PARTICIPANTS' HANDBOOK

TRAINING IN FAMILY PLANNING COUNSELLING FOR ALTERNATIVE HEALTH WORKERS

NATIONAL FAMILY PLANNING BOARD

OF JAMAICA

WITH ASSISTANCE FROM

THE ASSOCIATION FOR VOLUNTARY SURGICAL CONTRACEPTION

AND THE

UNITED STATES AGENCY FOR INTERNATIONAL DEVELOPMENT

1994

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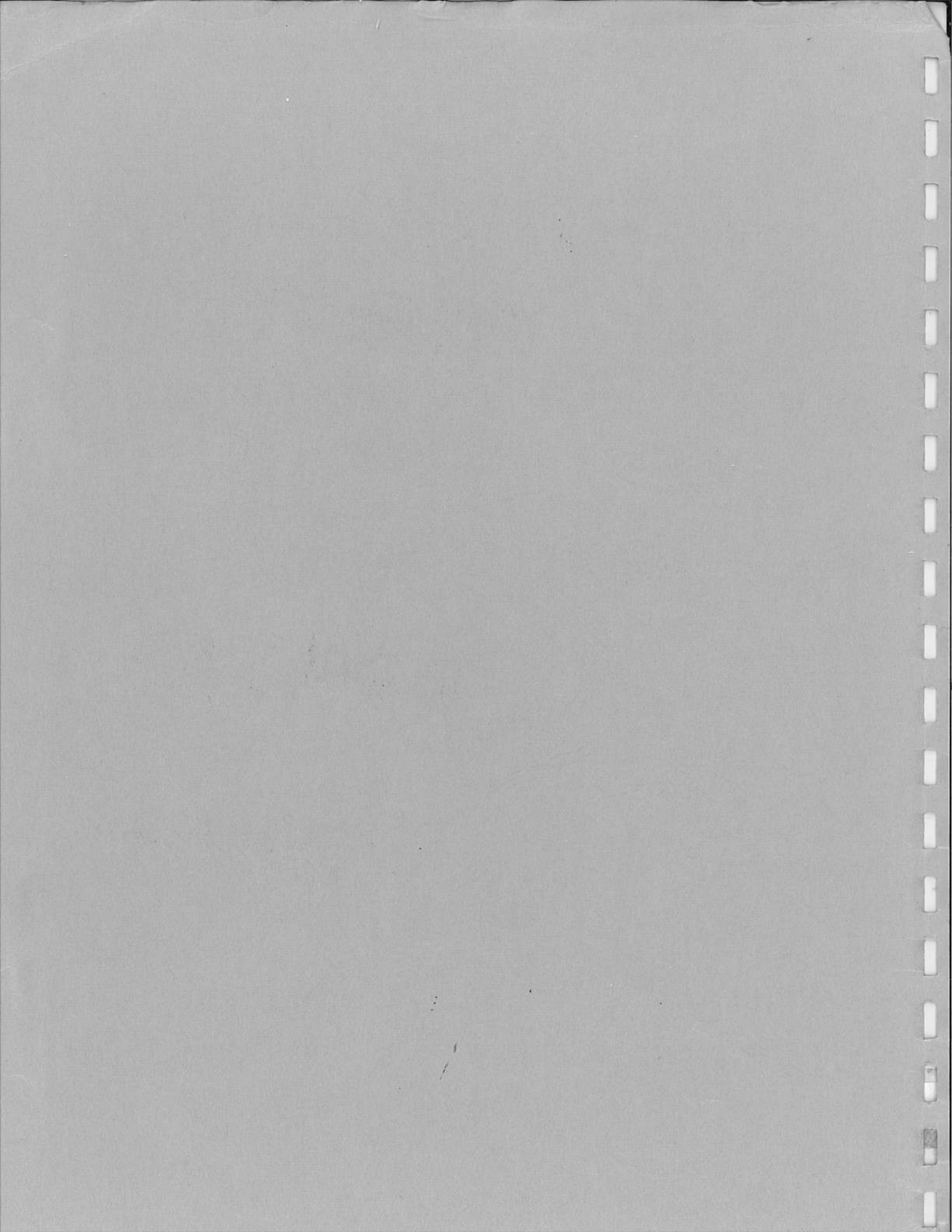

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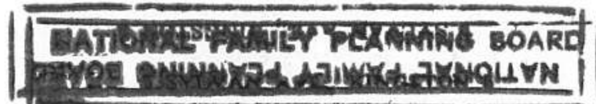

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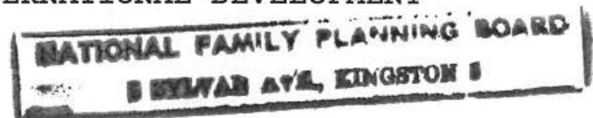

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PARTICIPANTS' HANDBOOK

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RIGHTS OF THE FAMILY PLANNING CLIENT

Every family planning client has the right to:

1.	*Information:*	To learn about the benefits and availability of family planning.
2.	*Access:*	To obtain services regardless of sex, creed, color, marital status, or location.
3.	*Choice:*	To decide freely whether to practice family planning and which method to use.
4.	*Safety:*	To be able to practice safe and effective family planning.
5.	*Privacy:*	To have a private environment during counselling or services.
6.	*Confidentiality:*	To be assured that any personal information will remain confidential.
7.	*Dignity:*	To be treated with courtesy, consideration, and attentiveness.
8.	*Comfort:*	To feel comfortable when receiving services.
9.	*Continuity:*	To receive contraceptive services and supplies for as long as needed.
10.	*Opinion:*	To express views on the services offered.

Source: International Planned Parenthood Federation. Rights of the client. London: 1992.

WORKSHEET:

THREE KINDS OF FAMILY PLANNING COMMUNICATION

Read each case. Decide whether it describes (M) motivation, (I) information-giving, or (C) counselling. Write the letter of your response on the line.

______1. A health care worker asks a woman, who expresses interest in voluntary sterilization, when she decided that she did not want more children.

______2. A maternity nurse tells a mother who has just delivered a baby that this is the right time to consider having her tubes tied so that she will not have to worry about becoming pregnant again.

______3. A doctor in the postpartum hospital ward discusses various family planning methods and tells how each one works.

______4. A social worker in a hospital tells a woman who is seeking an abortion that she needs to have an IUD inserted.

______5. A nurse meets with a woman who expresses concerns about irregular bleeding following an insertion of NORPLANT. The nurse reassures her that the bleeding is normal and will probably diminish over time.

______6. A doctor responds to the client's concern about vasectomy by explaining that his sexual ability will not be negatively affected by the operation.

______7. A field worker explains to his clients how to take the pill and what to do if they forget one.

______8. A doctor checks that a woman has reached an informed decision by reviewing with the client her reasons for wanting a sterilization.

______9. A nurse shows a film to women waiting for their prenatal visits and gives a brief talk about postpartum contraception.

______10. A supervisor in a factory tells male workers that they need to use condoms.

______11. A nurse talks to clients about NORPLANT, the IUD, and permanent methods only, since these are the most effective methods.

PERSONAL QUALITIES NEEDED FOR FAMILY PLANNING COUNSELLING

* Desire to work with and help people
* Belief in the value of family planning
* Respect for people and for their right to make decisions for themselves
* Comfort with discussing human sexuality
* Comfort with the expression of feelings
* Self-awareness of one's values and limitations
* Unbiased attitudes towards different population groups (for example, individuals of different age, ethnicity, religion, race, class, education, or gender)
* Tolerance for values that differ from one's own
* Empathy for clients
* Supportive attitude towards clients
* Ability to maintain confidentiality
* Unbiased attitudes towards various family planning methods
* Professionalism

SKILLS NEEDED FOR FAMILY PLANNING COUNSELLING

* Create a comfortable atmosphere for the client
* Present information clearly
* Encourage questions
* Listen and observe attentively
* Ask questions to encourage the client to share information and feelings
* Guide the counselling interaction
* Speak the client's language

KNOWLEDGE NEEDED FOR FAMILY PLANNING COUNSELLING

About contraception:

* Reproductive anatomy and physiology
* Common myths, rumours, and misconceptions about family planning
* Contraceptive technology: how the methods work, advantages, disadvantages, Instructions for clients about how to use each method correctly and safely, and how to handle side effects or complications
* How to prevent the spread of sexually transmitted diseases, including HIV infection

About family planning counselling:

* Purpose of counselling: To help clients make informed and voluntary decisions regarding their reproductive life
* Distinctions between counselling, information-giving, and motivation
* Special counselling needs of clients, including those considering permanent methods, women in the perinatal period, and STD prevention

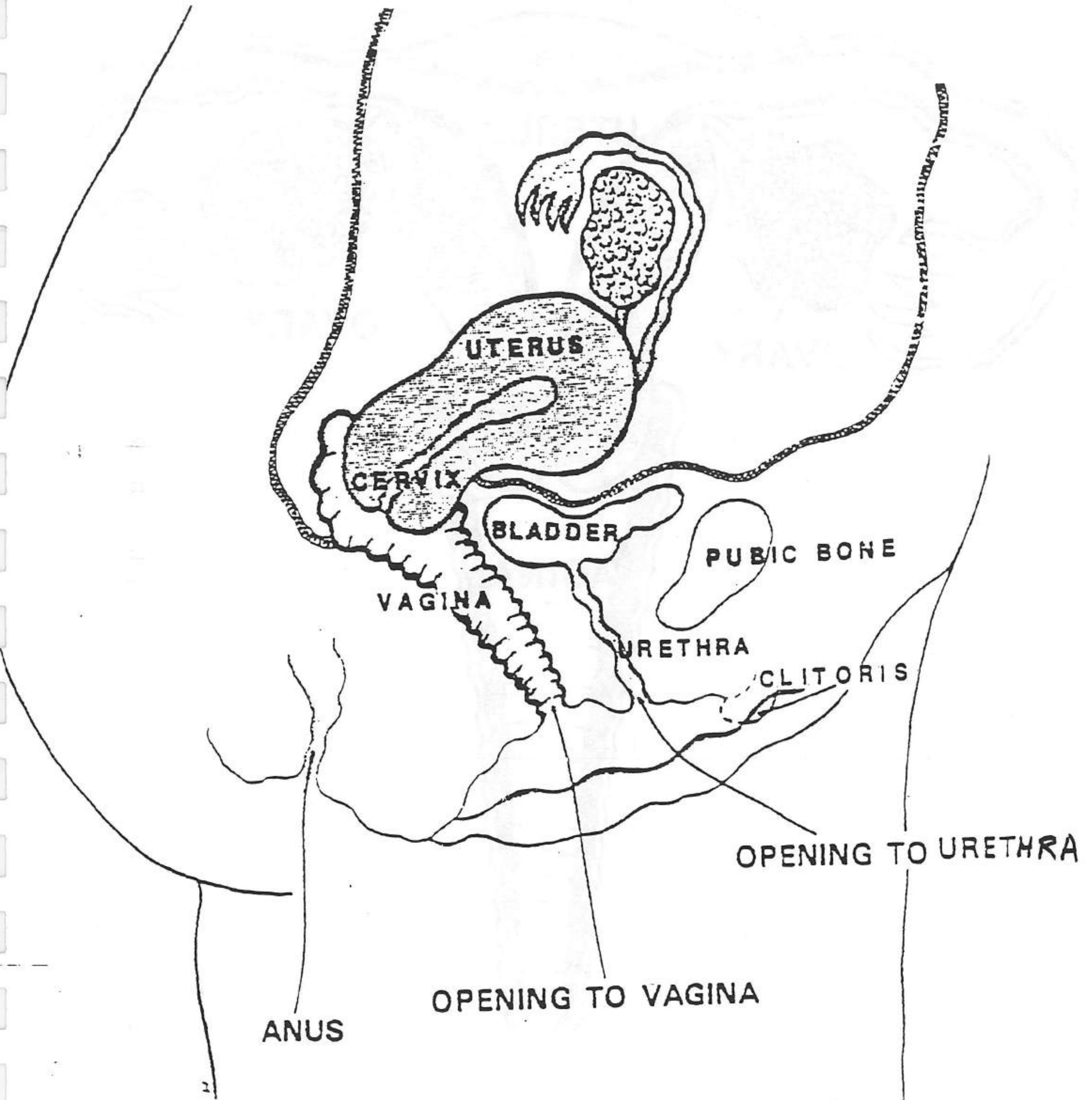
About the clients:

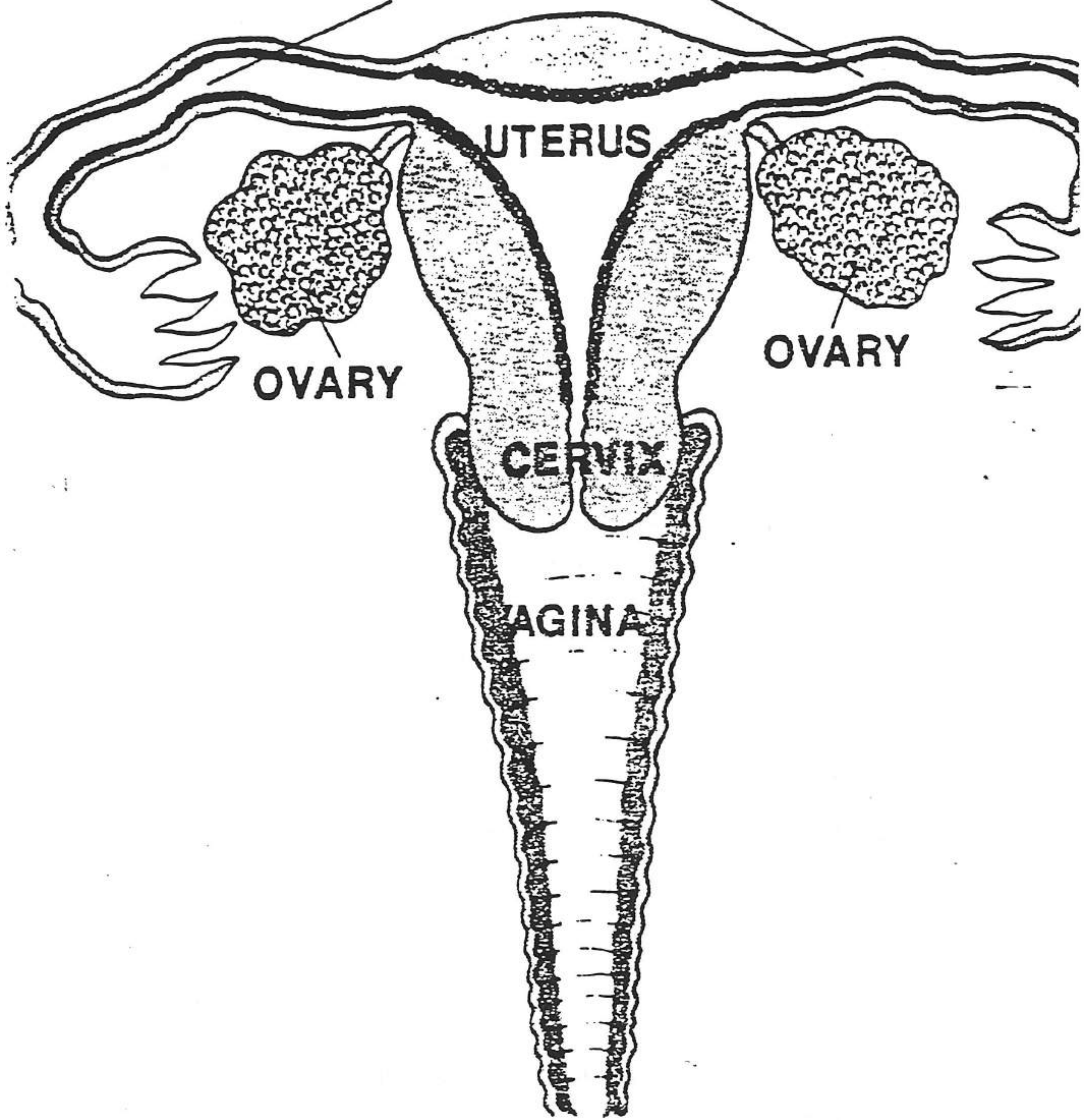
* Local culture, including sexual norms and practices
* How clients reach decisions on family planning and the influences on those decisions
* Factors inhibiting successful contraceptive use

About family planning services:

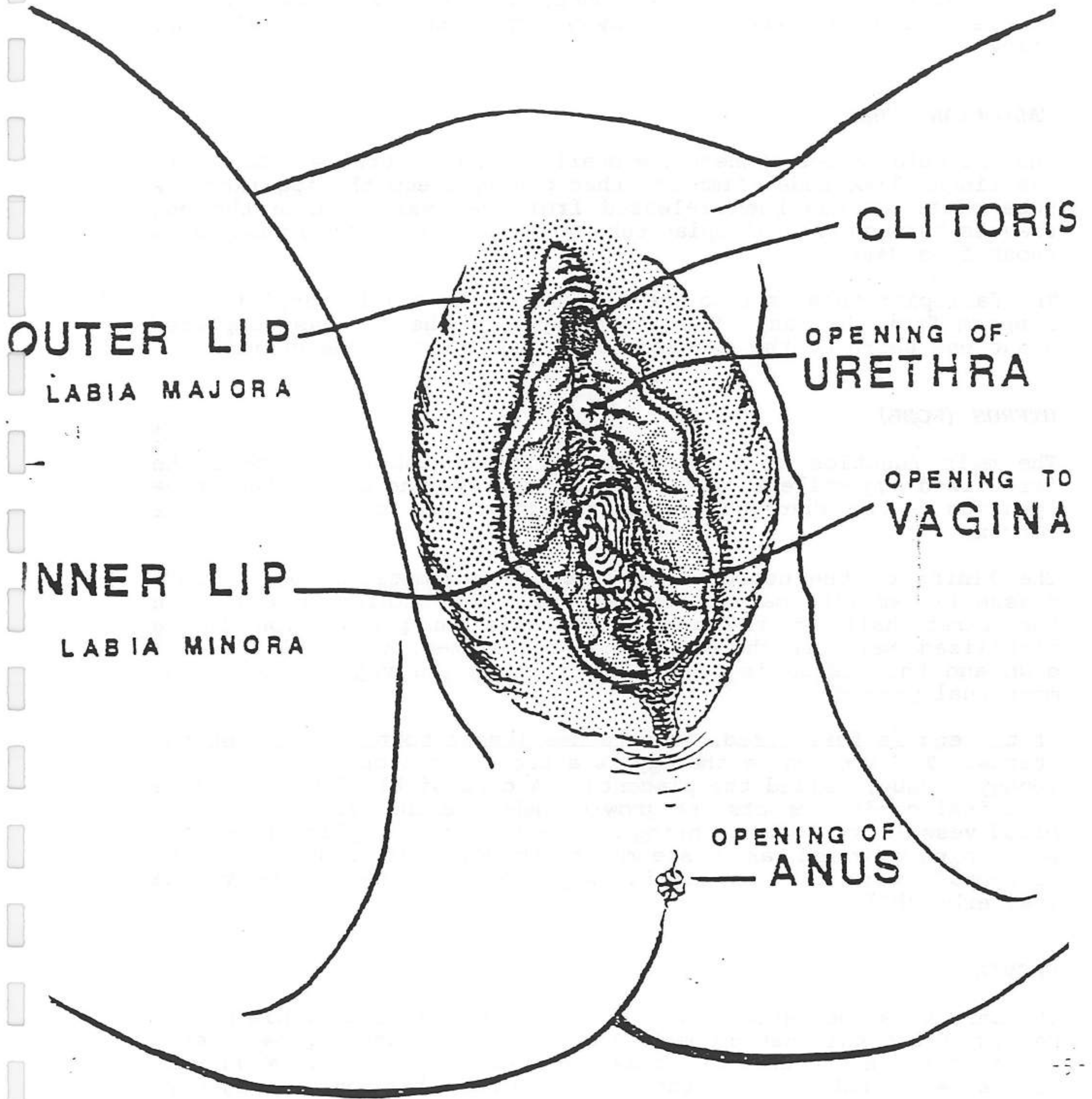
* Policies and procedures of the service site, including client eligibility and record-keeping
* Referral networks and procedures
* Government policies and laws regarding family planning

THE FEMALE REPRODUCTIVE SYSTEM




FALLOPIAN TUBES
UTERUS
OVARY
OVARY
CERVIX
VAGINA

THE VULVA



OVARIES

There are two ovaries, one on each side of the uterus near the open end of each fallopian tube. Ovaries store eggs and produce reproductive hormones. Each month, an egg leaves one of the ovaries and enters into the nearby fallopian tube. (see Ovulation, below)

FALLOPIAN TUBES

The fallopian tubes connect the ovaries with the uterus. Each tube has finger-like ends (fimbria) that gently sweep the egg into the tube after it has been released from the ovary. Then the egg travels through the fallopian tube to the uterus, a trip that takes about five days.

The fallopian tube is also the site where the egg is fertilized by a sperm from the man. When that happens, the egg has completed about one third of the distance from the ovary to the uterus.

UTERUS (WOMB)

The main function of the uterus is to nourish and protect the fertilized egg while it develops into a baby. The uterus has three openings -- two where the fallopian tubes come in, and one at the cervix.

The lining of the uterus is called the endometrium; it is soft tissue filled with many blood vessels. This lining builds up in the first half of the menstrual cycle in preparation for a fertilized egg. If the egg is not fertilized, the lining breaks down and the tissue is passed out through the vagina during the menstrual period.

If the egg is fertilized, it attaches itself to the lining of the uterus. The area where the egg is attached develops into a thick, spongy tissue, called the placenta. A cord of blood vessels (the umbilical cord) connects the growing baby and the placenta. These blood vessels are able to bring nutrients from the placenta to the developing baby and take waste materials away. After delivery, the placenta's work is done and it is pushed out through the vagina ("afterbirth").

CERVIX

The cervix is the narrow neck of the uterus. In the middle of the cervix is a canal that connects the uterus with the vagina. Sperm travel through the cervical canal to reach the uterus. Menstrual discharge and babies leave the uterus through this same passageway.

VAGINA

The vagina is a tube that connects the uterus with the outside of the body. When it is empty, it has no inner space at all. Except for the tiny cervical canal opening, the vagina is a dead-end passageway. This is important for clients to know, since it means that there is no way for tampons, condoms, or contraceptive sponges can get "lost" in the vagina or travel into the rest of the body.

Sperm are released from the man's penis in the vagina during sexual intercourse. Menstrual blood and babies pass through the vagina.

VULVA

The area around the opening of the vagina is called the vulva. There are folds of skin which can be seen from outside. The outer folds are called "labia majora"; they are thick, contain fat and sweat glands, and are covered with hair. The inner folds are called "labia minora" and are thinner. Between the labia minora are the clitoris, the opening of the urethra, and the opening of the vagina. The clitoris is a small organ which is sensitive to touch, gets larger during sexual intercourse (like the penis), and gives pleasurable feelings when stimulated. The labia minora form a hood over the clitoris. The opening of the urethra (the tube that carries urine from the bladder) is just below the clitoris, and the opening of the vagina is below that.

MENSTRUAL CYCLE

The time from the start of one menstrual period to the beginning of the next is called the "menstrual cycle". For most women the menstrual cycle is about 28 days long, but it is also normal for some women to have cycles as short as 21 days or as long as 35. The length of the menstrual cycle can also change from month to month for any individual woman.

During the menstrual cycle, an egg is prepared for release from the ovary. At the same time, the lining of the uterus becomes thicker to make a "nest" for the egg in case it is fertilized. If not, the egg and the lining are passed from the uterus through the vagina; and the whole cycle starts again.

All the steps in the menstrual cycle are coordinated by female hormones (estrogen and progesterone) produced in the ovaries and released into the bloodstream.

OVULATION

When an egg is released from an ovary, this is called "ovulation". Usually one egg is released each month. The ovaries take turns with ovulation -- one month the egg will be released from one ovary, and the next month from the other, and so on. Ovulation happens at about the middle of the woman's menstrual cycle. Fourteen days later, the woman's menstrual period will start if the egg is not fertilized.

FERTILIZATION

The egg must be fertilized within 24 hours after being released from the ovary. Only one sperm, out of the millions deposited by the man, will be able to penetrate the egg. This happens in the fallopian tube, about one-third of the distance to the womb. The fertilized egg continues its trip to the womb and attaches itself to the lining of the uterus (see Uterus, above).

MENSTRUATION

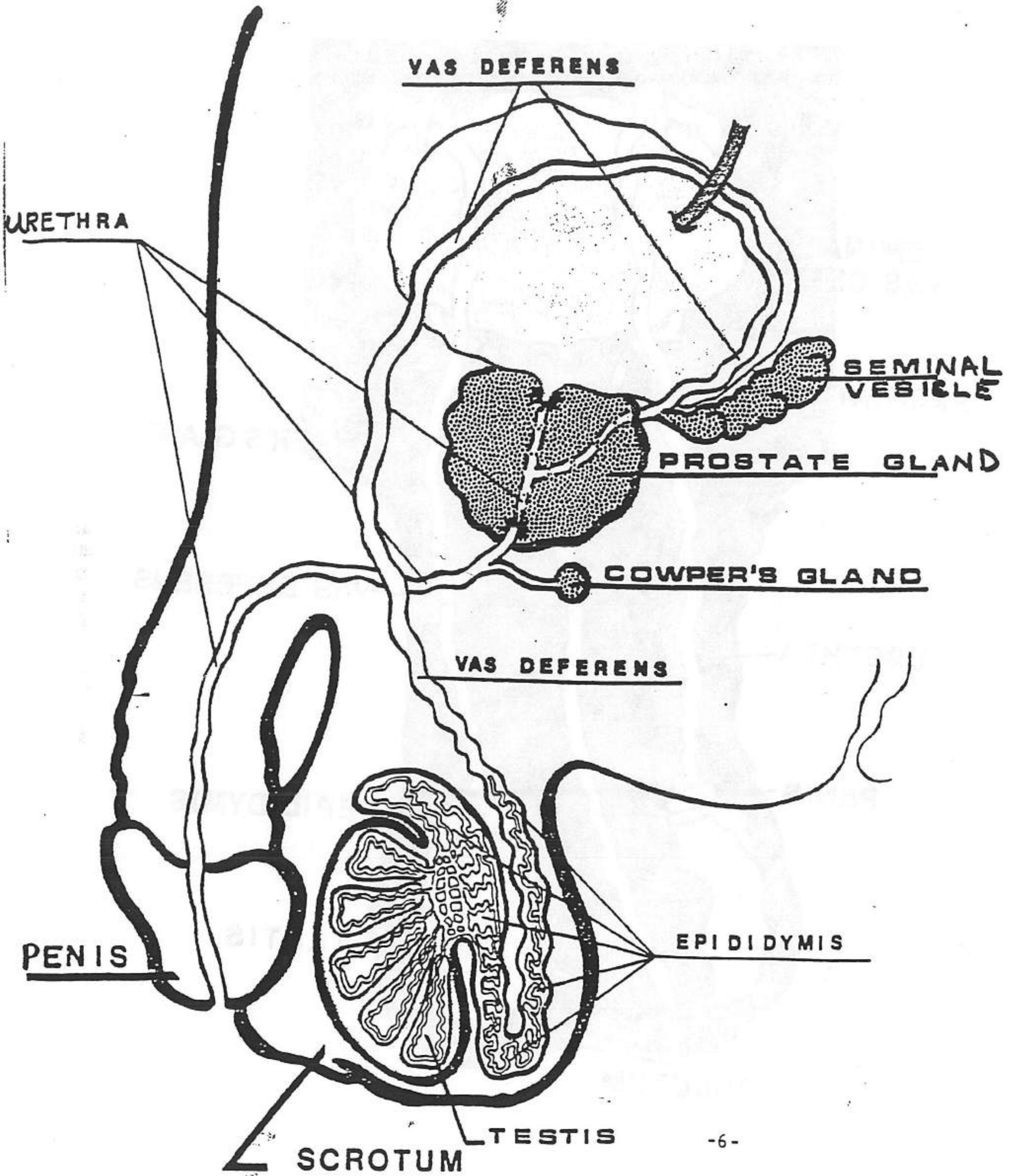
If the egg is not fertilized, the lining of the uterus breaks down. The blood and tissue are passed through the cervical canal and the vagina. The muscles in the walls of the uterus contract to push out the unneeded lining -- some women feel these contractions as menstrual cramps. The sight of this blood and tissue coming from the vagina is called the "menstrual period". The length of each period is usually three to five days, but it varies from woman to woman and from month to month for an individual woman.

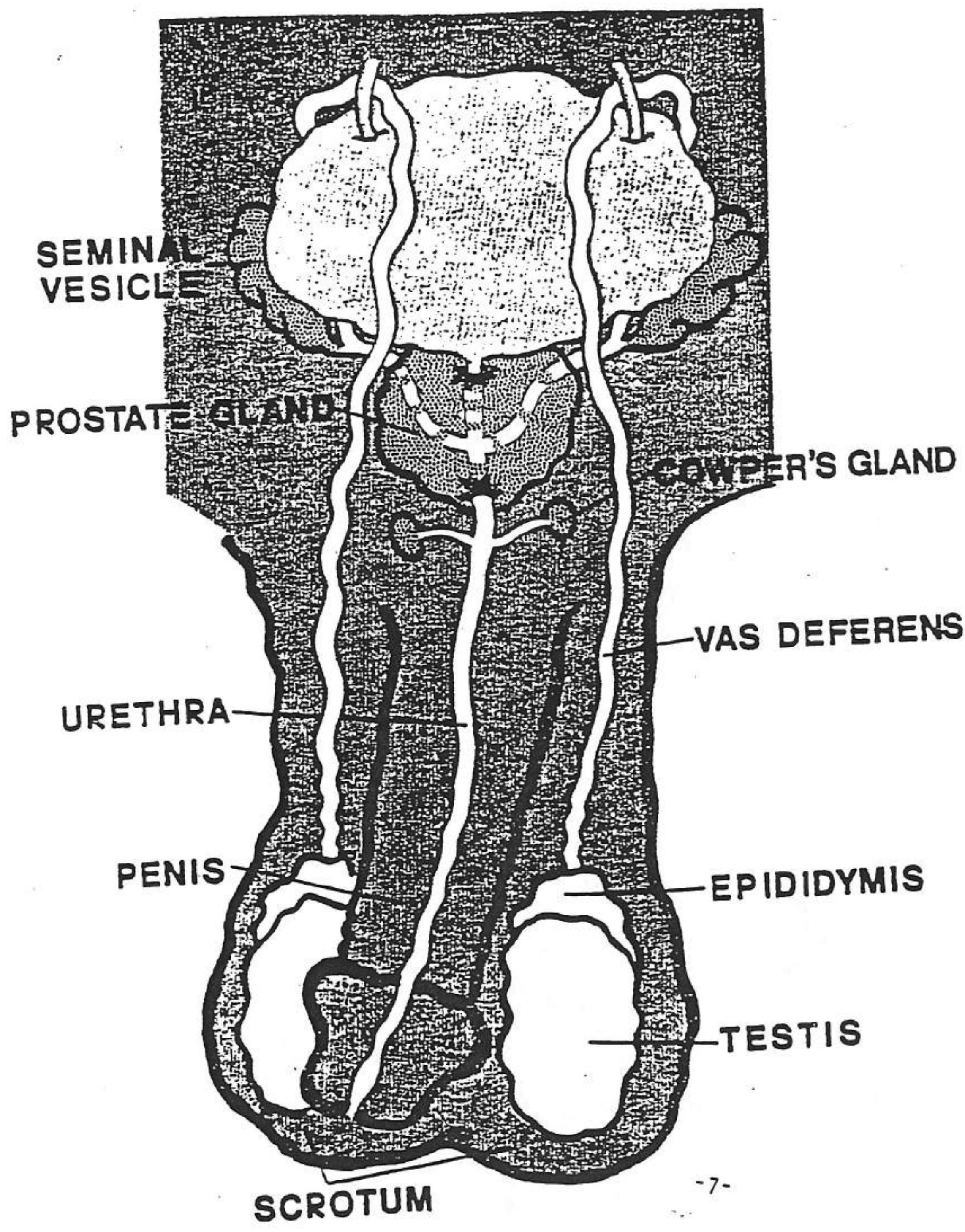
The first menstrual period is usually between the ags of 12 and 15; but it is normal for some girls to start as early as 9 or as late as 17 or 18.

MENOPAUSE

After 30 to 40 years of menstruating, the woman's ovaries stop releasing eggs and reduce the level of hormone production. This happens gradually, with the woman noticing changes in her menstrual cycle, until she stops having periods altogether. The complete end of menstrual periods is called "menopause" and usually occurs between the ages of 40 to 50.

THE MALE REPRODUCTIVE SYSTEM





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SCROTUM

The scrotum is the sack of skin that holds the man's two testicles (balls).

TESTICLES

Each testicle produces two things -- sperm and male hormones. Sperm are the seeds that fertilize the female egg. Hormones are chemicals that give the man masculine characterics (such as muscle tone, body hair, beard, and deep voice) and sex drive. Sperm leave the testicles through the epididymis. The hormones are released directly into the blood.

EPIDIDYMIS

The epididymis is a tube that leads from each testicle to the vas deferens. The epididymis provides an environment in which the sperm develop the ability to swim and fertilize eggs.

VAS DEFERENS

The vas deferens are long thin tubes that transport sperm from each testicle to the glands that produce semen (the fluid that comes out during sex). The vas deferens start in the scrotum and go up into the abdomen and around the urinary bladder. Then they meet with the tubes that come from the seminal vesicles. Sperm leave the epididymis and swim through the vas deferens in preparation for ejaculation (discharge).

SEMINAL VESICLES

There are two seminal vesicles. These are small glands located near the base of the urinary bladder. They produce a liquid that nourishes the sperm.

The sperm from the vas deferens are mixed with the fluid from the seminal vesicles in a small duct. Although a man releases hundreds of millions of sperm during discharge, these sperm are so small that they make up only two to five percent of the volume of semen (the fluid that is discharged during sex). Most of the semen comes from the seminal vesicles.

PROSTATE GLAND

The prostate gland is at the base of the bladder. It produces a fluid that protects the sperm against the natural acid in the woman's vagina. The two ducts from the seminal vesicles enter into the prostate gland, where the seminal fluid and sperm mix with the prostate fluid. The final product (semen) is released into the urethra, which carries the semen out of the man's body through the penis.

ERECTION AND EJACULATION

When a man feels sexual desire, the flow of blood into the penis increases and the flow of blood out decreases. The spongy tissue in the penis soaks up the extra blood, making the penis larger and harder. This is called erection.

