>Contraceptive technology update</td>
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<td>IUD insertion/removal</td>
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<tr>
<td>Implants insertion/removal</td>
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<tr>
<td>Syndromic diagnosis and management of STIs</td>
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<tr>
<td>Prevention of mother-to-child transmission of HIV/AIDS</td>
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<tr>
<td>HIV/AIDS testing and counselling</td>
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<tr>
<td>Screening for cervical cancer VIA/VILLI</td>
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<tr>
<td>Integration of counselling and testing for HIV into FP</td>
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<tr>
<td>Application of the Balanced Counselling Strategy Plus</td>
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<tr>
<td>Targeted postpartum care for mother</td>
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<td></td>
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</tr>
<tr>
<td>Targeted postnatal care for newborn</td>
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<tr>
<td>Infection prevention</td>
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</table>

### 11. MENTEE’S OVERALL COMMENT

_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________
_________________________________________________________________________________________________________________________________________

### 12. MENTOR’S NAME

(a) Designation __________________________________________ Date _______________________________
This Checklist has been adapted from “Checklists for Trainers” in the National Comprehensive Reproductive Health Curriculum for Service Providers (DRH/MOH 2006)

Each clinical assessment checklist contains the steps/tasks expected to be performed by the mentee when conducting the relevant procedure or providing the respective service. Prior to assessing the mentee’s clinical performance, the mentor is expected to review the steps involved and the expected outcomes. The mentee should have observed the activity as a demonstration before practicing the skill him/herself. Immediately after the skill is completed, the mentor should meet with the mentee to provide constructive feedback regarding the learning progress and to define the areas for improvement.

While practicing skills with peers, mentees should use the Skills Assessment Checklist to ensure that they are meeting all requirements and expectations of assessment.

1. FACILITY NAME ____________________________________________________________

2. DISTRICT ________________________________________________________________

3. PROVINCE _______________________________________________________________

4. FACILITY CATEGORY/CODE __________________________ (HOSPITAL=1, HEALTH CENTRE=2, DISPENSARY=3,)

5. MENTEE’S NAME _________________________________________________________

6. DATE OF MENTORSHIP/OBSERVATION ______________________________________

7. MENTEE’S UNIT OF DEPLOYMENT ________________________________ (E.G., MCH/FP OR CCC/ART)

8. DESIGNATION OF THE MENTEE OR OBSERVED PROVIDER (CIRCLE APPROPRIATE CODE)
   a. Enrolled Nurse/Midwife (Certificate)
   b. Registered Nurse/Midwifenv (Diploma)
   c. Degree Nurses (Degree)
   d. Clinical Officers (Diploma)
   e. Medical Officers
   f. Others (Specify) _________________________________________________________

MENTOR’S NAME ____________________________________ Designation _______________ Date ______________

73
Insert the score for every observed or performed task as follows:
0: Skill/task was not applicable to the client
1: Skill/task completed incorrectly or omitted
2: Skill/task completed but not satisfactorily
3: Skill/task completed satisfactorily

This checklist can be used on three different dates.

<table>
<thead>
<tr>
<th>Score</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
</table>

### SECTION 1: General or Social Skills

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Establishes and maintains a warm and cordial relationship:</td>
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</tr>
<tr>
<td>Greets the client</td>
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<tr>
<td>Introduces self</td>
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<tr>
<td>Welcomes client to the clinic.</td>
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<tr>
<td>Documents all information and procedures in appropriate tools</td>
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<tr>
<td>Gives client a return date for next visit</td>
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</tbody>
</table>

**TOTAL SCORE ON SECTION 1**

### SECTION 2: Physical Exam

<table>
<thead>
<tr>
<th>Task</th>
<th>Score</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prepare the examination area for physical exam</td>
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</tr>
<tr>
<td>Counsel and prepares the client for physical exam</td>
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<tr>
<td>Wash hands before starting examination using recommended guidelines</td>
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<tr>
<td>Collect Comprehensive Health History</td>
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<tr>
<td>Assess general overall health state</td>
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<tr>
<td>Assess head</td>
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<tr>
<td>Assess eyes</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Assess ears</td>
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<td></td>
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<tr>
<td>Assess nose and sinuses</td>
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<tr>
<td>Assess mouth, pharynx, neck</td>
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<tr>
<td>Listen to heart rate and rhythm</td>
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<tr>
<td>Listen to internal breath sounds</td>
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</tr>
<tr>
<td>Take vital signs including pulse, BP, heart rate, temperature</td>
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<td></td>
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<tr>
<td>Inspect and palpate abdomen</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect and examine reproductive organs</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Inspect arms and legs for swelling</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Check pulses in extremities</td>
<td></td>
<td></td>
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</tr>
<tr>
<td>Give the client feedback about the findings</td>
<td></td>
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<tr>
<td>Inform the client of next steps</td>
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<tr>
<td>Lymph Node Exam</td>
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<tr>
<td>Use index and middle fingers in rotary motion, noting tenderness or enlargement</td>
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<tr>
<td>Palpate cervical lymph nodes bilaterally</td>
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<tr>
<td>Palpate axillary nodes, with patients opposite arm on your shoulder, and palpate along the pectoralis</td>
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<tr>
<td>Step behind patient to palpate supraclavicular nodes</td>
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<tr>
<td>Breast Exam</td>
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<tr>
<td>Inspect breasts from front and sides, noting size, symmetry, shape, contours, skin, scars</td>
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<tr>
<td>Ask patient to raise both arms and inspect again</td>
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<tr>
<td>Ask client to place hands on waist, press elbows forward and inspect again</td>
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</tbody>
</table>
**U4** Conduct bimanual palpation using proper draping technique and client in sitting position

