Health Extension Service Level - IV

Module Title: Manage Comprehensive Family Planning Service

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Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

- Introduction to population and family planning
- Planning family planning service

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Describe population and family planning
- Plan family planning service

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below.
3. Read the information written in the “Information Sheets”. Try to understand what are being discussed. Ask your trainer for assistance if you have hard time understanding them.
4. Accomplish the “Self-checks” which are placed following all information sheets.
5. Ask from your trainer the key to correction (key answers) or you can request your trainer to correct your work. (You are to get the key answer only after you finished answering the Self-checks).
6. If you earned a satisfactory evaluation proceed to “Operation sheets
7. Perform “the Learning activity performance test” which is placed following “Operation sheets” ,
8. If your performance is satisfactory proceed to the next learning guide,
9. If your performance is unsatisfactory, see your trainer for further instructions or go back to “Operation sheets”.

Information Sheet 1- Population and family planning

1.1 Introduction to population and family planning

The current Ethiopian natural population increase is 2.6%. It will take 27 years for the population to double in size, which will make Ethiopia to be the fifth country with the greatest projected population increase by adding more than 83.4 million people from 2018 to 2050 (World Population Data, 2018.) This makes the total population of Ethiopia 139.6 million in 2030 and 190.9 million in 2050. With the current age structure, 45% of the population will be under 15 years of age which will put great pressure on the country's economy. As the population that is more youthful is growing, investment in family planning will provide an opportunity for a demographic dividend (DD) in the country. Accordingly, it requires concerted activity to increase the country's Contraceptive prevalence rate (CPR) and improve the method mix.

Family planning helps people have the desired number of children, which as a result improves the health of mothers and contributes to the nation's social and economic development. In most developing countries, including Ethiopia, it is common practice for women to have too many children, too close to one another. As a consequence, the population size of the country has grown dramatically but economic growth has not kept in parallel with it. Such an unbalanced population size will inevitably have a negative impact on the wellbeing of the nation. Family planning is one of the strategies which is proving to be effective in tackling these problems.

1.1.1. Unwanted pregnancy and its outcome

Unwanted pregnancy is either **mistimed** (occurs earlier than desired) or **unwanted** (is not wanted at all) at the time of conception. Un intended pregnancies are higher when: Outcomes of un wanted pregnancy includes the following;

- High infant mortality
- Less breastfeeding
- Less preventive care and treatment
- More infant illness

Figure 1: Outcome of unwanted pregnancy

1.1.2. Family planning methods

Commonly there are two family planning methods by which unwanted or unplanned pregnancy can be prevented. These contraceptive methods are generally classified into natural and artificial (modern) methods.

1.1.2.1 Natural family planning

Natural family planning (NFP) is the method that uses the body's natural physiological changes and symptoms to identify the fertile and infertile phases of the menstrual cycle. Such methods are also known as fertility-based awareness methods.

During the menstrual cycle once a month an egg is released from one of a woman's ovaries (ovulation); it can stay alive in the uterus for about 24 hours. Men can always produce sperm cells, and these can stay alive in the female reproductive system for about two to five days after being deposited in the vagina during sexual intercourse.

This means, from a fertility point of view, women have periods of time during their cycle when they are unlikely to conceive, whereas men have no 'safe period'.

Note: These methods depend on the awareness and ability of the couple to identify the fertile and infertile phase of each menstrual cycle, and also require cooperation between the couple to abstain from, or to have, sexual intercourse, depending on whether they are trying to avoid or achieve pregnancy.

- Advantages: -
  - ✓ Preferred contraceptive method for women who do not wish to use artificial methods of contraception for reasons of religion, or who, due to rumors and myths, fear other methods.
- Disadvantages: -
  - ✓ Unreliable in preventing unwanted pregnancy.
  - ✓ It takes time to practice and use them properly.
  - ✓ It do not protect against sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV).
- Effectiveness: - Can vary from couple to couple, and all these methods are less effective for couples who do not follow the method carefully.

1.1.2.1.1 Types of natural family planning methods

There are three major classifications of natural family planning methods:

I. Periodic abstinence (fertility awareness) method

- ✓ During the menstrual cycle, the female hormones estrogen and progesterone cause some observable effects and symptoms:
- ✓ Estrogen produces alterations in the cervical mucus, which changes from thick, opaque and sticky to thin, clear and slippery as ovulation approaches.
- ✓ Progesterone produces a slight rise in basal body temperature (temperature at rest) after ovulation. Otherwise, the function of progesterone on the cervical mucus is just the opposite effect of estrogen-it makes the cervical mucus thick, opaque and sticky.

- ✓ Observation of these changes provides a basis for periodic abstinence methods.

The three common techniques used in periodic abstinence methods, namely:

- Rhythm (calendar) method
- Basal body temperature (BBT) method
- Cervical mucus (ovulation) method.

A. Calendar or rhythm method

- ✓ Is the most widely used of the periodic abstinence techniques
- ✓ Is a calculation-based approach where previous menstrual cycles are used to predict the first and the last fertile day in future menstrual cycles
- ✓ This method requires a good understanding of the fertile and infertile phases of the woman's menstrual cycle.
- ✓ It is based on the regularity of the menstrual cycle and the fact that an ovum (egg) can only be fertilized within 24 hours of ovulation.

Advice to women using the calendar method

- o For irregular cycles, identify the longest and the shortest cycles recorded over six to eight cycles.
  - ✓ Subtract 18 from the shortest cycle (gives the first day of the fertile phase).
  - ✓ Subtract 11 from the longest cycle (gives the last day of her fertile time).
  - ✓ Avoid sex, use a barrier method, or use withdrawal during the fertile phase calculated.

Advantages of the calendar or rhythm method

- o It does not require daily monitoring of fertility indicators.

Disadvantages of the calendar or rhythm method

- o It is associated with a high failure rate and can be difficult to use in the case of irregular menstrual cycles. It also takes a long time to learn and use it properly.

Effectiveness of the calendar or rhythm method

It is about 95% effective if a woman uses it correctly

B. Basal body temperature (BBT) method

- The basal body temperature method is based on the slight increase in the body temperature of women at rest by about 0.3–0.5°C during and after ovulation, due to the action of an increased level of progesterone secreted by the corpus luteum.
- The rise in body temperature sustained for three consecutive days indicates that ovulation has occurred, and it remains at this increased level until the start of the next menstrual cycle.
- This natural family planning method may be selected if the woman is not willing to touch her genitalia to check her cervical secretions (as in the cervical mucus method), but is willing to abstain from sexual intercourse with her spouse for long periods of time.
- It is difficult for a woman to use natural family planning methods if her menstrual cycle is irregular, as it may disturb the subtle changes in body temperature and cervical secretions, as a result of hormonal effects.

Advantages and disadvantages of BBT

Table 1: Advantages and disadvantages of BBT

Advantages	Disadvantages
No side-effects for this method. Encourages discussion about family planning between couples.	High failure rate if the couple do not clearly understand the method. Requires several days of abstinence. Needs a longer duration to practice, understand and use properly. False interpretation or indications in the case of fever, as this may mislead the result of BBT. A special thermometer may be required.

- Effectiveness of BB- is about 98% effective if the woman uses the method correctly

In this regard, you should explain that the woman needs to do the following:

- Place the temperature chart and thermometer at her bedside and decide initially whether to take her temperature either orally, vaginally or rectally, and use that same method all the time.
- Take the temperature immediately after waking up and before getting up from the bed in the morning, and before doing anything like drinking tea or coffee.
- Shake the thermometer to lower the mercury below 35oC and place it either rectally or vaginally for about three minutes, or orally for four to five minutes to measure her body temperature.
- The rectal and vaginal routes are more consistent, but the oral route is adequate if it is used consistently.
- Read the thermometer after the required time and record the temperature; interpret whether there has been a rise in the temperature. Near ovulation, she will notice a rise of 0.3°C–0.5ºC.
- Abstain from (avoid) sexual intercourse from the first day of menstrual bleeding until the temperature has risen above the regular temperature and stays up for three full days.
- Know that after the third day (peak day) it is safe to have unprotected sexual intercourse, until the next menstrual bleeding begins.

How long does the ovum remain viable?

- The ovum remains viable for at least 24 hours. It is important to note that because the woman cannot be sure exactly when she ovulated, she should be cautious about resuming sexual intercourse.

C. Cervical mucus method (CMM)

The cervical mucus method (or Billings method) is based on the recognition and interpretation of changes in cervical mucus and sensations in the vagina, due to the effect of changes in estrogen levels during the menstrual cycle.

This method is also an ovulation method used by women trying to get pregnant and have a child.

Mechanism of action of CMM

- The level of estrogen during the menstrual cycle influences the cervical gland to secrete mucus that changes from a sensation of dryness in the vagina (characterized by thick, viscous and sticky mucus), to a sensation of wetness in the vulva (characterized by thin, white, slippery and stretchy thread like, transparent strands similar to uncooked egg white), during ovulation.
- Using this method, these are the times when it is safe to have sexual intercourse:
  - ✓ After menstruation ends the dry days (absence of cervical secretions) will start, and during these days it is safe to have sexual intercourse every other night until a woman starts to feel wet in her vagina. Every other night is suggested, as it will help women from confusing semen with cervical mucus.
  - ✓ It is also safe from the evening of the fourth day after the peak day, to the beginning of the next menstruation. Once a woman has ovulated, her cervical mucus will begin to dry up, so the peak day is the last day of cervical or vaginal wetness.

Effectiveness of CMM - The effectiveness of the cervical mucus method is about 97% if women use it correctly (Family Planning: A Global Handbook for Providers, WHO, 2007).