When sexual desire reaches a peak (orgasm), the sperm are released from the epididymis, travel through the vas deferens, and mix with seminal fluid and prostate fluid to make semen. Muscle contractions around the urethra force the fluid out through the penis. This is called ejaculation (or "coming").

Sexual desire, erection, and ejaculation are all coordinated by the male hormones produced in the testicles.

BASIC INFORMATION ON CONTRACEPTIVE METHODS

SHORT-TERM METHODS

THE PILL

TELL

What it is: The woman takes the pill by mouth.

How it works: The pill, if taken every day, stops the egg from leaving the ovary every month.

Effectiveness: **If the pill is used correctly,** it is very effective. It is more effective than the IUD, condoms, or spermicides. If 100 typical women use pills for one year, three of them will get pregnant.

Advantages:

* Very effective.
* May protect against infections in the tubes and the womb.
* May protect against some forms of cancer.
* Does not interrupt lovemaking.
* Causes menstrual periods that are more regular, with less bleeding.

Disadvantages:

* May not be good for women over the age of 35 who smoke.
* The woman must remember to take a pill every day. If the woman misses taking the pill for two or more days, she may get pregnant.
* Side effects: Some women may have mild nausea, dizziness, headaches, spotting, weight gain, or tender breasts, especially during the first three months.
* Does not protect against HIV infection and other STD's.

HELP

Good method for a woman who:

* has heavy, painful menstrual periods
* has sex often
* would like to have children someday
* has a daily routine
* is anemic

Not the best method for the woman who:

* hates taking pills of any kind
* is forgetful
* lives at a great distance from a place where pills are available
* needs to hide the fact that she is using a contraceptive method

Should not be used by a woman who:

* is over 35 and smokes cigarettes
* is very fat
* has high blood pressure
* has diabetes
* has been breastfeeding for less than six weeks (unless minipill is available)
* has sickle-cell anemia
* has heart disease, blood clots, or cancer
* gets migraine headaches
* has abnormal vaginal bleeding
* has liver problems (eyes or skin that look yellow)

EXPLAIN

* Take one pill at the same time every day according to instructions.

* Take the first pill on the fifth day of the menstrual period.

* Some pill packets have 28 pills. If using the 28-pill packets, take one pill a day until the packet is empty, then start taking pills from a new packet the next day.

* Other pill packets have 21 pills. If using the 21-pill packets, take one pill a day until the packet is empty, then wait one week to start the new packet.

* If you forget to take one pill, take it as soon as you remember, even if it means taking two pills on one day.

* If you forget to take the pill on two or more days in a row, take two pills every day until you catch up. Also, use another method of family planning or else do not have sex until that packet of pills is finished.

* If you miss two or more menstrual periods, or if you miss a period after you forgot to take a pill, stop taking the pills and have a pregnancy test.

* Give instructions on how and where to get more pills, and where to go if the woman has problems. Describe the following signs of possible problems:

WARNING SIGNS: You should see your health care provider immediately if you have:

A: Abdominal pain
C: Chest pain or shortness of breath
H: Headaches that are severe
E: Eye problems -- blurred vision, double vision, partial blindness.
S: Severe leg pain.

HOW TO ANSWER MYTHS AND RUMOURS ABOUT THE PILL

MYTH: The Pill is a strong, dangerous drug. Using it can cause permanent damage to a woman.

RESPONSE: The Pill has been tested more extensively than any other drug. It is a safe, effective contraceptive method that has been used by millions of women. Very few have had any ill effects. In fact, statistics show that the Pill is safer than pregnancy and childbirth for most women. The hormone dosage in today's pill is much lower than in the original Pill from the 1950's.

MYTH: The Pill causes infertility.

RESPONSE: The Pill does not cuase infertility. After the woman stops using the Pill, conception may be delayed. However, this delay is usually not more than three months. Studies have shown that within 24 months, there is no difference between the rate of conception of women who used the Pill and women who did not.

MYTH: The Pill causes cancer.

RESPONSE: Many studies have been done on the Pill and cancer. None have shown that the Pill causes cancer. In fact, the Pill provides protection against two types of cancer: cancer of the ovary, and cancer of the endometrium (lining of the uterus).

MYTH: The Pill causes birth defects.

RESPONSE: Many studies have been done on this topic. There is no evidence that a child conceived during or after a mother's use of the Pill is more likely to be deformed than the average baby.

MYTH: The Pill will build up in the woman's body.

RESPONSE: Pills dissolve in a woman's stomach, just like other medicines that are swallowed.

CONDOMS

TELL

What it is: A condom is a thin sheath made of rubber.

How it works: The man puts the condom on his erect penis before he puts his penis inside the woman's vagina. A condom holds the semen so it does not pass into the woman's vagina. After the man ejaculates, he removes his penis from the woman's vagina, carefully holding the base of the condom so it does not leak. Each condom can be used only once.

Effectiveness: Condoms are effective if the man uses them correctly every time he has sex. If 100 typical couples use condoms for one year, 12 of the women will get pregnant.

Advantages:

* Rubber condoms help protect against sexually transmitted diseases.
* Available without prescription or medical examination.
* No side effects.

Disadvantages:

* May interrupt lovemaking, or cause embarrassment for people who do not want to touch their genitals.
* Sometimes a condom tears or leaks.
* Decreases the sensations during sex for some men and women.

HELP

Good method for:

* a man or woman who has more than one sexual partner
* a man or woman who can make putting on a condom part of foreplay
* a man or woman who thinks he or she might have or get a sexually transmitted disease
* couples who want to space their children
* couples who have agreed together to use condoms
* couples who are worried about side effects of other methods
* couples who have sex only once in a while

Not the best method for:

* couples who do not want more children
* men who will not use condoms regularly and carefully

Should not be used by:

(Condoms are safe for anyone.)

EXPLAIN

* Roll a condom onto the erect penis. Leave a small space at the tip to collect semen. After sex, hold the condom around its rim as the penis is withdrawn. Then the condom will not slip off and spill semen.

* A condom must be used every time a couple has sex. Condoms should not be reused. Store unused condoms in a cool, dark place if possible.

* Condoms are more effective when couples use foaming spermicidal tablets at the same time.

* Remember to tell clients how and where they can get more condoms.

HOW TO ANSWER MYTHS AND RUMOURS ABOUT THE CONDOM

MYTH: If the condom comes off, it can travel through the woman's body.

RESPONSE: Except for when a woman is in labor, the opening from the vagina into the womb is tiny. A condom cannot get through it. If a condom comes off during sex, the woman can remove it.

MYTH: Use of condoms will weaken a man, causing impotence.

RESPONSE: There is no medical reason why condom use should cause impotence.

MYTH: Men only use condoms with prostitutes.

RESPONSE: Condoms are used by married couples all over the world. In Japan, for example, condoms are the most widely used contraceptive among married couples.

MYTH: Condoms often break during sex.

RESPONSE: New, properly stored condoms are very strong. You can demonstrate a condom's strength by blowing up one like a balloon. Properly used, a new condom is unlikely to break. Only an old or used condom, or a condom that has been stored in a hot place, is likely to deteriorate to the point that it will break.

SPERMICIDES

TELL

What it is: Spermicides come as foams, jellies, foaming tablets, and vaginal suppositories.

How it works: Spermicides kill the man's seeds (sperm). The woman puts the spermicide high in her vagina before the man puts his penis inside. The woman must follow the instructions on the package. She must use the spermicide every time she has sex.

Effectiveness: Spermicides are not very effective. If 100 typical women use spermicides for one year, 21 will get pregnant.

Advantages:

* Helps protect against sexually transmitted diseases.
* Available without prescription or medical examination.

Disadvantages:

* Lovemaking might be interrupted to put spermicide in, or to wait for spermicidal tablet to work.
* May cause mild irritation in the vagina.
* Supplies may be expensive and difficult to find.

HELP

Good method for a woman who:

* dislikes visiting doctors and having pelvic examinations
* wants to space her children
* has sex only once in a while
* thinks she might have or might get a sexually transmitted disease

Not the best method for a woman who:

* does not want more children
* dislikes touching her genitals
* does not want to or forgets to put in the spermicides before sex

Should not be used by a woman who:

* finds that the spermicides irritate her or her partner's genitals. This happens rarely and is not dangerous.

EXPLAIN

* The woman puts the spermicide high in her vagina before sex. The time she must leave between insertion of the spermicide and sex varies with the type of spermicide used. The woman must follow the instructions on the package.
* The woman must use the spermicide every time she has sex, and, if the man comes more than once, repeat insertion before he discharges again.
* Spermicide are more effective when couples use condoms at the same time.
* Remember to tell clients how and where they can get more spermicides.

HOW TO ANSWER MYTHS AND RUMOURS ABOUT SPERMICIDES

MYTH: Spermicides lead to deformed babies.

RESPONSE: There is no medical evidence for this rumour.

MYTH: Spermicides, contraceptive sponges, and diaphragms cause cervical cancer.

RESPONSE: These methods actually prevent cervical cancer: they protect the cervix against sexually transmitted diseases, which cause cancer.

NATURAL METHODS

TELL

What it is: Natural methods are ways to identify the days of the month when the woman is most likely to get pregnant. There are three approaches: calendar (rhythm) method, basal body temperature (BBT), and cervical mucus method.

How it works: There is a time each month when a woman can most easily get pregnant. This is called the "unsafe" time. The woman and her partner do not have sex during this time. A doctor, nurse, or counsellor teaches the woman how to identify the unsafe time, which is usually around 14 days before her next period.

Effectiveness: Natural methods are not very effective. The couple not only has to be diligent to identify the unsafe time for sex, but they then have to be disciplined to abstain during that time.

Advantages:

* No supplies needed
* No side effects
* Permitted by some religions and cultures that do not permit other methods
* Can be used with other family planning methods
* Can be used to plan a pregnancy

Disadvantages:

* Takes time to learn
* Woman must keep careful, daily records
* Difficult to determine the safe time
* Couples must avoid sex for seven to 14 days each month.
* Difficult for women with irregular periods
* Does not provide protection against HIV and other sexually transmitted diseases

HELP

Good method for couples who:

* have agreed together to use this method
* want to space their children
* have religious or moral beliefs that do not allow them to use other methods
* do not mind if pregnancy occurs

Not the best method for:

* a woman who has more than one sexual partner
* a woman who might have difficulty charting cycles or recognizing signs of fertility
* couples who are not both willing to cooperate in using this method
* couples who are certain they do not want more children

Should not be used by a woman who:

* for medical reasons should not get pregnant

EXPLAIN

* Couples who choose natural methods need special instruction and counselling for at least two months. Tell them where there is a counsellor with special training in natural methods.
* The following descriptions are for the health worker's general knowledge. This information does not take the place of full counselling by an instructor trained in natural methods.

For all natural methods:

The safest way to use a natural method is not to have sexual intercourse during the unsafe (fertile) time. If you do have intercourse during the fertile time, use a back-up method of contraception until four days after you have detected ovulation.

CALENDAR (RHYTHM) METHOD:

How to tell when you may be fertile:

Write down the number of days in each of your last six menstrual cycles. A menstrual cycle lasts from the first day of your period until the day before your next period starts. To find out how long your menstrual cycle is, just count the days.

Now pick out the longest of the six cycles and the shortest of the six cycles.

To decide which part of the month is your fertile time, subtract 18 from the shortest cycle and subtract 11 from the longest cycle. For example, if your shortest cycle is 26 days and your longest cycle is 34 days, you need to abstain from sexual relations from Day 8 (26 minus 18 = 8) through Day 23 (34 minus 11 = 23).

Why some couples use a back-up method with the calendar method:

When used alone, the calendar method may be unreliable, especially for women with irregular menstrual cycles.

The calendar method greatly restricts the number of days on which intercourse is permitted; this may be too difficult for some couples.

The fertile time can be affected by many things such as stress or poor diet. The fertile days may not occur at the same time each month.

BASAL BODY TEMPERATURE METHOD (BBT)

How to tell when you may be fertile:

Because this method only indicates when ovulation has already occurred, it is difficult to determine the beginning of the fertile period. The safest way to use BBT is to avoid intercourse, or use a back-up barrier method, during at least the first half of your cycle until three days after your BBT has risen.

You can assume your fertile days are over when your BBT has risen about .2 to .5 degrees centigrade (.4 to 1.0 degrees Fahrenheit) and has remained elevated for three full days. All three days should have higher readings than any of the previous six days in that cycle. Your temperature will stay elevated until your next period begins.

When to take your temperature:

Take your temperature every morning before you get out of bed and before you begin any kind of activity, including talking, eating, drinking, smoking, or sex. You can use the thermometer either orally or rectally, whichever you choose, but you must choose one site and use this same site every day. Oral temperature requires five minutes with the mouth closed; rectal temperature requires three minutes.

Record your temperature every day on a special BBT chart, or in a notebook.

CERVICAL MUCUS METHOD

How to tell when you may be fertile:

You may be fertile when you feel a sensation of wetness at the opening to your vagina or when you can see mucus on your finger, underpants, or tissue paper.

You may not see mucus until a few days after menstrual bleeding has ended. When mucus begins to appear, it is sticky, pasty, or crumbly and may range in color from yellow to white. As the fertile time approaches, the mucus increases in amount, becomes clearer in color, wetter, stretchy, and slippery. The mucus resembles raw egg white and can be stretched between two fingers. After the fertile time, the mucus usually becomes sticky and pasty again and decreases in amount. After the fertile time, some women see no mucus for the remainder of their menstrual cycle.

How to record your mucus:

Use a notebook to keep a daily record of your observations, including your menstrual period, spotting, dryness, and mucus.

If you wish to prevent pregnancy:

Do not have sexual intercourse on any day that you feel or see mucus on your fingers, on tissue paper, or on your underpants.

Do not have sexual intercourse until the fourth day after the "peak symptom day". The peak symptom day is the last day of the wettest mucus.

Do not have sexual intercourse during your menstrual period, because the blood may hide the mucus.

Do not have sexual intercourse if you are unsure whether there is mucus. Spermicides, vaginal infections, some drugs, and sexual intercourse can all affect the normal pattern of a woman's mucus.

If you do have sexual intercourse at any of these times, use another contraceptive method, such as condoms.

LACTATIONAL AMENORRHEA METHOD (LAM)

[Exclusive Breastfeeding]

TELL

What it is: By feeding the baby only with breast milk, the new mother can prevent pregnancy.

How it works: LAM stops the egg from leaving the ovary each month.

Effectiveness: If used correctly, LAM is very effective up to six months postpartum. LAM is less effective after the baby is six months old, after the baby gets other food, or after the woman has her period again.

Advantages:

* Breast milk is the best food for the baby. Breastfeeding can help protect the baby from getting sick.
* No need to buy family planning supplies.
* Can be combined with other FP methods.

Disadvantages:

* The woman must be willing to breastfeed every time the baby is hungry, both day and night.
* May be hard to do (for example, in the work place).
* Other family members should not give the baby food or liquids.
* May cause some women to develop soreness or infections in their nipples or breasts.
* Does not protect against HIV infection or other sexually transmitted diseases.

HELP

Good method for a woman:

* Whose menstrual periods have not returned, who had her baby less than six months ago, **and** who is fully or nearly fully breastfeeding.

The definition of fully breastfeeding is:

Breastfeeding whenever the baby desires, on both breasts, with any two feedings regularly no more than six hours apart, **and**

Not regularly substituting other food or liquids for breast-milk meals.

Should not be considered an effective method for a woman:

* Who has started her menstrual periods again.
* Who has breastfeedings that are regularly more than six hours apart.
* Who regularly gives her baby food or liquids.
* Whose baby is six months old or older.

EXPLAIN How to use breastfeeding for contraception:

* Breastfeed your baby on demand (at least 6 to 10 times a day) on both breasts.

* Breastfeed your baby at least once during the night.

* There should be no more than six hours between breastfeedings.

* The baby does not need any other foods until he or she is 4 to 6 months old, as long as:

  -- the baby is growing well and gaining weight.
  -- you are eating a balanced diet and resting in order to have a good milk supply.

* Once the baby begins having food or drink other than breast milk, breastfeeding will be less effective as a contraceptive. When the baby begins having other food or drink, you may be able to get pregnant even without seeing your menstrual period return.

* When your menstrual periods return, you can get pregnant again, and breastfeeding is no longer an effective contraceptive. (Bleeding in the first 56 days after delivery is not menstrual bleeding.)

WITHDRAWAL

TELL

What it is: The man takes his penis out of the woman's vagina before he comes.

How it works: If the man's sperm do not enter the woman's vagina, she will not get pregnant.

Effectiveness: Withdrawal is not very effective. Even when the man pulls out before coming, some sperm may have been released in pre-discharge fluid.

Advantages:

* No need for medication or supplies
* Can be used when other methods are not available
* No side effects
* Permitted by some religions and cultures that do not permit other methods

Disadvantages:

* Not very effective
* Requires man's self-control
* May reduce pleasure of love-making
* Provides no protection against sexually transmitted diseases

HELP

Good method for individuals who:

* have religious or moral beliefs that do not allow them to use other methods
* do not mind if pregnancy occurs

Not the best method for couples who:

* are not both willing to cooperate in using the method

Should not be used by:

* couples who are certain they do not want to have children
* women who should not get pregnant for medical reasons

LONG-TERM METHODS

INJECTABLES

TELL

What it is: The woman gets an injection every three months in her arm or buttock. It is called Depo-Provera, or DMPA.

