Ethiopian TVET-System

Health Extension Service

Level III

Based on Jan.2018G.C Occupational Standard

Module Title: Promoting and Managing Comprehensive Family Planning Service

TTLM Code: HLT HES3 0919 v1

This module includes the following Learning Guides

LG55:Promote family planning services

LG56: Plan family planning services

LG57:Provide family planning Services

LG58: Monitor family planning services

Instruction Sheet	LG55: Promote family planning service

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

- selecting influential representative
- consulting voluntary groups
- promoting & educating family planning practice
- Aproach to family planning service

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to –

- identify and consult Influential community representatives and voluntaries
- organize and promote Family planning practice promotion and education in partnership with the community and relevant organizations on the basis of inter-sectoral approach
- Sustain Family planning practice promotion and education activities involving the resources of the community on the basis of stakeholders' genuine participation
- support Family planning practices to take self-care approach in line with individual needs for changing unhealthy behavior on the basis of healthy promotion and strategic behavioral change approach of FMOH

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 teacher for assistance if you have hard time understanding them.
4. Accomplish the "Self-checks". In each information sheets.

5. Ask from your teacher the key to correction (key answers) or you can request your teacher 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 and LAP Tests if any”. However, if your rating is unsatisfactory, see your teacher for further instructions or go back to Learning Activity.
7. After You accomplish Operation sheets and LAP Tests, ensure you have a formative assessment and get a satisfactory result;
8. Then proceed to the next information sheet

Information Sheet-1	select influential representative and consult voluntary groups

The framework is designed as a logic model, linking inputs and activities with outputs and the outcomes and impacts determined for FP.

• Includes the inputs required at the policy, service, community, and individual levels to achieve the desired public health and human rights outcomes and impact

• Situates these four levels within the country context that affects both the supply of and demand for family planning

• Shows how the four levels support the three broad categories of reproductive rights (Rs):6

- Rights to reproductive self-determination
- Rights to sexual and reproductive health services, information, and education
- Rights to equality and nondiscrimination • Links the current focus on quality of care in FP
- Availability
- Accessibility o Acceptability
- Quality • Reflects the principles of public health and human rights programming:
- Public health—beneficence, equity, autonomy
- Human rights—participation, accountability, nondiscrimination, empowerment, and link to international treaties • Applies to all phases of the program life cycle (i.e., needs assessment, planning, implementation, monitoring and evaluation, scale-up, and sustaining) • Presents the importance of accountability mechanisms for the effective redress of rights violations and handling of alleged or confirmed vulnerabilities • Promotes the agency of individuals to make reproductive health choices that are free from discrimination, violence, and coercion

The framework clearly depicts the need for program planners to think beyond what happens during client provider interactions to the effects of the policy and resource environment (does it support or hinder choice and method access and clients' rights?) as well as community factors (do socio cultural and gender norms support clients' right and ability to make autonomous FP decisions?). It guides systematic thinking that includes and

goes beyond what happens at the service delivery point to consider whole programs, not just individual services.

Self-Check 1	Written Test

***Instructions**:* Answer all the questions listed below. Illustrations may be necessary to aid some explanations/answers. Write your answers in the sheet provided in the next page.

1. List reproductive rights
2. Indicators of quality of care in FP

Information sheet 2	Approach to family planning service

2.1. Approach to family planning service

The objective of family planning service is to reduce morbidity and mortality of mothers and children by spacing child-bearing; preventing unplanned and unwanted pregnancy. Increase the awareness, knowledge and skills of communities to utilize family planning service.

2.1.1. Family planning service delivery models

Door-to-door service delivery

A door-to-door service providing family planning packages at household level. The service includes education, counseling and the provision of contraceptive methods, such as oral pills, condoms and injectables. This programme is cost-effective, and the preferred way to reach the majority of people in their homes.

Facility-based service delivery

The major advantage of using this approach is that it can provide medically complex methods, such as IUCDs, hormonal implants and sterilization. This approach works well for those living close to any of these health facilities.

Community-based distribution (CBD)

In areas that do not have any type of health facility nearby, family planning services may be made available through **community-based distribution** or CBD programmes.

In this approach, CBD workers, usually village women are trained to educate their neighbours about family planning and to distribute certain contraceptives.

In their training, the CBD workers learn the basic concepts of family planning, how each method must be used, what the precautions and side effects are for each method, and how to keep simple records and report the information to their supervisors. CBD programmes usually distribute condoms; some also provide pills and spermicides.

Commercial retail sales

In both urban and rural areas, if people are willing to obtain contraceptives from sources outside the healthcare system, **commercial retail sales** (sometimes called social marketing) can make some contraceptive methods very accessible. In these approaches, contraceptives, such as oral contraceptive pills, condoms and injectables, are sold at reduced, subsidised prices in pharmacies, from market stalls, and so on.

When a commercial retail sales approach is used, the retailers are often the customers' only source of information about the products. These retailers should be given training in basic information about the products, and how to refer people who have problems with a contraceptive

Other delivery methods

A number of other service delivery methods have been used. Some companies provide family planning services during certain hours at the workplace. Although generally at a higher cost, family planning services are often available from private for-profit healthcare providers. Other approaches involve training paramedics, pharmacists, traditional birth attendants, midwives, traditional healers and outreach workers to provide family planning services.

2.3 **Family planning and the Health Extension Service**

The roles of Health Extension workers in provision of family planning services

As part of your role as health extension worker, you have several important roles to play in the provision of family planning services.

Using document review (sources: kebele council, and other organizations), Group discussions, interview with individuals and residents and Home visit to discuss with household members by using health development army collect base line data on the following areas:

Box 1:Information to be collected on family planning
▪ Number of households by age, sex, religion, occupation, source of income, average monthly income, and annual birth and death rates.
▪ Knowledge, attitude and practice of family planning;
▪ Number of contraceptive users and type of contraceptives they are using
▪ Number of contraceptive nonusers and why they don't use
▪ Number of contraceptive non users, but who want to use
▪ Information on when the contraceptive users started using the services
▪ Information on taboos

- Number of mothers that breast feed
- Number of mothers who got pregnant according to their plans
- Number of mothers who got pregnant outside their plans
- Useful and harmful traditional practices

After collecting the above survey some of your role could be:

- Provision of education on family planning by using interpersonal communication
- Educating and mobilizing communities for family planning services
- Providing sustained family planning counseling
- Mobilizing communities for active participation in family planning
- Strengthening and implementing coordinated family planning Using exemplary family planning service users to promote the services

Table 2.Summary of family planning services to be given by health extension workers at health posts

Level of facility	Type of health professional available	Family planning service
Health post	Health extension workers	▪ The above activity mentioned in box 1 plus ▪ Counseling on family planning and other SRH issues ▪ Counsel natural family planning method ▪ Provide injectable ▪ Implanon insertion ▪ Refer to health center for long acting and permanent methods ▪ Planning based on local data

2.4 Contraceptives Supply Management

A strong supply and distribution chain gives women the confidence that their preferred contraceptive option will be available when they take time away from work and their families to travel to their local health clinic.

The purpose of LMIS is:

To collect, analyze, organize and report data that will be used in the decision-making process. The information provided by the LMIS not only enhances customer service by improving the quality of data used to make management decision but also, foster a more accurate forecasting system.

Logistics management includes a number of activities to ensure that clients are able to choose, obtain, and use quality family planning method.

To ensure that this basic right is in place, the contraceptive supply management system is expected to provide excellent customer service by fulfilling the six rights. Availability contraceptive products whenever they need.

The Six "Rights"

- The RIGHT goods
- in the RIGHT quantities

- in the RIGHT condition delivered . . .
- to the RIGHT place
- at the RIGHT time for the RIGHT cost

The Pipeline

Definition

Pipeline is defined as the entire chain of storage facilities and transportation links through which supplies move from the manufacturer to the consumer, including port facilities, central warehouse, regional warehouses, district warehouses, all service delivery points, and transport vehicles. In a logistics setting, the logistics system is often called a pipeline.

Reporting and Ordering in the new system

According to the new Integrated Pharmaceutical Logistics System (IPLS), Health Centres and Hospitals are required to report and order every two months. They calculate their own order quantities, ordering sufficient quantities of all pharmaceuticals to bring stock levels up to the maximum level; PFSA will resupply them accordingly.

Health Post re-supply

Health Posts complete one part of the Health Post Monthly Report and Re-supply Form every month and carry the report to the Health Centre. The Health Centre uses the information found on the Health Post Monthly Report and Re-supply Form to complete the form and calculate the quantity of pharmaceuticals needed by the Health Post
Each month, the Health Centre will issue enough stock to bring the Health Post up to its Maximum Stock Level of 2 months of stock for contraceptives(You will learn this in detail in your Community health service management module).
2.2 Family planning programme management

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.

2.2.1 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 the mout. 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)t he annual(work)plan.

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 (any where 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 in to two: the core and the comprehensive plan. The core plan is the summa rised 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 harmonised, 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.

Self-Check 2	**Written Test**

***Instructions**:* Answer all the questions listed below. Illustrations may be necessary to aid some explanations/answers. Write your answers in the sheet provided in the next page.

1. **Define family planning service**
2. **List three of the most common family planning delivery models in Ethiopia**
3. **List the six rights in contraceptive management**
4. **List all Information to be collected on family planning**

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2 points**

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

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Instruction Sheet	LG56: Plan family planning service

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

- Introduction to population and family planning
- Resource mapping
- Identification of family planning target group
- Developing action plan

1. This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to –

- Conduct Resource mapping is using the standard format of FMOH
- identify Family planning eligible are and the number of expected target group for
- calculate family planning Practice is from the catchments using standard statistical method

Learning Instructions:

9. Read the specific objectives of this Learning Guide.
10. Follow the instructions described below
11. Read the information written in the “Information Sheets”. Try to understand what are being discussed. Ask you teacher for assistance if you have hard time understanding them.
12. Accomplish the “Self-checks”. in each information sheets.
13. Ask from your teacher the key to correction (key answers) or you can request your teacher to correct your work. (You are to get the key answer only after you finished answering the Self-checks).
14. If you earned a satisfactory evaluation proceed to “Operation sheets and LAP Tests if any”. However, if your rating is unsatisfactory, see your teacher for further instructions or go back to Learning Activity.
15. After You accomplish Operation sheets and LAP Tests, ensure you have a formative assessment and get a satisfactory result;

Information Sheet-1	• Introduction to population and family planning

1.1. Introduction to Family Planning

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 proving to be effective in tackling these problems.

1.2. Definition of Family Planning

Family planning is defined as the ability of individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility.

Family planning is a means of promoting the health of women and families and part of a strategy to reduce high maternal, infant and child mortality. People should be offered the opportunity to determine the number and spacing of their own children. Information about FP should be made available, and should actively promote access to FP services for all individuals desiring them.

1.3. History of Family Planning

Humans have been practicing Family Planning (FP) for a long time. Evidence suggests that people were using natural family planning methods in ancient times – abstinence and breast feeding being prime examples. The condom was introduced mainly to prevent STIs among the British royalty in the 18th century. But, FP as we know it today began in the middle of 20th century, particularly after the discovery of the pill – the wonder drug which is said to have changed the world forever.

Not much was known about family planning in Ethiopia before the mid-1960s. The modern family planning service in Ethiopia started as The Family Guidance Association of Ethiopia (FGAE), established in 1966. FGAE's only family planning services were provided from a single-room clinic run by one nurse, at the former St Paul Hospital in Addis Ababa. FGAE's programme activities and services are now broadly spread all over the country, creating a vast network.

In the last 20 years, with the adoption of the population policy in 1993, numerous local and international partners in family planning have come together to assist the government in expanding family planning programmes and services. The National Population Office was established to implement and oversee the strategies and actions related to the population policy. In 1996, the Ministry of Health released Guidelines for Family Planning Services in Ethiopia to guide health providers and managers, as well as to expand and ensure quality family planning services in the country.

The Ministry of Health designed new outlets for family planning services in the form of community-based distribution, social marketing and work-based services, in addition to the pre-existing facility-based and outreach family planning services. Social marketing is about making available family planning methods at an affordable price using private retailers. Work-based services are services made available to users' at their place of work, such as factories, prisons and schools. Moreover, in the last decade, integration and linkage between family planning services and HIV/AIDS care, along with maternal and other reproductive health services, has been emphasized in guidelines and strategic documents with the aim of enhancing family planning utilisation.

Currently, the service has been provided to rural communities at household level through the Health Extension Programme (Figure 1.3). Access to these services has been almost universal for all urban and rural communities, so that every woman in the population can get any contraceptive method of her choice free of charge. This is covered in more detail in the next study session.

1.4. Rationale of Family Planning

To prevent harm arising from pregnancy and childbirth and in order to safeguard their health, women have the right to FP education, information and capacity' The Constitution of The Federal Democratic Republic of Ethiopia, Article 35.9.

1.4.1. Health Benefits

'Family planning saves lives of women and children and improves the quality of life for all. It is one of the best investments that can be made to help ensure the health and well-being of women, children, and communities.' WHO 1995.

Family planning reduces mortality and morbidity from pregnancy and childbirth. Spacing childbirth with intervals of three to five years significantly reduces maternal, perinatal and infant mortality rates. Use of FP prevents the depletion of maternal nutritional reserves and reduces the risk of anemia from repeated pregnancies and birth.

Pregnancy and childbirth poses special risk for some groups of women – adolescents, women older than 35 years of age, women with more than four previous births and women with underlying medical diseases. It is estimated that if all these high risk pregnancies are avoided through the use of family planning 25% of maternal deaths can be prevented (Royston 1989). Moreover, unwanted pregnancy leads to unsafe abortion with its resultant short term and long term complications that include death. These suffering and deaths from complications of unsafe abortion can be prevented with use of family planning.

Apart from limiting and spacing birth family planning methods have other non-contraceptive benefits. If properly and consistently used condom provides protection from sexually transmitted infections including HIV. The Lactational amenorrhea (LAM) Method, LAM, provides special nutritional benefits to the infant and protects the infant from infections. In addition, LAM establishes mother-child bonding early in life that continues through later life. It also reduces the risk of breast cancer in the mother.

1.4.2. Social and economic benefits

Individual: Pregnancy and childbirth poses a risk to the life of the woman. Repeated pregnancies and childbirth restrict women from education, employment and productivity resulting in poor status of women in the community with the resultant poor living standard. Family planning helps women to pursue their education for a better employment opportunities and payment.

Family: Increased family size leads to income and resource sharing. Repeated and too many pregnancies entail early weaning with the consequent high infant morbidity and mortality as well as the high cost of alternative infant feeding options. In addition, the

children tend to be underfed, ill-housed and undereducated culminating in future unemployment and being a burden to the family and the community at large. Death of a mother results in disruption of the family.

Community: Increase in population size leads to increased man/land ratio reduced production and income with consequent urban migration. Furthermore, increase in population size results in poor social services, poor education, compromised women empowerment, increased non-productive segment of the population, deforestation, and over consumption of resources that aggravates poverty.

Global: Uncontrolled population growth intensifies famine, war and migration which are collectively termed 'demographic entrapment'. Moreover, deforestation, erosion and resource depletion and global warming are consequences of population explosion.

All these individual, family, community and global effects of uncontrolled population growth can be minimized through strong FP programs and services that respect the rights and informed decisions of women and men.

1.4.3. Meeting individual/couples fertility benefits

Meeting individual fertility needs promotes women's right to whether to be pregnant, when to be pregnant. Furthermore, meeting individual fertility needs is essential to attain sexual and reproductive health and rights of women.

1.5. Contraceptive Options

The following methods are available for use in Ethiopia. For ease of description, the methods are broadly categorized into two: Natural Family Planning Methods and Modern Family Planning Methods.

- **Natural Family Planning Methods**
  - ✓ Abstinence
  - ✓ Fertility awareness based methods: Standard Days Method (SDM), Rhythm(Calendar) Method, Two Days Method, Cervical Mucus (Billings ovulation) Method, Sympto-thermal Method
  - ✓ □ Lactational Amenorrhea Method (LAM)
  - ✓ Withdrawal Method
- **Modern Family Planning Methods**
  - ✓ Male and Female Condoms/Diaphragms and other barrier methods

- ✓ Vaginal Contraceptive Foam Tablet and Jellies
- ✓ Emergency Contraceptives
- ✓ Progestin-Only Pills
- ✓ Combined Oral Contraceptives
- ✓ Injectable contraceptives
- ✓ Implants
- ✓ Intra-Uterine Contraceptive Devices
- ✓ Bilateral tubal ligation
- ✓ Vasectomy

Self-Check 1	**Written Test**

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. What is family planning?
2. What is the Rationale of Family Planning?
3. What is the role of health professionals in providing family planinnig?
4. Why the objectives of the National Population Policy have not yet been met?

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2points**

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

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Information Sheet 2	Resource mapping

Mapping is sketching the topography of your kebele on paper by using scale. Map of your kebele will be divided according to different administrative areas like gote.

Gote is the smallest administrative area next to kebele. Whenever you sketch the map of your kebele you have to face your north pole. **N**

Key

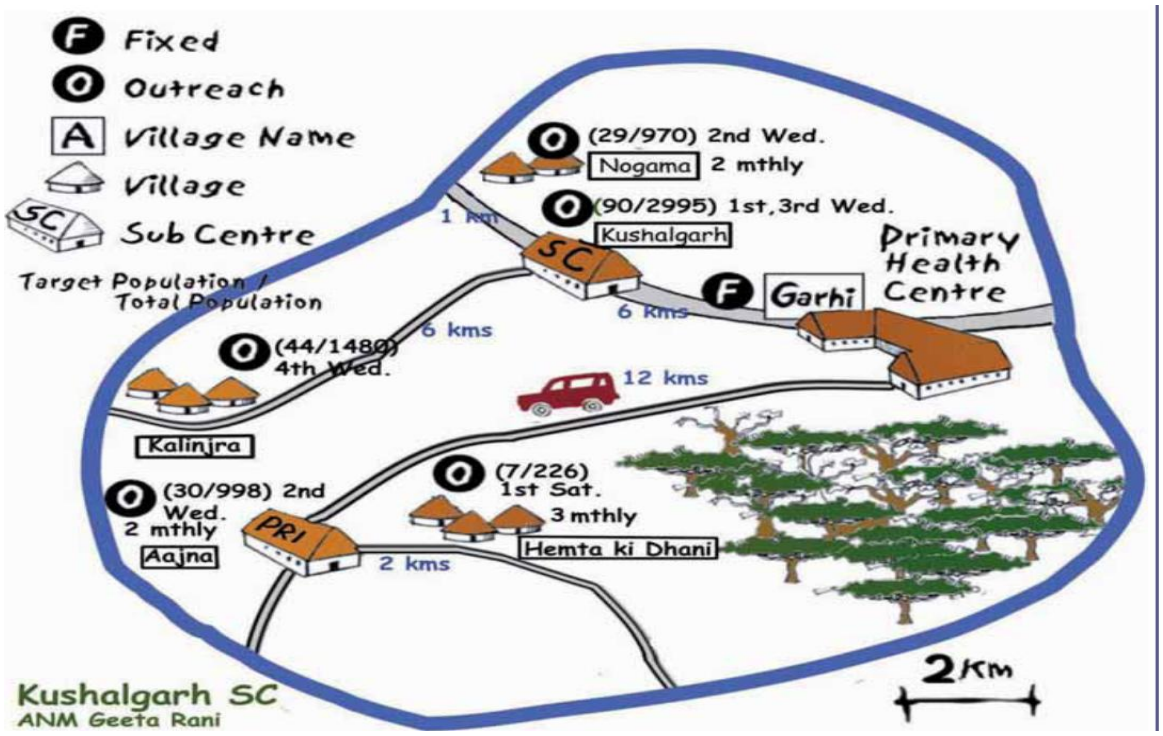

Fig1.1. Map showing kebele level immunization site

1.1 Zoning

Zoning is using different boundary to divide the kebele in to different gotes for the sake of administrative purpose. This will facilitate our service delivery activities and also can simplify our preliminary data collection.

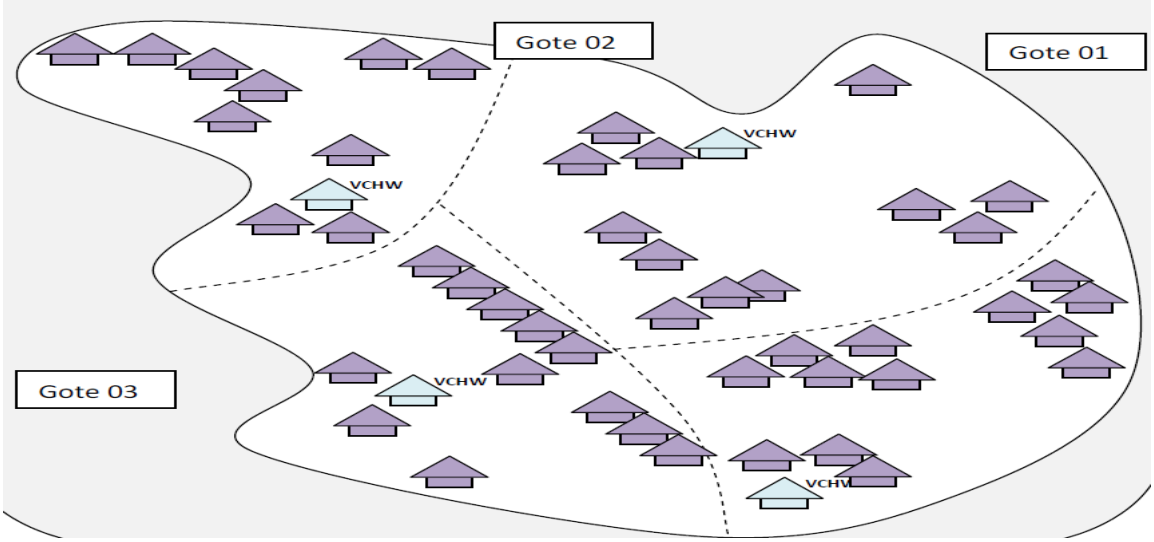

Fig 4.2. Example of zoning of kebele in to different gotes

1.2 Numbering

Numbering is used for house hold identification purpose. The number will be given for the kebele, gote, and for the house. For example a house number for one house hold found on 23th order of gote three will be 01-03-023 i.e. 01(kebele code, 03(gote code) and 023(house number). Use the following steps to come up with the final numbering;

Household numbering in a Gote

1. The HEW supervisor in consultation with kebele administration will decide to give number codes to each Gote within the kebele
2. Select the house of one voluntary community health worker within the Gote
3. Give that house the first number for that Gote. For example, if the Gote code is 01 the first household number is 01-001
4. Continue to serially number all households in the neighborhood of that voluntary community health worker's house/catchment area
5. Once all the households in the catchment area of that voluntary community health worker is complete, shift to the neighborhood/catchment area of the next voluntary community health worker
6. Depending on the last number used, give this voluntary community health worker's household the next available number. For example, if the last number of the household in the previous neighborhood was 01-052, then the household number of the voluntary community health worker's house in the next neighborhood will be 01-053.
7. Continue till all the households in the Gote have been numbered
8. Later on when new households are created within the Gote, the next available number will be assigned to that household

Self-Check 2	Written Test

***Instructions**:*Answer all the questions listed below. Illustrations may be necessary to aid some explanations/answers. Write your answers in the sheet provided in the next page.