**U5** Conduct bimanual palpation with patient lying on exam table, arm on side of exam raised above head.

**U6** Use first three fingers and rotary motion, noting consistency, induration, tenderness, nodules, masses

**U7** Repeat breast examination appropriately on opposite breast

### TOTAL SCORE ON SECTION 2

<table>
<thead>
<tr>
<th>SECTION 3: Pelvic Exam</th>
<th>Score</th>
<th>Date</th>
<th>Date</th>
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</thead>
<tbody>
<tr>
<td><strong>A</strong> Maintains pleasant demeanour with client and answers all questions</td>
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<tr>
<td><strong>B</strong> Explains procedures</td>
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<td><strong>C</strong> Politely asks woman to get undressed</td>
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<tr>
<td><strong>D</strong> Ensures privacy for entire procedure</td>
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<tr>
<td><strong>E</strong> Lower Abdominal Exam</td>
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<tr>
<td><strong>E1</strong> Position the client for examination and expose the entire abdomen</td>
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<tr>
<td><strong>E2</strong> Inspect the abdomen for swelling or bulges, abnormal colouring, scars, stretch marks, rashes, and lesions</td>
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<tr>
<td><strong>E3</strong> Palpate all areas of the abdomen to identify masses, areas of tenderness, or muscular resistance.</td>
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<tr>
<td><strong>E4</strong> Using deeper pressure, determine size, shape, consistency, tenderness, mobility and movement of any masses.</td>
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<tr>
<td><strong>E5</strong> Identify any tender areas; if present, check for guarding or rebound tenderness</td>
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<tr>
<td><strong>E6</strong> Examine for urethrocele and rectocele and uterine prolapse.</td>
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<td><strong>F</strong> External Genitalia Exam</td>
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<tr>
<td><strong>F1</strong> Position the client in lithotomy or dorsal position and drape her</td>
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<td><strong>F2</strong> Turn on light and direct it towards the genital area</td>
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<tr>
<td><strong>F3</strong> Wash hands with soap and water, dry appropriately, don gloves</td>
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<tr>
<td><strong>F4</strong> Inspect external genitalia and perineum for scars, tears, warts, sores, ulcers, lacerations, FGC scars, discharge.</td>
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<tr>
<td><strong>F5</strong> Palpate external genitalia; feel for any irregularities or nodules.</td>
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<tr>
<td><strong>F6</strong> Examine skene’s glands and Bartholin’s glands for discharge and tenderness; if present, take a smear for Grams stain to test for gonorrhoea and chlamydia, if laboratory facilities are available</td>
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<tr>
<td><strong>G</strong> Speculum Exam</td>
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<tr>
<td><strong>G1</strong> Select speculum, show it to woman and explain the procedure.</td>
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<td><strong>G2</strong> If possible, warm the speculum using warm clean water; lubricate the speculum depending on the procedure.</td>
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<td><strong>G3</strong> Insert speculum appropriately, using fingers to help relax muscles</td>
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<tr>
<td><strong>G4</strong> Place speculum in appropriate position with handle down, open blades and tightened screws to keep in place</td>
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<tr>
<td><strong>G5</strong> Exam cervix, identifying normal and abnormal findings</td>
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<tr>
<td><strong>G6</strong> Remove speculum correctly by gently pulling it away from cervix, bringing blades together and withdrawing to observe walls of vagina</td>
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<tr>
<td><strong>G7</strong> Properly disinfect speculum and other instruments</td>
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<tr>
<td><strong>H</strong> Bimanual Pelvic Exam</td>
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<tr>
<td><strong>H1</strong> Appropriately lubricate the examining fingers</td>
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<tr>
<td><strong>H2</strong> Insert pointing and middle fingers with palm up</td>
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<tr>
<td><strong>H3</strong> Examine cervix noting length, size, shape, position and consistency</td>
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<tr>
<td><strong>H4</strong> Palpatate the uterus and check for size, shape, location, consistency, mobility, and tenderness</td>
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<tr>
<td>H5</td>
<td>Note abnormalities like lumps, softness, pain, or rigidity</td>
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<tr>
<td>H6</td>
<td>Move finger along inside of vagina and note lumps, tears, scars</td>
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<tr>
<td>I</td>
<td>Recto-vaginal Exam</td>
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<tr>
<td>I1</td>
<td>Explain procedure to the patient.</td>
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<tr>
<td>I2</td>
<td>Change gloves if necessary</td>
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<tr>
<td>I3</td>
<td>Correctly insert middle finger of pelvic hand into the rectum and index finger into the vagina</td>
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<tr>
<td>I4</td>
<td>Examine the uterus and recto-vaginal space for tenderness, masses and surface characteristics.</td>
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<tr>
<td>I5</td>
<td>Dispose of gloves</td>
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<td>J</td>
<td>Observe all infection prevention protocols</td>
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<td>K</td>
<td>Assist the woman to sitting position or offer her to rest, if needed</td>
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<tr>
<td>L</td>
<td>Politely ask woman to dress</td>
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<tr>
<td>M</td>
<td>Discuss findings from pelvic exam procedures</td>
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<td>N</td>
<td>Provide woman a return date, if necessary</td>
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**TOTAL SCORE ON SECTION 3**