How it works: The injection, like the pill, stops the egg from leaving the ovary every month.

Effectiveness: **The injection is one of the most effective methods.** If 1,000 typical women get injections for one year, four will get pregnant. (If 100 typical women get injections for one year, fewer than one will get pregnant.)

Advantages:

* Very effective.
* Does not interrupt lovemaking.
* The woman does not have to remember to do something every day.
* No need to buy supplies.

Disadvantages:

* Side effects: After two or three injections, some women may stop having their periods. Others may have irregular periods, or more bleeding. (These menstrual changes are not harmful.)
* A woman may not be able to become pregnant for several months after she stops having injections.

HELP

Good method for a woman who:

* lives in a remote area
* prefers having injections to taking pills
* cannot remember to take pills every day
* may not want more children
* is not worried if her menstrual periods stop

Not the best method for a woman who:

* wants children but has had none
* will worry if her menstrual periods change
* has diabetes
* has heart disorders or blood clots
* has been breastfeeding for less than six weeks
* has liver problems (eyes or skin that look yellow)

Should not be used by a woman who:

* may be pregnant
* has cancer of the breast or genitals
* has abnormal vaginal bleeding

EXPLAIN

* If possible, get the first injection during the first five days after your menstrual period starts. This way you can be sure that you are not pregnant.

* Get the next injection in two or three months (two months for Noristerat; three months for Depo-Provera). [Remember to tell her when to return for her next injection.]

* If you miss your menstrual period, you are probably not pregnant. Injectables can make menstrual periods stop.

* If you want a baby, stop the injections. It may take several months before you can become pregnant.

WARNING SIGNS: See your health care provider immediately if you have:

* menstrual periods twice as long, or twice as much blood as usual

* bleeding between periods for more than seven days

HOW TO ANSWER MYTHS AND RUMOURS ABOUT INJECTABLES

MYTH: Injectable contraceptives (DMPA, or Depo) cause cancer.

RESPONSE: A 1986 World Health Organization study found no increase in cancer among women using DMPA. That study also indicated that DMPA provides protection against cancer of the ovary and cancer of the endometrium (lining of the uterus).

MYTH: Developed countries unload contraceptives which are not approved for their own women, like Depo, on developing countries.

RESPONSE: DMPA has been approved by Sweden, the United Kingdom, France, and West Germany for use nationally, as well as for export and foreign assistance. It has also been given approval by the WHO and the International Planned Parenthood Federation. In 1993 it was approved for use in the United States; before that time, it was not included in foreign assistance from the U.S.

NORPLANT

TELL

What it is: NORPLANT consists of six match-stick size plastic capsules. A doctor or nurse places NORPLANT under the skin of a woman's upper arm by making a very small cut. The capsules can stay in for up to five years. They have to be removed at the end of 5 years.

How it works: NORPLANT stops the egg from leaving the ovary and makes it difficult for sperm to enter the womb.

Effectiveness: **NORPLANT is one of the most effective methods.** If 10,000 typical women use NORPLANT for one year, only four will become pregnant. (If 100 typical women use the method for one year, fewer than one will become pregnant.)

Advantages:

* Very effective.
* Prevents pregnancy for a long time (up to 5 years).
* Can be used by all age groups.
* Works immediately (within a few hours) after insertion.
* The woman does not have to remember to do something every day.
* Does not interrupt lovemaking.
* Does not require a pelvic examination.
* Has few side effects.
* Can be felt, but not seen.
* Can be removed at any time.
* Normal fertility returns almost immediately after the NORPLANT is removed.
* Breastfeeding women can use NORPLANT six weeks after the birth of their baby.

Disadvantages:

* Side effects: Some woman may have irregular periods, spotting, or no periods at all.
* A trained doctor or nurse must insert and remove NORPLANT.
* Requires a small cut in the arm that may leave a tiny scar.
* After two years, NORPLANT may not be as effective in women weighing more than 70 kg (155 lb).

HELP

Good method for a woman who:

* desires long-lasting contraception
* does not want more children, but does not feel ready for sterilization

Not the best method for a woman who:

* will worry if her menstrual periods change
* has diabetes
* has been breastfeeding for less than six weeks

Should not be used by a woman who:

* is pregnant or thinks she is pregnant
* has a history of heart attack, chest pains due to diagnosed heart disease, or stroke
* has cancer of the genitals or the breast
* has a history of blood clots
* has unexplained vaginal bleeding (until diagnosed and treated)
* has acute liver problems or jaundice (eyes or skin that look yellow)

EXPLAIN

* A woman comes to the clinic during the first seven days after the start of her period. If she breastfeeds her baby and has no periods, she should come to the clinic when the child is six weeks old. She should wear a blouse or dress with loose sleeves that will permit a bandage on the upper arm.

* The insertion is done by a trained doctor or nurse. A small incision is made and the implants are placed one at a time under the skin. The procedure should take no longer than 10 to 15 minutes. The woman is given an injection in the arm, so she will not feel much pain or discomfort.

* After the insertion, the incision is covered with a small adhesive bandage and protective gauze. For a day or two, there may be some tenderness in this area, but this is not serious. The woman should keep the area dry and leave the gauze bandage in place for three days. She should keep the small adhesive bandage on for a day or two longer.

* A woman can resume normal activities immediately, but she should avoid heavy lifting for three to five days.

* If NORPLANT is inserted during menstruation, the couple may have sexual relations as soon as they like. The method becomes effective within a few hours after insertion.

* A woman should not pull or scratch the area where the capsules were inserted.

* Generally, the woman should return for follow-up after three months, then once yearly until the NORPLANT is removed. Some clinics recommend that the woman return after one week to check the site of the insertion.

* If the woman wants to have a child, or wants the implants removed for any reason, she should return to the clinic to have them taken out.

* The NORPLANT must be removed after five years (because it is no longer effective).

* Removal is a simple procedure, which, like insertion, requires only one incision and local anaesthesia. However, it must be done by someone trained in NORPLANT removal.

* If the woman moves to another area, she should ask her clinic for the name and address of the clinic nearest her new home that offers NORPLANT services.

WARNING SIGNS: A woman should call or return to the clinic if:

-- Her arm hurts or feels hot.
-- She sees any capsules coming out of her arm.
-- She develops an infection at the sight of insertion.
-- She bleeds more than usual during her period, and it bothers her.
-- She has severe headaches which occur repeatedly.
-- She has problems with her eyes (such as blurred vision or dark spots in front of her eyes) which she did not have before the insertion.
-- She has severe lower abdominal pain.
-- She gets jaundice (yellow skin or eyes).
-- She misses her period, has pain in her belly, or has dark or spotty bleeding between her periods. These are signs that NORPLANT has failed and the woman may be pregnant. The pregnancy could be dangerous for her.

INTRA-UTERINE DEVICE (IUD)

TELL

What it is: An IUD is a small device that is usually made of plastic or copper. A doctor or nurse places the IUD in the woman's womb. It is usually left in place for three or more years.

How it works: The IUD stops the mans' seeds from meeting the woman's egg.

Effectiveness: The IUD is very effective. If 100 typical women use the IUD for one year, three will get pregnant. The Copper T 380A is effective for up to 8 years.

Advantages:

* Very effective.
* Prevents pregnancy for a long time (up to 8 years).
* Does not interrupt lovemaking.
* The woman does not have to remember to do something every day.
* No need to buy supplies.

Disadvantages:

* Side effects: May cause painful or heavy periods; may cause cramps or spotting. (These side effects usually go away after several months.)
* If the woman is exposed to sexual infections, the IUD makes it more likely that the infections will spread to the womb and tubes. These infections could cause her to become infertile. This can happen if she has many sex partners, and also if her partner has sex with other partners (and brings an infection back to her).
* A trained health worker must insert and remove the IUD.
* The IUD may come out without the woman knowing, and she can get pregnant.
* The IUD does not offer protection against HIV or other sexually transmitted diseases.

HELP

Good method for a woman who:

* wants a method with no bother
* has children and does not want more children soon
* has successfully used an IUD in the past
* is breastfeeding

Not the best method for a woman who:

* has painful or long menstrual periods
* wants children but has had none
* has had a pregnancy outside of the womb
* dislikes touching her genitals (to feel for the string)

Should not be used by a woman who:

* has active cervical or pelvic infections, including sexually transmitted diseases
* has had pelvic inflammatory disease
* may be pregnant
* has abnormal vaginal bleeding or genital cancer
* has more than one sexual partner or a partner with more than one partner

EXPLAIN

* A trained health worker puts the IUD in the womb, usually when the woman is menstruating. It is a simple procedure but often causes temporary pain and bleeding. Aspirin or acetominophen (Panadol, Paracetamol, Tylenol) helps relieve the pain.

* Two small strings attached to the IUD hang into the vagina. A woman should check the strings by putting her finger high up in her vagina after each menstrual period. She should see the health care provider if:

  -- she cannot feel the strings
  -- the strings have gotten longer or shorter
  -- she can feel the plastic part of the IUD

* The Copper T-380 should be replaced after eight years. The Lippes Loop (coil) may remain as long as the client wants if there are no problems.

* The health worker should give the woman a written record that tells the kind of IUD she has, and when it she be removed.

* Only a trained health worker should take out the IUD.

WARNING SIGNS: A woman should see her health care provider immediately if she has:

- P: Period late (pregnancy), abnormal spotting, or bleeding.
- A: Abdominal pain, pain during sex.
- I: Infection exposure, abdominal discharge.
- N: Not feeling well -- fever, chills.
- S: Strings missing, shorter, or longer.

HOW TO ANSWER MYTHS AND RUMOURS ABOUT THE IUD

MYTH: A woman who uses the IUD will never be able to have a baby, even after she has the IUD removed.

RESPONSE: Almost all women who use the IUD will be able to have babies after they have the IUD removed. Women who already suffer from pelvic infections or who are exposed to sexually transmitted diseases do face a higher risk of infertility and should use other methods of contraception.

MYTH: The IUD causes cancer.

RESPONSE: Extensive studies have shown that the IUD does not increase the risk of cancer.

MYTH: The IUD can travel through a woman's body.

RESPONSE: The IUD cannot be pushed out of the uterus during sexual intercourse. It is too big to travel through the body. The IUD usually stays in the womb until a health worker removes it. If it does come out by itself, it usually comes out through the vagina.

MYTH: If a woman becomes pregnant while using an IUD, it will become imbedded in the baby's body.

RESPONSE: Very few women become pregnant while using an IUD. In the rare cases when they do, the IUD cannot become embedded in a baby or cause a deformity. However, women who do become pregnant using an IUD face an increased risk of miscarriage.

FEMALE STERILIZATION

TELL

What it is: Sterilization for women is a simple operation. It closes the tubes between the woman's ovaries, where the eggs are made, and the womb. After the operation, the woman can no longer get pregnant. Sterilization is meant to be permanent.

A doctor does the operation in a clinic or hospital. The woman is given some medicine so she does not feel much pain or discomfort. After the operation, she still has her periods. She is able to have sex just as before.

How it works: When the tubes are closed, the man's sperm cannot swim up to reach the egg, and the egg cannot travel to the womb.

Effectiveness: Sterilization is one of the most effective methods.

Advantages:

* A woman who has had a successful sterilization no longer has to worry about getting pregnant.
* Does not interrupt lovemaking.
* There is nothing to buy or remember.
* Usually has no side effects.

Disadvantages:

* Sterilization is an operation. All surgery has some risks, such as bleeding and infection. But serious problems usually do not happen.
* Most woman usually have a little pain or soreness after sterilization. These problems usually go away by themselves or with simple treatment or pain medication.
* There is a small chance that the operation will not succeed.
* Sterilization is intended to be permanent. It is difficult to reverse.
* Sterilization does not protect against HIV or other sexually transmitted diseases.

[The following information about what happens during and after surgery is usually given only to clients who express a serious interest in the procedure.]

What happens during surgery:

* The operation is done in a clinic or hospital. It usually takes no more than 30 minutes. The woman is given some medicine so she does not feel much pain or discomfort. The doctor will make one or two small cuts in your belly. The doctor closes the tubes by tying them or by closing them with bands. Sometimes the doctor removes a small piece of each tube.

There are several ways the doctor can reach the tubes:

* Minilaparotomy: The doctor cuts the tubes through a small cut in the lower part of the belly. The cut is just above the pubic hair.

* Minilaparotomy after childbirth: After childbirth, a woman's tubes are high in the belly and are easy to reach. The doctor reaches the tubes by making a small cut just below the navel.

* Laparoscopy: The laparoscope is a long, thin instrument. The doctor puts the laparoscope through a cut into the woman's belly. The doctor can see the tubes and reach them through the instrument.

What happens after surgery?

The woman rests for a few hours before going home. At home, she rests for a few days after surgery. She does not lift anything heavy or do any heavy work for at least one week after the operation. The nurse or doctor gives her instructions about what to do after surgery.

A woman who has her tubes tied while she is in the hospital after childbirth can expect to stay one or two days in the hospital.

HELP

May be an appropriate method for a woman who:

* Has all the children she ever wants to have

* Prefers one of the most effective methods

* Wants a permanent, one-time method

* Has just delivered a baby, and has had adequate counselling prior to delivery. Sterilization surgery may be done within 48 hours of vaginal delivery or 28 or more days after delivery.

* Has just had an uncomplicated abortion and whose uterus is not infected. Sterilization surgery may be done on the same day as the abortion. However, adequate counselling and informed decision making must be guaranteed.

<u>Requires more careful consideration when a woman:</u>

* Has just delivered a baby, but has not had adequate counselling prior to delivery. If informed decision making cannot be guaranteed, it is best to delay sterilization and provide an interim short-term method. (Postpartum women who are <u>fully breastfeeding</u> are protected against pregnancy for at least six weeks after delivery.)

* Has characteristics associated with regret following sterilization, such as:

    -- Young age
    -- Few or no children
    -- Pressure from partner, relative, or health worker
    -- Unstable marriage/union
    -- Unrealistic expectations about sterilization
    -- Unresolved conflict or doubt about sterilization
    -- Excessive interest in reversal
    -- Temporary stress, including stress from delivery or abortion
    -- Partner not in agreement

* Has conditions that are precautions for elective surgery, such as heart disease, uncontrolled diabetes, severe anemia, or bleeding disorders. These conditions should be treated or managed before sterilization surgery is performed.

<u>Should not be used by a woman who:</u>

* Has not been fully informed about female sterilization.

* Wants more children.

* Is pregnant or strongly suspected to be pregnant.

* Has vaginal, cervical, or pelvic infection. The infection should be treated and the procedure delayed until it has been cured.

* Has just had a baby and has any of the following conditions:
  -- umbilical hernia
  -- intra- or postpartum fever
  -- prolonged rupture of membranes
  -- hypertensive states
  -- antepartum or postpartum hemorrhage not completely resolved after delivery
  -- history of postpartum psychosis

  In these cases, the client should be advised to wait for an interval procedure.

* Has just had an abortion with complications. The client should be advised to wait until the complications are completely resolved.

EXPLAIN Before surgery:

* When sterilization may be performed:

-- If you are sure you want no more children, sterilization may be done at any time you and the service provider believe you are not pregnant.

-- For the woman who has just delivered a baby: Sterilization may be done within 48 hours of delivery, or 28 or more days after delivery.

-- For the woman who has just had an uncomplicated abortion and whose uterus is not infected: Sterilization may be done on the same day as abortion.

* When sterilization takes effect:

-- Female sterilization begins to prevent pregnancy as soon as the surgery is performed. But if the surgery is done during the middle of the menstrual cycle (day 10 to day 20), use another contraceptive method until you have your next period.

* Preparing for the operation:

-- Do not eat any solid food or drink alcohol for eight hours before the surgery.
-- Do not take any medication for 24 hours before the surgery (unless the doctor performing the operation tells you to).
-- Bathe thoroughly, especially your belly, genital area, and upper legs, the night before the procedure.

-- Wear clean, loose-fitting clothing to the clinic.
-- Do not wear nail polish or jewelry to the clinic.
-- If possible, bring along a friend or relative to escort you home afterward.

During surgery:

* For clients having local anaesthesia for any of the procedures below: You will be awake during your surgery. The doctor will inject the anaesthesia in your belly, where the cut will be made. It may sting for a few second; then your belly will feel numb. You may feel a little pain and cramping during the procedure. The doctor and nurse may talk to you during the operation.

* For clients having interval minilaparotomy (not after childbirth): The doctor will cut the tubes through a small cut in the lower part of your belly. The cut is just above the pubic hair. You will rest a few hours before going home.

* For clients having minilaparotomy after childbirth: After delivery, your tubes will be high in your belly and easy to reach. The doctor will reach the tubes by making a small cut right below your navel. You will stay one or two days in the hospital before going home.

* For clients having laparoscopy: The laparoscope is a long, thin instrument. The doctor will put the laparoscope through a cut in your belly. The doctor will see the tubes and reach them through the instrument. Your belly will be inflated slightly with a small amount of carbon dioxide gas to make it easier for the doctor to see the tubes. After the procedure the gas is released, but you may feel a little bloated, and some women report pain in their shoulders over the next day or so.

When you return home:

* After the operation, you may feel a little pain, soreness, or swelling where the cut is. You should rest at home for one or two days. You should avoid heavy work or lifting for one week.