1. What is resource mapping?
2. Why we give number for got during mapping ?

Note: **Satisfactory rating - 20 points** **Unsatisfactory - below 20 points**

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

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Information Sheet 3	• Identification of family planning target group

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3.1. Target groups for planning

The following groups of people are target groups for family planning

- Adolescents
- Females in child baring age
- Post abortion
- Post partum
- Women's living with HIV

Some family planning methods, such as condoms, help prevent the transmission of HIV and other sexually transmuted infection. family planning /contraception reduce the need for abortion especially unsafe abortion .family planning reinforces people's right to determine the number and spacing of the children

Self-Check 3	Written Test

Instructions*:*Answer all the questions listed below. Illustrations may be necessary to aid some explanations/answers. Write your answers in the sheet provided in the next page.

1, who are target group for family planning?

2. Explain the reason why this groups are target group.

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2 points**

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

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

4.1. COSTED IMPLEMENTATION PLAN

The CIP specifies the interventions and activities to be implemented, and itemizes the financial and human resources needed to meet the comprehensive national FP goals.

4.1.1. Operational Goals

- Increase the CPR amongst married women from 42 percent in 2014 to 55 percent by 202066

- Reduce the TFR from 4.1 in 2014 to 3.0 in 202067

- Reach 6.2 million additional women and adolescent girls with FP services by 2020 as compared to 201168

4.1.2. Strategic Priorities

The strategic priorities in the CIP represent key areas for financial resource allocation and implementation performance. Strategic priorities reflect the issues and interventions that must be acted upon to reach the country's goals. Based on a desk review and key stakeholder interviews, a Technical Support Team from the Health Policy Project (HPP), funded by USAID, identified five strategic priorities. These priorities serve as the foundations of the thematic areas for CIP activities:

- Priority # 1—Demand Creation: To strengthen demand for and increase acceptability of FP services, especially long-term methods, by providing targeted, easily accessible, and accurate information to the population on the full method mix.

- Priority # 2—Service Delivery and Access: To increase the number of skilled providers delivering high-quality contraceptive services and ensure access for all populations, especially youth and pastoralists, through an effective referral system, outreach and mobile clinics, and adolescent and youth-friendly sexual and reproductive health (SRH) services.

- Priority # 3—Procurement and Supply Chain: To improve the distribution of FP commodities and consumables from the central level to service delivery points by

increasing the capacity of healthcare workers to manage the logistics system and the PFSA by improving human resource and commodity supply chain logistics to manage the national supply chain.

• Priority # 4—Monitoring and Coordination: To improve multi sectoral coordination in the planning, implementation, and monitoring of FP programmes at all levels.

• Priority # 5—Financing: To increase the budget allocation for family planning both at the federal and regional levels to ensure reproductive health commodity security.

Intervention and activity mapping to FP2020 commitments The GOE is determined to meet its FP2020 commitments, which prioritise outreach to specific population groups and an increase in uptake of LARCs—interventions that cut across core components of an FP programme. When resources are limited, they should be directed to areas that have the greatest potential to meet those commitments and reduce the unmet need for family planning. In the case of a funding gap between resources required and those available, FP2020 activities should be given precedence to ensure the greatest impact and progress towards the objectives laid out. These activities will enable the MOH to focus resource and time investments on coordination and leadership for CIP execution. However, all of the components necessary for a comprehensive FP programme (all of the activities that support, complement, and complete the FP programme) have been detailed by activities and costed; the strategic priorities of the plan will be used to guide national priorities for additional and new funding and programme development.

All activities under the five thematic areas will address the eight FP2020 goals. Notably, while the CPR, TFR, and uptake goals presented in Commitment 1 are cross-cutting in nature, Thematic Area 5 will speak more to Commitments 2 and 3 (increase financing for family planning). Thematic Area 3 will contribute to Commitment 4 (commodity security). Thematic Areas 1 and 2 will especially align with Commitments 5, 6, and 7 (increase uptake of LARCs and expand service delivery for youth and hardest-to-reach groups). Thematic Area 4 will contribute to Commitment 8 (monitor contraceptive availability).

4.1.3. Thematic Areas

Across the five thematic areas, there are 23 strategic outcomes for implementing a full FP programme in Ethiopia. Each thematic area is further detailed with expected results,

activities, sub-activities, inputs, outputs, and timeline information. Refer to Annex A: Implementation Framework with Full Activity Detail.

Demand creation (DC) Strategy The wide gap between knowledge about contraceptives and their use indicates the need for a focused communications strategy to ensure FP programme coordination and increase demand. A behaviour change communication (BCC) strategy will be developed to streamline communication efforts with consistent messages targeting priority groups. The BCC strategy will be informed by formative and assessment research. Campaigns should be adaptable for different cultural audiences and populations.69 For example, campaigns that speak to the needs of the population will often need to be specific to regions or even districts. Thus, regional input and stakeholder engagement in the strategy development process will be critical. The formative research will outline the knowledge, attitudes, and perceptions of the audience so the campaign addresses the actual needs of the target population.70 Successful campaigns can result in increased demand, increased acceptance of family planning amongst family members, increased knowledge and access to FP services, and informal peer-to-peer advocacy for FP methods amongst users.71

Once an evidence-based strategy is developed, a series of demand creation activities will be implemented at the national, subnational, community, and interpersonal levels. Multiple media outlets—including mass media; information, education, and communication materials; interpersonal communications; advocacy campaigns; and champions—will increase demand and uptake of services.72 By increasing knowledge and awareness of family planning at all of these levels, the demand creation strategy will increase the desire to access FP services and lower the barrier to access.

In addition, specific demand creation efforts will be targeted at youth (ages 15–19), community and religious leaders, and men as husbands and fathers. Youth have a tendency not to access FP services, as they do not feel they need to “plan a family”; thus, the BCC strategy will utilise appropriate terminology to help overcome this barrier. Meanwhile, there is a rising trend amongst urban youth to access emergency contraceptives on an ad hoc basis rather than using contraceptives more consistently and appropriately to their health needs and reproductive desires. Demand creation activities that make the full spectrum of contraceptives better understood and more

relevant to youth can significantly improve the welfare of the population through the prevention of unintended pregnancies.

Community and religious leaders strongly influence women's decision to access family planning. Historically, traditional, community, and religious leaders have perceived FP use negatively. However, with concerted outreach efforts that listen to and address their concerns, these leaders can become some of the strongest supporters for family planning in their communities. Successful partnership efforts by the Benishangul-Gumuz RHB with local sharia leaders to support family planning within their communities are good examples of how government and religious leaders can work together to support FP use to improve the health of community members.73 MOH and RHBs will identify and work more with national- and community-level leaders to improve the acceptability of family planning.

Although men share responsibility for reproductive health decisions, lack of a specific focus on them can lead to the belief that family planning is not men's concern. However, male involvement is crucial to a successful demand creation campaign. Barriers for uptake include power and gender dynamics that inhibit women from making open decisions about FP use in their households. Providing information to men about how family planning can improve health outcomes for women and children, as well as dispelling myths and misconceptions, is important in ensuring their support.74

Ultimately, women must feel empowered and knowledgeable about family planning to make the decision to access it. Embracing family planning as a community, such as by providing an opportunity for satisfied FP users to share their stories through the Health Development Army (HDA), will increase community and women's awareness that FP decisions not only can be made by women, but that this kind of decision making about their health and reproductive outcome is a core right of all women. Combined with the demand creation campaign focusing on influencers such as community leaders and husbands, mass media campaigns on women's rights to FP decision making will increase acceptance.

Strategic outcomes DC1. Increase awareness of available FP methods and how to access them by developing and executing a comprehensive BCC strategy tailored to specific target groups and cross-cutting issues: To increase FP acceptability, a

comprehensive BCC strategy will be developed. The MOH will spearhead this strategy development process, in consultation with RHBs and other key stakeholders for FP programme implementation. The FP Technical Working Group (TWG) will identify key target groups and priority cross-cutting issues to address through demand creation activities. Potential target groups include young married women, youth ages 15–19, men, pastoralists, community leaders, and service providers. Cross-cutting issues to be tackled by BCC include addressing myths and misconceptions about family planning, especially around LARCs; the intersection of religion and FP use; women's empowerment and access to family planning; and regional and cultural backgrounds as they relate to FP acceptability and use.

DC2. Increase awareness of and demand for family planning, especially LARCs: Using the key messages developed by the new communications strategy, targeted BCC campaigns will be developed to increase FP awareness and knowledge. Mass media will be leveraged to reach the population nationally, and existing outreach models, such as the HDAs and use of the HEWs, will be leveraged to reach target communities at a more personal level. Innovative mobile platforms will be used to provide access to information about family planning on demand, such as the Mobile 4 Reproductive Health systems in operation in Kenya and Tanzania.75 This outreach mechanism is believed to be most optimal for youth ages 15–24.

DC3. Increase awareness of and demand for FP services amongst both in- and out-of-school youth: To improve the knowledge of sexual and reproductive health and family planning as they relate to married and unmarried youth, demand creation activities will focus on improving the quality and depth of information available to youth. Peer educators, both male and female, will be trained to provide accurate FP and reproductive health information and promote health-seeking behaviour amongst both male and female youth. Communication materials specifically targeting youth will be distributed through youth centres and schools. Furthermore, support systems for youth—parents, caregivers, and teachers—will be given the tools to advise them effectively on why family planning is relevant to them, how it can impact their health, and how FP use can benefit their welfare by preventing unintended pregnancies.

DC4. Establish and sustain engagement with national- and community-level advocates of family planning, including traditional and religious leaders: To increase the

engagement of community and religious leaders who have the ability to promote family planning within the community, the MOH and RHBs will take a step-by-step approach. First, they will engage the leaders and address their concerns. Through these discussions, the MOH and RHBs then will identify FP champions. Leaders already working in health will be cultivated, leveraging their ongoing work by integrating family planning into it, and tools will be developed to support FP advocacy.

DC5. Increase male engagement in FP issues: Special Men's Day events will be held at the regional level to raise awareness of family planning amongst men. In addition, male role models will be selected and cultivated to provide community leadership and guide group education, including discussion sessions and participatory methods for learning. Additionally, these male role models will conduct community outreach and mobilisation. While increasing men's support of women's FP-related rights, male engagement activities will focus on countering the concept of family planning as only a women's issue. In addition, other activities will include men as a target group for specific programming and messaging, including strategies DC1 and DC3.

DC6. Build capacity of women to ensure they are knowledgeable of their rights for making FP decisions and empowered to act on them: To increase women's empowerment within the community, especially in rural areas and emerging regions, existing programmes will be leveraged to include family planning within women's empowerment activities. Also, HDA activities will feature women who are satisfied with family planning to build other women's confidence in their knowledge of and ability to make an informed choice about family planning while feeling that the community is supportive of their decisions. These activities will complement the demand creation activities amongst community leaders and men (outlined in strategies DC3, DC4, and DC5), as well as a mass media campaign (outlined in DC2) to raise awareness of the rights of women to make FP decisions and address community norms that act as barriers to contraceptive access.

Service delivery and access (SDA) Strategy Ethiopia's strategy focuses on making a wide range of high-quality methods available and accessible while ensuring rights and equity amongst regions and population groups. Primary focus will be placed on increasing the number of FP service providers who can appropriately counsel and deliver a full range of methods by implementing a series of trainings throughout the

country, especially in the pastoralist and emerging regions. Some of the activities that will support access to service delivery include an expansion of established networks of providers, development of mobile outreach services for family planning, and increased training for HEWs in these hardest-to-reach regions.

Uptake of long-acting methods is disproportionately low, partly due to the lack of appropriate skills amongst service providers at all levels. Thus, emphasis will be placed on increasing the clinical capacity of providers to administer long-acting reversible and permanent methods, and reduce provider bias towards shorter-term methods. In combination, the health system will be strengthened to improve the availability, accessibility, and quality of FP services to promote full access, choice, and rights. Referral systems will be streamlined so that women can more easily access FP services at higher-level facilities. New guidelines will be developed to integrate other reproductive, maternal, newborn, and child health (RMNCH) services with family planning. Facilities will be upgraded to improve privacy—a right for women accessing services and a factor critical to ensuring quality of service delivery.

Young people ages 15–19 in Ethiopia have high unmet need for family planning. They experience stigma, providers often refuse to offer FP services to them due to their age or marital status, and services fail to provide them with privacy and confidentiality. Accordingly, this strategy prioritises building additional FP access points for youth by instituting youth corners in health facilities, training service providers in youth-friendly services, increasing the capacity of youth centre staff to provide FP information and education, and strengthening the capacity of college and university clinics to provide high-quality FP information and services.

Strategic outcomes SDA1. Increase the number of trained health providers at all levels to provide the full spectrum of FP services: Currently, three out of four women rely on injectables for contraception. To address this reliance on a single method and promote access to a full spectrum of FP methods and services, all service providers will be trained to provide the entire range of FP services available at their level, with a rights-based focus. A pool of trainers will be created at the regional level. These trainers will train nurses and midwives on the full spectrum of FP methods, with emphasis on counselling and LARCs. Moreover, physicians and health officers will be trained on both LARCs and permanent FP methods to ensure that the full method mix is available to the

population. The expansion of available services at all service delivery levels will likely result in a shift in method mix to a more balanced distribution.

SDA2. Strengthen the referral system to streamline and simplify the process for women to access higher-level health facilities for FP services: When some FP methods are not available at a facility, clients will be referred to a higher-level facility so they can access their method of choice. Thus, the referral system and feedback mechanism need to be institutionalised and strengthened. A handout on the use of referral and feedback forms will be developed and then distributed to the regions, woredas, and facilities. Service providers will also be oriented as to the importance of referral and feedback forms for increasing their awareness.

SDA3. Increase availability and accessibility of high-quality FP services in emerging regions: Some emerging regions lack access to a range of FP methods due to the significant distance from the community to the health facility. Accordingly, regional trainer pools will be developed and used to train health professionals on inserting and removing implants and IUDs, so that LARCs are available at the community level. Moreover, mobile outreach services will be piloted in emerging regions to increase access to LARCs and address geographic barriers to services provided at higher-level health facilities.

SDA4. Increase quality of FP services, especially in the area of counselling, privacy, and informed choice: Rights-based FP programmes can be measured by the quality of counselling, which is vital to realise informed choice and maintain privacy and confidentiality. Characteristics of high-quality FP service delivery include the provision of appropriate and complete information to clients, freedom for the client to choose, client-provider interaction that is professional and confidential and respects informed choice, and technically competent staff with the appropriate tools and supplies to provide adequate service. Combined with the medical skills capacity-building training covered under SDA1, FP services providers will be trained in counselling techniques that acknowledge privacy and informed choice. The culture of quality improvement will be institutionalised by establishing quality assurance teams within health facilities. Furthermore, the MOH and RHBs will work together to assess and identify facilities that need renovation to ensure clients' right to privacy during FP counselling. Based on the assessment findings, selected health facilities will be renovated.

SDA5. Increase FP uptake by increasing opportunities for women to access FP services through RMNCH service integration: Integrating family planning into other RMNCH services, such as antenatal care, delivery, and child immunisation services, will play a paramount role in improving FP uptake and reducing unmet need. The MOH will develop a service integration manual and train nurses, midwives, and health officers on integrated services provision, including postpartum family planning. To increase awareness of integrated FP and MNCH service provision, and maintain coordination amongst the RMNCH programmes, FP and MNCH focal persons at all levels will hold periodic coordination meetings.

SDA6. Increase the number of FP service access points for youth: To improve access to FP services for youth and adolescents, FP and SRH trainings will be organised for youth centre staff across the country so they can effectively engage youth in conversation about family planning, impart knowledge regarding the full spectrum of FP options available to them, and refer them to youth-friendly service providers should they choose to receive an FP service. In conjunction, additional health facilities will be made more youth friendly by establishing youth corners and training service providers on youth-friendly services. To address the FP needs of university students, advocacy meetings will be organised to ensure high-quality FP service delivery by university and college clinics.

SDA7. Increase the number of private sector providers who can provide a full spectrum of high-quality FP services: The private sector plays an important role in providing health services in Ethiopia. Capacity building and quality improvement will also encompass the private sector, so all women have access to a full spectrum of FP choices wherever they may choose to access health services. To ensure that capacity-building trainings cover those key FP service components especially lacking in the private sector, an assessment will be conducted first. Based on the assessment findings, the FP training programme will be adapted.

Procurement and supply chain (PSC) Strategy Because the central-level supply of FP commodities is generally adequate, forecasting, quantification, and procurement will continue as in recent years. However, improved data are necessary to provide more accurate forecasting. Specific activities will help strengthen the capacity of facility staff to (1) report on contraceptive commodity distribution and place orders in an accurate

and timely manner; and (2) ensure that contraceptives are delivered to hospitals, health centres, and health posts to achieve commodity security in both urban and rural areas.

At the national level, the MOH, in collaboration with the PFSA and relevant stakeholders, is responsible for forecasting, quantifying, and procuring contraceptive commodities and consumables. The PFSA is responsible for procurement, storage, and distribution of contraceptives and consumables from the central warehouse all the way to the service delivery point. Support will be provided to ensure that the FP commodity supply remains secure and consistently available. Specific activities will build the capacity of the MOH, PFSA, Food, Medicine and Health Care Administration and Control Authority (FMHACA), and RHBs. Activities also will ensure that data are used to improve commodity availability; contraceptives in stock are used; and the procured contraceptives are safe, effective, and of high quality.

Strategic outcomes PSC1. Conduct annual quantification of contraceptive commodities and supplies. The MOH will conduct forecasting for annual contraceptives and related commodities, as well as quantifications and the supply plan, by collaborating with relevant stakeholders and partners. Forecast accuracy will also be done on an annual basis to check and confirm that they are aligned with actual demand and FP programme performance. Stock availability and stockout rates will also be monitored annually.

PSC2. Conduct quality assurance testing of contraceptives. Support will be provided to the FMHACA to improve capacity in registration and conduct post-market surveillance on contraceptives, including quality assurance testing.

PSC3. Improve the PFSA's capacity to use data generated at the facilities to ensure the timely distribution of commodities. Trainings will be provided at the federal and regional levels for PFSA staff on data aggregation and analysis to increase their capacity to gather and utilise facility-generated data monthly to inform commodity distribution plans.

PSC4. Ensure that capacity is sufficient at all levels for streamlined distribution of commodities from the national level to health posts. Support will be provided for the decentralisation of the PFSA distribution system. Trainings on stock management and

monitoring and evaluation (M&E) will be provided to health facility staff to improve the quality of recording and reporting of contraceptives consumption.

To advance monitoring mechanisms for stock outs, appropriate information and communications technology (ICT) will be identified and piloted in selected regions. For example, the automated short message service (SMS) stock-tracking tool used by social franchises presents a potential opportunity to scale up into the public health system. To facilitate the distribution of commodities, the PFSA and MOH will build and equip regional warehouses.

Monitoring and coordination (MC) Strategy Specific activities will aim to improve coordination amongst various government sectors and ensure that FP objectives and activities are aligned across all regions. The MOH will strengthen its coordination with other line ministries, including the Ministry of Finance and Economic Development (MOFED); MOE; Ministry of Agriculture; and Ministry of Women, Children and Youth Affairs, amongst others.

To improve coordination between the public and private sectors while ensuring oversight from the MOH, specific activities will aim to facilitate dialogue between the two sectors, clarify the roles of each, and explore opportunities to increase the number of public- private partnerships. Leveraging the resources already available in the private sector can effectively and efficiently increase access to high-quality FP services and products.

Monitoring the progress of FP activities is also critical for successful implementation of this CIP. The planned activities will and should change over time based on findings from regular monitoring. Data must be recorded, and successes and lessons learned should be documented so that programme improvements can be made and best practices scaled up. To ensure that FP-related data are readily available and accurate, responsible staff at the facility level will receive follow-up training on data entry. Throughout the health system level, health officers will engage in data aggregation and review exercises to help data analysis and use become routine. Finally, technical assistance will be provided at the regional and federal levels to ensure that technical staff and policymakers are comfortable in using data to inform decision making.

Successful monitoring of FP activities must include identifying successful strategies and ongoing bottlenecks. The activities included in the monitoring and coordination of this plan will help to identify successful approaches to reaching youth and under-served populations with FP services, document how the results were achieved, and disseminate evidence through coordinated mechanisms to ensure that the most effective approaches and best practices can be replicated countrywide.