The conditions which can affect correct use of CMM

- ❖ If a woman has a vaginal or cervical infection.
- ❖ If a woman has recently had sexual stimulation (which will increase vaginal secretions).
- ❖ If a woman is currently taking drugs for colds or sinusitis, which maydry up mucus secretions.
- ❖ If a woman is in physical or emotional stress.
- ❖ If a woman is currently breastfeeding.

Advantages of CMM: - are similar to those associated with the use of the basal body temperature method.

Disadvantages of CMM:-has a high failure rate because it needs several days of abstinence and a lot of experience in using the method to be effective. It is also difficult to use this method in the case of vaginal infections, as the cervical mucus secretions may be misleading.

Method of CMM

You will need to carefully instruct women to be able to:

- Use a chart to record their mucus pattern.
- Look at their cervical mucus in the morning, and every time after using the toilet, using a clean cloth or tissue paper to determine the color and consistency of the mucus.
- Touch the secretion to determine its stretchiness and slipperiness
- Feel how wet the sensation is in their genitalia when they are walking.
- Abstain from sexual intercourse on the day when mucus appears regardless of its consistency, until the third evening after the 'peak day'

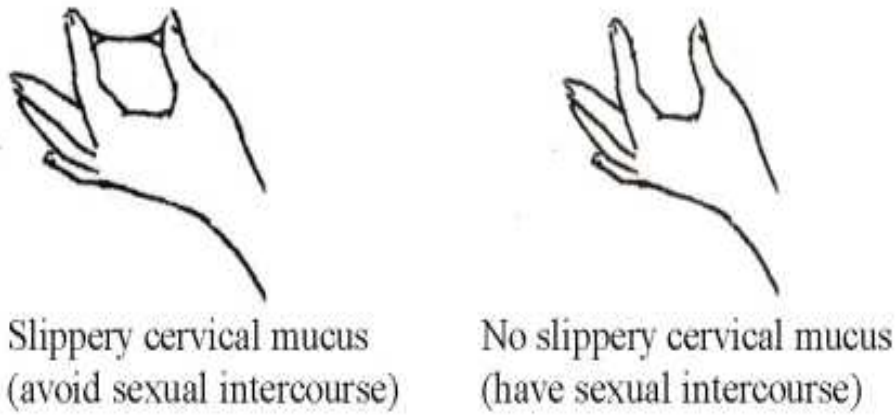

Figure 2: Diagrammatic illustration of slippery and non-elastic cervical mucus.

II. Locational amenorrhea method (LAM)

- The locational amenorrhea method (LAM) is the use of breastfeeding as a contraceptive method.
- Locational means breastfeeding and amenorrhea means not having monthly bleeding. In this case, there is a delay in ovulation caused by the action of prolactin hormone from the effect of lactation or breastfeeding.
- An infant's suckling of the nipple sends neural signals to the mother's hypothalamus (part of the brain), which influences the anterior pituitary gland to secrete prolactin to stimulate the breast for milk production.
- This, in turn, inhibits the secretion of follicle stimulating hormone (FSH) and luteinizing hormone (LH), and as a result ovulation does not occur.
- While women are exclusively breastfeeding, prolactin continues to be secreted and pregnancy is unlikely.
- When prolactin levels decrease, the woman's monthly bleeding may return, and if she continues to have unprotected sexual intercourse she may get pregnant.
- But the duration of suppression of ovulation is quite variable, depending on the breastfeeding status of the mother and the condition of the infant.

To be fully effective the following three conditions must be met:

1.The woman's menstrual period must not have returned

2. The baby must be exclusively breastfed frequently, day and night.

- Exclusive breastfeeding, means the infant receives no food or fluids other than breast milk
- The baby must be less than six months old.
  - ✓ This is because from six months onwards the baby needs to begin receiving complementary foods while continuing to be breastfed.
  - ✓ The reduction in the amount of suckling at the breast may affect the hormonal mechanism, resulting in ovulation and menstruation returning, indicating a return of the woman's fertility.

- ✓ If any one of these three criteria changes, another contraceptive must be started immediately to prevent an unwanted pregnancy, and to ensure healthy birth spacing of at least three years.

Factors affecting LAM: -

- Any factor that causes a decrease in suckling can result in the return of ovulation and decreased milk production.
- These factors include supplemental feeding of the infant, reduction in the number of breastfeeds or long intervals between breastfeeds, maternal stress and maternal/child illness. In these cases, the client should not rely on LAM

Table 2: Advantages and disadvantages of LAM

Advantages	Disadvantages
Effectively prevents pregnancy for at least six months.	Not a suitable method if the mother is working outside the home.
Encourages the best breastfeeding pattern.	No protection against STIs including HIV.
Can be used immediately after birth.	If the mother has HIV, there is a small chance she may pass it to her baby in breastmilk.
Does not interfere with sexual intercourse.	Not effective after six months.
No hormonal side-effects.	

Effectiveness of LAM-If the woman follows the method correctly — it is 98–99% effective

Important points about LAM

- ❖ Women should use both breasts to breastfeed their babies on demand, with no more than a four hour interval between breastfeeds during the daytime, and no more than a six hour interval between breastfeeds during the night-time.

- If they are unable to fulfill these conditions, you should advise and provide them with a complementary family planning method.
- If a woman has any risk of STI/HIV infection, you should advise her to use condoms.
- If a woman wants to continue using LAM as a contraceptive method, but she fails to fulfill the LAM criteria, you should offer her advice on a complementary contraceptive method.
- In this case, the best choice would be a non-hormonal contraceptive (condoms, spermicides, diaphragms, IUCDs, and voluntary surgical contraception), because they don't enter into the blood stream and interfere with breast milk.
- If these non-hormonal contraceptives are not available, the next best choice would be to provide a progestin-only method, such as progestin-only pills, a DMPA injectable, or implants, as these do not interfere with breast milk production.
- Note that contraceptive methods containing estrogen reduce the production of breast milk and generally are not recommended for lactating women.

III. Coitus interrupts (withdrawal or pulling out) method

- Coitus interrupts or withdrawal is a traditional family planning method in which the man withdraws or pulls out his penis from his partner's vagina and ejaculates outside, keeping his semen away from her genitalia.

Mechanism of action of withdrawal method

- Coitus interrupts prevents fertilization by stopping contact between spermatozoa in the sperm and the ovum or egg.

Advantages of withdrawal method

- It is important for you to teach this method as part of natural family planning methods. It costs nothing and requires no devices or chemicals. It is available in any situation and can be used as a back-up method of contraception.

Disadvantages of withdrawal method

- It has several disadvantages. Interruption of the excitement of sexual intercourse may result in the incorrect or inconsistent use of this method, as well as decreasing sexual pleasure for both partners.
- A high failure rate may be due to a lack of self-control, and semen containing sperm may leak into the vagina before the person ejaculates.
- There is a further possibility of premature ejaculation by the man. In addition, the couple is not protected from STIs, including HIV.

Effectiveness of withdrawal method

- It is about 73% effective if used correctly

1.1.2.2 Artificial Family planning methods

Contraception/Artificial Birth Control = the use of mechanical, chemical, or medical procedures to prevent conception from taking place as a result of sexual intercourse. These include:

I. Oral Contraceptive Methods

- Oral contraceptives are pills that a woman takes by mouth to prevent the occurrence of pregnancy.
- The pills contain hormones which are similar to the natural female reproductive hormones, estrogen and progesterone. Oral contraceptives are commonly known as ‘the pill’, ‘combined pill’, ‘birth control’ or ‘mini-pill’.
- The pill works mainly by changing the body’s hormone balance so that the woman does not ovulate.
- It is more effective if taken correctly and consistently.
- Most women can take the pill without developing any side-effects. However, a small number of women develop mild side effects, which usually go away within days or weeks of starting the pill.

Figure 3: Pictorial illustration of a sample of combined oral contraceptive (COC)

Progesterone-only (or progestin-only) oral birth control pills (or minipills) come in packs of 28 pills and women take one every day. They contain a synthetic form of the progesterone hormone called progestin, and no estrogen

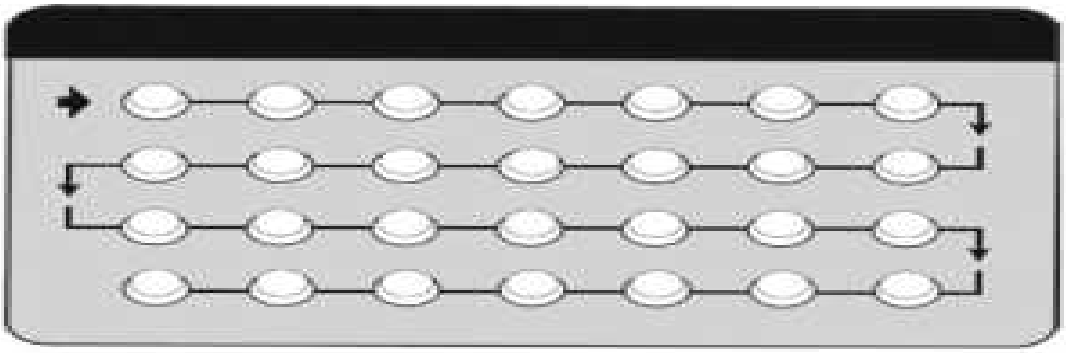

Figure 4: Diagrammatic illustration of progestin-only contraceptive (pop)

II. Injectable Contraceptives

- Injectable contraceptives are artificial hormonal preparations administered by a deep intramuscular injection into the muscle of the arm or buttock, to be effective immediately.
- From the injection site they are slowly absorbed into the bloodstream and the body gets sufficient levels of hormone to provide contraception for one to three months, depending on the type of injectable contraceptive used.
- Injectable contraceptives can consist of progesterone-only preparations, or combined estrogen and progesterone preparations

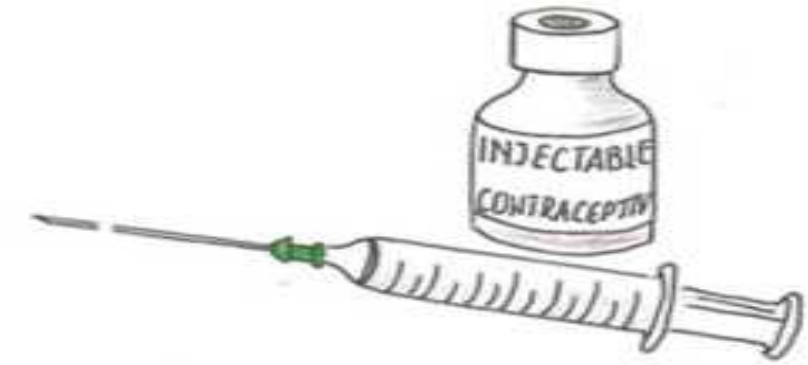

Figure 5: Sample injectable contraception and syringe with needle.