* Keep the wound clean and dry. You may bathe on the day after surgery, but do not let the dressing get wet. [To the health worker: Following the clinic's protocol, tell the woman when she can remove the bandage.]

* Do not pull or scratch the would while it is healing.

* Return to the clinic after one week for a health worker to check that the wound is healing properly [and removal of sutures, if necessary].

* A small amount of pain or swelling around the cut is normal. This usually disappears within seven days. Take acetaminophen (paracetamol, panadol) for minor pain or discomfort, as instructed. You may be given other medications to take in case of infection.

* You may have sex as soon as it is comfortable for you.

WARNING SIGNS: Come back to the clinic or go to a hospital at once if you have any of these warning signs. Be sure to tell the health worker that you have had sterilization surgery.

-- Fever within one week after surgery

-- Pain in your belly that gets worse or does not go away

-- Vomiting or diarrhea for longer than one day after surgery

-- Bleeding or pus in the wound

-- In the future, if you miss your period, if you think you may be pregnant, if you have pain in your belly, or if you have dark or spotty bleeding between your periods. Watch for these signs at any time after the operation. They are very important. These signs may mean the operation has failed and you may be pregnant. The pregnancy could be dangerous for you.

HOW TO ANSWER MYTHS AND RUMOURS ABOUT FEMALE STERILIZATION

MYTH: Female sterilization is a painful, complicated procedure.

RESPONSE: Female sterilization is a simple, out-patient procedure performed under local anaesthesia. Women may experience some pain after the procedure, but this discomfort is normally temporary and minor, and can usually be controlled with standard treatments like Panadol.

MYTH: Sterilization makes a woman weak.

RESPONSE: There is no difference in strength, gynecological problems or psychological adjustment among women who have been sterilized, and those who have not. If anything, women become stronger from not having to endure continuing pregnancies.

MYTH: After sterilization, a woman will not have menstrual periods.

RESPONSE: There is no evidence of menstrual disruption in sterilized women. Sterilization is <u>not</u> hysterectomy, which is the surgical removal of a woman's uterus. The ovaries, which produce female hormones, are also left untouched. So menstruation should remain the same. However, some women have sterilization in their 40's, which is close to the natural time for menopause and may explain where this rumour got started.

MYTH: Sterilization makes a woman frigid.

RESPONSE: Blocking the tubes does not change any of the functions which influence sexual desire. In fact, some women find that they enjoy sex more because they do not need to worry about getting pregnant.

MYTH: A sterilization can be undone or untied ("pulled") after five years.

RESPONSE: Sterilization is intended to be a permanent procedure. Although it can, in some cases, be reversed, the reversal operation is expensive and is not always successful. Except in the rare cases in which the sterilization procedure is unsuccessful, the tubes remain closed permanently.

VASECTOMY

TELL

What it is: Vasectomy is a simple operation. It closes the tubes between the man's sex glands (testes) and the other glands that produce the man's sexual fluids (semen). Each tube is called a vas. A doctor does the operation in an office or clinic. The man is given some medicine so he doesn't feel much pain or discomfort. The operation does not change a man's appearance, voice, strength, or sex life. Liquid still comes out of the penis during sex.

How it works: When the tubes (vas deferens) are closed, the man's seeds cannot swim to become part of the liquid (semen) that comes out of his penis during sex. His seed cannot join an egg. His partner can no longer get pregnant.

Vasectomy is meant to be permanent. The couple must be very sure that they do not want any more children.

Effectiveness: Vasectomy is one of the most effective methods. If 1,000 typical men have vasectomy surgery, only two will make his partner pregnant.

Advantages:

* A man who has had a successful vasectomy no longer has to worry about getting a woman pregnant.
* No interruption to lovemaking.
* Nothing to buy or remember.
* The operation usually has no serious side effects.

Disadvantages:

* Vasectomy is an operation. All surgery has some risks, such as bleeding, bruising, and infection. But serious problems usually do not happen.
* Some men have a little pain, soreness, bruising, or swelling after vasectomy. These problems usually go away by themselves or with simple treatment or pain medication.
* There is a small chance that the operation will not succeed.

* Vasectomy is intended to be permanent. It is difficult to reverse.
* Vasectomy does not protect against HIV or other sexually transmitted diseases.

[The following information about what happens during and after surgery is usually given only to clients who express a serious interest in vasectomy.]

What happens during surgery?

* Vasectomy is usually done in a doctor's office or clinic. It usually takes no more than 20 minutes. The man is given some medicine so he will not feel much pain or discomfort. He is awake during the operation.

* There are two techniques that the doctors can use to reach the man's tubes:

  -- Incisional: The doctor makes two small cuts on either side of the scrotum. Through these cuts, the doctor reaches the tubes and blocks them.

  -- No-scalpel: The doctor makes one tiny puncture in the scrotum. The tubes are blocked in the same way as in the incisional technique. The method is called no-scalpel because it does not use a knife (scalpel) to cut the scrotum.

What happens after surgery?

* The man goes home after a short rest. At home, he rests for one day after surgery. He avoids strenuous work and exercise for at least two days after the operation.

* Before vasectomy, the man's body has stored some sperm. After vasectomy, these sperm must leave the body before the man can have sex without fear of causing pregnancy. The man or his partner must use another method of family planning, like condoms, until he has ejaculated his stored sperm. They must use another method for the first 12 weeks or the first 20 times they have sex after vasectomy.

* After vasectomy, the same amount of semen comes out of the penis as before. The only difference is that the semen does not contain sperm.

HELP May be an appropriate method for a man who:

* Has all the children he ever wants to have.
* Prefers one of the most effective methods.
* Wants a permanent, one-time method.
* Has a partner who has medical conditions which limit the use of other FP methods.

Requires more careful consideration when a man:

* Has characteristics associated with regret following vasectomy, such as:
  - -- Young age
  - -- Few or no children
  - -- Pressure from partner, relative, or service provider
  - -- Unstable marriage
  - -- Unrealistic expectations about vasectomy
  - -- Unresolved conflict or doubt about vasectomy
  - -- Excessive interest in reversal
  - -- Temporary stress
  - -- Partner not in agreement
* Has conditions that are precautions for elective surgery, such as heart disease, uncontrolled diabetes, bleeding disorders, large hydrocele, or genital/scrotal infection. These conditions should be treated or managed before vasectomy is performed.

Should not be used by a man who:

* Has not been fully informed about vasectomy.
* Wants more children.

EXPLAIN Before surgery

When vasectomy takes effect:

* Vasectomy does not work immediately. It usually takes 12 weeks or 20 ejaculations to clear sperm from the tubes. Use condoms, or ask your partner to use another method, until after the 12 weeks or 20 ejaculations.

Preparing for vasectomy:

* Bathe thoroughly, especially your genital area and upper thighs.

* Wear clean, loose-fitting clothing to the clinic.

* Bring a clean, snug-fitting undergarment to wear for comfort after the operation.

* Do not take any medication for 24 hours before the surgery (unless the doctor performing the vasectomy tells you to).

During surgery

* The procedure takes place in a doctor's office or clinic. It usually takes no more than 20 minutes. You will be awake during your surgery. You will be given some medicine so you do not feel much pain or discomfort. The doctor will inject the local anaesthetic in the scrotum where the cut or puncture will be made. This may sting for a few seconds; then your scrotum will feel numb.

* For clients having incisional vasectomy: The doctor will make two cuts on either side of the scrotum. Through these cuts, the doctor will reach the tubes and block them. The doctor and assistant may talk to you during the procedure.

* For clients having no-scalpel vasectomy: The doctor will make one tiny puncture in the scrotum. Through this puncture, the doctor will reach the tubes and block them.

* You will rest for less than an hour before going home.

When you return home

* Rest at home until the day after surgery. You may resume your normal activities after one or two days. But avoid heavy work or lifting for at least two days. This will help the wound to heal.

* Keep the wound clean and dry. You may bathe on the day after surgery, but do not let the wound get wet. After three days, you may wash the wound with soap and water.

* Do not pull or scratch the wound while it is healing.

* Wear a snug undergarment or scrotal support for at least two days after surgery. This will help you be comfortable.

* For men who have bandages: Keep the bandage on for three days after the operation.

* You may have a little pain, bruising, or swelling where the wound is. Watch to be sure that it does not get worse. A small amount of pain, bruising, or swelling that does not get worse is normal. This usually goes away within a week. Take acetaminophen (paracetomol, panadol) for minor pain or discomfort. Do not take aspirin since it could increase bleeding. An ice pack may help relieve the pain, bruising, or swelling.

* You may have sex as soon as it is comfortable for you. This is usually two or three days after the operation. Remember, you or your partner must use another method of contraception for 12 weeks or 20 ejaculations after vasectomy.

WARNING SIGNS: Come back to the clinic or go to a hospital at once if you have any of these warning signs. Be sure to tell the health worker that you have had a vasectomy.

- -- Fever within one week after surgery
- -- Bleeding or pus in the wound
- -- Pain or swelling around the wound that gets worse or does not go away
- -- If your partner ever misses a period or thinks she is pregnant. This is very important. It may mean the operation has failed, and your partner may be pregnant.

<u>Other instructions:</u>

* For men who have stitches that must be removed: Return to the clinic one week after the operation. A health worker will remove the stitches and check to see how the wound is healing.

* When semen analysis is available: After 12 weeks or 20 ejaculations, return to the clinic. The staff will check your semen to be sure there are no sperm.

* Vasectomy does not protect you against HIV infection or other STD's. Aside from abstinence, latex condoms offer the best protection against these infections.

HOW TO ANSWER MYTHS AND RUMOURS ABOUT VASECTOMY

MYTH: Vasectomy is the same as castration.

RESPONSE: Castration involves removing the testes. During a vasectomy, no part of a man's external anatomy is removed, and the testes are not affected. Only one or two tiny openings are made and two tiny tubes are cut or tied off. Vasectomy in no way resembles castration.

MYTH: Vasectomy causes weight gain in men, just like castration causes weight gain in animals.

RESPONSE: Castration causes weight gain in animals because the testes, which are the source of the male hormones, are removed. With no male hormones, the animal loses muscle mass and becomes fatter. Since vasectomy is not castration, and the testes are not affected, the production of male hormones is the same as before the operation. There is no weight gain, no increase in fat, and none of the other changes commonly associated with castration, such as loss of masculine features like beard, deep voice, and strength.

MYTH: A sterilized man cannot perform sexually.

RESPONSE: The operation does not affect a man's sexual performance. The man's anatomy remains intact -- the penis is not affected and the glands that produce sexual fluids (semen, or come) are not touched. Therefore, the man can get an erection, have orgasm, and ejaculate fluids the same as before. The only difference is that three months after a vasectomy, no sperm will be in his semen. A sterilized man will have all his sexual strength. Some men even find that, without the fear of unwanted pregnancy, they have more desire for sex and more pleasure than before.

MYTH: A vasectomy can cause heart problems and undermine the immune system.

RESPONSE: There is no increased risk of either cardiovascular disease or immune problems for men who have had a vasectomy. The long-term effects of vasectomy have been studied extensively. No ill effects have been shown.

VALUES CLARIFICATION WORKSHEET

Read the following statements. Decide whether you agree (A), disagree (D), or are unsure (U). Write the letter for your response in the left margin next to the statement.

1. If a woman wishes to have a tubal ligation, she should have one, even if her spouse disagrees.
2. If a man wishes to have a vasectomy, he should have one, even if his spouse disagrees.
3. If a woman has many children, the health worker should encourage her to be sterilized, even if the woman appears to have doubts.
4. A 21-year-old woman with only one child should not be allowed to have a tubal ligation.
5. If a woman never experiences childbirth, she will feel like less of a woman.
6. Adolescents should not have sexual intercourse.
7. Birth control should be available to adolescents and unmarried adults, as well as married couples.
8. In family planning counselling, the health worker should use her or his expertise to tell a client which is the best contraceptive method to use.
9. A family planning service provider should be responsible for a client whose contraceptive method fails.
10. In a couple, it is the woman who should be responsible for using contraceptives.
11. If a man has a vasectomy, he is less of a man.
12. Birth control causes sexual promiscuity.
13. Most people with STDs have had many sex partners.
14. Schools should provide sexuality education.
15. Religion is a barrier to family planning.

CONTRACEPTIVE METHODS AND THEIR POSSIBLE IMPACT ON SEXUALITY

Contraceptive Method	Possible Impact on Sexuality
Condom	* May reduce sensation. * May interrupt lovemaking. * May help prolong erection or avoid premature ejaculation. * Protection provided against STDs may increase pleasure and reduce worry.
Spermicides	* May interrupt lovemaking. * Causes irritation for some women and men. * May improve vaginal lubrication. * Involves touching oneself.
Norplant	* Since Norplant can cause spotting, it can affect frequency of sex -- some cultures and religions forbid sexual relations when the woman is bleeding. * Not linked to lovemaking. * Some women report decrease in libido. * Some women report vaginal dryness.
Injections & Oral contraceptives	* Not linked to lovemaking. * Causes changes in bleeding patterns for some women (see comments about bleeding in Norplant section). * Some women report decrease in libido.
Intrauterine Device (IUD)	* Not appropriate if a woman or her partner have more than one partner. * Some women may not want to touch themselves to check strings. * Some men feel the string. * Causes heavier periods for some women, which may curtail sexual activity. * Not linked to lovemaking.
Tubal Ligation	* Not linked to lovemaking. * Some woman and men associate fertility with sexuality.
Vasectomy	* Not linked to lovemaking. * There are many untrue beliefs about its effect on sexuality (loss of virility, impotence, loss of libido, reduced performance). * Some men and women associate fertility with sexuality.
Fertility Awareness Methods	* Couples may worry about correctly identifying the "safe time" for having sex. * The man and woman need self-control during the "unsafe time".
Withdrawal	* Men need to concentrate on pulling out prior to ejaculation. * Women may be worried about men pulling out "in time". * Some men and women feel less satisfied when the man does not ejaculate inside the woman's vagina.

HAND-OUT:
BACKGROUND INFORMATION ON STD'S

What are STD's?

Sexually transmitted diseases (STD's) is the term used to describe all diseases that are passed from one person to another through sexual contact. Genital sex is usually involved, but these diseases can also be passed through oral sex, anal sex, and close physical contact without having intercourse. STD's are sometimes called "venereal diseases" (VD) and are widespread throughout the world.

Signs and symptoms: The following are the most common signs that someone has an STD. However, many people who have STD's, especially women, have no signs of being ill. A woman's only indication of illness may be her partner telling her that he has a disease and she should get checked.

SIGNS IN WOMEN:

* Sores or bumps inside the vagina or around the entrance to the vagina or anus
* Pain during urination
* Discharge (fluid) from the vagina that is:
  - bad-smelling
  - unusual looking (green or yellow colour, or foamy)
  - much more than normal

SIGNS IN MEN:

* Sores on or around the penis or anus
* Discharge (fluid) from the penis
* Pain during urination

Possible long-term effects of STD's:

Infertility: STD's generally start, for women, in the vagina and, for men, in the urethra. If not treated, the infection can spread into the uterus and fallopian tubes (women), or into the prostate gland, bladder, and vas deferens (men). Such infections can leave scar tissue that can block the fallopian tubes and vas deferens, leaving the man or woman sterile.

PID: If an STD is not treated in a woman it can even spread outside the reproductive organs. This is called pelvic inflammatory disease (PID). In addition to infertility, PID can lead to ectopic pregnancy, which can have serious complications. The signs are:

* Pain or tenderness in the lower abdomen
* High fever
* Pain during menstruation, or pain and bleeding during sexual intercourse
* Smelly discharge from the vagina

Illness in the baby: Some STD's can be passed from mother to baby, either during pregnancy or during delivery. This can cause serious illness to the baby.

Serious illness or death: Some STD's are associated with increased risk of cancer. Syphilis and AIDS can lead to insanity and death.

Treatment of STD's: Most STD's can be treated. Treatment varies depending on the particular disease. Medication may be given in pills, through injections, or with creams. Regardless of the type of medication, it must be taken for the entire time prescribed by the doctor, even if the symptoms go away. If not, a few remaining germs can multiply and spread, causing the illness to re-occur in a short time.

If a client is diagnosed with an STD, his or her partner(s) probably have it, too, whether they have symptoms or not. They should both be treated for the STD. If not, the untreated partner can pass the disease back to the treated one. Both partners should complete the prescribed treatment before they have sex, to be sure that none of the germs will be passed from one to the other.

There is no cure for herpes, although sores can be treated.

There is no cure for AIDS.

Prevention of STD's:

The only sure way to prevent getting an STD is to abstain from sex and sexual contact. However, most people find this to be impractical.

Being faithful to one's partner is a good strategy to reduce exposure to STD's. However, if the partner is not faithful as well, you can still get an infection.

Condoms can prevent spread of STD's by keeping germs from passing from one person to the other during intercourse. Spermicidal foams, creams, or jellies containing "Nonoxynol-9" have been found to kill the AIDS virus.

Relationship to Family Planning:

As noted above, condoms and spermicides can help to prevent the spread of STD's. However, other FP methods give no protection against STD. That is why prevention of STD's should be included in FP counselling.

IUD's do not cause STD's. However, if a woman who is using an IUD is exposed to an STD, it can spread more easily from the vagina into the uterus. That is why women who have more than one sex partner are discouraged from using IUD.

Information adapted from: Arkutu, A.A. Your health, your pregnancy: A guide for the African woman. Family Care International, New York, 1992.