Strategic Outcomes MC1. Improve FP service delivery by clarifying roles and responsibilities, and streamlining national-level programme coordination: Using the CIP as a foundation, a detailed, annual FP programme implementation plan (workplan) will be developed to define each ministry's role in supporting family planning and clarify each partner's responsibilities. Workplan implementation will be reviewed semi-annually, and an overarching CIP mid- plan assessment will be conducted in 2018.

MC2. Improve coordination with the private sector to better leverage its resources in FP service provision: The MOH will take the stewardship role and reach out to private sector organisations providing FP services, including social franchises. A market segmentation analysis will be conducted, with results disseminated through regional workshops. At the same time, existing guidelines for private sector provision of FP services will be reviewed and revised as necessary to ensure coordination with public sector FP service delivery, and supportive supervision of social franchises will be conducted to improve quality, coordination, and oversight.

MC3. Ensure that regional objectives and perspectives are integrated into the national-level plan, so family planning becomes a priority on the development agenda for the regions: An FP coordinator will be designated in each region to improve coordination amongst partners and stakeholders; this coordinator, along with other regional representatives,

will be included in the annual process to develop the national FP workplan. Other health and non-health private sector and civil society representatives will be involved in the workplan development process to ensure that it includes coordination efforts and is responsive to the needs of the community. The FP TWG or similar groups at the regional level will be instrumental in contributing to the development of annual national and regional FP workplans.

MC4. Increase the evidence base for FP programming and improve data use for FP programmes: Case studies on effective interventions for reaching target populations will be conducted as part of programme evaluations and disseminated to partners and stakeholders as evidence for further action through a biannual FP meeting. This meeting will also be a platform to engage policymakers in family planning.

MC5. Ensure the availability of service delivery data through leveraging the Health Management Information System (HMIS): Additional trainings will be conducted to ensure that health facility staff can enter HMIS data accurately and on time, and refresher trainings will be conducted based on an updated HMIS training database. At the federal level, the FP TWG will review quarterly HMIS data to identify bottlenecks and regions where data analysis needs additional support.

Financing (F) Strategy To address the limited financial commitment to family planning from domestic sources commensurate with need, the MOH will advocate increased funding within national and regional budgets. The ministry will cultivate FP advocates within the MOFED and Parliament by developing an advocacy strategy. This approach will ensure that the national budget includes a growing line item for FP programming that meets the increasing demand for FP services as BCC and FP access activities expand over the next five years.

Similar advocacy efforts will be conducted at the regional level to establish line items for family planning in regional government budgets. Regions that already have a line item for FP commodities will strive to increase their budgets while also advocating additional budget lines for FP programming and the purchase of supplies and consumables needed for high-quality FP service delivery. Inter-regional knowledge sharing will be encouraged so that advocacy approaches effective in one region can be replicated in others, and regional staff can build a support system for resolving similar challenges in their regions. The activities outlined here will help to achieve the sustainability of FP programmes in Ethiopia.

Strategic outcomes F1. Advocate increased funding for family planning from the federal government: The MOH will develop an advocacy strategy to gain buy-in from parliamentarians to support increases in the ministry's FP line items. Evidence-based advocacy briefs will be drafted to show how increased funding from the government can

improve the livelihood of Ethiopia's citizens and how investments in family planning can yield both economic and health benefits. The MOH will hold advocacy meetings with the MOFED and parliamentarians, and proactively track the national government's progress towards meeting its FP2020 commitment to increase the budget for family planning.

Parallel efforts will be made at the regional level to secure or increase FP line items. Inter-regional knowledge-sharing meetings will be held throughout the five-year period

to share successes and challenges amongst the regions, and replicate effective approaches and best practices.

Self-Check -4	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. What are reflected by Strategic priorities?
2. List priorities serve as the foundations of the thematic areas for CIP activities

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2 points**

Score = _____

Rating: _____

Name: _____ Date: _____

Instruction Sheet	LG57: **Monitor family planning services**

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

- Family planning services data collection and report
- Monitoring of family planning services

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to –

- Prepare Registration book for family planning services according to HMIS standards of FMOH
- collect, update and sustain Family planning services data on the basis of HMIS guideline of FMOH
- Report and communicate Family planning activities to the higher level and relevant body on the basis of HMIS procedure of the FMOH
- revise Plan on family planning for the catchments for a specific period of time
- Monitor Family planning Practice at kebele against plan

Learning Instructions:

16. Read the specific objectives of this Learning Guide.
17. Follow the instructions described below
18. Read the information written in the “Information Sheets”. Try to understand what are being discussed. Ask your teacher for assistance if you have hard time understanding them.
19. Accomplish the “Self-checks”. In each information sheets.
20. Ask from your teacher the key to correction (key answers) or you can request your teacher to correct your work. (You are to get the key answer only after you finished answering the Self-checks).
21. If you earned a satisfactory evaluation proceed to “Operation sheets and LAP Tests if any”. However, if your rating is unsatisfactory, see your teacher for further instructions or go back to Learning Activity.
22. After You accomplish Operation sheets and LAP Tests, ensure you have a formative assessment and get a satisfactory result;
23. Then proceed to the next information sheet

Developing and using work plans A work plans 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 the mout. Such a document is valuable tool for efficient and effective programme implementation, and should be used regularly and consistently as monitoring tool at all levels.

Basically, there are two types of plans:

(a) The strategic(long-term)plan (b)t he annual(work)plan.

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 gatherer. 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 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(any where 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 in to 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 harmonised, 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.

Box 2.1 for abetter understanding of the work planning process; also refer to the Health Management, Ethics and Research Module.

Box 2.1 Key points to remember in the work planning process

To get the greatest benefit from work plans and the work planning process, you need to understand:

- 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.

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 coasted. To determine these targets, begin by looking at the early objectives.

■ Your health post, in collaboration with the woreda Health Office, has set objectives to provide family planning information and educationto1,000 potential acceptors in your kebele during the first year of service delivery. How can you cascade this into short-term targets?

□ In this case, first divide the 1,000 potential acceptors by 12 months to get a monthly target for that site. Next, divide the number of potential acceptors to be visited each month by the number of Health Extension Practitioners at the service site, so that each Health Extension Practitioner will know how many people she will need to visit each month. Then, list down all possible activities that can be executed during the period and who would be responsible for each activity.

Remember that this target can be further divided by the number of working days per month and put on a calendar, so that each Health Extension Practitioner will have a work plan to use on a daily basis.

In this way, you can break down large overall objectives into smaller, more manageable units that enable you to develop a monthly work plan more easily, and to distribute the work load more equitably.

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.

Box 2.2 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.

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 aweek.

Targets serve three major purposes:

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

Box 2.3 Examples of SMART targets

An example of an *annual target* for a specific service delivery site: To achieve an average of 83 new acceptors per month over the next 12 months in the *kebele*.

An example of an *annual target* for a supervisor: To conduct supervisory visits to 10 Health Extension Practitioners each month of the year.

An example of a *monthly target* for Health Extension Practitioners: To provide information and education to 400 couples in three communities over the next month.

An example of a *monthly target* for Health Extension Practitioners: To locate and interview 15 clients each month who have dropped out of the programme in order to find out the reason why they have dropped out.

Developing monthly work plans Monthly work plans should be developed and used at all levels of a programme or organisation. 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.
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

Table 2.1 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.

Monitoring and evaluation
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, out puts, out comes and imp acts of health programmes, including family planning. The most common form of monitoring is often based on input and out put 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, analysed 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

Box 2.4 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).

Supportive supervision (SS) is a process of guiding, helping, training and encouraging staff to improve their performance in order to provide high quality health services through the use of integrated SS tools. A supervision session will include review of programme implementation at kebele level.

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.

Managing contraceptive supply

Record keeping and reporting Record keeping and reporting is one way that an organization can keep track of patterns of contraceptive use amongst its clients. Keeping records and preparing and analyzing reports are effective way to determine clients' needs and their use patterns, without doing a formal programme evaluation. Good examples of this a restock on hand (by method and brand),and consumption/ distribution(by method and brand),both of which can be easily collected and analysed on a routine basis. This information can be collected by using simple HMIS records, forms and reports (for details, refer to National HMIS technical guidelines).

Types of recording forms Inventory controlcar(ICC): This form should be keptatall storage facilities that manage a significant number of inventory items. The purpose of the ICC is to have an up-to-date and continuous record,
In one location, of all transactions for each item in the inventory (refer to HMIS forms).

Daily activity register(DAR): The register is designed to be used when contraceptives are dispensed to family planning clients. It provides a daily log of the number of client visits, sub divided by the types and quantities of Contraceptives dispensed to each client on a monthly basis. When anew month begins, service providers should begin anew DAR. The DAR should be totalled on a monthly and quarterly basis (refer to HMIS forms).

Quarterly report/requisition: This form serves several purposes. It provides summary information from the DAR and ICC concerning the number and types of clients served, and quantities of each type of contraceptive received an dispensed over a three-month period(refer to HMIS forms).

Inventory control system The average monthly consumption (AMC) is equivalent to one month's supply. It is usually the monthly average of the quantity of that product that has been dispensed to users during the past three or six months. Information on the quantities dispensed is taken from the DAR or summary reports of dispensed-to-user data

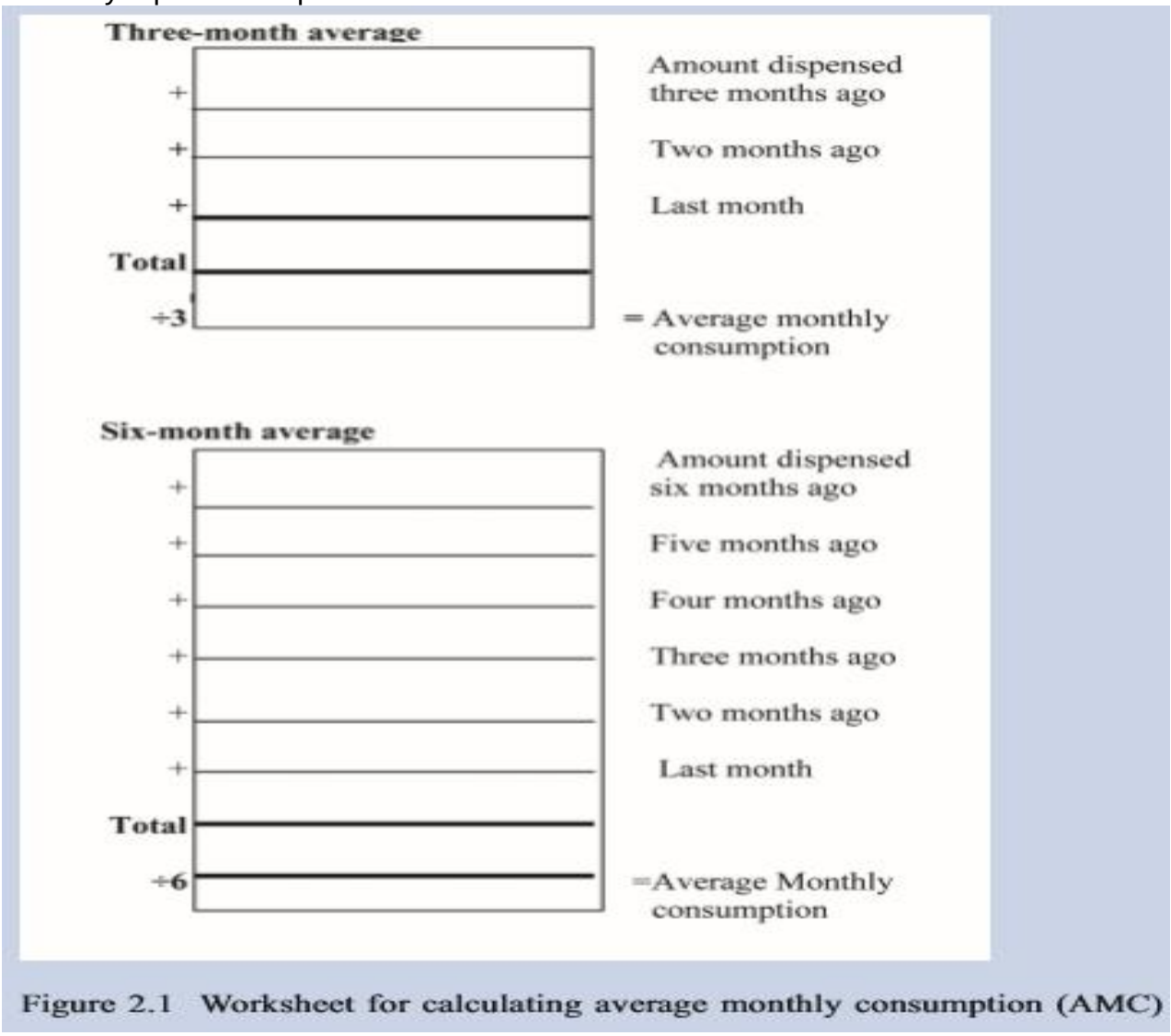


Figure 2.1 Worksheet for calculating average monthly consumption (AMC)

Assessing your supply status To make sure your supplies are adequate, do the following calculation for each of your contraceptive products:

Stock in hand÷AMC (average monthly consumption) =Months of supply in stock

This calculation will tell you how long your current supply will last if consumption stays at the current rate. If the months of supply in your stocks are less than the time remaining before your next delivery of supplies, then you may need to arrange for an emergency delivery

Family planning programme communications

Communication activities are an integral part of virtually every family planning programme. They are used to promote the idea of family planning programmes, as well as specific contraceptive methods, and to highlight locations where services and products are available. Almost all media are used to promote family planning communications, including radio, television, billboard sand brochures. The importance of the family planning programme can also be communicated through interpersonal communication, for example by involving 'satisfied users' who are given materials to distribute to their friends and members of their communities. In the Ethiopian context, a successful model household can be used to communicate the message to their peers.

Part of your future role will be to identify all potential means of communication available in your localities, so that you will be able to make use of them in

Communicating aspects of the family planning programmes in your community,

4.1. Data collection

After developing or availing data collection tool you need to develop action plan that will assist your data collection process. **Action plan**; is a plan/time table that contains types of activity undertaken, time required and responsible body for undertaking that activity. You can develop your action plan based on the following sample;

S.No		Date	Responsible body	Remark
1	Discussion with kebele administration concerning base line data collection	12/01/2008	Health extension worker/HEW	
2	Assignment of gote leaders to support the data collection process	13/01/2008	Kebele administration	
3	Preparation of copies of questioner	14/01/2008	HEWs	
4	Start collection of data on gote 1	15/01/2008	HEWs	
5				
6				
7				
8				
9				

10	Checking data quality	23/01/2008	HEWs	
11	Compilation of collected data	24/01/2008	HEWs	
12	Analysis of collected data	26- 30/2008	HEWs	
13	Preparation of community profile	02/02/2008	HEWs	
14	Reporting to the woreda health office	04/02/2008	HEWs	

Based on your action plan you will start your data collection by selecting a gote and house you will start collecting data. When you proceed the data collection process you have to strictly follow the numbering you already give for each houses.

During the data collection processes you have to strictly check the completeness and quality of your data daily in the evening. Be sure that no house hold was missed when you collect data. You can use different techniques of data collection like, **respondent interview** to collect informational data that you can obtain from the individuals and also you can use **observation** for the presence and absence of services like latrine, insecticide treated nets, environmental cleanliness and etc.

One questioner will be use for collecting data from one house hold. Every questioner will contain house number, name of kebele, name of gote, date and finally your signature. So you have to feel all the information on the place provided to you. You will feel the response you get from the individual on the space provided to you. Finally after the end of data collection from every household in the kebele you will then start to compile the data first to gote level and finally to kebele level. Similarly you can find the data compiling form on the annex 2 of the end of this module.

4.2. Data analysis

Data analysis is summarizing and describing your finding in a clearer way so that you can easily use the data for the purpose you intend. It enables you to present information in more useful way. The result obtained from the analysis will help you to develop community health profile data, for planning community health services, implement, monitor and evaluating your activities to identify weather you progress as planned, to assess the effect of your activities on the knowledge, perception, behavior, and on the health of individuals and the community as whole and finally to share your result for all stake holders in your kebeles.

After data collection you may come up with two types of data's. One is **quantitative /continuous,** is **a** type of data that is continues and measured in terms of numbers. For example age is continuous variable and number of house hold is continuous variable. The other is **qualitative /categorical**, is a type of data that is not directly measured in number and categorized in to different categories. For example sex is categorical. A man can be either a male or a female, the other is occupational status, and any person will be categorized in to one of the categories like merchant, employ, student, house wife.

We will use summary measures to analyze the data. The most frequently used summary measures in your context are numbers, percentage and proportion. **Number**; is simply the total amount of the variable in the data. For example; number of under-one children who took measles vaccine, number of females who took family planning service, number of households that have latrine. The answer is absolute number. The other summary measure is **proportion**, is simply the number of times the observation occurs in the data, divided by the total number of response. For example, proportion of male in the total population, proportion of households who had latrine.

$$\text{proportion of male in the popula} = \frac{\text{Number of male}}{\text{Total population}} = \frac{1650}{2{,}800} = 0.59$$

= So proportion of male individuals in the total population is **0.59**.

$$\text{proportion of house hold having latrine} = \frac{\text{Number of HH with latrine}}{\text{Total HH in the kebele}} = \frac{670}{1320} = 0.53$$

= So **0.53** of the total households have latrine

The other summary measure is **percentage**; it is simply multiplying the proportion with 100 then you will get percentage. For example taking the above two examples, percentage of male sex from the total population is 59 percent(59%) and we can also get percentage of households having latrine by multiplying the proportion 0.53 by 100 then we can get 53%. Then we will summarize every figure in the compiled data as needed. These summary measures will help you in determining monitoring and evaluation of your performance in health programs you have discussed in different modules.

4.3. Data presentation

Data presentation; is a way by which we give a brief explanation for our audiences using different data presentation techniques like table, graphs and charts.

Importance of diagrammatic representation

- They have greatest attraction than simple figures.
- They help in deriving the required information in less time
- They facilitate comparison between different groups
- To easily track changes over time
- They have greatest memorizing value than mere figures

4.3.1. Table

Table is an orderly and systematic way of presenting numerical data in rows and column? A horizontal component is called **raw** of a table while the vertical component of a table is called **column** of a table. So in order to use table for presenting a data , first we have to group the data in to categories of the variable and counting the number of occurrence of each category. During constructing a table we have to follow the following principles

1. Table should be as simple as possible
2. Table should be self explanatory. For that purpose
   - Title of the table should be clear and to the point and should answer the what? when? where of the data content in the table
   - Each column and row should be labeled
   - Total of the column or the raw should be shown in the last column and in the last row
3. If the data are note original their source should be give in the foot note

Example

Table4.1: over all immunization status of children in Dewachefa woreda, august, 2009

Immunization status	Number	Percent
Not immunized	75	35.7
Partially immunized	57	27.1
Fully immunized	78	37.2
Total	210	100.0

Source: dewachefa woreda health office 2009 annual report.

Construction of graphs

The choice of the particular form among the different possibilities will depend on personal choice or the type of the data we have.

- Bar chart and pie chart are commonly used for qualitative/ categorical data types like sex, occupation,
- Histogram is used for quantitative continues data type like age, height, weight
- There are however a general rules that are commonly accepted about construction of graphs
- These are
    1. Every graph should be self explanatory and as a simple as possible
    2. Titles are usually placed below the graph and it should again answer the what? When? And where? Issue of the graph.
    3. Key should be used to differentiate variables if more than one is shown
    4. The axis , x-axis and y-axis of the graph should be labeled clearly
    5. The unite in to which the scale is divided should be clearly indicated

4.3.2. Bar chart

Bar diagram are used to represent and compare the frequency distribution of discrete/categorical variables and categorical series. When we represent data using bar chart, all the bars must have equal width and the distance between bars must be equal. Usually during constructing bar chart the bar represents the magnitude and the height or length of the bar represents the size or frequency.

Example:

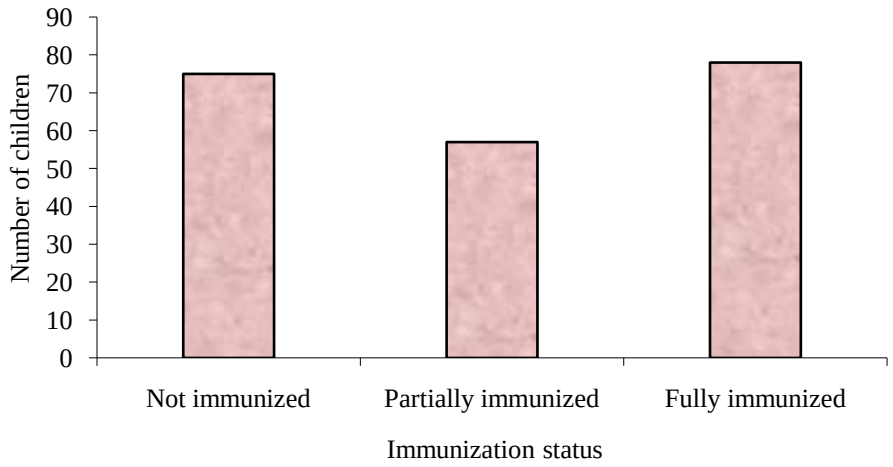


Fig4.1: represents immunization status of children in dewachefa woreda, august 2009

4.3.3. Histogram

- Histogram are frequency distributions with continues data values.
- It is used to represent quantitative or continuous data
- To construct a histogram , we draw the interval boundaries on horizontal line and the frequencies on vertical line
- Non-over lapping interval that cover all of the data value must be used
- Bar are then drawn over the interval in such a way that the areas of the bar are all proportional in the same way to their interval frequency
- Example: Consider the data on time (in hours) that 80 college students devoted to leisure activities during a typical school week:

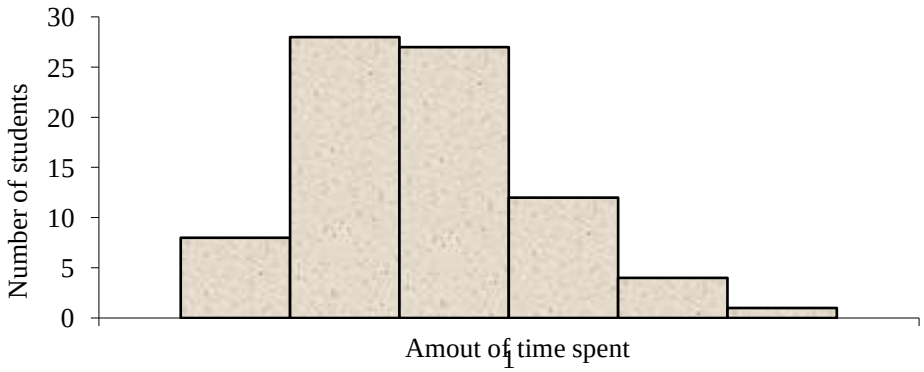


Fig4.2; shows time of 80 college students devoted to leisure during their school week, Gondar, 2005.