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<tr>
<th>SECTION 4: Cervical Cancer Screening</th>
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<td>I10</td>
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**TOTAL SCORE ON SECTION 4**
### SECTION 5: Postnatal and Postpartum Care

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<tr>
<th>Task</th>
<th>Score</th>
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</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
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<tr>
<td>A Weigh mother</td>
<td></td>
</tr>
<tr>
<td>B Take vital signs, including BP, pulse, respiration, and temperature</td>
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<tr>
<td>C Listen to heart and breath sounds</td>
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<tr>
<td>D Assess pain or physical discomfort</td>
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<tr>
<td>E Provide physical exam (see Section 2) if needed</td>
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<tr>
<td>F Assess uterine tone, fundal height</td>
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<tr>
<td>G Assess presence of lochia and/or vaginal discharge</td>
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<tr>
<td>H1 Importance of hygiene and washing hands when handling baby</td>
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<tr>
<td>H2 Maternal nutrition</td>
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<tr>
<td>H3 Danger signs for mother (excessive lochia loss, fever, severe lower abdominal pains, foul smelling vaginal discharge )</td>
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<tr>
<td>H4 Danger signs for baby (poor feeding, breathlessness, low or high temperatures, signs of infection of umbilical cord, eyes, or skin)</td>
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<tr>
<td>H5 Healthy timing and spacing of pregnancies</td>
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<tr>
<td>H6 Lactation Amenorrhoea Method (LAM) (mention specifically)</td>
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<tr>
<td>H7 Return to sexual activity as soon as comfortable to do so</td>
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<tr>
<td>H8 Return to fertility 4–6 weeks</td>
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<tr>
<td><strong>Baby</strong></td>
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<tr>
<td>I Weigh and take length of baby</td>
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<tr>
<td>J Take temperature</td>
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<tr>
<td>K Undress baby</td>
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<tr>
<td>L Listen to breath sounds, count respiratory rate, observe for chest retractions or grunting</td>
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<tr>
<td>M Inspect for any skin rashes, infections, or abnormal presentations</td>
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<tr>
<td>N Inspect umbilical cord or stump</td>
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<tr>
<td>O Mention benefits of breastfeeding to mother</td>
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<tr>
<td>P Ask mother to put baby on the breast and observe feeding technique (positioning, attachment, and sucking )</td>
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<tr>
<td>Q Provide vitamin A supplements per guidelines</td>
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<tr>
<td>R Discuss immunizations with mother</td>
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<tr>
<td>S Offer/ refer mother and baby for other health services as appropriate</td>
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<tr>
<td><strong>For-HIV exposed baby</strong></td>
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<tr>
<td>T1 HIV testing DBS at six weeks</td>
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<tr>
<td>T2 Advise mother on exclusive breastfeeding. Emphasize no mix feeding</td>
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<tr>
<td>T3 Discuss medications, such as Nerapine and Cotrimoxazole, and appropriate timing, if necessary</td>
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</table>

**TOTAL SCORE ON SECTION 5**
### SECTION 6: Family Planning, HIV Counselling and Testing, STI Prevention and Management, and Balanced Counselling Strategy Plus