III. Contraceptive Implants

- A contraceptive implant is a reversible, long-acting progestin which resembles the natural hormone progesterone in a woman's body.
- It consists of flexible tubes or rods, each about the size of a match stick, inserted under the skin of a woman's upper arm by a trained professional.
- Implants can give continuous protection for three to seven years, depending on the number of rods inserted.
- This method of contraception has been used for more than 25 years.
- There are four types of contraceptive implants used today.
- These are Norplant, Jadelle, Implanon and Sino-implant, according to their sequence of discovery.

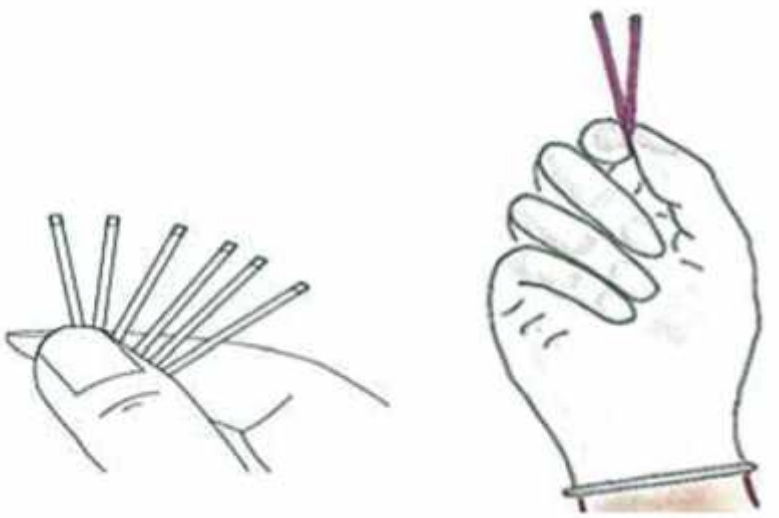

Figure 6: Sample Six Norplant rods Jadelle or Sino-implant.

IV. Implanon

- Implanon is a single-rod contraceptive implant prepared from another type of progestin, which gives effective protection for three years.
- It looks like a small flexible plastic matchstick.
- It can be inserted into the arm following a simple procedure, similar to an injection, and you do not need to make an incision as with other implants.
- Implanon is the best option for women who have had one or more children, or who may want children in the future.
- It has been introduced for use in Ethiopia, and has been approved by the Ministry of Health to be provided by you at health post level, once you have been given proper training.

Implants have the following effects:

- They stop the release of the egg from the ovary by slowly releasing progestin artificial progesterone) into the client's body.
- The progestin in implants causes thickening of the cervical mucus, which makes it harder for sperm to move through the cervix.
- The progestin also causes thinning of the endometrial lining, making it less likely that a fertilized egg will implant in the uterus.

- Progestin slows the transportation of eggs along the fallopian tube by reducing peristalsis.

Implants should not be given to women who have:

- serious liver disease
- problems of blood clots
- unexplained vaginal bleeding
- And/or had breast cancer.

Timing of contraceptive implant insertion and removal

Implants can be inserted at any time during the menstrual cycle, preferably within seven days of menstruation or post-abortion. It can also be inserted six weeks after delivery if the mother is fully breastfeeding. Generally, it can be inserted at any time, providing it is possible to confirm that the woman is not pregnant.

Implants can be removed:

Implants can be removed:

- At any time during the menstrual cycle.
- At the end of five years of use for Norplant or Jadelle, or three years of use for Implanon, when their effectiveness drops after the intended years of Use and the risk of intrauterine and ectopic pregnancy may increase.
- If the client wishes, at any time it is possible to remove an implant after
- Providing the necessary counseling.
- The removal of an implant is not a very complicated procedure, but it does require special training and practice under direct supervision. Following removal of any implants, the level of hormonal prevention drops quickly, and the women's fertility returns within two to six months.t any time during the menstrual cycle.
- At the end of five years of use for Norplant or Jadelle, or three years of use for Implanon, when their effectiveness drops after the intended years of use and the risk of intrauterine and ectopic pregnancy may increase.

- If the client wishes, at any time it is possible to remove an implant after providing the necessary counseling.
- The removal of an implant is not a very complicated procedure, but it does require special training and practice under direct supervision.
- Following removal of any implants, the level of hormonal prevention drops quickly, and the women's fertility returns within two to six months.

V. Intrauterine Contraceptive Devices (IUCD)

An intrauterine device (IUD) is an effective, safe, long acting, cost-effective contraceptive method used in many countries, including Ethiopia. It consists of a small, flexible plastic device inserted into a woman's uterus and is left in place for long periods of time, providing continuous protection against pregnancy for a minimum of 10 years. It is also known as an intrauterine contraceptive device (IUCD), and we commonly use this term in the rest of the session. The copper-bearing IUCD brand TCu-380A is widely available in Ethiopia

- **Types of IUCD:** There are three different types of IUCD. These are:

✓ **Copper-bearing IUCDs**, which are made of plastic with copper sleeves and/or copper wire on the plastic, such as TCu-380A and MLCu-375

✓ **hormone-releasing IUCDs**, which are made of plastic and steadily release small amounts of progesterone or other progestin hormone s, such as LNG-20 and Progestasert.

✓ **Inert or unmediated IUCDs,** which are made of plastic or stainless, steel only, such as Lippes Loop and Chinese stainless steel rings.

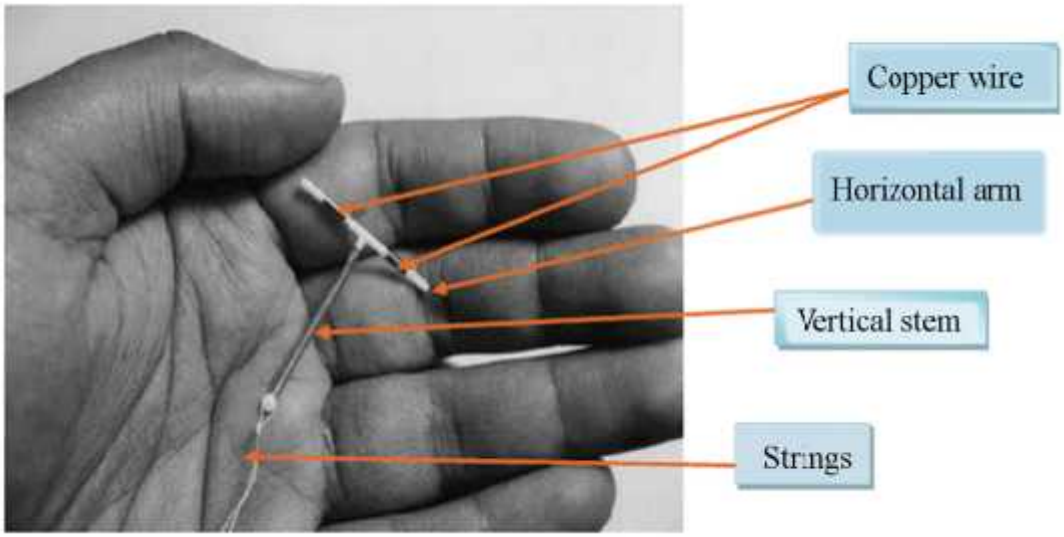

Figure 7 Copper T IUCD (TCu-380A).

VI. Barrier Contraceptive Methods

Introduction

Barrier contraceptive methods are another type of contraceptive method used for preventing pregnancy and certain sexually transmitted infections. Various male and female barrier methods of contraception have been in use for centuries, and they are one of the oldest methods in use. They are designed to prevent the passage of sperm into the uterus during the sexual act. The success of such methods depends on the quality of the barriers, and the motivation and willingness of the couple to use the method. The male condom is the only male barrier known, while a number of different female barriers exist, such as the diaphragm, female condom and cervical cap, all of which are widely available. Spermicides are often used in conjunction with barrier method

Types of barriers

Barrier contraceptives are broadly classified into two main types: mechanical barriers and chemical barriers.

Mechanical barriers

Mechanical barriers are devices that provide a physical barrier between the sperm and the egg. Examples of mechanical barriers include the male condom,

female condom, diaphragm, cervical cap, and sponge. The condom is the only contraceptive method that helps prevent sexually transmitted infections (STIs).