BACKGROUND INFORMATION ON SOME SEXUALLY TRANSMITTED DISEASES

DISEASE	*SIGNS AND SYMPTOMS*	*RESULTS IF UNTREATED*	*SPECIFIC INSTRUCTIONS*
HIV/AIDS (Human Immuno-deficiency Virus/ Acquired Immune Deficiency Syndrome)	Unexplained tired feeling, with excessive sweating at nights. Loss of weight. Swollen glands. Chronic diarrhoea. Sore mouth. Fever.	Cure not yet discovered. You can be a carrier (passing the infection without showing any sign or symptom yourself). Cancer of various kinds (more commonly, skin cancer). Pneumonia.	1. Go to the doctor. 2. Reduce number of sexual partners. 3. Avoid prostitutes. 4. Avoid swallowing fecal matter (do-do), semen or urine. 5. Use condoms. 6. Stop use of drugs, e.g. cocaine, heroin. 7. Do not share injection needles.
GENITAL HERPES	Many blister-like, painful sores on genital area. Painful urination. Swollen glands in groin.	Cure not yet discovered. Women -- Increased risk of cancer of the cervix. Babies -- Brain damage and sometimes death to those babies infected during birth.	1. Go to a doctor immediately. 2. If pregnant, let doctor know. 3. Wear loose underwear. 4. Avoid sexual intercourse until all sores are healed. 5. Keep sex organs very clean. Soak genitals in salt water daily. 6. Have a routine pap smear every year.

GONORRHEA (GC, strain, dose, clap)	Pus discharge from the sex organs. Painful, burning sensation while passing urine.	Sterility and arthritis in both men and women. In men, pain in testes. Inability to pass urine.	1. Go to a doctor. 2. Do not have sex until all signs and symptoms have cleared and you have completed your medication. 3. Do not take alcohol while on medication. 4. Your sex partner(s) must be examined and treated.
NON-GONOCOCCAL OR NON-SPECIFIC URETHRITIS (NGU)	Discharge from sex organs, usually watery. Symptoms mild or absent.	As above	As above.
PELVIC INFLAMMATORY DISEASE (PID, tube infection)	Severe lower abdominal pain. Vaginal discharge. Fever. Vomiting and nausea.	Recurrent lower abdominal (belly bottom) pain with infection of the tubes may result in sterility and surgery (operation).	As for gonorrhea. 1. Bed rest is essential until pain subsides. 2. Follow doctor's instructions carefully.
MONILIA OR CANDIDA (vaginal thrush)	Men may note whitish areas on tip of penis, some itching and soreness, but often there are no symptoms. Women: thick, curdy, white discharge with intense itching and soreness of vagina and vulva.	Newborn babies may have mouth and throat infection (thrush).	1. Go to a doctor. 2. Try not to scratch. 3. Wear cotton underwear. 4. Your sex partner(s) must be treated at the same time.

TRICHOMONIASIS (Trich)	Men may have discharge from penis with itching, but usually no symptoms. Women: frothy, watery, greenish discharge with offensive odor; some itching and soreness of vagina and vulva.	Chronic infection may increase your chances of getting cancer of the cervix.	1. Go to a doctor. 2. No alcohol should be taken during treatment. 3. Your sex partner(s) must be treated at the same time.
SYPHILIS (Hair cut, bad blood)	Painless pimple, blister, or sore on the penis, vagina, anus, lips, breast. Rash over body or on the hands and feet. Sore throat, fever, headache. Hair may fall out in patches.	Symptoms will disappear, but the germs will remain in the body, resulting in heart disease, blindness, dearness, crippling, brain damage, paralysis, madness, and death. Babies born to mothers who remain untreated may be born dead, or suffer from sniffles, sores, rashes, deformity and later have other complications.	1. Visit a doctor as soon as any signs and symptoms appear. 2. Insist that your sex partner(s) goes/go to the doctor. 3. Take full course of medication prescribed. 4. Do not take alcohol while being treated.

INFORMED CONSENT FOR VOLUNTARY SURGICAL CONTRACEPTION

What is informed consent?

Informed consent is the client's voluntary decision to undergo a sterilization procedure, with full knowledge and understanding of what is involved. Consent is voluntary when it is given of the client's own free will and is not obtained by means of special inducement (such as cash payment), deceit, pressure, or other forms of coercion. In order to make an informed choice regarding sterilization, the client must be told and must understand the six elements of the informed consent form.

What are the six elements of the informed consent form?

1. Temporary methods of contraception are available to the client or the client's partner. The client has a choice between temporary and permanent methods.

2. Sterilization is a surgical procedure. The client will undergo an operation.

3. There are risks and benefits associated with the procedure. (See Handouts 6-2 and 6-4.)

4. The client will no longer be able to have children. Fertility will be ended.

5. The effect of this procedure is permanent. If the possibility of reversal is a factor in the client's decision for sterilization, the client should not have the procedure.

6. The client has the option to decide against the procedure without sacrificing the right to other services. The client may change his or her mind at any time before the operation.

Why is informed consent important?

Making sure that the client understands the procedure and his or her other options, <u>before</u> undergoing the procedure, will help to:

* increase client satisfaction
* diminish the possibility of regret later on
* protect against possible legal action.

When should informed consent be obtained and documented?

In principle, informed consent may be obtained at any time before the operation. In terms of the counselling process, informed consent should be documented after the client requests the procedure and after the counsellor determines that the client's decision has been made voluntarily and with full understanding of the facts.

Informed consent *cannot* be obtained under the following circumstances:

* when a woman is sedated
* when a woman is in labour
* when a woman is experiencing stress before, during, or after a pregnancy-related event or procedure

Who may obtain and document informed consent?

The nurse responsible for hospital/clinic admission is usually the person responsible for obtaining and documenting the client's informed consent. However, in some settings other staff begin the counselling process, and the physician obtains and documents the client's informed consent. It is always the surgeon's responsibility to verify informed consent by talking with the client just prior to the procedure.

If you notice any warning signs that informed consent has not been achieved, it is your responsibility to postpone the procedure and refer the client for additional counselling.

Who is ultimately responsible for the consent form being signed?

The surgeon performing the procedure has ultimate responsibility for ensuring that informed consent is obtained and documented for every client who undergoes a sterilization procedure.

How should informed consent be obtained and documented?

Even though the elements of informed consent have been thoroughly discussed during counselling, you should read the entire form with the client before he/she signs it.

<u>If the client can read,</u> he or she should read each point aloud to the counsellor.

Pre-discharge (postpartum): The immediate postpartum woman may be distracted by physical discomfort or concern for her newborn. For others, the most pressing need is to go home and resume care of her family. Family planning may be a low priority at this time. Breast-feeding should be started prior to leaving the hospital.	To assess whether the pre-discharge client is receptive to family planning questions at this time, the health worker can ask the same questions as for antenatal (see above). The emotional and physical stress of pregnancy and delivery may motivate the woman to want to end her fertility. However, after she recovers her strength and feels healthy again, the woman may change her mind and regret such a decision. Counselling allows the health worker to determine whether the woman or couple were already planning to have no more children prior to delivery, or if the decision is being made under stress. If the decision was made before-hand to terminate fertility, the pre-discharge period is the best time for voluntary sterilization -- it is most convenient for the woman and easiest for the physician.
Post-natal visit: Primary concern is to confirm health of the newborn baby and/or the mother's recovery. If the woman has not resumed sexual activity, this visit may mark the end of postpartum abstinence -- which means that the woman may now have concerns about delaying or preventing pregnancy.	Status of breast-feeding should be discussed -- both for the infant's health and in terms of preventing pregnancy by delaying ovulation. To assess the post-natal client's family planning questions needs, the health worker can ask the same questions as for antenatal (see above).

POSTPARTUM INTRAUTERINE DEVICE (PPIUD)

from "Postpartum IUD Insertion: Clinical and Programmatic Guidelines", Association for Voluntary Surgical Contraception.

Rationale: PPIUD services provide women with an option for a long-acting and reversible contraceptive method that is convenient, safe, and practical. It is convenient in that the woman can have the IUD inserted after birth, before leaving the hospital, without requiring an extra visit to a service provider.

Insertion technique:

Manual insertion: Inserted with two fingers of one hand, while the other hand is placed on the belly to hold the uterus in place.

Insertion using ring forceps: The IUD is passed through the cervix and into the uterus with a special instrument (ring forceps). This is appropriate for postplacental insertion or any time within 48 hours after delivery, while the cervix is still wide open.

Timing of insertion:

Postplacental insertion: immediately (within 10 minutes) after the placenta comes out; either manually or with ring forceps.

Insertion after caesarean section: The IUD is placed in the uterus manually or with a ring forcep, before closing the uterine incision.

Immediate postpartum insertion: within 48 hours after delivery, or before leaving the hospital (no more than one week postpartum); with ring forceps.

Interval insertion: more than six weeks after delivery; with vaginal inserter.

Post-abortion insertion: The IUD can be inserted immediately after an induced abortion or miscarriage, as long as the cervix or uterus are not infected and the uterus is completely empty. The vaginal inserter can be used.

INSERTION FROM ONE TO SIX WEEKS AFTER DELIVERY IS NOT RECOMMENDED BECAUSE THE UTERUS IS SOFT AND THE RISK OF PERFORATION MAY BE HIGHER.

Effectiveness: Copper T380A is effective for eight years of use. The rate of unplanned pregnancies for PPIUD is about the same as for interval insertion (1.0 to 2.8 per 100 users over 24 months).

Expulsion of IUD: The side effect of PPIUD that differs from interval insertion is that the IUD is expelled from the uterus twice as often as for interval insertions. This is most likely to happen in the first few weeks after insertion.

COUNSELLING

* *Postpartum insertion:* Emphasis should be placed on counselling clients during the antenatal period, when clients have time to consider and discuss their family planning options with their partners. Also, their decisions at that time are not influenced by emotional and physical stresses of labor and delivery.

* *Post-abortion insertion:* Since the woman can ovulate again within three weeks after abortion, counselling and contraception at the time of the abortion is important to protect the woman against another unwanted pregnancy.

CONTRAINDICATIONS FOR PPIUD

Sexual history:

-- Women who currently have a sexually transmitted disease (STD).

-- Women who are at high risk for STD -- that is, they have more than one sexual partner, or their partner has more than one sexual partner.

-- Women with a history of pelvic inflammatory disease (PID).

Difficulties in pregnancy or delivery:

-- Membranes ruptured longer than 24 hours before delivery.

-- Fever or other signs of abdominal or pelvic infection.

-- Postpartum hemorrhage that continues after emptying the uterus.

-- Bleeding problems caused by eclampsia or pre-eclampsia.

Medical history:

-- Severe anemia.

-- Abnormal Pap smear, or other signs of genital cancer.

-- No access to a health center for follow-up.

<u>POST-INSERTION INSTRUCTIONS:</u> Ask or explain the following:

-- What does the client already know about IUDs?

-- Tell the woman what kind of IUD she has received. Show her either a sample or picture of the IUD sot hat she can see how it looks and how large it is.

-- The IUD will prevent pregnancy for 8 years (Copper T380A).

-- Within a few weeks, the IUD strings will probably come down from the womb into the vagina. A health care worker will shorten the strings during the follow-up visit if they are troublesome.

-- There is a possibility that the IUD may be pushed out, especially during the first few weeks after insertion. This can happen if she has cramps in her lower abdomen. She may find the IUD if it is expelled. She can have another IUD inserted, if she chooses. If the IUD comes out during her postpartum hospital stay, she can get another before she goes home. Otherwise, the IUD can be replaced at the six-week visit.

-- Explain how to check for the IUD strings. She should do this at least once a month, after her period; but she should not start checking for the strings until after 6 weeks postpartum. She should return to the clinic if the strings seem to be missing and she can no longer feel them.

-- Once menstruation returns, some women with IUDs have more cramping and heavier bleeding during their periods.

-- The IUD will not protect her or her partner against HIV infection and other sexually transmitted diseases. Aside from abstinence, rubber condoms offer the best protection against HIV infection and other STDs.

-- Describe the warning signs for potential complications:

* late period or other signs of pregnancy

* bleeding or spotting between periods or after intercourse

* severe pain in her belly

* pain during intercourse

* unusual discharge from her vagina beyond six weeks postpartum

* missing, shorter, or longer strings

* if she can feel the IUD itself when checking for the strings

-- Tell the woman where to seek help if any of these warning signs occur.

-- She can have the IUD removed if she changes her mind about the method. It is best if she not try to remove the IUD herself.

-- She needs to return for routine follow-up. The first follow-up visit for PPIUD clients is usually done at the six-week postpartum check-up. After that, an annual pelvic exam is recommended.

-- She can go to a health facility anytime if she has questions or concerns.

-- Give the client a written copy of these instructions.

COUNSELLING STEPS: GATHER

* Family planning counselling has six basic steps. You can remember them with the word GATHER.

* Counselling should suit the individual client. Each step will differ from client to client. Change how you counsel to suit each client's needs.

* Clients may be men or women. For ease of understanding, the client is referred to as "she" in this hand-out.

G: Greet

Purpose: Put the client at ease and show her that she has your full attention.

* How are you today? How is your family?
* What can I do for you today?

A: Ask/Assess

Purpose: Assess the client's family planning needs (short-term, long-term, or permanent) and knowledge.

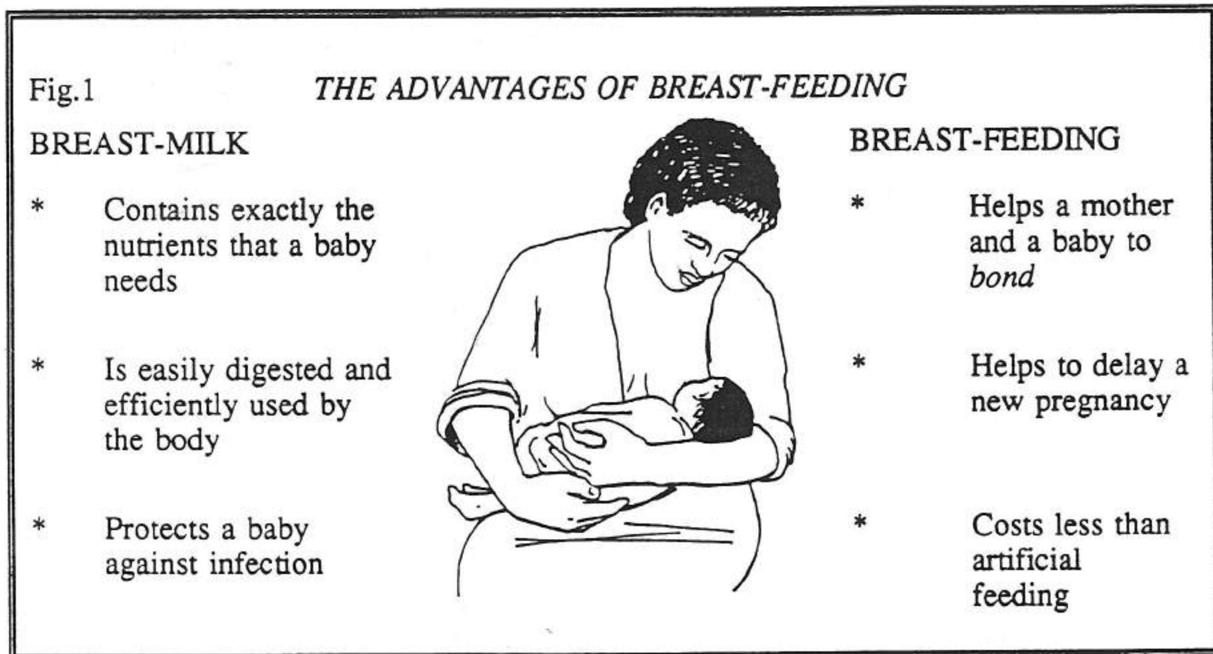
* How many children would you like to have?
* When would you like to have your next child?
* What are your thoughts about preventing pregnancy until you are ready for another child?
* What do you know about family planning?
* What methods have you used? What was your experience with them?