<table>
<thead>
<tr>
<th></th>
<th>Score</th>
<th>Date</th>
<th>Date</th>
<th>Date</th>
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<tbody>
<tr>
<td>A</td>
<td>Explore clients reproductive health goals</td>
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<tr>
<td>B</td>
<td>Take reproductive health history, including name, age, marital status, parity, last menstrual period, date of last delivery, occupation, medical and surgical history, future fertility intentions</td>
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<tr>
<td>C</td>
<td><strong>Rule out pregnancy</strong></td>
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<tr>
<td></td>
<td>C1 Have you abstained from sexual intercourse since last menstruation or last delivery?</td>
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<td></td>
<td>C2 Did your menstruation start in the last seven days?</td>
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<td></td>
<td>C3 Did you have a baby less than six months ago and are you exclusively breastfeeding?</td>
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<td>C4 Have you had a baby in the last four weeks?</td>
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<td></td>
<td>C5 Have you had a miscarriage or abortion in the last seven days?</td>
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<td>C6 Have you been using a reliable contraceptive consistently and correctly?</td>
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<td>D</td>
<td><strong>Balanced Counselling Strategy Plus (BCS+)</strong></td>
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<td></td>
<td>D1 Algorithm</td>
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<td></td>
<td>D2 Display all method cards for the client to see</td>
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<td></td>
<td>D3 Ask specific questions listed in the algorithm correctly and in order; set aside method cards not appropriate for the client</td>
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<td></td>
<td>D4 Give information on methods that are not set aside in the order of their effectiveness (mode of action, benefits, and side effects)</td>
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<td>D5 Ask client to choose method that is most convenient for her/him</td>
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<td></td>
<td>D6 Review brochure for selected method with client</td>
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<td>D7 Demonstrate proper use of WHO Medical Eligibility Criteria</td>
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<td>D8 Ask client to select another method if limitation exists</td>
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<td>D9 Provide counselling and education about method chosen using method brochure</td>
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<td>D10 Determine client’s comprehension; reinforce information if needed</td>
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<td>D11 Ensure that the client has made a definite decision</td>
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<td>D12 Provides the method chosen (extent of additional procedures depend on method chosen, see appropriate section of Checklist if needed)</td>
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<td>D13 Refers when necessary</td>
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<td>D14 Provides back-up method</td>
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<td>D15 Encourage client to involve partner through discussion or clinic visit</td>
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<td>D16 Discuss RTI/STI/HIV/TB transmission and prevention</td>
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<td>D17 Conduct Risk Assessment for RTI/STI/HIV/TB</td>
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<td>D18 Conduct necessary physical and/or pelvic assessment if necessary (see appropriate section of Checklist if needed)</td>
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<td></td>
<td>D19 Treat client syndromically, if RTI/STI symptoms present</td>
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<td>D20 Refer client appropriately, if needed</td>
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<td>D21 Discuss and offer client an opportunity for cervical cancer screening</td>
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<td>D22 Discuss dual protection with the client</td>
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<td>D23 Ask if the client knows how to use a condom</td>
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<td>D24 Demonstrate how to use condom</td>
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<td>D25 Offer condoms and instruct on correct and consistent condom use</td>
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<td>E</td>
<td>Demonstrate how to use a condom properly</td>
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<tr>
<td>F</td>
<td>Offer condoms and instruct on correct and consistent condom use</td>
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<tr>
<td></td>
<td>Discuss and offer client the opportunity for HIV testing and counselling</td>
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<tr>
<td>G</td>
<td>HIV Testing and Counselling</td>
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<tr>
<td>H</td>
<td>Discuss benefits of knowing status and couples testing</td>
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<tr>
<td>H1</td>
<td>Explain testing process</td>
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<td>H2</td>
<td>Obtain consent for HIV testing</td>
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<td>H3</td>
<td>Emphasize importance of disclosure to partner and family</td>
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<tr>
<td>H4</td>
<td>Conduct rapid HIV test</td>
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<td>H5</td>
<td>Collect sample correctly; uses the required sample volume per test</td>
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<td>H6</td>
<td>Ensure proper labelling for clients samples</td>
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<tr>
<td>H7</td>
<td>Use buffer solution correctly including correct timing, interpretation of results, and proper recordkeeping</td>
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<td>H8</td>
<td>If the client HIV-negative, discuss the importance of remaining negative and inquiring about partner’s status.</td>
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<tr>
<td>I</td>
<td>Encourage partner/couples testing or re-testing as appropriate</td>
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<tr>
<td>J</td>
<td>If client is HIV-positive, discuss positive health living and prevention including good nutrition, safer sex, future fertility desires, regular check-ups for opportunistic infection, psychosocial support, exercise, and rest</td>
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<tr>
<td>K</td>
<td>Discuss follow-up and management for HIV-positive clients, including the need for frequent CD4 counts, haemogram, liver function test</td>
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<tr>
<td>L</td>
<td>Refer HIV-positive clients to CCC using referral form</td>
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<tr>
<td>M</td>
<td>If HIV-positive, assess client’s eligibility for ARVs</td>
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<tr>
<td>N</td>
<td>Provide cotrimoxazole prophylaxis, if appropriate</td>
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TOTAL SCORE ON SECTION 6