Chemical barriers

Chemical barriers or spermicides are sperm-killing substances, available as foams, creams, gels, films or suppositories, which are often used in female contraception in conjunction with mechanical barriers and other devices. Spermicides are usually available without a prescription or medical examination.

VII. Permanent Family Planning Methods or Voluntary Surgical Contraception (VSC)

Sterilization is the most effective, and one of the most widely used contraceptive methods available worldwide. It is often the best contraceptive choice when desired family size has been achieved. Both tubal ligation in women, and vasectomy in men, are one-time procedures that are safe, inexpensive and relatively straightforward to do for a trained person.

Sterilization does not require constant use of a contraceptive method, regular visits to health facilities or repeated expenditure on contraceptive supplies. Although sterilization procedures usually demand a greater investment in skill, training and equipment than temporary methods of contraception, they provide lifelong protection against pregnancy, and are therefore more cost-effective. Since voluntary surgical contraception (VSC) procedures are almost always irreversible, clients require effective counseling before making any decision.

VIII. Emergency contraception (EC)

Emergency contraception (EC) is a method used to prevent unwanted pregnancy, and is usually effective up to five days following unprotected sexual intercourse. Unprotected sexual intercourse means that either the woman did not use any contraceptive method to prevent pregnancy, or the birth control method failed (for example, a condom broke,

The use of emergency contraception should be the last option for a woman who has experienced accidental and unprotected sexual intercourse, or whose birth control method has failed, or for whom abortion is not acceptable or accessible. Emergency contraception can involve the use of either hormonal pills, or a copper-bearing intrauterine contraceptive device (IUCD). However, neither method is a substitute for the correct use of other regular contraceptives.

Situations when emergency contraception is appropriate emergency contraception can be appropriate:

- In cases where the woman has not used contraception
- In cases where sex has been forced or coerced, or the woman has been raped
- When a woman must deal with a contraceptive mistake, such as a condom breaking or used incorrectly, an IUCD dislodging, a diaphragm removed too early, or the man failing to withdraw before ejaculation.

Types of emergency contraception
In an emergency situation there are two major types of emergency contraceptive methods available:

- Hormonal methods, known as emergency contraceptive pills (ECPs)
- Copper-bearing intrauterine contraceptive devices (IUCDs).
-

Emergency contraceptive pills

Emergency contraceptive pills (ECPs) are hormonal methods of contraception that can be used to prevent pregnancy following unprotected sexual intercourse. Some women call this method ‘morning-after pills ‘or ‘post coital pills’.

Intrauterine contraceptive devices (IUCDs)

A copper-bearing IUCD can be used within five days of unprotected sexual intercourse as an emergency contraceptive. In a woman’s normal menstrual cycle ovulation occurs on the 14th day before the next menstrual bleeding. So an IUCD can be inserted within

five days of unprotected sexual intercourse, provided it is after the earliest calculated day of ovulation (e.g. up to day 19 in the case of a 28-day cycle). Implantation may occur 6–12 days after ovulation. Therefore, inserting an IUCD would be effective in making implantation difficult, but would not cause the abortion of an existing implanted fetus.

Self-Check – 1	Written test

Name…… ID……. Date…….

Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: Choose the best answer (2 pts. each)

1. Which family planning method serves as a dual protection?

A. IUCD B. Condom C. Implanon D. lactation amenorrhea

2. Which contraceptive method methods depend on the awareness and ability of the couple to identify the fertile and infertile phase of each menstrual cycle?
A. Artificial contraceptive method B. Natural contraceptive method C. both

3. Implants should not be given for women with:

A. serious liver disease B. problems of blood clots C. unexplained vaginal bleeding D. all

Test II: Short Answer Questions

1. List outcomes of unwanted pregnancy (3 points)
2. Discuss the contraceptive barriers (4)
3. Describe situations when emergency contraception is appropriate (3)

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 8 points** **Unsatisfactory – below 8 points**

Information Sheet 2- Planning family planning services

2.1. Introduction

Family planning is not separate, but an important integral part of other health programmes. The planning, implementation, monitoring and evaluation processes of all health programmes, including family planning, are very similar and integrated. In this section, you will learn the general concepts of the planning, monitoring and evaluation processes, and their application to the family planning programme.

2.2 Developing and using work plans

A work plan is a document developed by the manager and staff, which lists all planned activities, the date on which they will occur or by which they will be accomplished, the resources they will require, and the person who is responsible for carrying them out. Such a document is a valuable tool for efficient and effective programme implementation, and should be used regularly and consistently as a monitoring tool at all levels.

Basically, there are two types of plans:
(a) The strategic (long-term) plan
(b) The annual (work) plan.

A. Strategic (long-term) plans

A strategic plan is a well-developed document that determines what an organization intends to be in the future, and how it will get there. It is the process by which the organization assesses its current situation and decides how to scale up to achieve its vision. Strategic planning is the way in which it directs its efforts and resources towards what is truly important for the sector.

Strategic planning is carried out at all levels.

Annual (work) plans

Work plans (also known as operational plans) are distinguished from long term plans in that they show how the broader objectives, priorities and targets of the strategic plan will be translated into practical activities, which will then be carried out over a much shorter time period (anywhere from a week to a year). However, there should be complete harmony between the strategic objectives and the annual targets.

The annual plan is sometimes divided into two: the core and the comprehensive plan. The core plan is the summarized form of a plan which mainly focuses on annual targets, major objectives, and major activities, while the comprehensive plan deals with detailed activities, including time of execution and cost. It can be cascaded to monthly, weekly and daily tasks.

Note that, in the Ethiopian health sector context, currently all health services and programmes are integrated and harmonized, so there is no room for parallel or vertical plans. In the planning process, you need to ensure that family planning is integrated into other health programmes.

Key points to remember in the work planning process

- the steps in the work planning process and who should be involved how to develop an annual work plan
- how an integrated and aligned annual work plan should be linked with monitoring and evaluation
- techniques that can be used to design integrated work plans for individual service delivery sites or staff members
- the benefits of work planning, as well as the importance of keeping the process flexible to respond to changes throughout the course of the programme.

2.3 Cascading objectives

one way to develop short-term work plans is to divide the yearly objectives into quarterly or monthly targets, so that detailed activities are identified and costed. To determine

these targets, begin by looking at the yearly objectives.

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Definitions of objectives and targets

Although there are many definitions for objectives and targets, for the purposes of this discussion and the examples shown here, the distinction between objectives and targets is defined as follows. An objective shows the anticipated results of the work conducted at one or more service delivery sites, and reflects the impact or changes that are expected in the population covered by this programme. Objectives should be SMART and refer to the measurable results that are expected in a designated population within a specified period of time. Usually there will be several objectives relating to one programme goal.

SMART objectives

An example of an objective: To recruit 5,000 new acceptors in 10 kebeles by the end of the first year. SMART is not a word, but an acronym (or combination of initial letters) representing:

- S - Specific
- M - Measurable
- A - Achievable
- R - Reliable
- T - Time bounded.

Accordingly, the above objective is SMART because it is specific to recruiting, measurable in terms of recruiting 5,000 new acceptors, achievable and reliable, as it can be executed within a given period of time that is by the end of the first year.

2.4 Targets

Targets restate programme objectives for service delivery workers in numerical terms. They state the expected results and/or the intended activities of each service delivery component of the programme over a short time period, such as a quarter (three months), one month, or a week. Keep in mind that targets serve three major purposes:

- Planning a programme.
- Motivating staff towards achievement.
- Guiding the monitoring and evaluation process.

2.5 Developing monthly work plans

Monthly work plans should be developed and used at all levels of a programme or organization. They are particularly useful for Health Extension Practitioners and supervisors. The activities in work plans are based on the annual plan, which has been developed at woreda level, but also includes more detailed information on activities, such as which villages and households are to be visited, the timing of these visits and the dates of the supervisory visits, holidays, self-assessment sessions and training.

2.6 Summarizing activities in a Gantt chart

Once the work plan is completed, it is important to draw up a summary chart. This provides an important reference which can be used by all staff members, and communicates in a concise way what the project will do and when it will do it. This summary is called a Gantt chart and you can see an example in Table

Table 3: Sample Gantt chart with months marked in the Ethiopian calendar (EFY is the Ethiopian Fiscal Year)

Family planning implementation schedule for EFY 2003, X health post, Y *woreda*.														
Target	**Activity**	**Implementation Period**											**Responsible person**	**Remarks**
		Ham	Neh	Msk	Tikm	Hid	Tahs	Tir	Yek	Meg	Miaz	Gin	Sene	
Provide information and advice	a		X					X				X		Demeshi	In collaboration with local NGOs
	b			X	X	X						X	X	Kolole	
	c	X							X	X				Feyise	

A Gantt chart typically includes the following components:

- ✓ A column that lists major activities.
- ✓ Columns that mark a fixed period of time (days, weeks, months, years), showing when the activities will occur.
- ✓ A column that lists the person or people responsible for completing the activity

Self-Check – 2	Written test

Name…….. ID…….. Date…….

Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: Choose the best answer (2 pts. each)

1. As a health extension practitioner which type of planning is expected from you?

A. Annual plan B. long term plan C. strategic plan D. all

2. _____ restates programme objectives for service delivery workers in numerical terms A. Target B. Objective C. Plan D. goal

Test II: Short Answer Question

3. Construct a sample of objective for specific health care activity by abiding with the SMART principles (5 points)

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 5 points** **Unsatisfactory - below 5 points**

LG #37	LO #2- Manage and provide long-acting family planning services

Instruction sheet:

This learning guide is developed to provide you the necessary information regarding the following content coverage and topics:

- History taking and physical examination
- Counseling family planning
- Long acting family planning options
- Family planning for people with special need
- Linking FP with RH services

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, you will be able to:

- Take history taking and perform physical examination for a mother who come for family planning services
- Counsel a client for family planning services
- Provide a client a long acting family planning options
- Provide family planning for people with special need
- Linking FP with RH services

Learning Instructions:

- Read the specific objectives of this Learning Guide.