4.3.4. Pie chart

- Is used to represent both quantitative and qualitative/categorical data.
- Steps to construct pie chart
    1. Construct **frequency table**; is a table that show the magnitude and the number of times that the magnitude occur in the whole data. For example how many times a male sex occurs in you kebele survey data. Or how many of your population is male sex.
    2. Change the frequency in to percentage
    3. Change the percentage in to degrees, where: degree= percentage x 360^0
    4. Draw a circle and divide it accordingly

    Example:

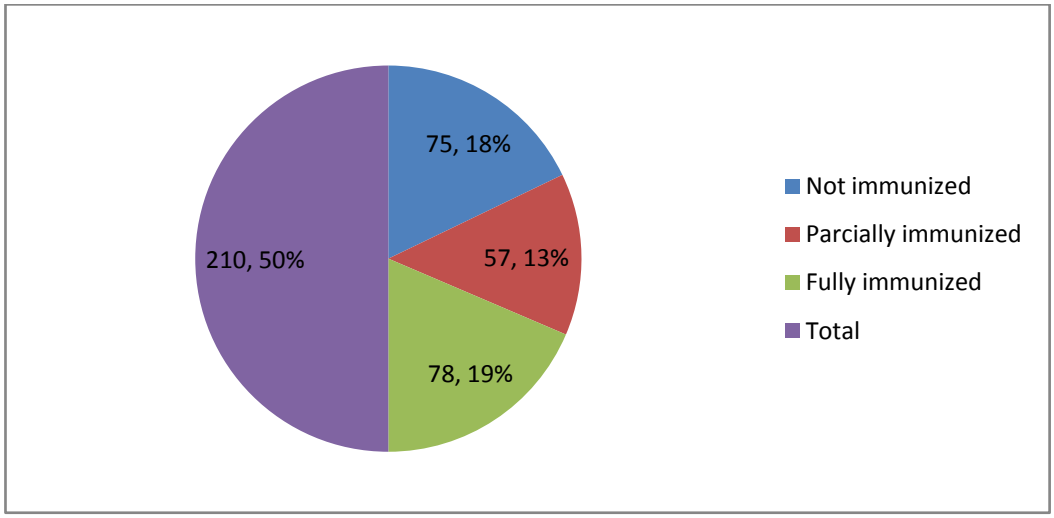


Fig 4.3; immunization status of children's in dewa chefa woreda, augest, 2009

Self-Check 1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

5. List Work planning process?
6. What are data presentation system?
7. What is action plan?

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2points**

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

Answer Sheet

Score = _____

Rating: _____

2.1. Recording and reporting

Recording and reporting is an essential component of managing health program implementation. It is a means of giving accreditation for our effort. Activity that is implemented but failed to registered and reported is like vomited diet. So we need to continuously register and report for woreda heath office in timely manner. The time schedule of reporting is different from service to service. There are services that will be reported immediately like epidemic condition, there are activities that will be reported in weekly manner, for example malaria and also there are activities which need to be reported in monthly manner. This is depends on the current community health information management system.

1.1 . Health management information system

System is a collection of components that work together to achieve a common objective. (Developing HMIS, WHO) In general, the primary purpose of the health system is to promote, restore or maintain health (from WHO definition). Health service development program (HSDP) in Ethiopia strives to reduce morbidity, mortality and disability, and improve the health status of the Ethiopian people through providing comprehensive package of preventive, promotive, rehabilitative and basic curative health services via a decentralized and democratized health system in collaboration with all stakeholders.

In the public sector, health system management includes the function of:

1. Client management/individual care(delivery of promotional, preventive, and curative health services to the population; working with the community
2. Health Unite/Facility management(managing service coverage/utilization, resource
3. Health system management (policy, planning, coordinating and managing, support to health unites.

Health Information System (HIS) is "a system that provides specific information support to the decision-making process at each level of an organization."(Hurtubise,1984). The purpose of HMIS is to routinely generate quality health information and use that information for management decisions to improve the performance of health services delivery. Quality HMIS information means that the information generated by HMIS is;

- Relevant
- Timely
- Complete- both in geographical coverage and in terms of range/amount of data it is supposed to provide
- Valid- provides the information that it is supposed to provide

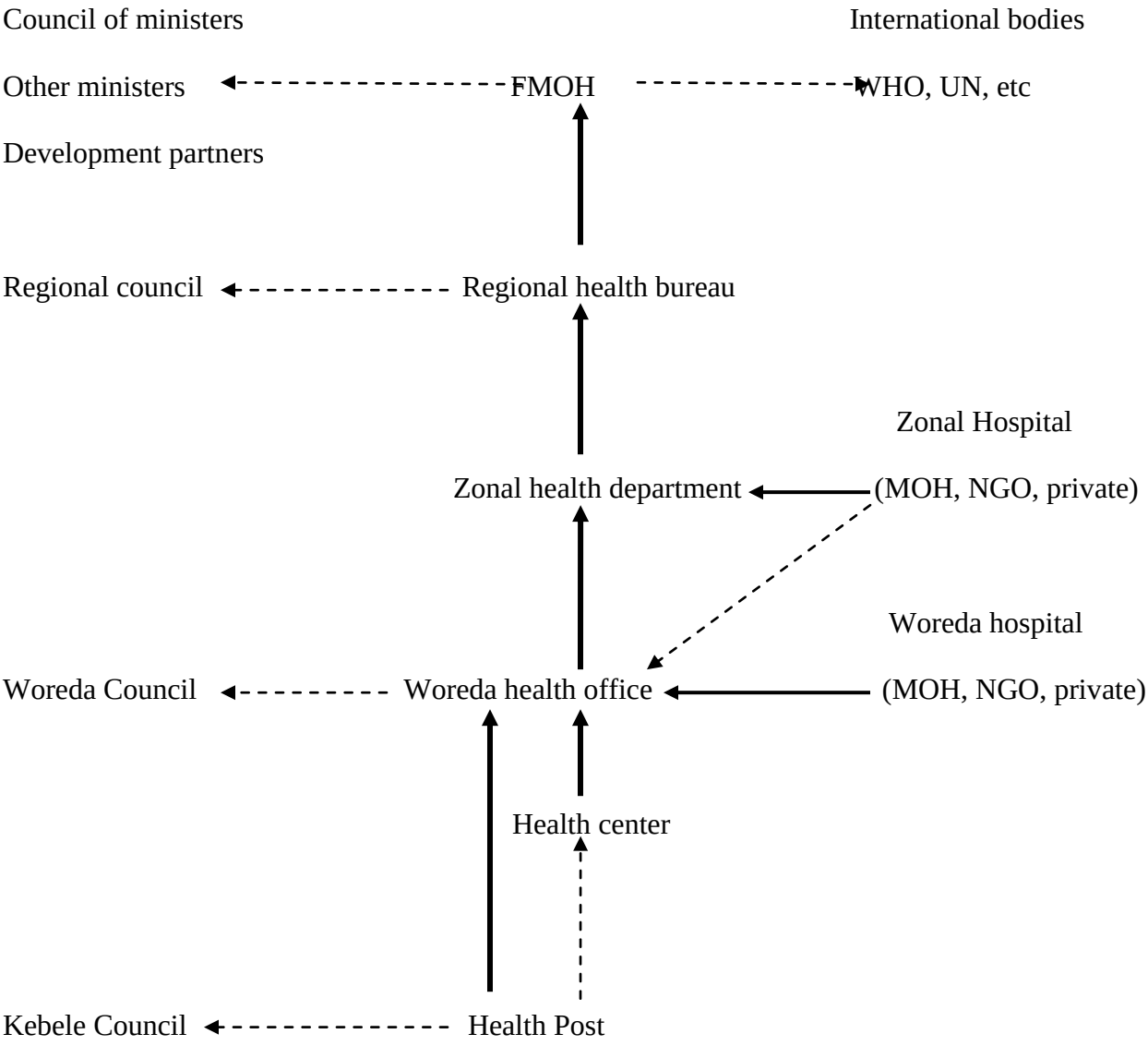
- Reliable- the information is consistent

Health management information system in Ethiopia is supposed to improve efficiency (time and money) and Effectiveness (meets performance expectation) of health service delivery.

✓ Principles of health management information system/reform includes

- Standardized – has a standardized definition through health sector and have standard recording and reporting instrument and procedure
- Integrated- Consists single source for each data item and have one report and one reporting channel
- Simplicity – It reduces number of data item, limited to those required by indicator selected and have user friendly forms and procedures throughout the system
- It is supported by Information communication technology/computer

✓ The following chart illustrates the integrated reporting channel of the current health management information system.



1.2 . What are the type of information's collected/generated by HMIS

Routine health management information needs for health management system includes;

1. Information on health service delivery performance and coverage for promotive, preventive and curative services is, for example you need to report services delivered like
   - Immunization service delivered to the community
   - Number of individuals attend health information on different sessions and topics
   - Number of households construct latrine facility
   - Number of households under training of family packages
   - Number of graduated model households in the kebele
   - Number of individuals who have got VCT service
   - Number of pregnant mothers attend ANC service
   - Number of pregnant mother got safe delivery service
   - Number of mothers got PNC service
   - Number of pregnant mothers got PMTCT service and etc

✓ All of the above services will be monitored in terms of percentage or coverage achieved out of the planned activities. For example ANC coverage, Measles coverage, percentage of pregnant mothers got PMTCT service

2. Information on disease and health condition
   - Number of patients got malaria treatment
   - Number of first aid service delivered
   - Number of children's got Deworming service and other services delivered
3. Information on health resource- include health post logistics and equipments
   - Number of RDT kit utilized
   - Number of VCT kit utilized
   - Number of mebendazole tablets used
   - Number of vaccines utilized

1.3 Family Folder

It is a house hold centered service delivery tool or registration book that will be used by health extension workers during provision of services like disease prevention, control and treatment for the house hold.

✓ The family folder has benefited the health extension worker and the house hold in that;

It contains information about the household that will help the HEW to identify the health (preventive, promotive and environmental health) needs of the family or household and give them the service or counsel them accordingly

a. The front and back sides of the Family Folder provide information on
   - Household characteristics – latrine, hand-washing, waste disposal & drinking water facilities, and LLITN availability
   - Household HEP package training & implementation status

b. The health card, integrated maternal and child care card are for recording disease information, preventive and promotive services to individual members of the household

✓ The family folder pouch has five basic parts; These are

1. Identification – Name of head of the family, Father and Grand father name
2. Household description,
3. Household characteristics,
4. HEP package training status and
5. Household implementation status parts

✓ This will be conducted based on numbering given to every house hold as you discussed in session four of this module

✓ Every data should be filled based on the information required on the family folder for each households in your kebele and every service provided and gabs identified for every households should also be handled accordingly

✓ This will facilitate your daily implementation and follow up activities

✓ Filled family folder for every house hold should be putted in separate compartment for every gotes- this will facilitate your tracking mechanisms as early as possible

✓ For further facilitation of retrieval process from the family folders she need to develop **Master family index** is an index that contain the name of the house hold head and their house hold number (annex6).

✓ Whenever any client comes for service, the HEW can create the household number using the name of the house hold head of the client. Ones the household number is known, it would be easy to identify the family folder.

1.4 . Health card

This health card will be given for every individuals of age greater than or equal to five years and used for tracing of their health problem whenever they come to health post. It has ten sections

1. Identification
2. Earlier health history
3. Disease information
4. Referral information
5. HIV/AIDS
   a. ART follow up
   b. Home based care and support for PLWHA

6. Tuberculosis
7. Family planning
8. History of Immunization
9. Height and weight status
10. Orphan support

There are two types of visits for every disease an individual will come to the health post. **New visit** is a type of visit when the client is visiting the health post. **Repeat visit** is a visit when the client visits the health post for the same disease for two and more times.

There are similarly two types of visits for family planning service. **New acceptor** is given for someone who has not received a contraceptive method from a recognized program before registration. **Repeat acceptor** is given for someone who is not a new acceptor.

Fig8.1. Health post family folder on shelf (photo by Mohammed Hussein, 2012)

1.5 . Integrated antenatal, Delivery, Postnatal and New born Care

This card is used to keep a longitudinal record of pre-pregnancy status, pregnancy follow up, delivery, post delivery care of the mother, and immunization & growth monitoring of the child that will help to:

- Identify high-risk pregnancies
- Danger signs during pregnancy and post-delivery
- Promote breast feeding
- Promote timely immunization of the newborn
- Early detection of growth faltering of the child
- Take appropriate actions for pregnancy, delivery, post-delivery and newborn/infant care

1.6 HMIS reporting formats

Before filling the report format you need to use tally sheet and record to take number of service delivered. Currently there are three reporting formats on work. These are

1. Disease reporting format
2. Epidemic(IDSR) reporting format – weekly epidemic summary form
3. Service delivery reporting format
    a. Quarterly service delivery report format(annex 8)
    b. Annual service delivery report format(annex 9)

1. 7. Data quality assurance

The data that you collect, compile and send to the woreda health office should be checked in regular base weather there is a discrepancy between what is sent to the woreda health office and what is there on record or at the health post. This will take an eight step procedure. You can see below the steps that we should follow.

1. Randomly select 12 data elements, one data element from each section of the previous Monthly/Quarterly Service Delivery and Disease Information Report forms. Write the selected data elements in the first column of the **data accuracy check sheet**.
2. Copy the aggregated figures of the selected data elements for a given month as recorded on the Tally sheet in second column of **data quality check sheet**, under the heading of "Aggregated figures from Tally sheet".
3. Using the corresponding household numbers on the Tally sheet recorded against each of the selected data elements, pick the relevant Family Folders.
4. Count the actual entries in the family folder related to a specific selected data element. Sum up the entries documented in each family folder and write the figure you counted in third column of check sheet, under the heading "Figures counted from Family Folders".
5. Repeat this procedure for all data elements.
6. If the figures in column 2 and 3 are same, tick under YES in column four. If they are not the same (do not match), write a tick under NO in column four. Repeat this procedure for all data elements.
7. Count the total ticks under "YES" and write in row of total for "YES". Repeat the procedure for "NO" column. The sum of YES and NO totals should be equal to the sample size of 12.
8. The total in number in the "Yes" column corresponds to the percentage of data accuracy in the following LQAS table. For example, if total "yes" number is 2, the accuracy level is between 30-35%; if total number in the "yes" column is 7, the accuracy level is between 65-70%

Table8.1. Data accuracy check sheet

Month for which data accuracy is checked_____				
Randomly Selected Data Elements from the monthly reporting form (Col. 1)	Aggregated figures from Tally sheet (Col. 2)	Figures counted from Family Folders (Col. 3)	Do figures from columns 2 & 3 Match?	
			Yes	No
1. Family planning acceptors				
2. Antenatal care				
3. Deliveries & outcome				
4. Postnatal care				
5. Child health				
6. Growth monitoring				
7. EPI				
8. Vaccines – doses opened				
9. Vaccines – doses given				
10. Health services				
11. Disease information – priority infectious diseases				
12. Disease information – immediately reportable diseases				
Total				

1.8 Evaluation

Evaluation is the methodical process of determining the worth of a system, project, course of action, campaign, etc. It involves the comparison of the actual performance of the system with the target you set to achieve. Evaluation can also defined as a systemic way of learning from experience and using the lessons learned to improve current activities and promote better planning by careful selection of alternatives for future action or as asking, "Did we achieve what we set out to do?" and comparing the present situation with the past in order to find out to what extent organizing purposes have been achieved.

Meaningful evaluation requires clear thinking, profound learning, modify/make new plans, takes corrective actions and provide feedback on time. It is carried out mainly as a way of looking at program activities, human resources, material resources, information, and facts and figures; in order to monitor progress and effectiveness, consider costs and efficiency, show where changes were needed, and help to plan more effectively for the future. Hence, evaluation is a continuous process.

Evaluation of service performance can do;

- To show the main achievements/findings
- To show where and how changes can be made
- To show how strength can be built upon
- To provide information
- To increase skills for planning and
- To increase skills in decision making

The result of your evaluation are expected to show

- What a program has been trying to do?
- What actually happened?
- Where the differences/gaps between the plan and the Actions has happened
- The reasons for the difference/gaps, and
- What needs to be done

Evaluation involves finding the answers to the following questions:

- Are workers performing well as planned?
- Is equipment functioning as effectively as expected?
- Are resources being utilized fully?
- Are records being maintained correctly?
- Are the collective actions of the workers producing expected results?

1.9 Steps of undertaking Evaluation

As we already define evaluation, it is a basic managerial function involving setting standard, evaluating against standard and taking corrective action.

1. **Establishing standard/ target of performance** - example; you may might want to increase the number of pregnant women attending antenatal care by 20% in your kebele by this year
2. **Measuring performance** – You will continuously record your daily implementation using record book and finally compile and put your monthly and annual performance. Then you have to compare with the standard you have set. Based on the above example you may achieve 30% of pregnant women attending antenatal care.
3. **Comparing performance with standard**- The third step in evaluation process is the comparison of your performance with your established standard.

Table8.5. Comparison between planned activity and actual performance

Activity	Planned(target)	Performance(actual)	Percentage achieved
Antenatal visit during the year	500	250	50%
Train model households during the year	180	120	66%
Number of community health information dissemination session conducted	3	2	66%

4. **Taking corrective action**- The fourth and final step in the evaluation process is taking corrective action whenever there is a deviation between planned and achieved target

   - After the evaluation of the performance you have to give effective and supportive feedback for your team members in the activity.

Self-Check 2	**Written Test**

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. *What are the type of information's collected/generated by HMIS*?
2. List objective of *Health management information system*?
3. _____is the methodical process of determining the worth of a system, project, course of action, campaign?

Note: **Satisfactory rating - 2 points** **Unsatisfactory - below 2points**

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

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Instruction Sheet	LG58: **Provide family planning services**

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

- Counseling family planning
- History taking and physical examination
- Providing information on available methods, with their advantage & disadvantage
  - ✓ Family planning methods
  - ✓ Natural
  - ✓ Artificial
- Mix Method of family Planning
  - ✓ Oral contraceptive
  - ✓ Inject able contraceptive
- IUCD
- Implant
  - ✓ Implanon sub dermal implant
  - ✓ Implanon insertion clinical skill
  - ✓ Barrier methods
  - ✓ Emergency contraceptive
- Family planning for people with special need
- Linking FP with RH services
- Identifying women prefer permanent method
- Continuous Follow up based on standard procedure

This guide will also assist you to attain the learning outcome stated in the cover page. Specifically, upon completion of this Learning Guide, you will be able to –

- Counsel on method mix for advantages, side effects, misconceptions, and compliance on continual usage is provided to clients based on national family planning guideline of FMOH
- Supply Method mix (OCP, injectables, implants, barrier methods) for clients according to family planning protocol of FMOH and client's preference.
- Refer Clients preferred permanent methods to the next higher health facility according to the standard procedure
- Provide Continuous follow up to family planning clients based on the standard guidelines

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 teacher for assistance if you have hard time understanding them.
4. Accomplish the “Self-checks”. In each information sheets.
5. Ask from your teacher the key to correction (key answers) or you can request your teacher 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 and LAP Tests if any”. However, if your rating is unsatisfactory, see your teacher for further instructions or go back to Learning Activity.
7. After You accomplish Operation sheets and LAP Tests, ensure you have a formative assessment and get a satisfactory result;
8. Then proceed to the next information sheet

Information Sheet-1	• Counseling family planning

Counseling family planning is one of the critical elements in the provision of *quality* family planning services. Through counseling, providers help clients make and carry out their own choices about reproductive health and family planning. Good counseling leads to improved client satisfaction. A satisfied client promotes family planning, returns when s/he needs to and continues to use a chosen method.

Counseling is a face-to-face, personal communication in which one person helps another to make decisions and then to act on them .In the context of family planning services, counseling is a process, which helps a client to decide if s/he wants to practice Family planning. If s/he does, counseling helps her/him to choose a contraceptive method that is personally and medically appropriate and that s/he wants, understands how to use, and is able to use correctly for safe and effective contraceptive protection

Good family planning counseling procedures have two major elements and occur when:

1. Mutual trust is established between client and provider. The provider shows respect for the client and identifies and addresses her/his concerns, doubts, and fears regarding the use of contraceptive methods.
2. The client and service provider give and receive relevant, accurate, and complete information that enables the client to make a decision about family planning.

Key Concepts in counseling

Informed Choice- is an individual's well-considered, voluntary decision based on options, information, and understanding. When applied to decisions about FP, the concept of informed choice means that individuals freely choose whether to use a contraceptive method and which one, based on their awareness and understanding of accurate information about the methods.

The concept of **informed and voluntary decision making** applies broadly to any health care decision and assumes that individuals have both the right and the ability to make their own health care decisions in a voluntary manner and with full information and understanding of the consequences of each option.