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SECTION 7: Implant Insertion and Removal

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<tr>
<th></th>
<th>Explain procedure to client</th>
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<tr>
<td>A</td>
<td>Have all necessary and proper equipment in reach</td>
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<tr>
<td>B</td>
<td>Ask client to lie on the table with non-dominant arm extended</td>
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<tr>
<td>C</td>
<td>Wash hands with soap and running water, dry them</td>
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<tr>
<td>D</td>
<td>Drape client’s arm with a sterile cloth (under arm and on top); open sterile implant package onto sterile drape</td>
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<tr>
<td>E</td>
<td>Wear sterile gloves</td>
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<tr>
<td>F</td>
<td>Clean site with antiseptic solution, preferably iodine</td>
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<tr>
<td>G</td>
<td>Identify correct site for insertion, inner side of upper arm 6-8cm above elbow crease in the groove between biceps and triceps</td>
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<tr>
<td>H</td>
<td>Apply local anaesthesia (2–4 ml 0.1 % lignocaine without epinephrine)</td>
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<tr>
<td>I</td>
<td>Follow below for two-rod implant procedures (Jadelle)</td>
</tr>
<tr>
<td>J</td>
<td>Check for anaesthetic effect before making 2mm incision with scalpel</td>
</tr>
<tr>
<td>J1</td>
<td>Insert the tip of the trocar through the incision with bevel facing up.</td>
</tr>
<tr>
<td>J2</td>
<td>Keep trocar sub dermal by tenting the skin with the trocar</td>
</tr>
<tr>
<td>J3</td>
<td>Advance trocar beneath the skin about 5.5 cm from incision to the correct mark near the handle of the trocar; remove the plunger when the trocar is advanced to the correct mark</td>
</tr>
<tr>
<td>J4</td>
<td>Load an implant into the trocar with tweezers or forceps; push the implant gently with the plunger to the tip of the trocar</td>
</tr>
<tr>
<td>J5</td>
<td>Hold the plunger steady and pull the trocar back along it until it touches the handle of the plunger</td>
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<tr>
<td>J6</td>
<td>Date</td>
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<tr>
<td>J7</td>
<td>Withdraw the trocar only to the mark closest to its tip (before inserting subsequent implant)</td>
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<tr>
<td>J8</td>
<td>Insert second implant at the side of the first one to form a V shape (about 15° apart)</td>
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<tr>
<td>J9</td>
<td>Fix the position of first rod with forefinger while advancing the trocar along the side of the finger to insert the second rod</td>
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<tr>
<td>J10</td>
<td>Withdraw trocar and plunger after completion of the insertion</td>
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**K Follow below for one-rod implant procedures (Implanon)**

| K1 | Hold applicator in upward position and confirm presence of Implanon |
| K2 | Stretch skin around insertion site with thumb and index finger; insert tip of the trocar at 20 degrees and release the skin |
| K3 | Lower applicator to horizontal position and lift skin with the tip of the trocar to keep it sub-dermal; gently insert trocar while tenting skin |
| K4 | Break seal of the applicator |
| K5 | Turn the obturator to 90° and fix it with one hand against the arm; slowly retract trocar out of the arm. |
| K6 | Check for the absence of implant from trocar; palpate the arm to confirm presence |

**Both implants continue as follows**

| L | Press edges of the incision together; close incision with a sterile skin closure (e.g., elastoplasts) |
| M | Cover incision area with compress and wrap gauze around the arm to ensure haemostasis |
| N | Apply elastoplasts on the incision site |
| O | Observe the client for a few minutes before discharge |
| P | Place trocar, plunger (if not disposable) and tweezers in 0.5% chlorine solution for 10 minutes for decontamination before cleaning |
| Q | Dispose needles and syringes in a puncture-proof container |
| R | Remove towels or drapes; place in 0.5% chlorine solution for 10 minutes before cleaning them |
| S | Dispose of waste materials properly |
| T | Dispose of gloves in leak-proof container or plastic bag |
| U | Wash hands with soap and running water; dry them |
| V | Instruct client regarding wound care including what to do if any problems occur; answer questions. |
| W | Inform client implant can be removed at any time |
| X | Ask client to remove the top bandage after 24 hrs and to return after seven days for follow-up; give her a return date for follow-up visit |
| Y | Complete client record file and Daily Activity Register |