1. Follow the instructions described below.
2. Read the information written in the “Information Sheets”. Try to understand what are being discussed. Ask your trainer for assistance if you have hard time understanding them.
3. Accomplish the “Self-checks” which are placed following all information sheets.
4. Ask from your trainer the key to correction (key answers) or you can request your trainer to correct your work. (You are to get the key answer only after you finished answering the Self-checks).
5. If you earned a satisfactory evaluation proceed to “Operation sheets
6. Perform “the Learning activity performance test” which is placed following “Operation sheets” ,
7. If your performance is satisfactory proceed to the next learning guide,
8. If your performance is unsatisfactory, see your trainer for further instructions or go back to “Operation sheets”.

Information Sheet 1- History taking and physical examination

1.1 Key Points

Medical requirements that are not essential to the provision of specific contraceptives act as major barriers to contraceptive choice and access to services.

- Only the provision of intrauterine contraceptive devices (IUCDs) and sterilization require physical exams.
- Determining if a client is pregnant can be accomplished through use of the Pregnancy Checklist.
- Some medical conditions can make pregnancy riskier.
- The MEC provide evidence-based criteria for determining if a client can safely use a contraceptive method.
- The MEC classification system uses 4 categories that describe whether a contraceptive method can be used in the presence of a given condition.

- A two-category MEC system exists for locations where resources for clinical judgment are limited.
- MEC Summary tables provide an easy way to determine client eligibility for each method.

- MEC guidelines are regularly updated to reflect the latest medical knowledge and practice.

1.2. Purpose of client assessment for family planning

The primary objectives of client assessment prior to provision of family planning methods are to determine whether the client:

- ✓ Is pregnant
- ✓ Has any conditions that affect the client's medical eligibility to start or continue using a particular method
- ✓ Have any special problems that require further assessment, treatment, or regular follow-up.

These objectives usually can be accomplished by asking a few key questions. Unless specific problems are identified, the safe provision of contraceptive methods, except IUCDs and voluntary female and male sterilization, does **not** require **physical or pelvic examinations.**

Where resources are limited, requiring medical evaluation and/or laboratory testing (e.g., blood sugar and hemoglobin) before providing modern contraceptive methods is **not** justifiable. Where demand for family planning services is high, medical requirements that is **not** essential to the provision of specific contraceptives act as major barriers to contraceptive choice and access to services. To enable clients to obtain the contraceptive method of their choice, **only** those procedures that are essential and mandatory for **all** clients in **all** (JHPIEGO, no date) settings should be required.

1.3. Assessment tasks required for specific methods

The table that follows summarizes the client assessment requirements for all contraceptive methods. Depending on answers given to the medical eligibility screening questions for specific methods, physical and pelvic examinations may be needed as indicated.

Table 4: Client assessment requirements for all contraceptive methods

Assessment	Fertility Awareness Methods (FAM), Lactational Amenorrhoea Method (LAM)	Barrier Methods (Male or Female Condoms)	Hormonal Methods*	IUCDs	Voluntary Sterilization (Female/Male)
Reproductive Health Background	No	No	No	No	No
STI History	No	No	No	Yes, to determine if at high personal risk	No
Physical Examination					
Female General (including BP)	No	No	No[a]	No[a]	Yes
Abdominal	No	No	No[a]	Yes	Yes
Pelvic Speculum	No	No	No[a, b]	Yes	Yes
Pelvic Bimanual	No	No	No[b]	Yes	Yes
Male (groin, penis, testes and scrotum)	N/A	No	N/A	N/A	Yes

(Adapted from Jhpiego, no date.)

*Hormonal methods include combined oral contraceptive pills (COCs), progestin-only pills (POPs), contraceptive implants and injectables (DMPA).

[a] If screening checklist responses are all negative (No), examination is not necessary.

[b] This is only necessary if pregnancy is suspected and pregnancy test is not available.

1.4 Information gathered during client assessment

Although taking a medical history is not required for providing contraceptive methods, it is helpful to gather basic information that will help the provider and the client discuss family planning method options, if the client agrees. This information can be gathered in a relaxed and friendly manner that puts the client at ease. Explain that for most family planning methods there will be no need for a physical or pelvic exam.

Information that can be gathered in a client history includes:

- Age of client (female)
- Number of living children
- Sex of living children

• Age of youngest child
• History of complications with pregnancy
• Current pregnancy status/date of last menstrual period
• Desire for more children
• Desired timing for birth of next child
• Breastfeeding status
• Regularity of menstrual cycle
• Number of current sexual partners
• Level of sexual activity (active, occasional, etc.)
• Chronic illnesses (i.e. heart disease, diabetes mellitus, hypertension, liver/jaundice problem, kidney/renal disease, cervical/breast cancer)
• Smoking status.

1.5 How to be reasonably sure a client is not pregnant

It is recommended that family planning providers assess whether a woman seeking contraceptive services might already be pregnant—because women who are currently pregnant do not require contraception. Further, the IUCD should never be inserted in pregnant women because doing so might lead to septic miscarriage. There is no known harm to the woman, the course of her pregnancy, or the fetus if COCs or DMPA are accidentally used during pregnancy.

You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy (e.g., breast tenderness or nausea) and she answers **"Yes"** to at least one of the questions on the Pregnancy Checklist. This checklist, "How to be reasonably sure a client is not pregnant," is highly effective and has been validated. When used correctly, it is more than 99% effective in ruling out pregnancy.

A pelvic examination is seldom necessary for family planning provision, except to rule out. In these situations, a sensitive urine pregnancy test (i.e., detects <50 U/ml of human chorionic gonadotropin hormone, or hcg) may be helpful, if readily available and affordable. If pregnancy testing is **not** available, counsel the client to use a temporary contraceptive method or abstain from intercourse until her menses occurs or pregnancy

is confirmed. To use the Pregnancy Checklist, ask the client questions 1–6 on the checklist. As soon as the client answers "yes" to any question, stop and follow the instructions at the bottom of the checklist.

When a woman is **more than 6 months postpartum** you can still be reasonably sure she is not pregnant if she:

• Has kept her **breastfeeding frequency high**

• has still had **no menstrual bleeding**

• has **no clinical signs or symptoms of pregnancy** (is amenorrhic)

Self-Check – 1	Written test

Name…… ID…… Date……

Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: True/ False questions (2 points each)

1. Determining if a client is pregnant can be accomplished through use of the pregnancy checklist.

2. IUCD should never be inserted in pregnant women

3. For a woman who is at more than 6 months postpartum and kept her breastfeeding frequency high we can be reasonably sure that she is not pregnant.

Test II: Short Answer Question

1. Describe the primary objective of client assessment for family planning (4points)
2. List Information that you are expected to gathered during client assessment (4)

You can ask you teacher for the copy of the correct answers.

Note: Satisfactory rating – 7 points Unsatisfactory - below 7 points

Information Sheet 2- Counseling family planning

2.1 Definition of terms

Counseling is a face-to-face communication that you have with your client or couple in order to help them arrive at voluntary and informed decisions. It is somewhat different from advice, in which you try to solve a client's problem by giving information and your personal opinion.

Family planning counseling is defined as a continuous process that you as the counselor provide to help clients and people in your village make and arrive at informed choices about the size of their family (i.e. the number of children they wish to have).

Informed choice is defined as a voluntary choice or decision, based on the knowledge of all available information relevant to the choice or decision. In order to allow people to make an informed choice about family planning, you must make them aware of all the available methods, and the advantages and disadvantages of each. They should know how to use the chosen method safely and effectively, as well as understanding possible side-effects.

Counseling can be conducted with

- ✓ Individual levels
- ✓ Couples and
- ✓ family

2.2 General principles of counseling and counselor characteristics

These are the important principles and conditions necessary for effective Counseling:

- Privacy — finds a quiet place to talk.
- Take sufficient time.
- Maintain confidentiality.

- Conduct the discussion in a helpful atmosphere.
- Keep it simple — use words people in your village will understand.
- First things first — do not cause confusion by giving too much information.
- Say it again — repeat the most important instructions again and again.
- Use available visual aids like posters and flip charts, etc.

2.3 Skills and characteristics of a counselor

The most important characteristics are:

- ∞ Respect the dignity of others.
- ∞ Respect the client's concerns and ideas.
- ∞ Be non-judgmental and open.
- ∞ Show that you are being an active listener.
- ∞ Be empathetic and caring.
- ∞ Be honest and sensitive.

Family planning counseling — the BRAIDED Approach

The acronym BRAIDED can help you remember what to talk about when you counsel clients on specific methods.

It stands for:

- B- Benefits of the method
- R-Risks of the method, including consequences of method failure
- A-Alternatives to the method (including abstinence and no method)
- I-Inquiries about the method (individual's right and responsibility to ask)
- D- Decision to withdraw from using the method, without penalty
- E- Explanation of the method chosen
- D- Documentation of the session for your own records.

2.4 Steps in family planning counseling: the GATHER approach

- G- Greet the client respectfully.

- A- Ask them about their family planning needs.
- T- Tell them about different contraceptive options and methods.
- H- Help them to make decisions about choices of methods.
- E- Explain and demonstrate how to use the methods.
- R- Return/refer; schedule and carry out a return visit and follow up.