In order to make a choice that is truly informed, the client needs to know:

- The range of all methods available (this assumes that a variety of methods actually are available, or that an effort is made to obtain or refer)
- Advantages/disadvantages of each possible side effects/complications
- Precautions based on her individual medical history
- Information on risks of not using any method, such as risks associated with pregnancy/childbirth versus risks associated with contraceptive use
- How to use the method chosen safely and effectively

Importance of counseling

- It ensures clients' right to informed and voluntary decision making
- It is an essential element of quality FP services
- It is a key determinant of the adoption and continuation of family planning

What does effective counseling do to clients?

- Enables clients to chose a method that suits their needs
- Enables clients to use their chosen method correctly
- Enables the client to continue using a FP method with satisfaction
- Informs and prepares clients for side effects

The most common setting in which counseling can take place are:

1 Individual counseling

It is the case in which an individual prefer privacy and confidentiality during counseling and it is important to respect the needs and interests of a client by finding a private room or place where you can talk with them**.**

2 Couple counseling

Couple counseling is when you give a counseling service to a couple or partner together. This is particularly common when they are thinking of using irreversible family planning measures, such as voluntary surgical methods.

3 Group counseling

Appropriate when clients are more comfortable in a group situation or when individual counseling is not feasible

- Greet clients in friendly manner
- Introduce benefits of family planning
- Elicit and discuss rumors and concerns about family planning
- Discuss family planning methods and encourage questions and group discussion
- Discuss how to obtain appropriate methods

Principles of counseling

Counseling should take place in a private quiet place where client and provider can hear each other. Confidentiality must be ensured, both in the process of counseling and the handling of client records. It is essential that counseling take place in a non-judgmental, accepting, and carryings atmosphere.

Box .1 Follow these guidelines while counseling clients:

- Create an atmosphere of privacy, respect, and trust
- Engage in two-way communication with the client
- Ensure confidentiality
- Remain nonjudgmental about values, behaviors, and decisions that differ from your own
- Show empathy for the client's needs
- Demonstrate comfort in addressing sexual and gender issues
- Remain tolerant with the client during the interaction and express interest
- Provide reliable and factual information tailored to the needs of the client
- Support the client's rights to sexual and reproductive health

Counselor characteristics

An effective counselor:

Believes in and is committed to the basic values and principles of family planning and client rights is accepting, respectful, non-judgmental, and objective when dealing with clients is aware of her/his own values and biases and does not impose them on clients understands and is sensitive to cultural and psychological factors (such as family or community pressures) that may affect a client's decision to adopt family planning always maintains clients' privacy and confidentiality.

Counselor skills

An effective counselor knows and possesses all technical aspects of family planning methods and is able to apply good interpersonal communication skills, and counseling techniques:

A. Praise

- Praise is the expression of approval or admiration.
- Praising reinforces good behavior by identifying and supporting the good things a client has done.

For example, praising clients:

- Shows that you respect their concern for their health
- Acknowledges difficulties they might have overcome to come to the health care facility
- Expresses approval for positive choices and actions

B. Encouragement

Encouragement means giving support, courage, confidence, and hope. In the health care setting, giving encouragement means letting clients or patients know that you believe they can overcome their problems and helping them find ways to do so. For example, encouraging clients:

- Points out hopeful possibilities
- Focuses on what is good about what they have done and urges them to continue
- Tells them that they are already helping themselves by coming to the health facility

C. Asking Questions during Counseling

Why Do We Ask Questions during FP Counseling?

- To assess the client's FP needs and knowledge
- To learn about the client's medical status, previous contraceptive use, personal circumstances, preferences, and concerns
- To actively engage the client and elicit information about his or her needs, concerns, and preferences
- To establish a good relationship by showing concern and interest
- To prioritize the key issues to target during the time available for counseling
- To determine the educational or language level that will be best understood by the client
- To avoid repeating information that the client already knows
- To identify areas of misinformation that needs to be corrected

Closed-ended questions usually will be answered by a very short response, often just one word. A closed question calls for a brief, exact reply, such as yes or no or a number. Closed questions are valuable for quickly getting basic information about the client's background, condition, and medical history

For example:

- How old are you?
- How many children do you have?
- Do you have a method in mind?
- Are you confident that you can remember to take a pill every day?
- Is your house far from this clinic?
- When was your last menstrual period?
- Are you currently using a FP method?

Open-ended questions are useful for exploring more in-depth information as well as the client's opinions and feelings. They usually require longer responses and so are more effective in determining what the client needs (in terms of information and emotional support) and what he or she already knows. Such questions often start with the words "How," "What," or "Why."

Examples of open-ended question include:

- How can we help you today?
- What do you like about the method you want to use?
- What have you heard about the method?
- How would you feel if you experienced changes in your monthly bleeding?
- What do you think could have caused this problem?

D. Listening

Tips for Active Listening

Establish and maintain eye contact.

- Demonstrate interest by nodding, leaning toward the client, and smiling.
- Sit comfortably and avoid distracting movements.
- Pay attention to the client (e.g., do not engage in other tasks while you are meeting with the client, do not talk to other people, do not interrupt the client, and do not allow others to interrupt).
- Listen to the client carefully. Do not become distracted and think about other things or about what you are going to say next.
- Listen both to *what* your clients say and to *how* they say it, and make note of tone of voice, choice of words, facial expressions, and gestures.
- Imagine yourself in your client's situation as you listen.
- Allow for pauses of silence at times during your interaction so that the client has time to think, ask questions, and talk.
- Encourage the client to ask questions.
- Encourage the client to continue talking by using expressions like "yes," "hmm," and "and then what?"
- Repeat what the client has said. (Note, however, that exact repetition of what the client has said should be used sparingly. Instead, counselors should use paraphrasing or reflecting, as discussed below.)

A. Reflecting

Is recognizing and interpreting the client's feelings and integrating what has been said into further discussion.

B. Clarification

Is asking questions to better understand what the client has said. These techniques convey to the client that the provider is listening to what she or he is saying, help the provider understand what the client has said, and encourage the client to continue talking.

C. Paraphrasing

Is restating what the speaker has said in your own words in order to demonstrate attention and understanding, and to encourage the speaker to continue.

Paraphrasing Guidelines

- Listen to the speaker's basic message.
- Give the speaker a simple summary of what you believe is the message. Do not add any new ideas.
- Observe the client's response and use it as a cue that confirms or denies the accuracy of your paraphrasing, or ask that the client to let you know whether you have correctly understood what he or she has said.
- Do not restate negative statements that people might have made about themselves in a way that confirms this perception. If someone says, "I really acted foolishly in this situation," it is not appropriate to say, "So, you feel foolish." Instead, you can try to understand the situation better by asking questions.
- Do not overuse paraphrasing.
- Your objective is to encourage the person to continue speaking

Factors influencing family planning counseling

There are different factors that affect the quality and effectiveness of communication in counseling. You should identify and address these factors in order to have successful family planning counseling sessions. These factors are divided into three broad categories

Factors related to provider

As a provider of family planning services, your ability to engage in effective communication, your technical knowledge, skills, attitudes and behaviors can influence the effectiveness of the counseling process. You will have your own values and beliefs on specific methods, and you must try not to let this show or you can affect the other person's choice. Stop reading for a moment and think about this from your own experience.

Sometimes you will be communicating with someone who differs from you in terms of their social status, gender or education.

How will this affect the counseling process?

Irrespective of gender, social and educational status, you have to show every client respect, help them feel at ease, and encourage them to explain their needs, express their concerns and ask questions. Respecting the rights of the client is essential to the quality and continuity of family planning services, including counseling.

Box 2 below summarizes the principles of the client's rights in all aspects of family planning services.

The following are the basic rights of all family planning clients:

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

(**Source**: International Planned Parenthood Federation)

Factors related to the client

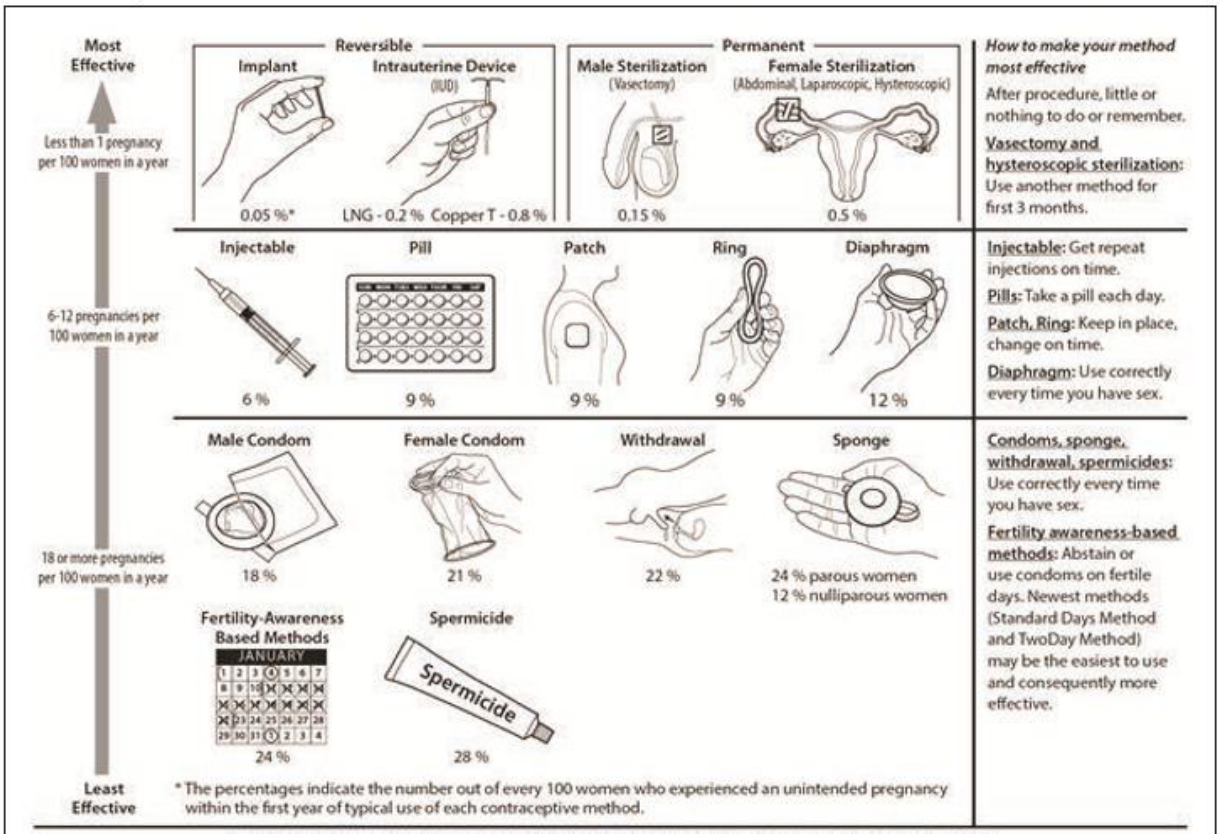
The client's level of knowledge and understanding may affect their choice. What they choose to do may also be affected by the extent to which they trust and respect you. Their personal situation may make it difficult for them to choose some methods, for example if their spouse or another family member has a different preference to them.

External/ programmatic factors

In most developing countries like Ethiopia, reproductive health services in general, and family planning programmes in particular, are limited and cannot be accessed by everyone. You may learn about some methods that you cannot offer to people in your community because of its unavailability. Moreover, the supplies of the family planning materials may not be regular and reliable.

In most health facilities the space or room for the provision of family planning is integrated with other reproductive health programmes. This can make it really difficult for you to find a place where privacy and confidentiality can be maintained.

FIGURE 3. The typical effectiveness of Food and Drug Administration–approved contraceptive methods



Self-Check -1	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. What is family planning counseling mean?
2. What are the most important principles when counseling members of your community?
3. Write shortly components of REDI framework in family planning counseling
4. What are the principles of the client's rights in all aspects of family planning services?
5. What factors are influence family planning counseling outcomes?

Note: **Satisfactory rating - 3 points** **Unsatisfactory - below 3 points**

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Short Answer Questions

Information Sheet- 2	Providing information on available methods, with their advantage & disadvantage

2.1.Concept of natural family planning methods

Physiological processes and observable changes 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 24hours. 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. What this means is that 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'.

"Fertility awareness" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. The fertile time is when she can become pregnant. This method is sometimes called periodic abstinence or natural family planning.

However, 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

Natural family planning methods are the preferred contraceptive method for women who do not wish to use artificial methods of contraception for reasons of religion, health or who, due to rumors and myths, fear other methods.

Disadvantages

Natural family planning methods takes time to practice and use them properly, which adds to their unreliability. Additionally, natural family planning methods do not protect against sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV). You should advise couples to use condoms to protect against STI.

How effective are fertility awareness methods?

The effectiveness of any method of natural family planning can vary from couple to couple, and all these methods are less effective for couples who do not follow instruction carefully and risk of pregnancy is greatest when couples have unprotected sex on the fertile days.

2.2. Types of Natural family planning

There are three major classifications of natural family planning methods:

1. Periodic abstinence (fertility awareness) method
2. Use of breastfeeding or lactational amenorrhea method (LAM)
3. Coitus interrupts (withdrawal or pulling out) method.

2.2.1. Periodic abstinence (Fertility awareness) methods

"**Fertility awareness**" means that a woman knows how to tell when the fertile time of her menstrual cycle starts and ends. (The fertile time is when she can become pregnant. In the menstrual cycle, the female hormones estrogen and progesterone cause some observable effects and symptoms Estrogen produces change in the cervical mucus, 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.

Progesterone produces a slight increase in basal body temperature after ovulation. The function of progesterone on the cervical mucus is just the opposite effect of estrogen. It makes the cervical mucus thick, opaque and sticky.

Knowing this changes provide bases for periodic abstinence

Fertility awareness methods are divided into three broad categories:

1. Calendar based methods
2. Cervical mucus
3. Basal body temperature method(BBT)

2.2.1.1. Calendar based (rhythm) method

The **Calendar based (rhythm) method** is a method by which a woman calculates the fertile days of her menstrual period and the couple avoids vaginal sex, or uses temporary methods during the fertile time. 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.

What do you know about the regular and irregular menstrual cycle of a woman?
A regular menstrual cycle is when monthly bleeding happens every 28 days.
An irregular menstrual cycle is when monthly bleeding is variable from month to month, for example it can vary from 25 to 32 days in some women.
Before relying on rhythm method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1.

The woman subtracts 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then, she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time.

Example 1
A woman's last six menstrual cycles were 28, 29, 29, 27, 31 and 27 days. Using this information, calculate and instruct her about how to use the calendar method to prevent pregnancy
The shortest of her last 6 cycles was 27 days, 27 – 18 = 9. She starts avoiding unprotected sex on day 9. The longest of her last 6 cycles was 31 days, 31 – 11 = 20. She can have unprotected sex again on day 21. Thus, she must avoid unprotected sex from day 9 through day 20 of her cycle.

However, if the client's menstrual cycle is regular and comes every 28 days or close to it, ovulation should occur about 14 days before the next period. For this reason, the woman should count backwards 14 days from her next period to calculate the day she will ovulate. Consequently, she should avoid sex from about seven days before that day until about two days after ovulation is expected.


Fig.4.1. White beads days are days when she can get pregnant and Brown bead days are days when pregnancy is unlikely

Example 2

A client comes to you and asks about using the calendar method to prevent Pregnancy. When you ask her about the history of her menstrual cycle over the last six months, she tells you it comes regularly every 29 days. Calculate the fertile period of your client and advise her when to avoid sex in order to prevent pregnancy.

Answer

Regular cycle 29 - 14 = 15

First day of fertile phase 15 - 7 = 8

Last day of fertile phase 15 + 2 = 17

Therefore, her fertile period is between the 8th and 17th days, and she should avoid sex between these days of the cycle.

Advantage of calendar (rhythm) method

- Greater involvement of partner to avoid pregnancy
- No prescription needed
- Increased communication between couple
- Increased awareness on how to become pregnant if conception is desired

Disadvantages of calendar (rhythm) method

- High failure rate if not used consistently and correctly
- Fewer "safe" days to have intercourse each month
- Training is essential
- No protection from STIs
- If periods are not regular, may not be as effective

Effectiveness of the calendar method

With consistent and correct use, about 5 pregnancies per 100 women in the first year of use will occur. This means more than 95 women will avoid potential unplanned pregnancy in the first year of use.

- What can a couple do if they are fear about using this method?
- Advised them to use additional methods, like condoms or other barrier methods, to prevent unwanted pregnancy. You should provide them with the necessary resources.

2.2.1.2. Basal body temperature method

The **Basal body temperature method** is a symptom-based method that relies on the woman's ability to notice a slight increase in her body temperature. The elevation in the temperature is as a result of hormonal changes that result in ovulation.

The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph.

She watches for her temperature to rise slightly—0.3° to 0.5° C just after ovulation (usually about midway through the menstrual cycle). The rise in body temperature sustained for three consecutive days indicate that ovulation has occurred, and it remains at this increased level until the start of the next menstrual cycle. In this section you will learn about when the rise in body temperature occurs, and what women need to know in order to use this method properly. It is difficult to a woman to use natural family planning method if her menstrual cycle is irregular, as it may disturb the subtle changes in body temperature and cervical secretions, as a result of hormonal effect

Advantage

- Increased communication between couple
- Increased awareness on how to become pregnant if conception is desired

Disadvantage

- High failure rate if not used consistently and correctly
- No protection from STIs
- Training is essential
- False interpretation or indications in the case of fever, as this may mislead the result of BBT
- A special thermometer may be required

Effectiveness

With consistent and correct use, 1 pregnancy per 100 women using BBT method will get pregnant in the first year. This means that 99 of every 100 women relying on BBT method will not become pregnant. Its effectiveness will decrease dramatically to 80% if the woman does not use the method correctly. Effectiveness is greatest when the couple limits unprotected sexual intercourse to the period after ovulation.

Key points to remember on BBT

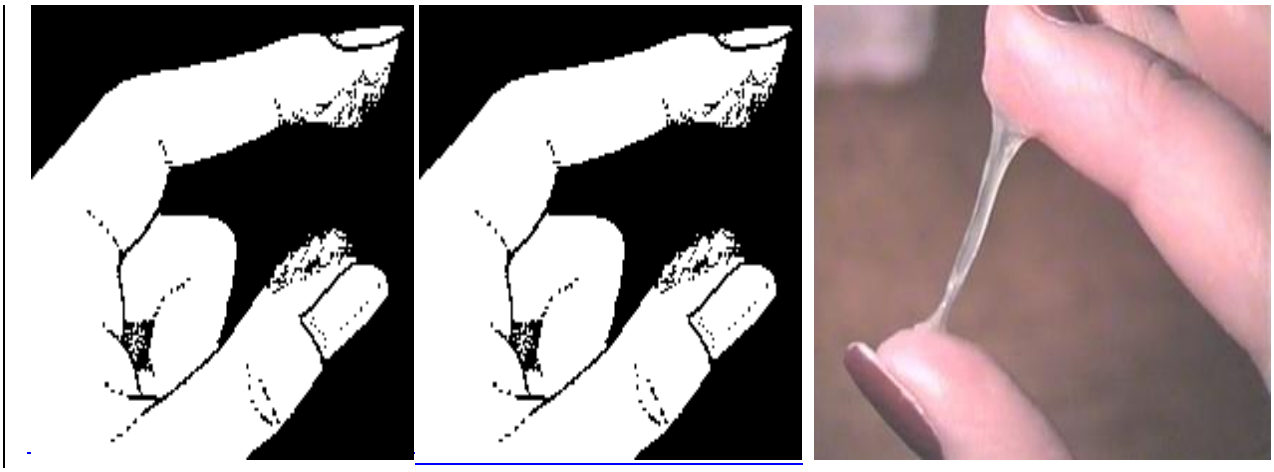
- Watch for a slight rise in temperature at about midway between the menstrual cycles.

Avoid unprotected vaginal sex from the first day of monthly bleeding until 3 days after the woman's temperature has risen above her regular temperature.

- All women can use the BBT method except those with fever.

2.2.1.3. Cervical mucus method (CMM)

Cervical Mucus Method is a symptoms-based fertility awareness method. The method relies on the woman's ability to predict her fertile days by following the characteristics of cervical mucus. This method is also an ovulation method used by women trying to get pregnant and have a child.



a) Early mucus b) Transitional mucous C) highly fertile mucous

Fig 4.3 types of cervical mucus

Mechanism of action cervical mucus method

The method works primarily by helping a woman know on what days she could become pregnant and the couple avoids unprotected vaginal sex during the fertile days.

As soon as she notices any secretions, she considers herself fertile and avoids unprotected sex. She continues to check her cervical secretions each day. The secretions have a "peak day"—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex

Instruct women 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 (see figures 4.3)
- Feel how wet the sensation is in their genitalia when they are walking.
- Abstain from sexual intercourse on the day when mucus appears,

Effectiveness

With consistent and correct use, 3 pregnancies per 100 women using cervical mucus method will get pregnant in the first year. This means that 97 of every 100 women relying on cervical mucus method will not become pregnant.

Advantage of cervical mucus method

- Increased communication between couple
- Increased awareness on how to become pregnant if conception is desire

Disadvantage of cervical mucus methods

It 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, secretions may be misleading.

2.2.1.4.Lactational Amenorrhea method(LAM)

Lactational Amenorrhea method (LAM) is a temporary family planning method based on the natural effect of breastfeeding on fertility. ("**Lactational** means related to breastfeeding; "**Amenorrhea**" means not having monthly bleeding)

The lactational amenorrhea method (LAM) requires 3 conditions and must be met:

1. The mother's monthly bleeding has not returned
2. The baby is fully or nearly fully breastfed and is fed often, day and night
3. The baby is less than 6 months old

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.

Advantage

- Effectively prevents pregnancy for at least 6 months
- Cheap
- Encourages the best breastfeeding
- Does not interfere sexual intercourse
- NO hormonal side effects
- Can be used immediately after birth.