**Removal**

<p>| A | Offer pre-removal counselling (seek for reason for removal and address any concerns); confirm removal |
| B | Offer a different method and/or conduct BCS+ counselling as necessary to select another method, if client desires |
| C | Describe the removal procedure; prepare the client. |
| D | Confirm location of implant/s on user card; locate implant/s by palpation and mark the distal end |
| E | Wash hands with soap and running water and dry hands; don sterile gloves |
| F | Clean site with antiseptic solution and drape the arm |
| G | Give anaesthesia (1 ml at the incision sites) and add as necessary up to 6 ml local anaesthesia |</p>
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<tr>
<td>H</td>
<td>Make a 2mm incision at the distal end of the implant longitudinally</td>
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<tr>
<td>I</td>
<td>Gently push implant from proximal side towards incision until tip visible</td>
</tr>
<tr>
<td>J</td>
<td>Grasp the implant/s with forceps (preferably mosquito); pull it out and show it to the client</td>
</tr>
<tr>
<td>K</td>
<td>If re-inserting implants, insert new set of through the same incision site but on the opposite direction (refer to insertion procedure above)</td>
</tr>
<tr>
<td>L</td>
<td>Close the incision with a butterfly closure</td>
</tr>
<tr>
<td>M</td>
<td>Apply sterile gauze with a pressure badge to prevent bleeding</td>
</tr>
<tr>
<td>N</td>
<td>If not re-inserting implant, dispose the material, decontaminate the instrument and the table properly</td>
</tr>
<tr>
<td>O</td>
<td>Remove gloves, wash hands, dry them</td>
</tr>
<tr>
<td>P</td>
<td>Offer/refer client for other health services as appropriate e.g., pre-conception counselling</td>
</tr>
<tr>
<td>Q</td>
<td>Record information in client’s file and the daily activity</td>
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**TOTAL SCORE ON SECTION 7**

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### SECTION 8: IUD Insertion and Removal

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<tr>
<td>A</td>
<td>Screen woman to ensure that she is eligible for IUD</td>
</tr>
<tr>
<td>B</td>
<td>Provide education and counselling about procedure</td>
</tr>
<tr>
<td>C</td>
<td>Ask client to empty bladder, wash perineum with soap and water, and remove clothes below waist</td>
</tr>
<tr>
<td>D</td>
<td>Position the client in lithotomy position; drape the client.</td>
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<tr>
<td>E</td>
<td>Remind client to let you know if she feels any pain</td>
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<tr>
<td>F</td>
<td>Wash hands and don gloves</td>
</tr>
<tr>
<td>G</td>
<td>Inspect external genitalia</td>
</tr>
<tr>
<td>H</td>
<td>Insert speculum to inspect vagina and cervix</td>
</tr>
<tr>
<td>I</td>
<td>Perform cervical cancer screening, if desired (refer to appropriate section of Checklist)</td>
</tr>
<tr>
<td>J</td>
<td>Swab the cervix</td>
</tr>
<tr>
<td>K</td>
<td>Gently grasp the cervix with tenaculum</td>
</tr>
<tr>
<td>L</td>
<td>Sound the uterus using no touch technique</td>
</tr>
<tr>
<td>M</td>
<td>Remove the uterine sound using the spongy holding forceps; read the measurement</td>
</tr>
<tr>
<td>N</td>
<td>Load IUD inside the pack and align the uterine measurement according to the guidelines</td>
</tr>
<tr>
<td>O</td>
<td>Insert the loaded IUD into the uterine fundus</td>
</tr>
<tr>
<td>P</td>
<td>Withdraw the inserter tube to release the IUD; remove plunger</td>
</tr>
<tr>
<td>Q</td>
<td>Gently push the inserter tube to the fundus. Remove the inserter tube</td>
</tr>
<tr>
<td>R</td>
<td>Use Mayo scissors to cut strings 3–4 cm from cervical opening</td>
</tr>
<tr>
<td>S</td>
<td>Remove tenaculum and examine cervix for bleeding; use disinfected forceps to place cotton on affected tissue for 30–60 seconds</td>
</tr>
<tr>
<td>T</td>
<td>Remove speculum. Inform the client that the procedure is over</td>
</tr>
<tr>
<td>U</td>
<td>Give the client a sanitary pad. Allow woman to rest</td>
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<tr>
<td>V</td>
<td>Immerse all equipment in 0.5% chlorine solution for 10 minutes before washing and rinsing</td>
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<tr>
<td>W</td>
<td>Remove gloves and dispose of them in leak proof container</td>
</tr>
<tr>
<td>X</td>
<td>Wash hands with soap and running water and dry them</td>
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<tr>
<td>Y</td>
<td>Record information on clients file, booklet, and the daily activity register</td>
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</tbody>
</table>
Z Discuss with client how to check for possible expulsion  
AA Discuss danger signs and what to do  
BB Discuss duration of effectiveness  
CC Discuss the fact that IUD does not protect from STI/RTI/HIV and the importance of dual method  
DD Remind the client that IUD can be removed anytime  
EE Inform client of follow-up schedule and return date (one month after next menses and then yearly)  
FF Issue the client a follow-up IUD reminder card  