Self-Check – 2	Written test

Name…… ID…… Date…….

Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: Choose the correct answer

1. _____ is a face-to-face communication that you have with your client or couple in order to help them arrive at voluntary and informed decisions.

A. Informed choice B. Counseling C. Advising D. Respect

2. All are important characteristic during client counseling for family planning except?

A. Respect the dignity of others B. Being judgmental C. open D. Being empathetic

3. Which one is necessarily the contents of our talk while we counseling the client on family planning services

A. Benefits of the method B. Risks of the method C. Alternatives to the method D. all

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 4 points** **Unsatisfactory – below 4 points**

Information Sheet 3- Long acting family planning options

3.1 Overview of long acting family planning

Long-acting family planning methods (LAFPM) can be permanent or reversible; are methods that prevent pregnancy more than three years per application which include sub-dermal implants, intrauterine devices (IUD) and male and female sterilizations. These methods have many advantages compared to other family planning methods. They are convenient, very effective, long-lasting, reversible and cost-effective. In addition to these the effectiveness of LAFPM are not dependent on compliance with taking the oral contraceptives daily or taking the regular injection at clinics; therefore they prevent the failure rate due to the incorrect use.

3.2 IMLPANON

3.2.1 Introduction

Implanon classic is a one-rod implant containing the hormone etonogestrel (ETG) that provides contraceptive protection for up to three years. Implanon uses a single contraceptive rod, which has led to easier insertion and removal than previous implants that required multiple rods. Implanon, first launched in Indonesia in 1998, is now used globally by millions of women. Implanon classic is being replaced with Implanon NXT. Implanon NXT is a sub-dermal contraceptive implant identical in composition to Implanon classic. Both are one-rod implants that are effective for up to three years. Both contain 68 mg of ETG, are prequalified by the World Health Organization (WHO), and are more than 99% effective at preventing pregnancy. The two differences between Implanon classic and Implanon NXT are: The rod in Implanon NXT can be detected by x-ray, and Implanon NXT uses an improved insertion device.

3.2.2 Implanon NXT Reference Guide

Contraceptive implants can be inserted for almost all women at the first clinic visit. To minimize the risk of problems, health care providers should conduct an assessment of the woman's health and provide good counseling to ensure that the client is aware of

side effects.

Implants may be inserted at any time during the menstrual cycle when it is reasonably certain that the client is not pregnant or at risk of being pregnant. If the client has been using no contraception, and she is inserted with Implanon NXT within 5 days of the start of her menstrual bleeding, there is no need for a backup method. Consider advising the couple to use a backup method or refraining from sexual intercourse for 7 days when insertion is done more than 5 days since the start of her menstrual bleeding. If the client is using another contraceptive method and wants to switch to implants, the best time to do so is shown in table 5 below. Inserting the rods at these recommended times will minimize the possibility of pregnancy.

Table 5: Current contraceptive users: Optimal times for switching to two roads or one rod

Table 3. Current Contraceptive Users: Optimal Times for Switching to Two-Rod or One-Rod

Current Method	When to Insert
Having menstrual cycles or switching from a nonhormonal method	• If she is starting within 7 days after the start of her monthly bleeding for two-rod, or 5 days after for one-rod, no need for a backup method. • If it is more than 7 days after the start of her monthly bleeding for two rod, or more than 5 days after for one rod, she can have implants inserted any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion. • If she is switching from an intrauterine device (IUD), she can have implants inserted immediately (see below)
Switching from a hormonal method	• Immediately, if she has been using the hormonal method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method. • If she is switching from injectables, she can have implants inserted when the repeat injection would have been given. No need for a backup method. • If she is switching from an IUD, she can have implants inserted immediately (see below).
Switching from copper or levonorgestrel (LNG) IUD	• If starting during the first 7 days of monthly bleeding, insert implant now and remove the IUD. No need for a backup method. • If starting after the first 7 days of monthly bleeding and she has had sex since her last monthly bleeding, start the implant now. It is recommended that the IUD be kept in place until her next monthly bleeding. • If starting after the first 7 days of monthly bleeding and she has not had sex since her last monthly bleeding, the IUD can stay in place and be removed during her next monthly bleeding, or the IUD can be removed and she can use a backup method for the next 7 days.

Adapted from: World Health Organization Department of Reproductive Health and Research, Johns Hopkins Bloomberg School of Public Health Center for Communication Programs Knowledge for Health Project. 2011. Family Planning: A

Self-Check – 3	Written test

Name…….. ID…….. Date…….

Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: Choose the correct answer (2 points each)

1. All are long acting family planning g method except:

A. Implanon B. IUCD C. injectable D. Jadelle

2. Which is/ are advantage/s of LAFPM compared to other family planning method?

A. Convenient B. long-lasting C. less effective D. A and B

Test I: short answer questions

1. What are the main difference between Implanon classic and Implanon NXT ?(4 points)
2. Under which condition do we obliged to advice the mother to use back up method for a client who is Implanon inserted for? (4points)

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 6 points** **Unsatisfactory – below 6 points**

Information Sheet 4 Family planning for people with special need

4.1 Introduction

FP service providers have a duty to ensure equitable access to services for all, including groups with special needs. These guidelines focus on the following categories of clients that are considered to have special needs:

4.2 Adolescents and youth

According to the national adolescent and youth health strategy, “Limited knowledge of sexual physiology, early marriage, limited use of contraceptives, limited access to reproductive health information, and girls’ limited agency over their sex lives all contribute to the high rate of unintended pregnancy.” Evidence suggests that fewer than 10% of married girls aged 15–19 years use any modern FP method. Almost one-third (31.1%) of adolescents have experienced unintended or mistimed live birth11, indicating limited access to FP services or access to youth friendly services.

Unmarried and married youth may have different sexual, FP, and other SRH needs. FP services can create an opportunity to discuss STIs, HIV, GBV, and other SRH issues. Because of ignorance and psychological and emotional immaturity, adolescents and youths’ compliance with the use of FP methods may not be optimal. In light of these facts, FP services need to be adolescent and youth-friendly and be accessible irrespective of their age and marital status. This implies services to be unbiased, non-discriminatory, affordable, confidential, convenient, and comprehensive.

4.3. HIV Positive People

For HIV positive People, dual method use helps to prevent transmission of HIV to an uninfected partner. The fertility intentions of HIV positive People are varied and the right of all women to decide their number and timing of children, regardless of HIV status need to be respected. Avoiding unintended pregnancy in HIV-positive women using FP is one of the four prongs of PMTCT. Regardless of their use of ART, HIV positive People can start and continue to use most contraceptive methods safely.

Health care providers working in ART clinics should inform and educate HIV positive People about the prevention of unintended pregnancy and the use of FP. Use of hormonal contraceptives in all HIV-positive women, regardless of ART use, is recommended, because the benefit to be obtained from using contraceptives outweighs the potential risk of unintended pregnancy. However, assessing eligibility using MEC is recommended for each family planning method.

4.4 Survivors of sexual violence

Sexual violence is a public health problem and a violation of human rights. Sexual violence is associated with numerous physical, psychological, and emotional consequences. Unintended pregnancy is one of the consequences of sexual violence. Hence, emergency contraception should be availed for all victims of rape who are at risk of pregnancy. ECPs and the IUCD are the available types of emergency contraception. Whenever prepackaged ECPs are not available, combined oral contraceptive or progesterone only pills (COC & POP) can be substituted. There are no known medical conditions for which ECP use is contraindicated. Providers should refer the national management guideline for victims of sexual assault.

4.5 FGC (Infibulation)

Female genital cutting (FGC) is a practice that involves altering the female genitalia for nonmedical reasons, and is internationally recognized as a human rights violation. Family planning service providers might have difficulty in providing IUCDs in women with infibulation. Therefore, such clients need to be counseled on other choices of

contraceptive methods.

4.6. Persons with disability, including mental disability

- Women and men with disabilities can and want to be productive members of society. Health service providers must ensure that – people with disabilities have access to counseling on sexual and reproductive health services and access to informed and voluntary FP services.
- The following are lists of recommendations to be taken to address the needs of people with disability:

    - Special consideration should be given to individuals who are mentally challenged or those with psychiatric disorders who might require specialized counseling, Where the nature of the disabilities does not allow for informed choice (e.g., severe mental challenge), a FP method should be provided only after full discussion with all parties, including parents, or next of kin, legal appointed representatives or guardians, depending on the degree of the mental disability. In the absence of these caretakers, the provider may decide on a method choice in the best interests of the client with serious mental disability, some drugs that are used to treat mental disorders may affect the bioavailability and efficacy of hormonal contraceptives in which case alternatives should be considered.

    - As much as possible, FP methods that do not seriously demand user compliance (e.g. Injectable, IUCD, and implants) should be encouraged to ensure efficacy and compliance.

    - The health care system need to be more accessible and friendly to PWDs such as providing wheelchair ramps, adjustable examination couches, and/or staff who are trained in sign language.
    - The reproductive rights of the individual must be considered in any of such decisions.

4.7. Daily laborers including the homeless community

In an expanding rural urban migration and fast urbanization, more people earn their life through the informal sector and are becoming homeless. Unintended pregnancy is more common which affects their future work life balance and income in the work place. This requires providing access to family planning through innovative approaches.