Disadvantage of LAM

- Not a suitable method if the mother is working outside the home
- If the mother have HIV small chance to transmitter
- No protection against STIs including HIV

- Not effective after 6months

Effectiveness of lactational amenorrhea method

Effectiveness depends on the user: Risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant. As commonly used, about 2 pregnancies per 100 women using LAM in the first 6 months after childbirth will occur. This means that 98 of every 100 women relying on LAM will not become pregnant.

2.2.1.5. Withdrawal method (Coitus Interrupts)

Withdrawal or pulling out (coitus interruptus) method, a man pulls his penis out of the woman and away from her genitals before he ejaculates. This method is the least effective method and not advisable. Sometimes a man is not able to pull out before he ejaculates. Even if the man pulls out in time, some liquid that contains sperm can leak out of his penis before ejaculation and cause pregnancy.

1.1.Type of barrier method

1.1.1. Mechanical Barrier

Barrier methods of contraception work by creating a physical barrier between sperm and egg cells so that fertilization cannot occur. They do not change the way the woman's or man's body works, and they cause very few side effects. The most common mechanical barrier methods are the condom, condoms for women, the diaphragm, cervical cap and sponge

1.1.2. Chemical Barrier

Spermicides, a form of chemical contraceptive that work by killing sperm, are often combined with mechanical barrier methods of contraception for greater effectiveness.

1.2. Male condom

Male condoms are more common than female condoms. A male condom is a thin sheath that is worn over the man's penis during sexual intercourse. The condom collects sperm so that the sperm are not released into a woman's vagina. Condoms are also called rubbers, sheaths, prophylactics, and many other names. Thus, in this study session, more emphasis will be given to the male condom than to any other barrier method and you will learn about it in detail. Condoms are the best protection against STIs and HIV. They can be used alone or along with any other family planning method.

Mechanism of action

The condom must be put on the man's penis when it is hard, but before it touches the woman's genitals. If he rubs his penis on the woman's genitals or goes into her vagina, he can make the woman pregnant or can give her an STI, even if he does not spill his sperm (ejaculate)

Common mistakes and important messages for condom users

The five most common mistakes are:

1. Not having a condom when needed.
2. Starting intercourse without a condom on the penis, then interrupting intercourse to put on the condom (or deciding not to use the condom at all).
3. Tearing the condom with a fingernail.
4. Not holding the rim of the condom when withdrawing the penis from the vagina, causing condom slippage and leakage.
5. Forgetting to use the condom altogether.

IMPORTANT

Clients need to be informed that:

1. They should not use two condoms at once. Placing two male condoms on a penis can raise the chance of tearing.
2. Used condoms should be thrown away after each sex act.
3. Male condoms and female condoms should not be used at the same time.
4. The condom must be used from 'start to finish' with every act of intercourse.

1.2.1. Advantages and disadvantages of male condom

Advantages

If used correctly and consistently with every act of sexual intercourse, help protect against risks of pregnancy, STIs, including HIV

Disadvantage

Condoms do have some disadvantages. The common ones are as follows:

- Women have to rely on the man's cooperation to protect themselves from pregnancy and disease.
- Some people connect condoms with immoral sex, sex outside marriage, or sex with prostitutes, and do not want to use them.
- Some people are too embarrassed to buy, ask a partner to use, put on, take off, or throw away condoms.
- Latex condoms may cause itching for a few people who are allergic to latex and/or lubricants.
- There is a small possibility that a condom will slip off during sex.
- Condoms can weaken and may break during use if stored for too long or in too much heat, sunlight or humidity, or if used with oil-based lubricants, such as Vaseline or edible oils.

1.3.Female condom

The female condom is not well known in Ethiopia. It is essentially a vaginal pouch (thin, loose-fitting and flexible plastic tube) with two rings at either end. One end of the pouch is open. The other end is closed. A woman inserts the closed end high up in her vagina over her cervix. The open end remains on the outside of her vagina. The vagina is now lined with the condom. When a woman has intercourse, the man inserts his penis into the open end of the woman's condom. Once intercourse is over and the man withdraws his penis, the condom containing the ejaculated sperm can now be removed and thrown away.

The female condom can be put in up to 8 hours before intercourse. A woman may need some practice before she can easily insert and position the condom within her vagina. The sides of the internal ring can be folded together and inserted into the vagina much like a diaphragm. The female condom is thinner than the male condom and is resistant to degradation by oil-based lubricants. A female condom should never be used when the man is also wearing a condom. The two condoms can stick together and tear, resulting in no protection at all

Fig female condom

Mechanism of action

Female condoms work by forming a barrier that keeps sperm out of the vagina, preventing pregnancy. Also keep infections in semen, on the penis, or in the vagina from infecting the other partner.

Effectiveness

Effectiveness depends on the user: Risk of pregnancy or sexually transmitted infection (STI) is greatest when female condoms are not used with every act of sex. Few pregnancies or infections occur due to incorrect use, slips, or breaks.

Protection against pregnancy:

When used correctly with every act of sex, about 5 pregnancies per 100 women using female condoms over the first year.

Protection against HIV and other STIs:

Female condoms reduce the risk of infection with STIs, including HIV, when used correctly with every act of sex.

Advantage

Unlike the male condom, erection is not necessary to keep the condom in place.

Female condoms do not reduce a male partner's stimulation. Female condoms are made of plastic, which rarely causes an allergic reaction

Disadvantage

Difficulty inserting the female condom

Inner ring uncomfortable or painful

Condom squeaks or makes noise during sex

Mild irritation in or around the vagina or penis

1.4. Diaphragm

The diaphragm is a soft flexible rubber cup shaped like a dome that is inserted into the vagina. The diaphragm blocks access to the cervix so that sperm cannot pass from the vagina into the uterus. The diaphragm must be covered on both sides and especially around its rim with spermicidal jelly, cream, or foam in order to form a tight seal around the diaphragm.

Fig Diaghram

Mechanism of action (how does it work)

Diaphragm works by blocking sperm from entering the cervix; spermicide kills or disables sperm. Both keep sperm from meeting an egg.

Effectiveness

As commonly used, about 16 pregnancies per 100 women using the diaphragm with spermicide over the first year. This means that 84 of every 100 women using the diaphragm will not become pregnant

Guide line for diaphragm insertion

How to insert the diaphragm

Insert your diaphragm before intercourse. It can be inserted up to 6 hours before intercourse. Once inserted, it is immediately effective.

1. Before inserting empty your bladder and wash your hands.
2. Take the diaphragm and hold it up to the light. Check the diaphragm for any tears or holes in the cup or for cracks along the rim before each use.
3. Squeeze at least a tablespoon of spermicidal jelly into the cup, and spread it around the rim and inside the cup with a clean finger.
4. Press the rim of the diaphragm together with the spermicide inside the dome.
5. While standing, squatting, or lying, gently push it all the way into the vagina with the dome side facing down and the jelly side directed toward the cervix.
6. Push the diaphragm in as far as it will go, making sure that the front rim is tucked up under the pubic bone. It should cover the cervix, which feels like the end of your nose.
7. Now you are ready to have intercourse. You can use more spermicide or lubrication if you want. For extra lubrication we recommend spermicidal jelly, or a water-based lubricant such as KY jelly.
8. If you put your diaphragm in more than 6 hours before having intercourse, you should insert more spermicide (such as an applicator of contraceptive jelly or foam,) into your vagina without removing the diaphragm.
9. Before each act of intercourse you should also insert more spermicide (as above) into your vagina, without removing the diaphragm.
10. The diaphragm needs to be used with a spermicide every time you have intercourse. Keep the diaphragm in place at least 6 hours after having sex but no longer than 24 hours.

11. To remove, slide a finger under the rim of the diaphragm to pull it down and out. Wash hands with mild soap and clean water, if Possible. Insert a finger into the vagina until the rim of the diaphragm is felt. Gently slide a finger under the rim and pull the diaphragm down and out. Use care not to tear the diaphragm with a fingernail. Wash the diaphragm with mild soap and clean water and dry it after each use.

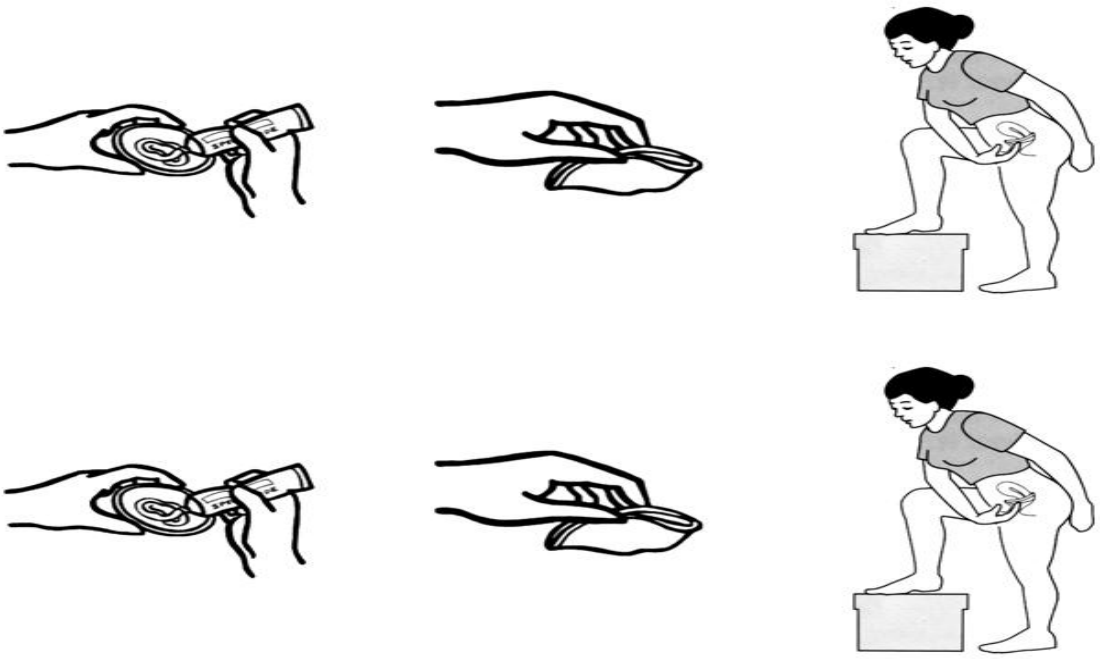


Fig 5.6 How to use Diaphram

1.5. Spermicides

1.5.1. Mechanism of use

Spermicides are sperm-killing chemicals inserted deep into the vagina, near the cervix, before sex. They are available in foaming tablets, melting or foaming suppositories, melting film, jelly and cream. Jellies, creams and foam from cans can be used on their own, with a diaphragm, or with condoms. Films, suppositories, foaming tablets or foaming suppositories can be used on their own or with condoms.

1.5.2. Effectiveness of spermicides

They work by causing the membrane of the sperm cells to break, killing them or slowing their movement. This keeps the sperm from meeting the egg. Spermicides are one of the least effective family planning methods, with a 29% chance of pregnancy, and as with other methods effectiveness depends on the user. Risk of pregnancy is greatest when spermicides are not used with every act of sex. In general, spermicides may be an appropriate choice for women who need back-up protection against pregnancy (for instance, if they forget to take their birth control pills). Spermicides should not be used alone as the primary method of birth control.

1.5.3. Advantages and disadvantages of spermicides

Spermicides are safe to use. They are a female-controlled method that almost every woman can use without the need to consult a healthcare provider first. They can increase vaginal lubrication, so that vaginal dryness and friction will be minimized. They are much easier to use with a little

practice and can be stopped at any time. They have no hormonal side effects. Unfortunately they are one of the least effective methods on their own.

1.6 Oral contraceptives are known also as the Pills or birth control pills. This medicine usually contains two types of hormones, estrogens and progestin and, when taken properly, prevents pregnancy. The pill works mainly by changing the body's hormonal balance so that the woman does not ovulate. In addition, the pill causes the mucus made by the cervix to thicken and form a 'mucus plug' in the cervix which makes it difficult for sperm to get through to the uterus to fertilize an egg. The pill also makes the lining of the uterus thinner, which makes it unlikely that a fertilized egg will be able to attach to the uterus.

Based on their hormone content, oral contraceptives are divided into two types:

- Combined oral contraceptives (COCs), which contain the hormones oestrogen and progesterone
- Oral contraceptives with a single hormone, known as progestin-only oral contraceptives. Both combined and progesterone-only oral contraceptives, not protect against sexually transmitted infections (STIs), including HIV/AIDS. If your client has or might get an STI, they should be given condoms to use regularly.

1.6.1 Combined oral contraceptives(COC)

Combined oral contraceptives (COCs) are pills that are taken once a day to prevent pregnancy. They contain the hormones estrogen and progestin. Combined oral contraceptives (COCs) are also called "the Pill," low-dose combined pills, OCPs, and OCs.There are many different brands, and they come in packs of 21 or 28 pills. Two brands, microgynon and Leo-femenal, both in packs of 28 pills, are the most popular ones in Ethiopia. One pill is taken every day. The first 21 pills have a combination of synthetic oestrogen and progesterone hormones. The last seven pills of a 28-day pack have no hormones and are called spacer pills. They are usually different in colour, and some brands contain iron. The iron in the pill can be taken as a supplement to avoid iron deficiency.

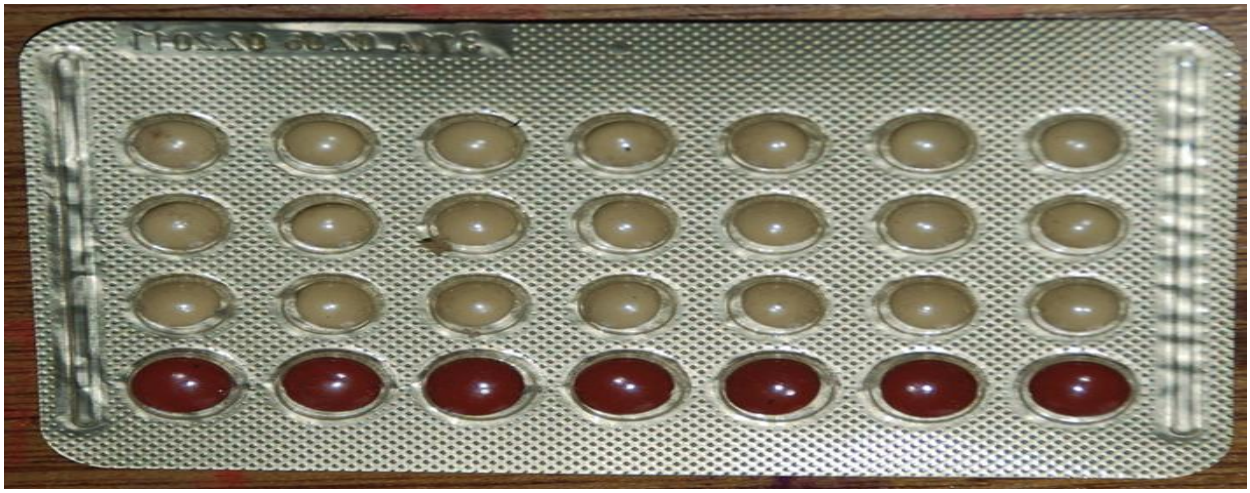


Fig 6.1 Combined oral contraceptive with spacer pills in bottom row

How effective are COCs?

Effectiveness depends on the user. It is 99.9% effective if used correctly and consistently. There is no delay in Return of fertility after COCs are stopped but don't protect against sexually transmitted infections (STIs) including HIV/AIDS

Side effects (that are temporary and not dangerous)

Changes in bleeding patterns including: lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, no monthly bleeding, headaches, dizziness, nausea, breast tenderness, weight change, mood changes, acne (can improve or worsen, but usually improves), blood pressure increases a few points.

Who can use COCs?

Women of any reproductive age or parity including women who:

- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Smoke cigarettes—if under 35 years old
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not taking antiretroviral medications

Who cannot use COCs?

Women who have the following conditions (contraindications):

- Pregnancy (but no proven negative effects on fetus if taken accidentally)
- Fully or nearly fully breastfeeding a baby less than 6 months old
- Has had a baby in the last 3 weeks
- Current or history of breast cancer
- Liver tumor, liver infection or cirrhosis or has developed jaundice while using COCs
- Age 35 or older and smoking
- Blood pressure 140/90 mmHg or higher
- Diabetes for more than 20 years or damage to arteries, vision, kidneys or nervous system caused by diabetes
- Current gallbladder disease
- Current or history of stroke, blood clot in legs or lungs, heart attack or serious heart problems
- Migraines with aura or migraines without aura at age 35 or older
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin)
- Planning major surgery that will keep her from walking for one week

When to start using COCs?

- Anytime (during the menstrual cycle) it is reasonably certain that the client is not pregnant
- Within 5 days after the start of her monthly bleeding

- Immediately when stopping IUD or another hormonal method. No need to wait for her next monthly bleeding.
- Postpartum:
- Six months after giving birth if using LAM
- At least after 3 weeks if not breastfeeding (on days 21 –28)
- Beyond those dates pregnancy has to be ruled out.
- Post abortion (after abortion or miscarriage) immediately or within 7 days

Advantages of COCs

- COCs are very effective contraceptives, giving women control over their own fertility when taken consistently and correctly.
- Fertility returns soon after stopping COC pills, which makes them an excellent option for women who want to become pregnant in the near future.
- Combined oral contraceptive pills decrease menstrual flow significantly in women with a normal uterus. Therefore, pill users are less likely to develop iron deficiency anaemia. Pills also decrease menstrual cramps and pain.

Disadvantages of COCs

Although they are advantageous in many cases, COCs have some disadvantages, and you should inform your clients about these disadvantages in order to help them choose from all available methods. One of the main disadvantages of COCs is that they are not recommended for breastfeeding women, because they affect the quality and quantity of milk. Very rarely, COCs can also cause strokes, blood clots in deep veins of the legs, or heart attacks. Those at highest risk are women with high blood pressure and women who are aged 35 years or older. Also bear in mind that the pills do not protect against STIs, including AIDS.

1.6.2. Progesterone only pills/Mini pills

POPs also called **mini pills**, unlike COCs, do not contain any estrogen, and therefore they can be used throughout breastfeeding and by women who cannot use methods with estrogen.

POPs work primarily by:

– Thickening cervical mucus (this blocks sperm from meeting an egg)

– Disrupting the menstrual cycle, including preventing the release of eggs from the ovaries (ovulation)

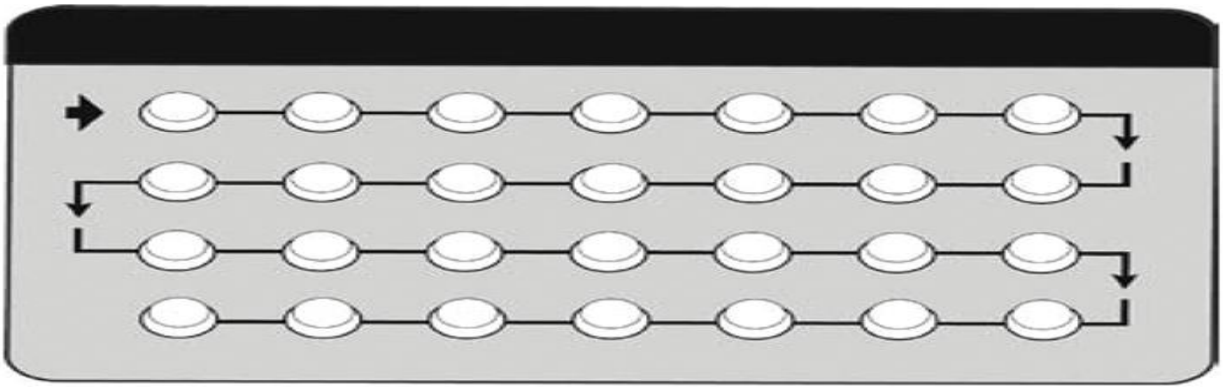


Fig.6.2. Progestin-only contraceptive

How effective are POPs?

Effectiveness depends on the user. For breastfeeding women:

When pills are taken every day, less than 1 pregnancy per 100 women using POPs over the first year

Side effects (that are temporary and not dangerous)

Changes in bleeding patterns including: Frequent bleeding, irregular bleeding, infrequent bleeding, prolonged bleeding, no monthly bleeding and for breastfeeding women lengthened postpartum amenorrhea, headaches, dizziness, mood changes, breast tenderness, abdominal pain and nausea.

Who can use POPs?

- Women of any reproductive age or parity including women who:
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have or have not had children
- Are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Have anemia now or had in the past
- Have varicose veins
- Are infected with HIV, whether or not taking antiretroviral medications

Who cannot use POPs?

Women who have the following conditions:

- Breastfeeding a baby less than 6 weeks old
- Liver tumor, liver infection or cirrhosis
- Current serious problem with blood clot in legs or lungs
- Taking medications for seizures (barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate) or tuberculosis (rifampicin)
- Current or history of breast cancer

When to start using POPs?

- Anytime it is reasonably certain that the client is not pregnant.
- No monthly bleeding – Any time it is reasonably certain that the client is not pregnant. A backup method needed for the first 2 days of taking pills.
- Immediately when switching from copper bearing IUD or another hormonal method if the client has been using the previous method consistently and correctly. No need to wait for next monthly bleeding.
- The day after the client finishes taking emergency contraceptive pills
- Having menstrual cycles or switching from a non hormonal method - within 5 days after the start of her monthly bleeding and no backup method; or more than 5 days after the start of monthly bleeding - anytime it is certain that the client is not pregnant and a backup method for the first two days of taking pills
- Postpartum:

- Fully or nearly fully breastfeeding - 6 weeks after giving birth, and anytime between 6 weeks and 6 months if her monthly bleeding has not returned
- Partially breastfeeding - at 6 weeks after giving birth; if less than 6 weeks and monthly bleeding has returned a backup method until 6 weeks have passed since giving birth; if more than 6 weeks and monthly bleeding has not returned anytime it is reasonably certain that she is not pregnant and a backup method for the first 2 days;
- Breastfeeding and monthly bleeding has returned - as advised for women having menstrual cycles
- Not breastfeeding - any time within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned – any time it is reasonably certain that she is not pregnant plus a backup method for the first 2 days of taking pills; if monthly bleeding has returned as advised for women having menstrual cycles

- Post abortion (after abortion or miscarriage) - immediately or within 7 days no backup method is needed. More than 7 days after, any time it is reasonably certain that she is not pregnant and a backup method for the first 2 days of taking pills.