IUD Removal  
GG Offer pre-removal counselling (seek for reason for removal and address any concerns); confirm removal.  
HH Offer a different method and/or conducting BCS+ counselling as necessary to select another method, if client desires  
II Describe the removal procedure; prepare the client.  
JJ Ask the client to empty the bladder  
KK Wash hands and dry them according to the guidelines  
LL Wear a pair of gloves; if IUD re-insertion, wear two pairs of gloves  
MM Remind client to let you know if she feels pain  
NN Insert speculum; swab the cervix three times with antiseptic solution  
OO Hold and pull IUD strings using controlled traction; when completely out, show the client and remove the speculum  
PP If removal is difficult, stop procedure and seek guidance on managing difficult removals  
QQ Place IUD in 0.5% chlorine solution.  
RR If re-inserting IUD, remove speculum and conduct insertion with new speculum (refer to insertion procedure above)  
SS If not re-inserting IUD, dispose of all materials, decontaminate the instruments and the couch  
TT Perform bimanual examination  
UU Remove gloves, wash hands and dry them  
VV Allow woman to rest  
WW Offer a different method and/or conduct BCS+ counselling as necessary to select another method, if client desires  
XX Offer/refer client for other health services as appropriate e.g., pre-conception counselling  
YY Record information on client’s file and the daily activity  

TOTAL SCORE ON SECTION 8
# SECTION 9: Referral and Service Linkages

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**A** Demonstrate ability to identify indications for referral

**B** Fill out necessary documents, records and referral forms

**C** Clarify with the client the reason, urgency and importance of referral

**D** Clearly explain the reason for referral using simple language

**E** Listen and address client’s concerns appropriately

**F** Organize the necessary referrals logistics (transport, communication, escort support as appropriate)

**G** Explain to the client the expectations of services at referral site, including cost of services and distance to the site.

**H** Give the client the necessary documents/instructions

**I** Seek referral feedback from client using client cards and/or seek feedback from the institution via formal communications between sites

**J** Document referral feedback appropriately and in the correct log

**Receiving a referred client**

**K** Demonstrate courtesy, welcoming and making client comfortable

**L** Receive and review referral documents

**M** Respond to client’s needs according to urgency and priority

**N** Clarify client’s understanding of reason for referral

**O** Respond to any concerns and provide emotional support

**P** Explain procedures and exams to be undertaken.

**Q** Explain costs and payments, if any, associated with procedures

**R** Provide services

**S** Document appropriately

**TOTAL SCORE ON SECTION 9**

**TOTAL COMPREHENSIVE SCORE ON ALL 9 SECTIONS**
Overall Findings and Feedback from Skills Assessment Checklist

a) Overall findings on mentee’s performance

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b) Main gaps identified by the mentor

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c) Mentee’s response on the gaps identified

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d) Mutually agreed Plan of Action to address identified gaps and priority areas

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MENTEES’ SIGNATURE_________________________________________ Date __________

MENTOR’S SIGNATURE __________________________ Date __________
This log intends to document practice competencies of the mentee’s clinical skills within the Mentorship Programme. After the mentor demonstrates each activity and the mentee is ready to practice with patients, he/she will use this Log Book to document his/her practice sessions with real clients.

### With each patient interaction, the following quality improvement issues should be observed:

- The mentor and the mentee should demonstrate professionalism in all undertakings and appropriate communication
- Appropriate infection prevention procedures must be demonstrated in the clinical skills
- Respect for clients rights should be observed at all times
- Policies and guidelines should be adhered to as appropriate
- Documentation and recordkeeping are mandatory including appropriate referral notes and protocol
- Supportive supervision for should be provided during each practice session

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**PELVIC EXAM**

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**CERVICAL CANCER SCREENING**

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**POSTPARTUM/POSTNATAL CARE**

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**IMPLANTS INSERTION**

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**IMPLANTS REMOVAL**

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| 4  |             |               |     |     |      |         |                |                 |                  |
| 5  |             |               |     |     |      |         |                |                 |                  |
| 6  |             |               |     |     |      |         |                |                 |                  |
| 7  |             |               |     |     |      |         |                |                 |                  |
| 8  |             |               |     |     |      |         |                |                 |                  |
| 9  |             |               |     |     |      |         |                |                 |                  |
| 10 |             |               |     |     |      |         |                |                 |                  |

**IUD INSERTION**

|    |             |               |     |     |      |         |                |                 |                  |
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**IUD REMOVAL**

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<th>Sex</th>
<th>Date</th>
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<th>Plan of Action</th>
<th>Contact Minutes</th>
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**BALANCED COUNSELLING STRATEGY PLUS**

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**HIV TESTING & COUNSELLING**

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**REFERRAL AND SERVICE LINKAGE**

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ANNEX 4  Mentorship Programme Evaluation Form

At the end of the Mentorship Programme, mentees should complete this form. Mentees’ names do not need to be given—this evaluation is anonymous—and forms will not be reviewed until the Mentorship Programme is complete.