4.8. People in emergency situations (IDPs and Refugees)

Violence against girls and women in humanitarian setting increases the risk of unintended pregnancy and its consequences. Demand for contraception is often found to be high during emergencies. Evidences suggest that nearly 40% of women experiencing displacement across diverse settings want to avoid becoming pregnant in the next two years. This makes contraception an essential part of any emergency health response. In this context, the government and partners need to:

- Include minimum FP and SRH service packages for emergency situations
- Work with emergency partners in training emergency taskforces to create access to informed and voluntary FP services Increase support to availability and access of essential SRH commodities in emergency situations

Self-Check – 4	Written test

Name…… ID…… Date…….
Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: short answer questions

1. Why adolescent and youth are mentioned as people with special need in context of family planning service provision? (4 points)
2. If you can't get emergency contraceptive for Survivors of sexual violence which family planning method do you give them as a backup?(4 points)

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 6 points** **Unsatisfactory – below 6 points**

Information Sheet 5 Linking FP with RH services

5.1 Overview

Service integration is an approach in which health care providers use opportunities to engage the client in addressing broader health and social needs beyond those promoting the initial health care encounter. In the case of family planning, it might be either using an internal referral mechanism (especially for long acting contraceptives) or direct provision of FP services depending on the context. Integration of FP with other RH and non-SRH service delivery units is cost-efficient and enables maximum utilization of health care services in one visit.

5.2. HIV Testing and Counseling (HTC)

HTC services can be good entry points for FP services, and vice versa. Both HIV and unintended pregnancy are, in most cases, the consequences of unprotected sex. Integrating HTC and FP service delivery is cost-effective and enables maximum utilization of health care in one visit. Health care workers who provide services for people living with HIV should have basic knowledge and counseling skills to provide FP services. Facilities should also create the enabling environment to strengthen the integration of FP services. Women at high risk of acquiring HIV infection can generally use all methods of contraceptives. With minimum input, both types of providers can deliver services to clients seeking HTC and FP services in one stop.

5.3 Comprehensive abortion care

A woman seeks safe abortion or post abortion care largely because of unintended pregnancy. Abortion and post abortion care may be the first encounter of a woman within the health system, so providers should utilize this opportunity to counsel and provide FP services to the woman or couple. The *Technical and Procedural Guidelines for Safe Abortion Services in Ethiopia* recommends that a woman should be provided with the choice of contraception immediately after abortion (MOH, 2014). Global evidence indicates that post abortion women accept family planning methods at a

higher rate when the method is offered at the same time and location as abortion or post abortion care treatment prior to discharge from the facility. Therefore this guidance recommends that post abortion family planning counseling and services be provided to women seeking abortion or post abortion care services prior to being discharged from the treating facility.

5.4. Antenatal care, delivery care, and postpartum care

Evidences suggest that there is high-unmet need for post-partum family planning in Ethiopia. This guideline advises integrating postpartum family planning (PPFP) into maternal, newborn, and child health services to increase the likelihood that every new mother will leave the clinic having made an informed choice about family planning.

During antenatal care visits, providers should discuss the benefits of spacing between births, counsel on family size, post-partum family planning and exclusive breastfeeding along with having a skilled birth attendant. Similarly, during delivery and post-partum period, providers should support breast-feeding; introduce locational amenorrhea method (LAM) and other immediate post-partum contraceptive options; injectable, implants, post-partum IUCD and others as per the MEC criteria 2015.

5.5. Child health, immunization, and other RH services

Child health and immunization services create a good opportunity for the provision of FP information and counseling. Furthermore, programs that address harmful traditional practice (HTPs,) gender-based violence (GBV), prevention and management of infertility, screening for Reproductive organ Cancer (ROC), life skill education and other RH services create opportunities for FP services. Hence, these services should be utilized to address issues related to FP.

5.6 Integration with other health services (inpatient and outpatients)

It is true that the large majority of health facility users visit a facility for an outpatient clinical service. In 2017 in Ethiopia, more than 36 million clients visited outpatient departments out of which, more than 18 million were women visits. With a minimum input to health care providers in an outpatient department, integration of family planning

services will provide an opportunity to expand access to quality FP service provision. Integration of services at OPD might be either using an internal referral mechanism (especially for long acting contraceptives) or direct provision of FP services at OPD level (especially for short acting FP services) depending on the context.

5.7 School Health program

Recognizing the more than 28 million adolescent and youth population that attend school, the ministry of health has started implementing a school health program in collaboration with the ministry of education. This school health program (SHP) aims to guide service providers and administrators at different levels of school to provide quality, standardized promotive, preventive, and curative health services to school students at the pre-primary, secondary and tertiary levels of education in a healthy environment. Sexual and reproductive health interventions including family planning services are components of the basic service packages. The health sector and partners working in the SRH area need to support capacity building, service provision and referral service to ensure access to quality SRH services includes family planning.

Self-Check – 5	Written test

Name…… ID…… Date…….
Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: short answer questions

1. Why it is important to link family planning service and comprehensive abortion care? (4 points)
2. Discuss the importance of Integration of FP with other RH and non-SRH service delivery units?(4 points)

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 4 points** **Unsatisfactory – below 4 points**

Operation Sheet 1- Steps in family planning counseling:

Steps in family planning counseling: the GATHER approach

Step1 Greet the client respectfully.

Step2 Ask them about their family planning needs.

Step3 Tell them about different contraceptive options and methods.

Step4 Help them to make decisions about choices of methods.

Step5 Explain and demonstrate how to use the methods.

Step6 Return/refer; schedule and carry out a return visit and follow up.

Operation Sheet 2- Implant NXT Insertion:

The following basic, non-sterile supplies are recommended for each insertion:
ν Examining table for the woman to lie on
ν Antiseptic solution
ν Local anesthetic (1% concentration without epinephrine)
ν Safety box
ν Dust bins with color-coded liners
ν 0.5% chlorine solution for decontamination
ν Decontamination buckets

The sterile instruments and supplies necessary for insertion of implants include:
ν Sterile surgical drape or a fenestrated towel
ν Sterile gauze swabs
ν Pair of surgical gloves
ν 5cc syringe and 21 gauge needle
ν Rods and trocar:
ν Two-rod implants: Set of two rods in sterile pouch; separate sealed packaged containing disposable trocar
ν One-rod implants: Rod loaded in trocar in sterile package
ν Ordinary Band-Aid/Elastoplast
ν Gauze bandage

Step-by-Step Instructions for Insertion of Implanon NXT

Step1. Greet the client, rule out pregnancy, determine that the client wants an implant, is aware of common side effects, accepts them, and has no medical condition that makes implants an inappropriate method per WHO MEC.

Step2: Explain the insertion technique and take the time to answer any questions the client may have.

Step3: Help position client on the table. Have the client lie on her back on the examination table with her non-dominant arm flexed at the elbow and externally rotated so that her wrist is parallel to her ear or her hand is positioned next to her head

Step4: Determine the optimal insertion area by measuring 8–10cm from the medial epicondyle of the humerus.

Step5: Prepare an instrument tray.

Step6: Wash hands thoroughly with soap and water and dry them.

Step7: Apply antiseptic solution to the incision area two times. Begin by wiping at the insertion site and move outward in a circular motion for 8–13 cm (3–5 inches). If an iodophor (e.g., Betadine) is used, allow to air dry for about 2 minutes before proceeding (iodophors require up to 2 minutes contact time to release free iodine.)

Step8: After verbally checking again to be sure the client is not allergic to the local anesthetic agent or related drugs fill a syringe with about 1mL of local anesthetic (1% without epinephrine.

Step9: Insert the needle just under the skin at the incision site (point closest to the elbow). Inject a very small amount of anesthetic to raise a small wheal (raised area). Then, without removing the needle, gently advance it under the skin for about 4–5 cm along the track where the rod will be inserted. This will raise the skin up from the underlying soft tissue. Pull back on the plunger to be sure the needle is not in a blood vessel. As you withdraw the needle, slowly inject the remaining local anesthetic in a track.

Step10: Put sterile gloves on both hands. (A separate pair of gloves must be worn for each client to avoid cross-contamination.) Note: Do not use powder with gloves. The tiny powder granules may fall into the insertion site and cause scarring (fibrous reaction). If gloves are powdered, wipe powder off glove fingers with sterile gauze soaked in sterile water or alcohol swabs.

Step11: Arrange instruments and supplies so that they are easily accessible. Make sure that the Implanon NXT package is intact and the tip of the rod is not protruding out of the trocar

Step12: Hold the applicator just above the needle at the textured surface area. Remove the transparent protection cap by sliding it horizontally in the direction of the arrow away from the needle. If the cap does not come off easily, the applicator should not be used. You can see the white-colored implant by looking into the tip of the needle. Do not touch the purple slider until you have fully inserted the needle sub-dermally, as it will retract the needle and prematurely release the implant from the applicator.

Step13: With your free hand, stretch the skin around the insertion site with thumb and index finger

Step14: Puncture the skin with the tip of the needle angled about 30°

Step15: Lower the applicator to a horizontal position. While lifting or tenting the skin with the tip of the needle (Figure 9), slide the needle to its full length. You may feel slight resistance but do not exert excessive force. If the needle is not inserted to its full length, the implant will not be inserted properly.

Step16: Keep the applicator in the same position with the needle inserted to its full length. If needed, you may use your free hand to stabilize or keep the applicator in the same position during the following procedure. Unlock the purple slider by pushing it slightly down. Move the slider fully back until it stops (Figure 10). The implant is now in its final sub-dermal position, and the needle is locked inside the body of the applicator. The applicator can now be removed

Step17: The applicator is for single use only and should be disposed of in accordance with the IP practices for handling of hazardous waste.

Step18: Cover the Incision by applying a Band-Aid or sterile gauze and tape. Sutures are not necessary and may increase scarring. Check for any bleeding.

Step19: Place instruments into a container filled with 0.5% chlorine solution for decontamination. Dispose of the needle and syringe by placing them in a puncture-proof container.