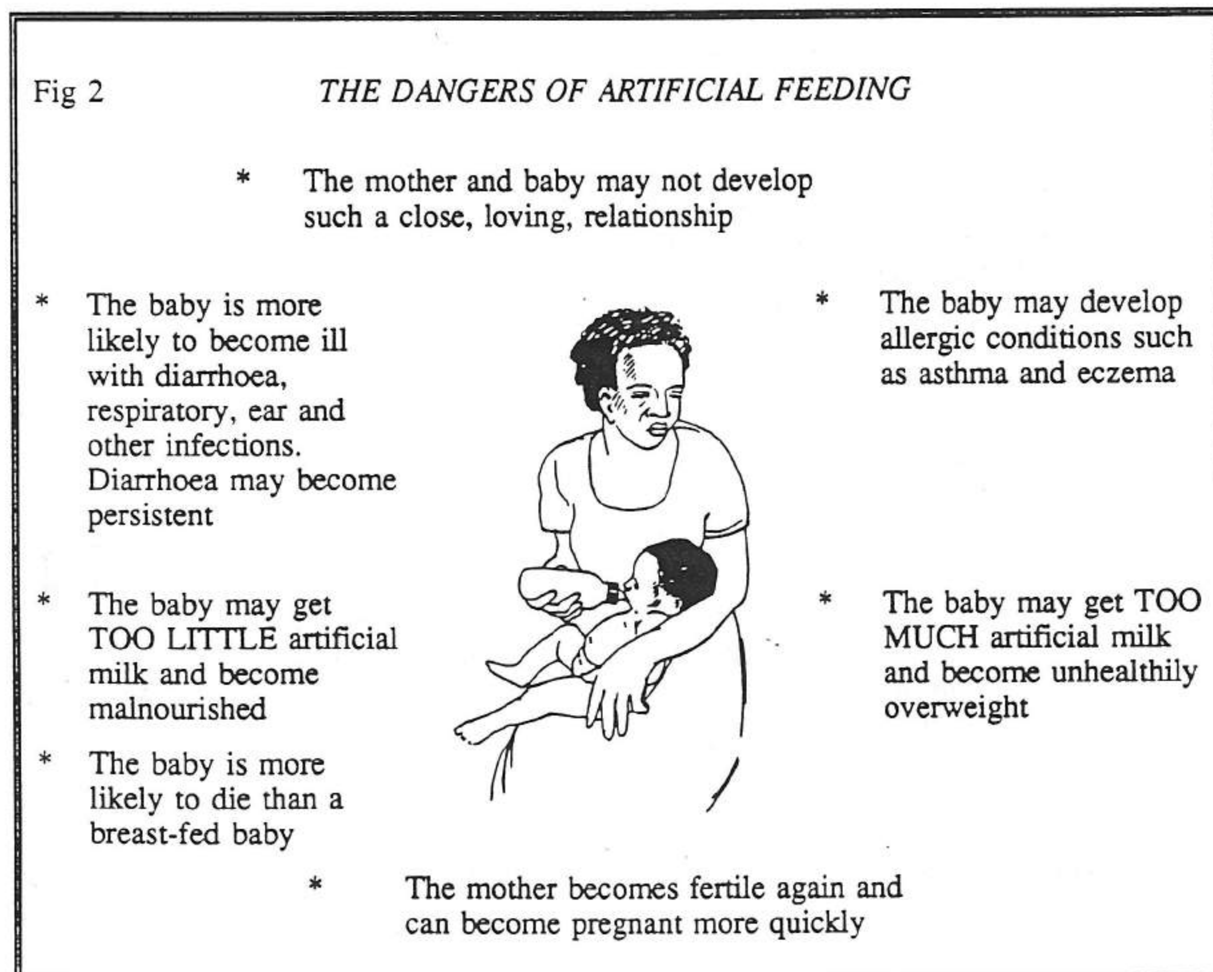
Staff confused about the differences between motivation, information-giving, and counselling	* Orient staff to the differences between these forms of communication and the role of each.
Unfamiliar local languages or dialects	* Train local personnel who speak the languages to do counselling. * Use an interpreter if needed. * When hiring new staff, look for someone who speaks the local languages.
Limited time for counselling	* Provide basic information about family planning in group sessions. * Conduct client flow analysis to see whether staff time can be used more efficiently. * Lengthen clinic hours or increase days. * Train and orient more workers.
Health personnel or other team members unconvinced of the value of counselling	* Provide orientation to other staff on what counselling is and why it is important.
Rumours about family planning circulating in the community	* Try to understand how the rumours have developed. Correct false information. * Provide balanced information about family planning. * Work with others in the community (for example, other health providers and outreach workers) to address rumours. * Address rumours in counselling.
Hesitant or doubtful client	* Create an atmosphere of trust. Try to put client at ease. * If client is accompanied by others (such as family members or spouse), find a way to talk to client alone. * Give the client time to think about what she or he has heard.

GUIDELINES FOR COUNSELLING LOG

DATE	*COUN-SELLING SITE*	*CLIENT'S NAME*	*AGE*	*PARITY*	*GRAVIDA*	*DOCKET NO. FOR ANC*	*FP METHODS USED IN PAST*	*FP METHOD CHOSEN*	*REFERRAL*	*REMARKS*

Figures 1 and 2 summarise the main advantages of breast-feeding and the dangers of artificial feeding.





Breast-feeding definitions

To discuss breast-feeding, it is helpful to be clear about the words for different sorts of infant feeding. If we say that a baby is 'breast-fed', it may mean that the baby is having nothing else; or he may be having bottle feeds, or other food and drinks as well as breast milk.

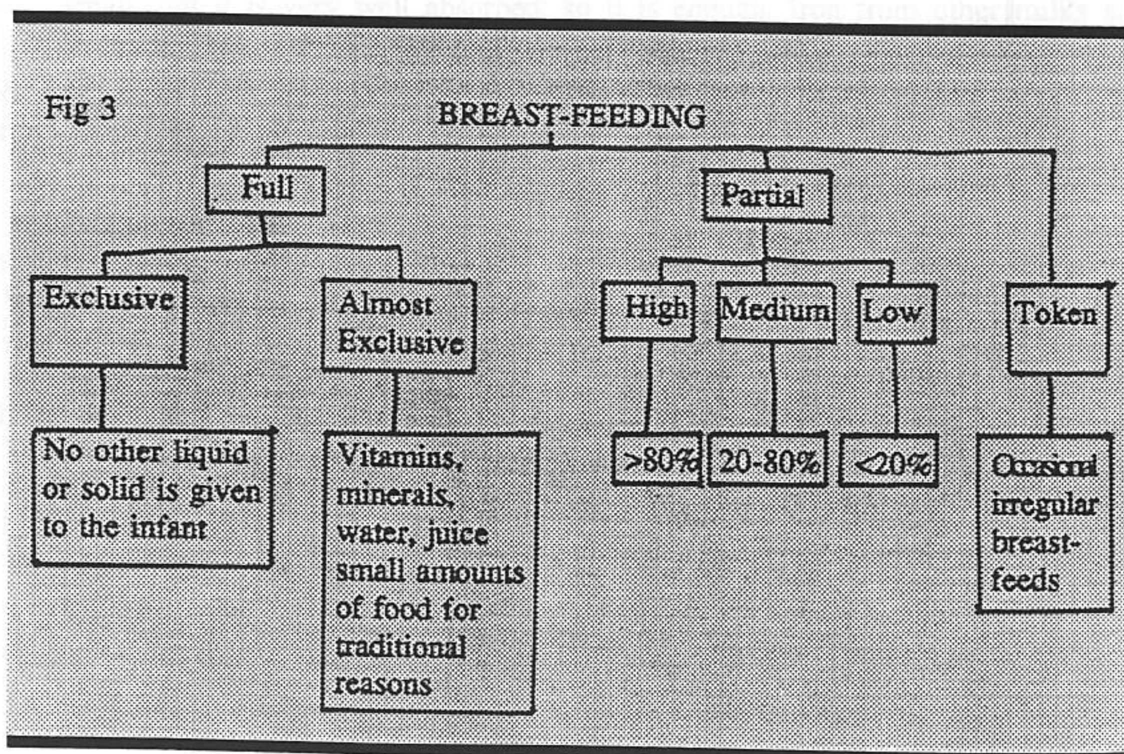
Exclusive breast-feeding means that the baby is only breast-fed and has no other food or drink.

Almost exclusive breast-feeding means that the baby is breast-fed, but also has vitamins or minerals, drinks of water or juice, or small amounts of a food given for traditional reasons.

Full breast-feeding means exclusive and almost exclusive breast-feeding considered together.

Partial breast-feeding means that the baby has some other feed in addition to breast-feeding. If less that 20% of feeds are other than breast-feeding, it is *high* partial breast-feeding; between 20% and 80% is *medium*; if more than 80% of feeds are other food, then it is *low* partial breast-feeding.

Token breast-feeding means that the child still breast-feeds sometimes, but has only small amounts of breast-milk. He gets most of the nutrients that he needs from other food.



Variations in milk composition

Colostrum is the thick, yellowish milk that the breasts produce in the first 2-3 days after delivery. It contains more antibodies, white blood cells and protein than the *mature milk* which is produced later.

Foremilk is produced at the beginning of a feed. It contains plenty of protein, lactose and water. It often looks greyish and watery, which may worry some mothers.

Hindmilk is produced towards the end of a feed. It contains about 3 times as much fat as foremilk, so it is rich in energy. It looks whiter than foremilk.

Lecture 3 How breast-feeding works

Three reflexes in the mother

Figure 3 shows the anatomy of the breast, and Figures 4 and 5 show the prolactin and oxytocin reflexes.

1. *Prolactin reflex*
   When the baby suckles, prolactin and oxytocin go from the pituitary gland near the brain to the mother's breasts.

   Prolactin makes the gland cells in the breast secrete milk.
   Important points to remember are:
   - If the baby suckles more, the breasts produce more milk.
   - If a baby suckles less, the breasts produce less milk.
   - More prolactin is produced at night, so breast-feeding at night helps to keep up the supply.
   - Prolactin and related hormones suppress ovulation, and this can help to delay a new pregnancy.
   - The mother's thoughts and feelings do not affect this reflex, so they do not prevent her from producing milk.

2. *Oxytocin reflex*
   When the baby suckles, oxytocin goes from the pituitary gland near the brain to the mother's breasts.

   Oxytocin makes the muscle cells round the glands contract, which makes the milk flow.
   Important points to remember are:
   - Oxytocin releases the milk in the breast for THIS feed.
   - The oxytocin reflex can be affected by the mothers thoughts and feelings. Good feelings help the milk to flow. Bad feelings may hinder the flow of milk.
   - Seeing or hearing or thinking about the baby can make the milk flow.

3. *Reflex within the breast*
   The amount of milk that a breast makes depends on how much is removed at each feed and how much remains after the feed. If more milk is removed, the breast makes more. If more milk remains, the breast makes less milk.

How a baby suckles

We use the word *suckle* for the action of breast-feeding. It is different from *sucking* from a bottle. The baby's suckling controls the production and flow of breast-milk.

To suckle effectively, a baby has to take the nipple, much of the areola and the tissues beneath into his mouth. He forms a long 'teat' out of the breast tissue, which contains the lactiferous sinuses. The nipple forms only about the posterior one third of this teat. The baby's tongue is forward over the lower gum, and curled around the 'teat' of breast tissue. As the baby suckles, a wave of peristalsis goes along the tongue from front to back, pressing milk out of the lactiferous sinuses.

Mothers have to learn how to get a baby to take enough breast into his mouth. Some have no difficulty at all. But other mothers and babies need help at first to get it right, from a midwife or from another experienced woman who knows what to do.
If a mother has help early, she can soon overcome any difficulty getting the baby to suckle in the right way. If she does not have help, she may have more serious problems.

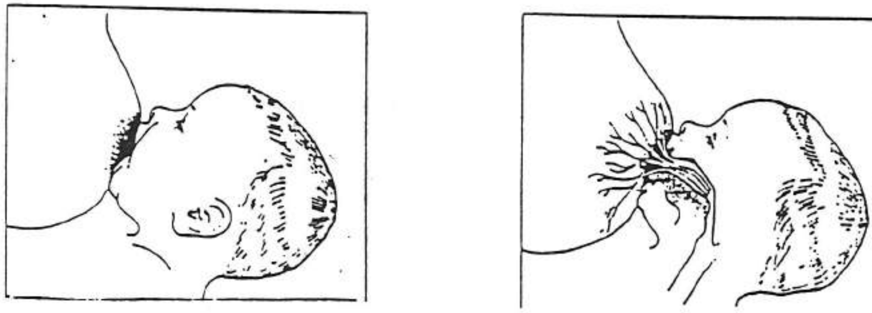


Fig. 6 Suckling in a good position

a) Appearance from the outside: the baby is close to the breast with his mouth wide open.
b) What is happening inside the baby's mouth: breast tissue forms a long teat in the baby's mouth. A wave goes along the baby's tongue, which presses milk out of the sinuses.

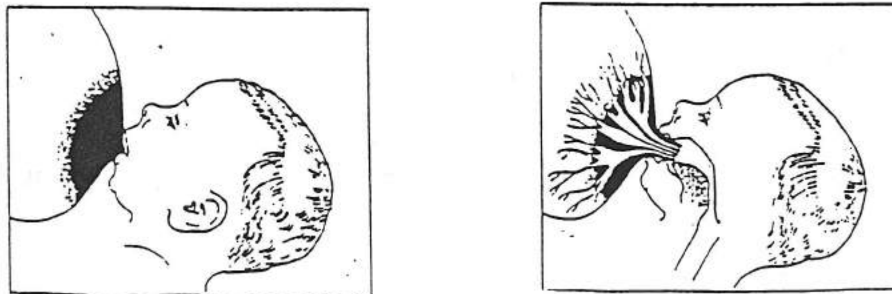


Fig. 7 Suckling in a poor position

a) Appearance from the outside. The baby is not close to the breast, and his mouth is not wide open. His lips point forward.
b) What is happening inside the baby's mouth. Only the nipple is in the baby's mouth. His tongue cannot reach the milk sinuses to press out the milk.

Effects of suckling in a poor position

If a baby does not take enough of the breast into his mouth, his tongue cannot press the milk out of the sinuses. He does not get enough milk. Also, sucking this way is painful for the mother, and it can damage the nipple skin.

A poor suckling position can be the cause of many breast-feeding problems:

* Engorged breasts;
* Sore and cracked nipples;
* Unsatisfied babies, who want to feed very often or for a very long time;
* Frustrated babies who fuss at the breast or who refuse to breast-feed;
* Mothers who believe that they do not have enough milk;
* Babies who fail to grow.

The main reasons why a baby may suckle in a poor position are:

* The mother is inexperienced, and has no-one to help her.
* The baby has been fed from a bottle, either soon after birth, or at any other time. "Nipple sucking" is often the result of a baby trying to suck from a breast in the same way that he has learned to suck from a bottle.
* There is some functional difficulty - for example, the baby is small and weak, the breasts are very engorged, the nipple is not protractile, or breast-feeding started too late.

Finishing a feed

When a baby finishes a feed, he usually comes off the breast by himself. There is usually no need to take him off the breast.
It is better to let him continue as long as he wants, so that he gets plenty of energy rich hindmilk.

One or both breasts?

Some babies want both breasts at every feed. But some babies are satisfied after suckling from one breast, or they may want only a little from the second breast. The mother can let the baby start on the other breast next time, so that he suckles both breasts equally. Then both breasts will continue to make plenty of milk.

Lecture 4 Health care practices and breast-feeding

How to prepare mothers antenatally for breast-feeding

It is generally considered important to discuss breast-feeding with a woman during pregnancy. However, it is not clear what is the best way to do this, to really help breast-feeding.

- *Informing* a woman about breast-feeding may help her to succeed.
  Informing her about hospital practices may be important - especially if these have changed.
- *Advising* a woman to breast-feed, however, may not change her mind, if she plans to bottle feed.
- *Examining the breasts* may help a midwife to anticipate a problem. However, it is difficult to tell before delivery which nipples will cause problems, as they often improve around the time of delivery. The woman may be discouraged from trying if she expects problems.
- *Preparation of the breasts* with nipple shells, stretching exercises and creams have not been proven to be of any benefit. Expressing colostrum is not necessary, though it is probably not harmful. If it is customary to express colostrum it may help to give mothers confidence.

How to help mothers to initiate breast-feeding

These maternity ward practices help mothers to initiate breast-feeding successfully:

* Letting the mother hold the baby, if possible with skin-to-skin contact, for the first two hours, beginning within a few minutes after birth.
* Encouraging the mother to let the baby feed as soon as he is ready, which is usually some time in the first hour or two. There is no fixed time, and it is not necessary to force the baby to the breast.
* Letting the baby stay in the same room as his mother, day and night, from the time of birth. The baby can be in the same bed as the mother, or in a cot close beside the bed where she can touch him easily (*"rooming in"*).
* Giving no food or drink other than breast-milk to a baby, unless a clinical need is demonstrated.
* A skilled, experienced person such as a midwife helping the mother with the first real feed. The midwife should ask the mother how she feels, observe the feed, make sure that the baby is suckling in a good position, and answer any questions that the mother may have.
* Unrestricted feeding - with no limits on time or frequency, (*"demand feeding"*).

Helping mothers to sustain breast-feeding

Health workers in health centres and the community have a responsibility to encourage and support mothers to continue breast-feeding after they have left the maternity ward. Every contact with a mother and baby may be an opportunity to help her with breast-feeding. During the course, you will learn how to help mothers in these situations.

* Mothers who breast-feed easily and well, with no problems:
  Encourage them to continue with exclusive breast-feeding for at least four months, if possible for six months.
  Encourage them to continue breast-feeding with adequate complementary foods up to 2 years or beyond.
  Encourage them to support and help other breast-feeding mothers.

* Mothers who have no difficulties breast-feeding, but who do not do it in the best way:
  For example, they do not give the baby colostrum. Or, they give other drinks or supplements which are not necessary; or, they do not feed the baby very often. Discuss breast-feeding with these mothers, to prevent possible problems in future.

* Mothers who have worries that are not serious problems:
  Reassure mothers who worry that their babies may be constipated; that breast-feeding may spoil their figures; that their breasts are too small (see page 00).

* Mothers who have problems with breast-feeding:
  Counsel and help mothers with breast problems such as sore nipples, engorgement, mastitis;
  Counsel mothers who are worried about their milk supply, or whose baby refuses to suckle.

* Mothers and babies who have come to you for another reason: Remember to discuss breast-feeding when you care for:
  - mothers who need family planning;
  - mothers who are ill;
  - children who are ill;
  - children who come for growth monitoring;
  - children who have come for immunization - including measles immunization at 9 months.