How are POPs used?

The client should always take one pill each day. When she finishes one packet, she should take the first pill from the next packet on the **very next day**. There is no wait between packets.

6.5 **Rumors and misconceptions**

There are many myths, rumors and misconceptions associated with taking oral contraceptives. You may be aware of some yourself. The most common Ones are listed in Box 6.1.

S.No	Myth/misconceptions	Fact
1	Women who stop taking the pill may not be able to get pregnant	Most women, who use a method of contraception, including the pill, can later get pregnant if they wish. The pill will not cause women to be infertile.
2	The pill cause cancer	The pill does not cause cancer. In fact, the pill actually reduces the risk of getting certain cancers, such as endometrial and ovarian cancers.
3	Oral pills build up in a woman's body.	Oral pills do not build up in a woman's body
4	Women need to rest from taking oral contraceptives	Women do not need a rest from oral contraceptives. They have to take them every day, whether or not they have had sex that day.
5	Women who stop taking the pill may not be able to get pregnant. They become infertile	Most women who use a method of contraception, including the pill, can later get pregnant if they
6	Oral pills build up in a woman's body.	Oral pills do not build up in a woman's body
7	Oral contraceptives cause birth defects or Multiple births	Oral contraceptives do not cause birth defects or multiple births
8	Oral contraceptives change	Oral contraceptives do not change women's sexual

	women's sexual Behavior.	behavior
9	Oral contraceptive pills collect in stomach	Oral contraceptives do not collect in the stomach. Instead, the pill dissolves each day.

1.7. Injectable contraception

The **contraceptive injection**, also known as '**the shot'**, contains progesterone or a combination of estrogen and progesterone. The injectable contraceptives depot med Roxy progesterone acetate (DMPA) and norethisterone enanthate (NET-EN) each contain a progestin like the natural hormone progesterone in a woman's body. In contrast, monthly injectable contain both estrogen and progestin. Note that combined injectable is not addressed in this module.

1.7.1.PROGESTIN-ONLY INJECTABLES

Progestin-only injectable contraceptives contain no estrogen. Therefore they can be used throughout breastfeeding and by women who cannot use methods with estrogen. They work primarily by preventing the release of eggs from the ovaries (ovulation).

How effective are progestin-only injectables?

Effectiveness depends on getting injections regularly: Risk of pregnancy is greatest when a woman misses an injection. As commonly used, about 3 pregnancies per 100 women using progestin-only injectable over the first year. This means that 97 of every 100 women using injectable will not become pregnant. When women have injections on time, less than 1 pregnancy per 100

Fig 7.1 DMPA injection

Advantage of DMPA

- Highly effective and safe
- Long acting (three months).
- Does not interfere with sexual intercourse.
- One of the most private and confidential methods.
- Convenient and easy to use (does not require a daily routine or supplies).

- Can be provided by a non-physician.
- Completely reversible (an average of 4 months' delay in return to fertility after discontinuing DMPA).
- Suitable for women who are not eligible to use an estrogen-containing contraceptive.
- Suitable for breastfeeding women (after 6 weeks postpartum).
- Provides immediate postpartum (in non-breastfeeding women) or post-abortion contraception.
- The prolonged absence of menses is an advantage for many women.
- May be used by women at any age or parity if they are at risk of pregnancy.
- Protects against ectopic pregnancy since ovulation does not occur

Disadvantage of DMPA

- There are menstrual changes for almost all women.
- Increased appetite causing weight gain for some women (0.5 kg, on the average, in the first year).
- Women who stop using DMPA take an average of four months longer than usual to get pregnant. This is because residual levels of DMPA exist for several months after the end of contraceptive protection from the last injection.
- Since DMPA is long acting, it cannot easily be discontinued or removed from the body if a complication occurs or if pregnancy is desired immediately.
- DMPA does not provide protection against STIs/HIV.

Who can use progestin-only injectables?

- Women of any reproductive age or parity including women who:
- Have or have not had children, or are not married
- Are of any age, including adolescents and women over 40 years old
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have just had abortion or miscarriage
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Are infected with HIV, whether or not on antiretroviral medications

Who cannot use progestin-only injectables?

Women who have the following conditions:

- Breastfeeding a baby less than 6 weeks old
- Active liver disease (severe cirrhosis of the liver, a liver infection, or liver tumor)
- Systolic blood pressure 160 or higher or diastolic blood pressure 100 or higher
- Diabetes for more than 20 years or damage to your arteries, vision, kidneys, or nervous system caused by diabetes
- History of heart attack, heart disease due to blocked or narrowed arteries, or stroke OR current blood clot in the deep veins of the leg or in the lung
- Unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition,
- Current or history of breast cancer

Management of side-effects and problems of injectable contraceptives

DMPA cannot be given to all women. In particular, it is not recommended for pregnant women, or those with breast cancer, or where a client has a history of diabetes (increased blood glucose level), advanced heart or liver disease, severe hypertension (increased blood pressure), or frequent severe headaches.

If a woman comes to you with concerns associated with this injection, do not underestimate or ignore her. Reassure her that the side-effects are not dangerous. Remember that counseling after side-effects have occurred is still useful, but not best practice. The best time to counsel a client about side-effects is when they make their contraceptive method choice. This is because many women encountering side-effects may not come to you at all, so it is important that you have given them the information beforehand.

First, you should advise her to wait until the effective days of the injection have passed. Then, if she is concerned about not having her monthly period, for example, she may want to change to another method. With irregular bleeding, reassure her that it is not harmful and usually reduces or stops after the first few months of use. On the other hand, if the bleeding is profuse and continuous, you should refer her for further investigation and management at the health post or hospital, as there may be another cause.

If she is suffering from headaches, suggest she takes Aspirin (500 mg), Ibuprofen (400 mg) or Paracetamol (500 mg), as needed, and provide her with the pain killer of her choice. Be aware that Aspirin and Ibuprofen may not be tolerated by a woman with gastritis or peptic ulcer diseases. In general, if her condition is severe, or if she is unhappy with your advice, refer her to the nearest health centre or hospital.

Timing of, and techniques for, DMPA injections

When to start DMPA injections

- In the first seven days after menstrual bleeding starts.
- Six weeks after childbirth, or at any time once menstruation has returned, indicating the woman is not pregnant.
- Any time within 4 weeks after giving birth; beyond 4 weeks and monthly bleeding has not returned if your client is not breastfeeding.
- Immediately, or within seventh day after a miscarriage or abortion.
- Immediately after stopping another method.

Injectable hormonal contraceptives are different from other injections because they are administered using deep intramuscular injection techniques. The vial must be shaken strongly before it is drawn into the syringe, to ensure the active ingredient is in suspension and not in the bottom of the vial. Following the procedure, the injection site should not be massaged or pressurised, because this may accelerate absorption of the drug. Infection prevention procedures are important.

Reinjection schedule

When the client comes to you to have her next or subsequent injection, you should check your records to see when you last gave her an injection. If it is the correct appointment date, give her the injection. If she comes to you up to two weeks before her appointment or up to one month after her scheduled appointment, you can still give her the injection. But if she is more than one month late, she can get another injection that day only if you can be sure that she is not pregnant.

She is unlikely to be pregnant if:

- she has had no sex since the day of her last injection
- she has used condoms or another method every time she has had sex since the end of her last injection
- she had a baby less than six months ago, is fully, or nearly fully, breastfeeding, and has not had her period since
- She has taken emergency contraceptive pills after every sex act since her last injection.

1.8.Overview of implants

Implants are small plastic rods or capsules, each about the size of a matchstick, that release a progestin like the natural hormone progesterone in a woman's body. With this method, a trained health worker puts small, soft tubes of progestin under the skin of a woman's arm. The implant then prevents pregnancy for 3 to 5 years, depending on the type of implant. Following are the available different types of contraceptive sub-dermal Implants:

1.8.1 Norplant:

Six (6) rods implant and effective for 7 years. Its production has stopped in 2004, but those mother who had the Norplant inserted previously, can continue to use for seven years starting from date of insertion.

1.8.2. Jadelle:

Two (2) rods implant and effective for 5 years, available in a sterile pack. This method is in use in Ethiopia, and is provided by many trained health professionals in health centers and hospitals but not at health post level

1.8.3 Sino-implant:

Two (2) rods implant and effective for 4 years, available in sterile package.

1.8.4 Implanon:

Has 1 rod, and is effective for 3 years. Over the 3 years use of Implanon less than 1 pregnancy per 100 women (1 per 1,000 women) will occur. Implanon is registered in Ethiopia and has been approved by ministry of health to be provided by health extension workers at health post level.
Next you will learn more about this method, its advantage, disadvantage, how to insert and manage its side effects.

Implanon is a new implant with only one rod or capsule that can be inserted just under the skin of the upper arm to deliver progestin in to the blood stream. Implanon is easy to use and has longer protection (3 years). It covers wide range of clients and fertility returns immediately after removal. Implanon make insertion and removal much easier and produced fewer side effects for users as compared with other implants. Implanon is inserted using a special designed preloaded

applicator that eliminates the need for a separate incision. Implanon insertion takes less than one minute for trained professional

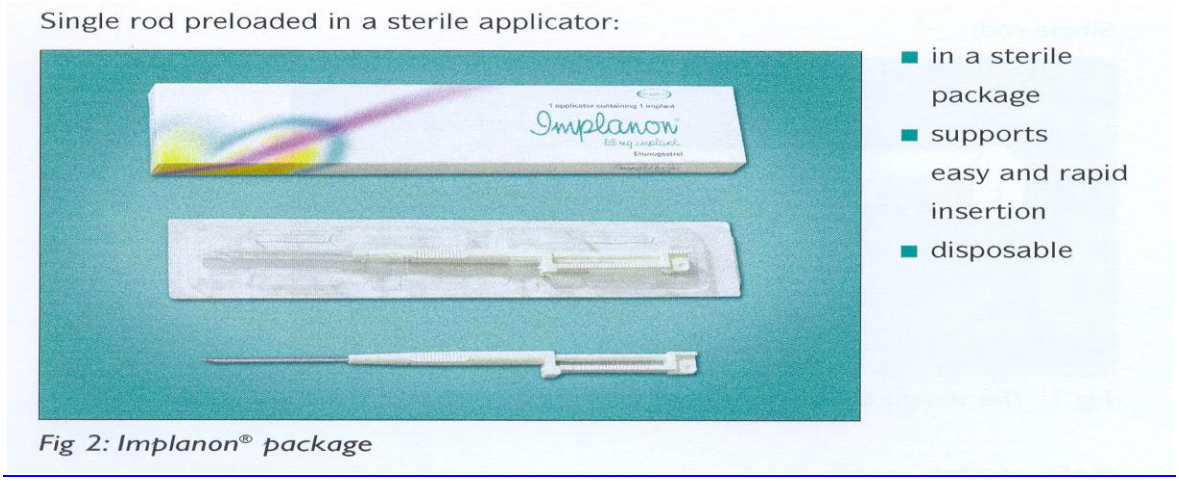


Fig 8.1. Implanon package

1.8.4.1 How effective is implanon?

Implanon provides effective, reliable and reversible contraception for a maximum of three years, after which time the implant should be removed and replaced with new one if the client still doesn't want to become pregnant and comfortable with the method. Implanon has proved to be extremely reliable in preventing pregnancy. This exceptional efficacy is mainly achieved by ovulation inhibition /ability to prevent release eggs from ovaries/, and thickening cervical mucus prevent entrance of sperm in to the uterus.

1.8.4.2 Who can use implanon?

Women of any reproductive age or parity including women who:

- Have or have not had children, or are not married
- Are of any age, including adolescents and women over 40 years old
- Have just had an abortion, miscarriage, or ectopic pregnancy
- Smoke cigarettes, regardless of age or number of cigarettes smoked
- Are breastfeeding (starting as soon as 6 weeks after childbirth)
- Have anemia now or in the past
- Have varicose veins
- Have HIV infection, whether or not taking antiretroviral medications

1.8.4.3 Who cannot use implanon?

- Breastfeeding a baby less than 6 weeks old
- Has blood clot in lungs or deep in legs.
- Ever had breast cancer.
- Unexplained vaginal bleeding: if the bleeding suggests a serious condition, help her choose a method without hormones to use until unusual bleeding is assessed.
- Serious liver disease or jaundice (yellow skin or eyes).
- Take pills for tuberculosis (TB), fungal infections, or seizures (fits).

1.8.4.4 When to start using implanon?

- She can start any day of the menstrual cycle if she is certainly sure of not pregnant
- If fully (or nearly fully) breastfeeding, can start from 6 weeks after childbirth.
- If partially breastfeeding, best to start 6 weeks after giving birth.
- After childbirth, if NOT breastfeeding: Can start immediately after childbirth
- Can start immediately after abortion or miscarriage
- If switching from pills, now is the best time to start.

1.9 Possible side-effects and its management

- Light spotting or bleeding, and irregular bleeding may be common among implanon users and this usually settled after one year.
- No monthly bleeding but not harmful
- Less common side-effects:Headaches(Can take paracetemol or ibuprofen for headache), lower abdominal pain, dizziness, breast tenderness, upset stomach (nausea), nervousness, acne or rash, change in appetite, weight gain
- Does not prevent STIs

1.10 Equipment and Instruments for Implanon Insertion

Following is the list of the equipment and instruments recommended for **Implanon insertion:**

1. Examining table for the client to rest her arm on.
2. Marker pen/optional/.
3. Soap for washing the arm.
4. Gloves.
5. One bowl for antiseptic solution
6. Antiseptic solution (iodine).
7. Sterile syringe with needle.
8. 2ml of lidocaine (1% without adrenaline),
9. Preloaded sterile Implanon and applicator containing a single rod
10. Ordinary band-aid or bandage.
11. Gauze/cotton ball.
12. Safety box
13. Gloves,

1.11 Overview of Intra uterine contraceptive device (IUCD)

The IUCD is a small object or device that is inserted into the womb by a specially trained health worker or midwife. Once in the womb, the IUD prevents the man's sperm from fertilizing the woman's egg. The IUD can stay in the womb for up to 10 or 12 years (depending on the kind of IUD it is) before it must be removed and replaced.IUDs are highly effective in providing long-term, reversible contraception.

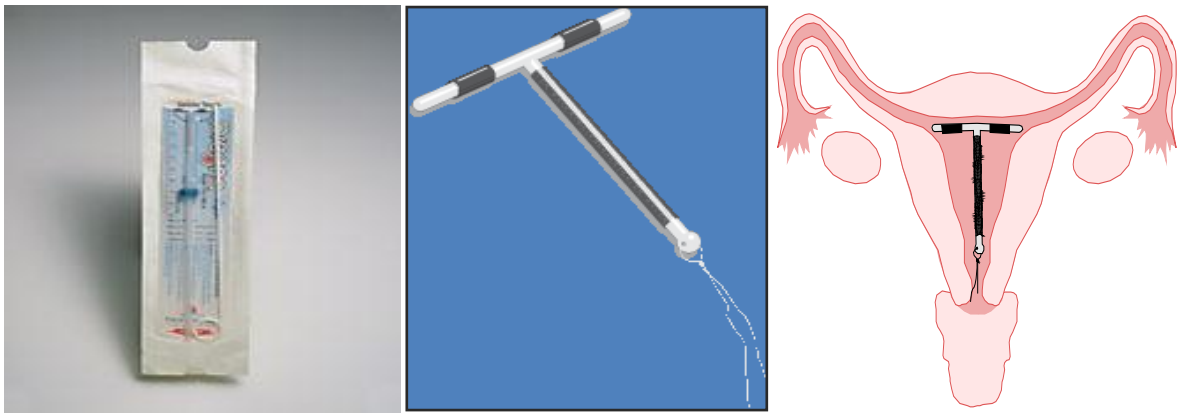


Fig 9.1. Intrauterine device

1.11.1 How effective are IUDs?

Is one of the most effective contraceptive methods with efficacy of nearly 100%. Pregnancy (failure) rate during the first year of use is less than 1 pregnancy for 100 women. Continuation rates and client satisfaction are also high. In addition, fertility returns soon after removal. In addition, IUCD is a good option for those who have to take medical precautions using hormonal methods, as there are no hormonal side effects with copper-bearing IUCDs. It does not interact with any medicine the client may be taking, so it is ideal for those who are taking antiepileptic or anti tuberculosis medications.

1.11.2 Who Can Use IUCDs?

Most women can use the Copper T IUD safely, including women who:

- Have or have not had children
- Are not married
- Are of any age
- Have just had an abortion or miscarriage (no infection)
- Are breastfeeding
- Have had PID
- Have vaginal infections
- Are infected with HIV or have AIDS and on ARVs

1.11.3 Who cannot use IUCDs?

Generally not appropriate for women:-

- With pregnancy (known or suspected)
- With unexplained vaginal bleeding
- Who is post partum between 48hrs-4wks
- With current pelvic infection
- With AIDS cases (clinically not well)

91.4 When can IUD be inserted?

- Having menstrual cycles - If starting within 12 days after the start of her monthly bleeding, no need for a backup method. If it is more than 12 days after the start of her monthly

bleeding, she can have the IUD inserted any time it is reasonably certain she is not pregnant. No need for a backup method.

- Switching from another method- immediately if the client has been using the previous method consistently and correctly or if otherwise reasonably certain she is not pregnant. No need to wait for a next monthly bleeding.
- For emergency contraception, within 5 days after unprotected intercourse. After taking emergency contraceptive pills (ECPs) (you will see in detail ECP in the next module), the same day that she finishes taking ECPs.
- No monthly bleeding – Any time if it can be determined she is not pregnant.
- Postpartum:
    - Any time within 48 hours after giving birth (requires a provider with specific training in postpartum insertion) or after 4 weeks after giving birth
    - Fully or nearly fully breastfeeding - If her monthly bleeding has not returned any time between 4 weeks and 6 months after giving birth. If more than 6 months after giving birth, any time it is reasonably certain she is not pregnant. No need for a backup method.
    - Partially breastfeeding or not breastfeeding – If more than 4 weeks since giving birth and her monthly bleeding has not returned, IUD can be inserted if it can be determined she is not pregnant. No need for a backup method.
    - Breastfeeding and monthly bleeding has returned - as advised for women having menstrual cycles
- Post abortion (after abortion or miscarriage) immediately or within 12 days if no infection is present. Beyond 12 days after abortion or miscarriage, anytime it is reasonably certain that she is not pregnant. If infection is present, after the infection has completely cleared.

9.1.4 How are IUDs inserted and removed?

You will not be expected to insert or remove IUCDs. These procedures should be performed only by service providers who have been trained, such as physicians, nurses and midwives. However, it is important for you to understand counseling clients on available options and refer to nearby health facilities if the woman chooses the method.

1.11.4 Side effects (that are temporary and not dangerous)

Changes in bleeding patterns (especially in the first 3 to 6 months) including:

- Prolonged and heavy monthly bleeding, irregular bleeding, more cramps and pain during monthly bleeding are expected with copper IUDs and usually become less over time.
- May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding
- Pelvic inflammatory disease (PID) may occur if the woman has Chlamydia or gonorrhea at the time of IUD insertion.

1.12 Emergency Contraceptive

Emergency contraception also called postcoital contraception is a form of birth control that may be used by women who have had unprotected sex or used a birth control method that failed. The method generally is reserved for specific situations and is not a regular method of birth control. Emergency contraception is used to prevent a pregnancy, not end one. Emergency contraception does not protect against sexually transmitted diseases.

Emergencies include

- When no contraceptive has been used
- When there is a contraceptive accident or misuse, including:
- Condom rupture, slippage, or misuse
- Diaphragm or cap dislodgment, breakage or tearing, or early removal.
- Failed coitus interrupts, withdrawal, (e.g., ejaculation in vagina or on external genitalia).
- Miscalculation of the periodic abstinence method.
- IUCD expulsion
- Returned for DMPA injection later than four weeks
- After sexual assault or rape

1.12.1 Types of Emergency contraceptive methods

Emergency Contraception is broadly divided in to two categories;

1. Hormonal pills ,known as emergency contraceptive pills (ECPs)
2. copper-bearing intrauterine contraceptive devices (IUCD)

1.12.2 Emergency contraceptive pills (ECPs)

Are hormonal methods of contraception that can be used to prevent pregnancy following an unprotected act of sexual intercourse. ECPs are sometimes referred to as "morning after" or "postcoital" pills. These terms have been replaced by the term "emergency contraceptive pills" because they do not accurately convey the correct timing of use. ECPs can be used up to five days following unprotected intercourse (120 hours). ECPs should not be used as a regular or on-going method of contraception. They are intended for "emergency" use only.

There are two types of emergency contraceptive pills

A. Pills containing a combination of a progestin and an estrogen
B. Pills containing a progestin only

How it Works

The precise mechanism of action of ECPs is uncertain and may be related to the time it is used in a woman's cycle. ECPs are thought to prevent ovulation, fertilization, and/or implantation. ECPs are not effective once the process of implantation of a fertilized ovum has begun. **ECPs will not cause an abortion** and have no known adverse effects on (the growth and development of) an established pregnancy.