LAP TEST	Performance Test

Name…… ID……..
Date……

Time started: _____ Time finished: _____

Case scenario: Suppose Wozero Misgane, a married woman who has one child, wants to space her second pregnancy, and comes to you for the first time to have family planning.

Instructions: Given necessary templates, tools and materials you are required to perform the following tasks within **1** hour. The project is expected from each student to do it.

Task-1 Council a client for family planning services
Task-2 Suppose on above scenario Wozero Misgane is eligible for Implanon. Insert Implanon for the client.

LG #38	LO #3- Monitor family planning services

Instruction sheet

This learning guide is developed to provide you the necessary information regarding the following **content coverage** and topics:

- Data registration and documentation
- Information Management, Monitoring and Evaluation
- Completing and submitting Report

This guide will also assist you to attain the learning outcomes stated in the cover page. Specifically, upon completion of this learning guide, **you will be able to**:

- Perform data registration and documentation
- Implement information management, monitoring and evaluation
- Complete and submit report

Learning Instructions:

1. Read the specific objectives of this Learning Guide.
2. Follow the instructions described below.
3. Read the information written in the “Information Sheets”. Try to understand what are being discussed. Ask your trainer for assistance if you have hard time understanding them.
4. Accomplish the “Self-checks” which are placed following all information sheets.
5. Ask from your trainer the key to correction (key answers) or you can request your trainer to correct your work. (You are to get the key answer only after you finished answering the Self-checks).
6. If you earned a satisfactory evaluation proceed to “Operation sheets
7. Perform “the Learning activity performance test” which is placed following “Operation sheets” ,

8. If your performance is satisfactory proceed to the next learning guide,
9. If your performance is unsatisfactory, see your trainer for further instructions or go back to “Operation sheets”.

Information Sheet 1- Data registration and documentation

Registers (or registries)

Allow health information to be maintained and retrieved by health care facilities for the purpose of education, planning, and research. Register is a formal or official recording of items, names or actions." Whereas, a registry is an organized system for the collection, storage, retrieval, analysis, and dissemination of information on individuals who have either a particular disease, a condition that predisposes to the occurrence of a health related event, or prior exposure to substance or circumstances known or suspect to cause adverse health effects.

Documentation

Documentation is defined as written evidence of interactions between and among health professionals, clients, their families, and health care organizations

Purpose

Through documentation ensures:

- Accurate data needed to plan the client's care in order to ensure the continuity of care
- A method of communication among the health care team members responsible for the client's care
- Written evidence of what was done for the client, the client's response, and any revisions made in the plan of care
- Compliance with professional practice standards (e.g., American Nurses Association)
- Compliance with accreditation criteria (e.g., the Joint Commission on Accreditation of Healthcare Organization [JCAHO])
- A resource for review, audit, reimbursement, education, and research
- A written legal record to protect the client, institution, and practitioner

Information Sheet 2- Information Management, Monitoring and Evaluation

1. Monitoring and evaluation of FP interventions

1.1. Introduction

Monitoring and Evaluation is one of the key components that helps policy makers, program managers, and health workers to track performance, to know areas of improvement and help for an overall strategic decision making at all level. As part of the overall health sector transformation plan, routine health management information system (HMIS), and population and facility-based surveys (EDHS, PMA 2020) were some of the information source for measuring FP program. Monitoring of family planning interventions helps to know the FP performance, tells which activities are more efficient and effective to meet the program objectives, informs to make data driven decisions, and identify challenges, opportunities and strengths during program implementation.

1.2. Monitoring

Monitoring is a process by which priority data and/or information is routinely collected, analyzed, used and disseminated to see progress towards the achievement of planned targets. This helps the managers take timely corrective actions in order to improve performance. It includes monitoring of inputs, outputs, outcomes and impacts of health programmes, including family planning. The most common form of monitoring is often based on input and output indicators using routinely collected service data. Monitoring of outcomes and impacts, on the other hand, requires the collection of target population level data, and for this reason is done at a higher level and for fewer selected priority areas only.

- **Monitoring consists of these components:**
  - ✓ **Routine data collection and aggregation** (combining data from different sources) is the means by which routine service data is collected, aggregated, analyzed and made ready for further performance monitoring.
    - ✓ **Performance monitoring** is the continuous tracking of required information on conducted activities and its indicators of success, in order to identify achievement gaps and lessons learnt. At all levels,

performance monitoring will be based on the developed annual plan. The routine data collection and aggregation process provides a summary of performance data. Based on agreed Health Management Information Systems (HMIS) performance indicators, the performance monitoring committee will review the adequacy of achievements against the annual targets on a regular basis.

At all levels, performance monitoring will be conducted regularly on a weekly, monthly, quarterly and annual basis, supplemented by semi-annual and annual review meetings. With regard to family planning, you need to know what has to be monitored and how — you can refer to national HMIS technical guidelines.

Common performance indicators for a family planning programme

Inputs (resources, activities)

- Total commodities (supplies, equipment, contraceptives) received.
- Training and technical assistance received by the staff.
- Supplies and contraceptives expended (subtract inventory from amount received).
- Number of educational materials received, by type.

Outputs (services, training, information, education and communication)

- Number of new clients, given by choice of contraceptive method.
- Number of providers trained.
- Number of households covered.
- Number of community meetings and number of people informed at meetings.
- Number of referrals for clinical methods.
- Number of contraceptives distributed, by contraceptive method.

Indicators of quality of care (Some of these indicators can only be measured through evaluation research, depending on the programme's Management Information System.)

- Providers' level of adherence to informed choice protocols.
- Method mix offered.

- Percentage of clients referred by other clients (an indicator of client satisfaction).
- Continuation rates in programme.
- Percentage of clients expressing satisfaction with the service.

Indicators of effectiveness:

- Indicators of knowledge of, attitudes towards, and practice of family planning in programme area.
- Indicators of impact
- Contraceptive prevalence rate (CPR) in area.
- Crude birth rate in area.
- Induced abortion rates in area (if available).
- Total Fertility Rates (TFR) in area.
- Infant mortality rate.
- Maternal mortality rate.
- Rate of high-risk births (women over 35 years with 5+ births).

1.3. **Evaluation**

Programme evaluation is the systematic process of data collection, analysis and interpretation of activities and the effects of a programme, or any of its components. Programme evaluations may be either process evaluation, which examines the appropriate execution of programme components, or outcome evaluation, which examines the benefits of implementing an intervention or any of its components.

Self-Check – 2	**Written test**

Name……. ID……. Date…….

Directions: Answer all the questions listed below. Examples may be necessary to aid some explanations/answers.

Test I: Choose the correct answer (2 points)

1. The process by which priority data and/or information is routinely collected, analyzed, used and disseminated is called:
   A. Evaluation B. monitoring C. Supervision D. Meeting

Test II: Short answer question

1. Discuss components of monitoring (5)
2. List at least five family planning program indicators of effectiveness (5)

You can ask you teacher for the copy of the correct answers.

Note: **Satisfactory rating – 6 points** **Unsatisfactory – below 6 points**

Information Sheet 3- Complete and submit report

4.4 Introduction to Health Management Information System (HMIS)

Ethiopia has been implementing the health management information system since 2008 to capture and provide core indicators to improve the provision of health services. The system is a major source of information for monitoring and adjusting policy implementation and resource use. Recently, the health information system, which uses HMIS, has been replaced by the district health information system (DHIS2), which provides aggregates of health information at a facility level.

The family planning service provision is one of the services, which need to be captured through the DHIS system. In this guideline, the major data that need to be captured in the DHIS and the tools used to collect clients information are described to help health care workers and health managers to follow FP services are well recorded and used for decision making. The major records are categorized as individual client's records, registers, and tally sheets.

3.2. Individual FP recording tools at Health Facilities

3.2.1. Integrated individual Folder

Any client who came to health facilities to receive FP service should visit medical record room and issued integrated individual folder that captures the basic demographic information of the client. The inside part of the folder contains a summary sheet to summarize summary of service provided for client at each visit and should be filled by service providers immediately after the service is provided.

3.1.2.1. Women's Card

All clients seeking FP services need to have a Women card. The card records their socio-demographic and health history including screening for family planning, past and current FP methods, the physical examination findings, and the client's current

FP method. The follow-up section of the card records the history and physical examination findings at the time of the visit.

3.1.2.2 Appointment Card

It is a small card, which is used to remind clients who have next appointment. The card contains the client demographic information, appointment date and reason for appointment.

3.1.2.3 Referral form

Referral form is used to transfer basic information from referring health facilities to accepting health facilities. The referral form is attached in which is based on the community-based health information system (CHIS) from HP to HC.

3.1.2.4 Family health Card [at health post level]

Any clients that visit health post should be issued a family health card. The card helps the HEW to capture all demographic information, FP provision and long-term FP removal. The HEW should keep all family health cards with appointments in a tickler box. Otherwise it should be put on the back on family folder.

3.1.2.5 Registers

A. Family Planning Register

Family Planning Register is a longitudinal register that is used to capture HMIS data related to family planning services. The information required to complete the FP register is obtained from woman's card. The register should be kept in the Family Planning service room. The service provider will obtain complete information on individual clients from a woman's card and copy all the required information to the family planning register. This will help to compile and generate monthly family planning service statistics reports.

B. Long Acting Removal Register

The Long Acting Removal Register is used to record data for clients who have had long acting family planning methods and who have returned for removal. The family

planning methods that are included for removal are implants (different types) and IUCD. Data is abstracted from women card and entered to the LAFP removal register by service providers.

Annex 1

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