Site ____________________________________________________________

Mentor’s name __________________________________________________

Mentorship duration _____________________________________________

Date of evaluation ______________________________________________

Please mark the box that most appropriately indicates the extent to which you agree or disagree.

<table>
<thead>
<tr>
<th></th>
<th>Strongly Agree</th>
<th>Agree</th>
<th>Neutral</th>
<th>Disagree</th>
<th>Strongly Disagree</th>
</tr>
</thead>
<tbody>
<tr>
<td>The mentorship course met my expectations</td>
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<tr>
<td>The content of the course was relevant to my needs</td>
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<tr>
<td>The training materials are relevant to my needs</td>
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<tr>
<td>The course organization helped me learn</td>
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<tr>
<td>I expect to use the skills gained from this mentorship by mentoring others</td>
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<tr>
<td>I would recommend this mentorship course to others</td>
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</table>

Three things I liked about the mentorship reference materials are:

________________________________________________________________________

________________________________________________________________________

________________________________________________________________________
Three things which I did not like about the mentorship course:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Things I would like to see changed about the mentorship course:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

Now that you have completed this mentorship course, what I plan to do next:

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________

__________________________________________________________________________________________
<table>
<thead>
<tr>
<th>Name</th>
<th>DESIGNATION / ORGANIZATION</th>
<th>EMAIL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Dr Issak Bashir</td>
<td>Head, DRH MOPHS</td>
<td><a href="mailto:drbashirim@yahoo.com">drbashirim@yahoo.com</a></td>
</tr>
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<td>2. Dr Shiprah Kuria</td>
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<tr>
<td>3. Betty Chepkwony</td>
<td>NASCOP</td>
<td><a href="mailto:f.chepkwony@yahoo.com">f.chepkwony@yahoo.com</a></td>
</tr>
<tr>
<td>4. Bernard M. Nyakundi</td>
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<td><a href="mailto:bnyakundi_2003@yahoo.com">bnyakundi_2003@yahoo.com</a></td>
</tr>
<tr>
<td>5. Jane M. Kanja</td>
<td>DTC-Nakuru</td>
<td><a href="mailto:janemumbi58@yahoo.com">janemumbi58@yahoo.com</a></td>
</tr>
<tr>
<td>6. Bellita Musau</td>
<td>Machakos DMOH</td>
<td><a href="mailto:bellincs@yahoo.com">bellincs@yahoo.com</a></td>
</tr>
<tr>
<td>7. Assumpta Matekwa</td>
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<tr>
<td>10. Ruth Muia</td>
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</tr>
<tr>
<td>11. Averie Baird</td>
<td>LSHTM</td>
<td><a href="mailto:averie.baird@gmail.com">averie.baird@gmail.com</a></td>
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<tr>
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</tr>
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<td>13. Ruth Maithya</td>
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<td><a href="mailto:ruth.maithya@amref.org">ruth.maithya@amref.org</a></td>
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<td>14. Dr Rose Masaba</td>
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</tr>
<tr>
<td>15. Joyce Lavussa</td>
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<td><a href="mailto:lavussaj@ke.afro.who.int">lavussaj@ke.afro.who.int</a></td>
</tr>
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<td>16. Purity Karimi</td>
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</tr>
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<td>25. Charlotte Warren</td>
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<td>26. Wilson Liambila</td>
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<td><a href="mailto:wliambila@popcouncil.org">wliambila@popcouncil.org</a></td>
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<tr>
<td>27. Edwin Odoyo</td>
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<td>29. Agnes Gichoho</td>
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<td>30. Irene Kasyoki</td>
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</tr>
<tr>
<td>31. Dr Muraya Joram</td>
<td>PASCO MOPHS-Central</td>
<td><a href="mailto:Muraya30@gmail.com">Muraya30@gmail.com</a></td>
</tr>
<tr>
<td>32. Dr Marsden Solomon</td>
<td>RH Advisor FHI360</td>
<td><a href="mailto:msolomon@fhi360.org">msolomon@fhi360.org</a></td>
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<tr>
<td>33. Jones N. Abisi</td>
<td>Senior Tech Officer FHI360</td>
<td><a href="mailto:jabisi@fhi360.org">jabisi@fhi360.org</a></td>
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<td>34. Dr Fred Akonde</td>
<td>OBG.GYNE Marie Stopes – Kenya</td>
<td><a href="mailto:Fred.akonde@mariestopes.or.ke">Fred.akonde@mariestopes.or.ke</a></td>
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Integra
Strengthening the evidence base for integrating HIV and SRH services

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