* Mothers and babies with special needs:
  Give extra help and support to mothers with:
  - low birth weight babies;
  - twins;
  - babies with disabilities.

* Mothers who have to work away from home:
  Help these mothers to continue breast-feeding after they return to work.

Lecture 5 Common breast-feeding problems

Flat and inverted nipples

- Antenatal preparation is of unproven benefit. Nipples improve around the time of delivery.
- Mothers need extra help to get the baby to take enough of the breast into his mouth. Often this help is all that is needed.
- If necessary express milk, and feed to baby from a cup until the baby can suckle.
- Simple techniques sometimes help to draw out nipple, to enable baby to suckle. eg, inverted syringe, suckling by older child.

Long nipples

- Baby may suckle only on nipple, and not on breast.
- Help mother to make sure that baby takes enough breast into his mouth.

Full breasts

Diagnosis

- Both breasts hot, heavy, hard, but milk FLOWS.

Treatment

- Frequent feeds.

Engorgement

Diagnosis

- Both breasts painful, tense, red shiny.
- The milk does NOT flow well.
- If the nipple is pulled tight, it may be difficult for the baby to take enough breast into his mouth.

Treatment

- If possible, get the baby to feed frequently.
- If feeding difficult, express milk until breasts softer.
- Warm compress, or a warm shower before feeds to help milk flow.
- If oedema is severe, cold packs may help to reduce oedema and relive pain. Apply these after feeds.

Blocked duct

Diagnosis

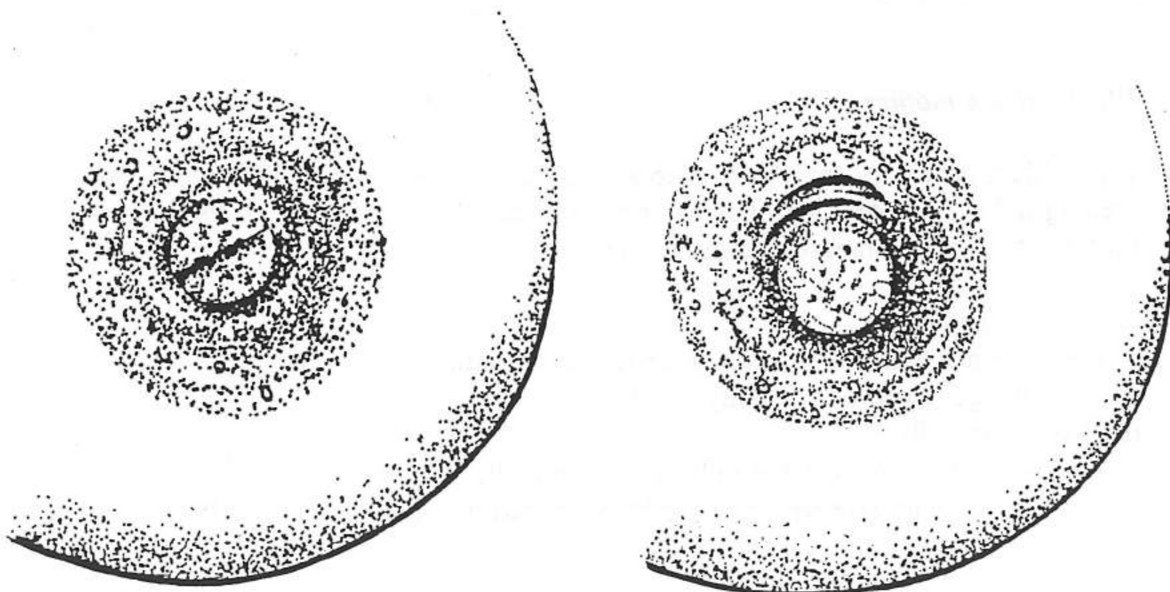
- A tender lump in one breast
- Mother is well and has no fever

Treatment
- Feed baby frequently, on breast with lump first.
- Gently massage the lump before and during feeds
- Feed baby in different positions, to suckle from all parts of the breast.
- Avoid tight clothing.

Mastitis
Diagnosis
- Hot, swollen, painful area in part of one breast,
- Mother has fever and is ill.

Treatment
- Breast-feed frequently, including from infected breast
- Express milk if necessary.
- Apply warm compresses and analgesics to relieve pain
- Rest in bed and time off work until better.
- Give appropriate antibiotic for 10 days

Sore nipples and nipple fissure
- Improving suckling position is often all that is needed.
- Put hindmilk onto nipple after a feed to aid healing.
- Dry nipples in the air - not covered up.
- Avoid extra washing of nipples, and do not use soap.
- Creams and ointments are not necessary.
- Check for candida (thrush) and if found, treat both baby and mother.



Lecture 7 Mothers nutrition, health, and fertility

Mother's nutrition

During pregnancy, an adequately nourished woman stores some fat, which is used later to make breast-milk.

Making breast-milk for a fully breast-fed baby uses about 700 Calories a day:
- 200 Calories come from fat stores.
- 500 Calories come from food.

So a woman needs about 500 Cals extra from food a day to make breast-milk. She also needs about 18-21 g extra protein a day.
She continues to need extra food to make breast-milk throughout the whole time that she is breast-feeding.

If a woman does not eat extra, her own body tissues are used to make milk for the baby. If she is undernourished, breast-feeding may make her more undernourished. It may take 6 months after she stops breast-feeding to build up her body stores again.

- *Moderately undernourished women* can produce enough breast-milk, but it is at the expense of their own bodies.
- *Severely undernourished women* may produce 20-30% less breast-milk than well-nourished women -but they may continue to produce 500 ml a day if the baby suckles often enough. The quality of the milk is still good and better than any artificial food. However, the amount of fat, vitamin A, and iodine, may decrease, and the baby is more likely to outgrow the supply at about 4 months.

Health workers should encourage women to eat more during lactation, especially women who are undernourished. The food is needed to make breast-milk, and to keep the woman's body strong and healthy. Extra food for the mother is cheaper than formula for the baby.

Illness of the mother

It is seldom necessary for a mother to stop breast-feeding because she is ill. Breast-feeding helps to protect the baby against infectious illnesses in the mother. Support mothers to continue breast-feeding in these ways:

Common illnesses

0 Reassure her that it is safe to continue breast-feeding.
  - encourage her to drink plenty.

0 If she is unwilling:
  - help her to express her milk while she is ill;
  - let someone else wetnurse the baby or feed him by cup and not bottle;

- help her to start again when she is better;

0 Explain how she can build up her milk supply again, if it decreased during the illness (see Section 3, Demonstration 3).

Tuberculosis

0 Keep the mother and baby together, and continue breast-feeding

0 Refer to you country's TB programme for the policy on
  - immunizing the baby with BCG
  - treating the baby with antituberculous drugs.

HIV infection (check new policy)

Most babies who get AIDS are infected before they are born. The risks of bottle feeding are greater than the chances of getting AIDS through breast-milk.

0 Breast-feed the baby normally.

Mental illness

0 Keep the baby with the mother if possible,

0 Let her breast-feed

0 Try to find a helper (usually a relative) to stay with her all the time to make sure that she does not neglect or injure the baby.

The mother is hospitalised

0 Try to admit the baby to hospital with the mother

0 If necessary show the family how to cup feed.

0 Help the mother to express her milk to keep up the supply

0 Support her to breast-feed again and build up her supply when she is well.

Breast-feeding and mother's medication

It is usually quite safe for a mother to continue breast-feeding when she is on treatment herself.

A very few drugs are definitely harmful

Anti-cancer drugs, anti-thyroid drugs, radioactive drugs, and repeated doses of ergot (one dose of ergot postpartum is not harmful)

A few drugs may decrease the milk supply

Oestrogens, thiazide diuretics.

Try to avoid using these in breast-feeding mothers.

A few drugs may cause mild side effects

Diazepam, barbiturates, tetracycline, sulphonamides, chloramphenicol.

Try to use an alternative drug. But if an alternative is not possible, do not stop breast-feeding. Watch the baby for any side effects.

Most drugs are safe
Most antibiotics, antipyretics, anticoagulants, most contraceptives, and long term drugs for TB, leprosy, epilepsy, and mental illness.

Breast-feeding and child spacing

Breast-feeding helps child spacing

Breast-feeding can delay the return of ovulation and menstruation, so it is an important way to delay a new pregnancy.

The baby must breast-feed frequently during the day and during the night to stimulate secretion of prolactin and other hormones.

A woman's chances of becoming pregnant are small (less than 2%) and she need not use another method of family planning if:
- the baby started suckling within an hour or two of delivery
- the baby is less than 6 months old
- her periods have not returned
- the baby is fully breast-fed as follows:
  at least 8-10 times in 24 hours
  with no interval of more than 6 hours between breast-feeds

Her chances of becoming pregnant are greater (perhaps 7-10%), and she should consider using another family planning method if:
- the baby is 6 months old or more
- she gives the baby other food or drinks

However, she has some protection if:
- her periods have not returned;
- she continues to breast-feed frequently;
- she breast-feeds before she gives a complementary feed. This may be helpful if she is unable to use another method.

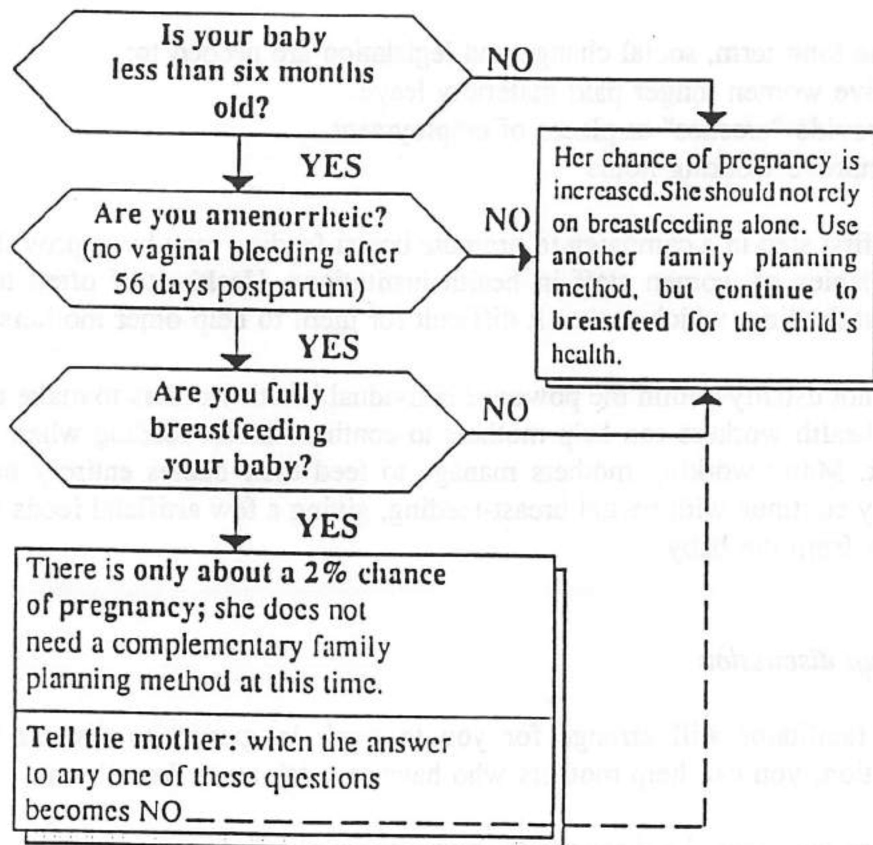
If her periods have returned, breast-feeding does not protect her.

Family planning helps breast-feeding

Many mothers are unwilling to continue breast-feeding if they have become pregnant again. So helping a mother to delay a new pregnancy is important to enable her to continue breast-feeding.

If a woman does not want to rely on breast-feeding to protect her, she should start another method of family planning by six weeks after delivery. Most methods are safe for breast-feeding.

Combined pills which contain oestrogen as well as progesterone may reduce the amount of breast-milk that the mother produces. Avoid oestrogen containing pills if possible. However, if no other method of family planning is available, it is better for both mother and child to use combined pills than to risk an early pregnancy.



Classwork 10

WOMEN AND WORK

Introduction

You may have to counsel a number of mothers who want to breast-feed, but who have to work away from home and leave the baby behind with a carer. This may be a problem which faces you personally in your working life.

In the long term, social change and legislation are needed to:
- Give women longer paid maternity leave
- Provide "creches" at places of employment
- Improve working hours

The first step in a campaign to promote breast-feeding may be to provide a creche for the babies of women staff in health institutions. Health staff often have problems breast-feeding, which makes it difficult for them to help other mothers.

It is not usually within the power of individual health workers to make these changes. But health workers can help mothers to continue breast-feeding when they return to work. Many working mothers manage to feed their babies entirely on breast-milk. Many continue with partial breast-feeding, giving a few artificial feeds while they are away from the baby.

Group discussion

The facilitator will arrange for you to work in groups to discuss how, in your situation, you can help mothers who have to work away from home.

Before you have the discussion:

1. Look back at Lecture 1, and review the benefits of exclusive breast-feeding, partial breast-feeding, and dangers of complete artificial feeding. Remember that the more breast-feeding a mother can do the better, even if she has to give a few artificial feeds.

2. Read the following section *'Mothers who work away from home'* which explains possible ways to help working mothers to breast-feed, or at least to partially breast-feed.

3. Think of mothers you know who have succeeded in breast-feeding while they are working. Think of how they managed, and of the kind of support that they needed.

MOTHERS WHO WORK AWAY FROM HOME

Discuss these possibilities:

0 If possible take your baby with you to work, or go home to feed him during breaks, or ask someone to bring him to you at work to breast-feed.

0 If your home is too far from your work place; if there are no creches; or if transport is too crowded; you can give your baby the benefit of breast-feeding in these ways:

0 *Breast-feed exclusively and frequently for the whole maternity leave.* This gives the baby the benefit of breast-feeding, and it builds up your supply. The first two months are the most important.

0 *Do not start other feeds before you really need to.*
Do NOT think "I shall have to go back to work in 12 weeks so I might as well bottle feed straight away."
Wait until about a week before you go back to work. Leave just enough time to teach the carer who will look after the baby.

0 *Continue to breast-feed at night, in the early morning, and at any other time that you are at home*
- This helps to keep up your milk supply.
- It gives the baby the benefit of breast-milk - even if you decide to give him one or two artificial feeds during the day.
- Many babies "learn" to suckle more at night, and get most of the milk that they need then. They sleep more and need less milk during the day.

0 *Learn to express your milk* soon after the baby is born, so that you can do it easily, (See Demonstration 2)

0 *Express milk before you go to work,* and leave it for the carer to give to the baby.
- Leave yourself enough time to express your milk in a relaxed way. You may need to wake up half an hour earlier than at other times. (If you are in a hurry, you may find that you cannot express enough milk.)
- Breast-feed the baby as soon as you wake up, before you get up.
- Express as much milk as you can, into a very clean cup or jar. Some mothers find that they can express 2 cups (400-500 ml) or more even after the baby has fed. But even 1 cup (200 ml) can give the baby 3 feeds a day of 60-70 ml each.
- Leave about ½ cupful (100 ml) for each feed that the baby will need while you are out. If you cannot express as much as this, express what you can. Whatever you can leave is helpful.
- Cover the cup of expressed milk with a clean cloth or saucer.
- Leave the milk in the coolest place that you can find -- in a refrigerator if you have one, or in a safe, dark corner of the house.

- Do not boil the breast-milk or reheat it for the baby. Heat destroys most of the anti-infective factors.

EBM stays in good condition longer than cow's milk, because of the anti-infective factors in it. Germs do not start growing in EBM for at least 8 hours, even in a hot climate, and outside the refrigerator. It is safe to give to the baby at least throughout one working day.

0 *If you decide to use cow's milk for some or all of the feeds:*
- To make 1 cup (200 ml) of feed, boil 2/3 cup of cow's milk and 1/3 cup of water. Add 1 spoonful of sugar.
- Leave 1/2 to 1 cup (100-200 ml) of mixture for each feed.
- Leave the mixture in a clean covered container.
- From the age of six months, give full strength cow's milk, and also drinks of water.

0 *If you decide to use formula:*
- Measure the powder for a feed into one clean cup or glass.
- Measure the water to make up the feed into another clean glass.
- Cover them both with a clean cloth, or put them in a covered pan.
- Teach the baby's carer to mix the milk powder and water when she is going to feed the baby. She must mix and use the formula immediately, because it spoils very quickly after it is mixed.

* Note: There are many different ways to leave milk for a baby. These are satisfactory methods. You may find that a different method is better for you in your situation.

0 *Teach the carer properly and carefully*
- Teach her to feed the baby with a cup, and not to use a bottle. Cups are cleaner, and they do not satisfy the baby's need to suckle. So, when the mother comes home, the baby wants to suckle at the breast, and this stimulates the breast-milk supply.
- Teach her to give all of one feed at one time. She must not keep it to give later; and she must not give a small amount every now and again.

0 *While you are at work express your milk 2-3 times*
- If you do not express, your milk supply may decrease. Expressing also keeps you comfortable, and reduces leaking.
- If you work somewhere where you can use a refrigerator, keep your EBM there. Carry a clean jar with a lid to store the milk, and to take it home for the baby.
- If you cannot keep the EBM, throw it away. Your baby has not lost anything - your breasts will make more milk.

If you are a health worker, make sure that your patients know and see how you manage. Then, they can follow your example.