Effectiveness of ECP

- Effectiveness of ECPs depends on how soon after unprotected intercourse they are taken. The sooner they are taken, the more effective they are.
- The use of combined oral contraceptives for emergency contraception reduces the risk of pregnancy by about 75%.
- The progestin-only regimen reduces the risk of pregnancy by about 85% after a single act of intercourse. This means, if 100 women had unprotected sex, about 8% would become pregnant compared to only 1% POP ECPs were taken.

Overall, ECPs are less effective than regular contraceptive methods. Because the ECP pregnancy rate is based on a one time use, it cannot be directly compared to failure rates of regular contraceptives, which represent the risk of failure during a full year of use. If ECPs were to be used frequently, the failure rate during a full year of use would be higher than those of regular hormonal contraceptives. Therefore, ECPs are not recommended for regular use. Additional factors determining effectiveness are timing of the two doses and exposure to repeated unprotected intercourse following ECP therapy before the return of menses

Side effects (that are temporary and not dangerous)

Changes in bleeding patterns including:

- Light vaginal bleeding for 1–2 days after taking ECPs
- Monthly bleeding that starts earlier or later than expected

In the week after taking ECPs: nausea, abdominal pain, fatigue, headache, breast tenderness, dizziness and vomiting (less frequent with progestin-only formulations)

Who can use ECPs?

All women can use ECPs safely and effectively, including women who cannot use ongoing hormonal contraceptive methods. Because of the short-term nature of their use, there are no medical conditions that make ECPs unsafe for any woman

When to use ECPs?

ECPs can be used any time a woman is worried that she might become pregnant within 5 days of unprotected sex. The sooner after unprotected sex that ECPs are taken, the more effective they are.

There are two types of ECP regimen in use:

1. Combined oral contraceptive pills: contain ethinyl estradiol and levonorgestrel or comparable formulations.
    - When high-dose pills containing 50 µg (micrograms) of ethinyl estradiol and 0.25 mg of levonorgestrel are available, two pills should be taken as the first dose as soon as convenient, but not later than five days (120 hours) after unprotected intercourse. The second two pills should follow 12 hours later.
    - When low-dose pills containing 30 µg ethinyl estradiol and 0.15 mg of levonorgestrel are available, four pills should be taken as the first dose as soon as

convenient but not later than five days (120 hours) after unprotected intercourse, to be followed by another four pills 12 hours later.

2. Progesterone-only pills:
   - When pills containing 0.75 mg of levonorgestrel are available, one pill should be taken as the first dose as soon as convenient, but not later than five days (120 hours) after unprotected intercourse, to be followed by another one pill 12 hours later.
   - When pills containing 0.03 mg of levonorgestrel are available, 20 pills should be taken as the first dose as soon as convenient but not later than five days (120 hours) after unprotected intercourse, to be followed by another 20 pills 12 hours later.

1.13 Copper-bearing intrauterine contraceptive devices (IUCD)

A Copper-T IUD can also keep the egg from attaching to the womb wall. The IUD must be inserted by a specially trained health worker within 5 days after having unprotected sex. The IUD can be kept in and continue to protect a woman from pregnancy for up to 10 or 12 years. Or she can have the IUD removed after her next monthly bleeding when it is certain she is not pregnant.

Mechanism of action

As emergency contraception, the copper-bearing IUD primarily prevents fertilization by causing a chemical change that damages sperm and egg before they can meet.

Effectiveness

IUCDs are highly effective as ECs. After unprotected sexual intercourse, less than 1% of women are reported to become pregnant if they use a copper-releasing IUCD as an EC. The client prefers using an IUCD for continuous, long-term contraception

Disadvantages

- It does not work if women are already pregnant.
- It has a limited time frame of 5 days following unprotected intercourse.
- Women still have a small chance of getting pregnant.
- IUCD insertion requires a trained professional.
- Does not provide protection from sexually transmitted infections

Self-Check -2	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. List all natural family planning methods with their advantages.
2. List indication and contraindication of IUCD
3. What is emergency contraceptive and when to use?
4. What is special advantage of using condom as contraceptive ?
5. List advantages of progesterone only contraceptive.

3..1. Men

Important Supporters, Important Clients

Providers can give support and services to men both as supporters of women and as clients.

Encourage Couples to Talk

Couples who discuss family planning— or without a provider's help—are more likely to make plans that they can carry out. Providers can:

- Coach men and women on how to talk with their partners about sex, family planning, and STIs.
- Encourage joint decision-making about sexual and reproductive health matters.

- Invite and encourage women to bring their partners to the clinic for joint counseling, decision-making, and care.
- Encourage the man to understand and support his partner to choose the contraceptive method she prefers.
- Encourage the man to consider taking more responsibility for family planning—for example, by using condoms or vasectomy.
- Suggest to female clients that they tell their partners about health services for men. Give informational materials to take home, if available.

Provide Accurate Information

To inform men's decisions and opinions, they need correct information and correction of misperceptions. Topics important to men include:

- Family planning methods, both for men and for women, including safety and effectiveness
- STIs including HIV—how they are and are not transmitted, signs and symptoms, testing, and treatment

- The benefits of waiting until the youngest child is 2 years old before a woman becomes pregnant again
- Male and female sexual and reproductive anatomy and function

Offer Services or Refer

Important services that many men want include:

- Male condoms and vasectomy services
- Information and counseling about other contraceptive methods, particularly methods that must have male cooperation, such as fertility awareness-based methods and female condoms
- Counseling and help for sexual problems
- STI/HIV counseling, testing, and treatment
- Infertility counseling
- Screening for penile, testicular, and prostate cancer

Like women, men of all ages, married or unmarried, have their own sexual and reproductive health needs. They deserve good-quality services and respectful, supportive, and nonjudgmental counseling.

1.1. Women Near Menopause

A woman has reached menopause when her ovaries stop releasing eggs (ovulating). Because bleeding does not come every month as menopause approaches, a woman is considered no longer fertile once she has gone 12 months in a row without having any bleeding.

Menopause usually occurs between the ages of 45 and 55. About half of women reach menopause by age 50. By age 55 some 96% of women have reached menopause.

To prevent pregnancy until it is clear that she is no longer fertile, an older woman can use any method, if she has no medical condition that limits its use. By itself, age does not restrict a woman from using any contraceptive method.

Special Considerations about Method Choice

When helping women near menopause choose a method, consider:

Combined hormonal methods

- Women age 35 and older who smoke—regardless of how much— should not use COCs.

- Women age 35 or older should not use COCs if they have migraine headaches (whether with migraine aura or not).

Progestin-only methods (progestin-only pills, progestin-only injectables, implants)

- A good choice for women who cannot use methods with estrogen.
- During use, DMPA decreases bone mineral density slightly. This may increase the risk of developing osteoporosis and possibly having bone fractures later, after menopause. WHO has concluded that this decrease in bone mineral density does not place age or time limits on use of DMPA.

Emergency contraceptive pills

- Can be used by women of any age, including those who cannot usehormonal methods on a continuing basis.

Female sterilization and vasectomy

- May be a good choice for older women and their partners who know they will not want more children.
- Older women are more likely to have conditions that require delay, referral, or caution for female sterilization

Male and female condoms, diaphragms, spermicides, cervical caps, and withdrawal

- Protect older women well because of women's reduced fertility in the years before menopause.
- Affordable and convenient for women who may not have sex often.

Intrauterine device (copper-bearing IUDs and LNG-IUDs)

- Expulsion rates fall as women grow older and are lowest in women over 40 years of age.
- Insertion may be more difficult due to tightening of the cervical canal.

Fertility awareness methods

- Lack of regular cycles before menopause makes it more difficult to use these methods reliably.

When a Woman Can Stop Using Family Planning

It is recommended to continue using a family planning method until 12 months with no bleeding have passed. No longer needs contraception once she has had no bleeding for 12 months in a row. *Copper-bearing IUDs* can be left in place until after menopause. The IUD should be removed 12 months after a woman's last monthly bleeding.

Relieving Symptoms of Menopause

Women experience physical effects before, during, and after menopause: hot flashes, excess sweating, difficulty holding urine, vaginal dryness that can make sex painful, and difficulty sleeping.

Providers can suggest ways to reduce some of these symptoms:

- Deep breathing from the diaphragm may make a hot flash go away faster. A woman can also try eating foods containing soy or taking 800 international units per day of vitamin E.
- Eat foods rich in calcium (such as dairy products, beans, fish) and engage in moderate physical activity to help slow the loss of bone density that comes with menopause.
- Vaginal lubricants or moisturizers can be used if vaginal dryness persists and causes irritation. During sex, use a commercially available vaginal lubricant, water, or saliva as a lubricant if vaginal dryness is a problem.

1.2. Clients with Disabilities

Health care providers should treat people with disabilities in the same way that they should treat people without disabilities: with respect. People with disabilities are at increased risk of being infected with HIV and other STIs. Many have been sterilized against their will, forced to have abortions, or forced into unwanted marriages, and many have experienced gender-based violence.

To counsel clients with disabilities, health care providers need to consider their preferences and the nature of their disability. For example, barrier methods may be difficult for some people with a physical disability, and women with an intellectual

disability may have trouble remembering to take a pill each day or dealing with changes in monthly bleeding.

Like all clients, people with disabilities need sexual and reproductive health education to make informed choices. People with intellectual disabilities have the same rights as other people to make their own decisions about contraception, including sterilization. They may need special support to do so. For a client with an intellectual disability who is unable to communicate her or his preferences clearly, someone whom the client trusts should participate and help to make an informed choice that is as consistent as possible with the client's preference. Especially for the choice of sterilization, health care systems should ensure that a process of supported decision-making is available.

To care for people with disabilities, programs should make it known in the community that they serve people with disabilities without discrimination. Facilities should be made physically accessible—for example, with ramps for wheelchairs and large bathrooms with grab bars. Outreach programs should make a special effort to identify and reach people in the community who have limited mobility. Print materials should have simple graphics, large print, and Braille, if possible, and information should be available in audio formats, such as CD or cassette tape, as well as in print. Providers may need especially to demonstrate actions as well as describing them, to speak slowly, and to pause often and check comprehension.

1.3. Sexually Transmitted Infections, Including HIV

Family planning providers can help their clients in various ways to prevent STIs, including infection with the human immunodeficiency virus (HIV).

What Are Sexually Transmitted Infections?

STIs are caused by bacteria, viruses, and parasites spread through sexual contact. Infections can be found in body fluids such as semen, on the skin of the genitals and areas around them, and some also in the mouth, throat, and rectum. Some STIs cause no symptoms. Others can cause discomfort or pain. If not treated, some can cause pelvic inflammatory disease, infertility, chronic pelvic pain, and cervical cancer. Some STIs can also greatly increase the chance of becoming infected with HIV.

STIs spread in a community because an infected person has sex with an uninfected person. The more sexual partners a person has, the greater his or her risk of either becoming infected with STIs or transmitting STIs.

Who Is at Risk?

Sexual behavior that can increase exposure to STIs includes:

- Sex with a partner who has STI symptoms
- Sex with a partner who has recently been diagnosed with or treated for an STI
- Sex with more than one partner—the more partners, the more risk
- Sex with a partner who has sex with others and does not always use condoms
- Sex without a condom with almost any new partner in a community where many people have STIs

What Causes STIs?

Several types of organisms cause STIs. Those caused by organisms such as bacteria generally can be cured. STIs caused by viruses generally cannot be cured, although they can be treated to relieve symptoms

STI	Type	Sexual transmission	Nonsexual transmission	curable
Chancroid	Bacteria	Vaginal, anal, and oral sex	None	Yes
Chlamydia	Bacteria	Vaginal and anal sex Rarely, from genitals to mouth	From mother to child during pregnancy	Yes
Gonorrhea	Bacteria	Vaginal and anal sex, or contact between mouth and genitals	From mother to child during delivery	Yes
Hepatitis B	Viral	Vaginal and anal sex, or from penis to mouth	In blood, from mother to child during delivery or in breast milk	No
Herpes	Viral	Genital or oral contact with an ulcer, including vaginal and anal sex; also genital contact in area without ulcer	From mother to child during pregnancy or delivery	No
HIV	Viral	Vaginal and anal sex Very rarely, oral sex	In blood, from mother to child during pregnancy or delivery or in breast milk	No
Human papilloma virus	Viral	Skin-to-skin and genital contact or contact between	From mother to child during delivery	No

		mouth and genitals		
Syphilis	Bacteria	Genital or oral contact with an ulcer, including vaginal and anal sex	From mother to child during pregnancy or delivery	Yes
Trichomoniasis	Parasite	Vaginal, anal, and oral sex	From mother to child during delivery	Yes

Common signs and symptoms that may suggest an STI include:

Symtoms	**Possible cause**
Discharge from the penis—pus, clear or yellow-green drip	Commonly: Chlamydia, gonorrhea Sometimes: Trichomoniasis
Abnormal vaginal discharge or pain during sex	Chlamydia, gonorrhea, pelvic inflammatory disease
Lower abdominal pain or pain during sex	Chlamydia, gonorrhea, pelvic inflammatory disease
Swollen and/or painful testicles	Chlamydia, gonorrhea
Itching or tingling in the genital area	Commonly: Trichomoniasis Sometimes: Herpes
Blisters or sores on the genitals, anus, surrounding areas, or mouth	Herpes, syphilis, chancroid
Warts on the genitals, anus, or surrounding areas	Human papillomavirus
Unusual cervical discharge— changes from normal vaginal discharge in color, consistency, amount, and/or odor	Most commonly: Bacterial vaginosis, candidiasis Commonly: Trichomoniasis Sometimes: Chlamydia, gonorrhea

Avoiding Sexually Transmitted Infections

Family planning providers can talk to clients about how they can protect themselves both from STIs, including HIV, and pregnancy (dual protection).

Choosing a Dual Protection Strategy

Every family planning client needs to think about preventing STIs, including HIV—even people who assume they face no risk. A provider can discuss what situations place a person at increased risk of STIs, including HIV and clients can think about whether these risky situations come up in their own lives. If so, they can consider 5 dual protection strategies.

One person might use different strategies in different situations; one couple might use different strategies at different times. The best strategy is the one that a person is able

to practice effectively in the situation that she or he is facing. (Dual protection does not necessarily mean just using condoms along with another family planning method.)

Strategy 1: Use a male or female condom correctly with every act of sex.

- One method helps protect against pregnancy and STIs, including HIV.

Strategy 2: Use condoms consistently and correctly plus another family planning method.

- Adds extra protection from pregnancy in case a condom is not used or is used incorrectly.
- May be a good choice for women who want to be sure to avoid pregnancy but cannot always count on their partners to use condoms.

Strategy 3: If both partners know they are not infected, use any family planning method to prevent pregnancy and stay in a mutually faithful relationship.

- Many family planning clients are in this group and thus are protected from STIs, including HIV.
- Depends on communication and trust between partners. Other strategies, which do not involve using contraceptives, include:

Strategy 4: Engage only in safer sexual intimacy that avoids intercourse or otherwise prevents semen and vaginal fluids from coming in contact with each other's genitals.

- This strategy will not prevent syphilis, genital herpes, or infection with human papillomavirus. These spread through skin-to-skin contact.
- Depends on communication, trust, and self-control.
- If this is a person's first-choice strategy, it is best to have condoms on hand in case the couple does have sex.

Strategy 5: Delay or avoid sexual activity (either avoiding sex any time that it might be risky or abstaining for a longer time).

- If this is a person's first-choice strategy, it is best to have condoms on hand in case the couple does have sex.
- This strategy is always available in case a condom is not at hand.

People at high risk of exposure to HIV can take PrEP—preexposure prophylaxis—to prevent HIV infection. PrEP consists of some of the same ARV drugs also used to treat infection. Hormonal contraceptives and PrEP can be taken at the same time. The

effectiveness of the contraception and of PrEP are not affected. Condom use while taking PrEP will help prevent both HIV and other STIs.

Contraceptives for Clients with STIs, Including HIV

People with STIs and people with HIV, whether or not they are taking antiretroviral (ARV) therapy, can start and continue to use most contraceptive methods safely. There are a few limitations, however. See the table below.

Special Family Planning Considerations for Clients with STIs, including HIV

Method	Has STIs	Has HIV
Intrauterine device (copperbearing IUD or LNG-IUD)	Do not insert an IUD in a woman who is at very high individual risk for gonorrhea and chlamydia, or who currently has gonorrhea, chlamydia, purulent cervicitis, or PID. (A current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUD during and after treatment.)	A woman with HIV clinical disease that is mild or with no symptoms, including a woman on ARV therapy, can have an IUD inserted. Generally, a woman should not have an IUD inserted if she has HIV clinical disease that is severe or advanced (WHO Stages 3 or 4). A woman using an IUD who becomes infected with HIV or whose HIV clinical disease becomes severe or advanced (WHO Stages 3 or 4) can safely continue using the IUD. A woman using an IUD can keep the IUD in place when she starts ARV therapy.
Female sterilization	If client has gonorrhea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured.	Women with HIV, including women on ARV therapy, can safely undergo female sterilization. The procedure may need to be delayed if she currently has an HIV-related illness.
Vasectomy	If client has scrotal skin infection, active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured.	Men who are living with HIV, including men on ARV therapy, can safely undergo vasectomy. The procedure may need to be delayed if he currently has an HIV-related illness.
Spermicides (including when used with diaphragm or cervical cap)	Can safely use spermicides.	Should not use spermicides if at high risk of HIV. Generally, should not use spermicides if she has HIV infection.
Progestin-only pills, injectables,	Can safely use progestin-only methods	Can safely use progestin only methods..

and implants		

Self-check 3	**Written test**

Directions: Answer all the questions listed below.

Part II say "True" if the statement is correct or "False" if the statement is incorrect (1 point each 5x1= 5%).

1. Providers can give support and services to men both as supporters of women and as clients.
2. DMPA decreases bone mineral density slightly there for women near menopause are not allowed to use DMPA.
3. Dual protection does not necessarily mean just using condoms along with another family planning method.)
4. A current IUD user who becomes infected with gonorrhea or chlamydia or develops PID can safely continue using an IUD during and after treatment.)
5. A woman using an IUD should be removed if infected with HIV or whose HIV clinical disease becomes severe or advanced (WHO Stages 3 or 4).

Part II. Choose the correct answer for the following alternatives (each 2 point 2x2=4%)

1. Which method is more difficult to use for a women near a menopause?
   A. Progestin only methods
   B. Intrauterine devise
   C. Fertility awareness method
   D. Female sterilization and vasectomy
2. Which method is difficult to use for a women with an intellectual disability
   A. Oral contraceptives (Pills)
   B. injectables
   C. Implants
   D. Intrauterine device

Part III. Give short and correct answer for the following essay item questions (5 point)

1. List and discuss the types of dual Protection Strategy

4.1. Family planning for people with special needs

Introduction

clients who may need special counselling or advice Unfortunately, a large number of women who wish to delay or prevent future pregnancies receive little or no information on safe, available, effective contraceptives for postpartum and post abortion use, including: how or where to obtain contraceptives and how soon after childbirth or abortion contraceptive methods should be initiated. To achieve the healthiest pregnancy outcomes, couples should wait at least two years after a live birth and at least six months after a miscarriage or abortion before trying to become pregnant again. Postpartum, post abortion, you ng people and clients with HIV have particular needs related to initiation of FP use, as well as emotional needs related to their personal circumstances (e.g., worries, stress or pain they might be experiencing).

Permanent FP methods, also called voluntary surgical contraception are among the most effective, popular and well-established contraceptive method options available for men and women who desire no more children.

In the previous study session of this module you have learned about different family planning methods.

1.1 **Overview of postpartum, post abortion and permanent family planning methods**

The **postpartum period** is defined as the year after childbirth. It is a time of transition, adjustment, and adaptation along with significant biological, social, and psychological changes.

In terms of changes in the woman's body, the postpartum period starts from the first minutes after delivery of a baby and placenta (you will see this in detail in your post natal module).

Postpartum contraception is the initiation and use of family planning methods in the first year after delivery to prevent unintended pregnancy particularly in the first 1-2 years after childbirth, when another pregnancy can be harmful to the mother or a breastfeeding baby.

Post abortion contraception is the initiation and use of family planning methods, most often immediately after treatment for abortion - within 48 hours, or before fertility returns (2 weeks post abortion). The objective is to prevent unintended pregnancies, particularly for women who do not want to be pregnant and may undergo a subsequent unsafe abortion if contraception is not made available during this brief and vulnerable interval.

Permanent/ voluntary surgical contraception are methods that make it almost impossible for a man or a woman to have any children. Since these operations are permanent, they are only good for those women or men who are certain that they do not want any more children.

1.2 Postpartum Family Planning

The postpartum period is a critical time for appropriate health interventions, as the majority of maternal and infant deaths and illness occur during this period. Women in their first year

postpartum and their families are a priority group to reach with family planning information and services. For this reason, it is important to systematically integrate family planning services with maternal, newborn, and infant services.

1.3 Return to Fertility after Childbirth

The timing of a woman's return to fertility after childbirth is difficult to predict and depends on her circumstances and breastfeeding schedule. It is important for postpartum women to initiate use of a family planning method before their fertility returns in order to avoid an unintended or mistimed pregnancy.

Breastfeeding women

For postpartum women who breastfeed exclusively (breastfeed often, on demand, 8 to 10 times a day, without giving any other liquids or foods to the baby), have no menses, and have an infant less than 6 months of age—which are the 3 criteria for the lactational amenorrhea method, or LAM there is a 1% risk of conception. Once 1 of these 3 criteria is no longer present, the woman is no longer protected from pregnancy.

Non- breastfeeding women

On average, women who do not breastfeed ovulate by the 45th day after childbirth, and possibly as soon as the 28th day after childbirth. Fertility begins prior to return of menses in 2 out of 3 women.

Women who are partially breastfeeding

Women who are partially breastfeeding are not using LAM and, therefore, are not protected from pregnancy. Return to fertility may occur prior to resumption of menses.

1.4 Postpartum Family Planning Counseling Messages

- Promote optimum health by advising exclusive breastfeeding and using LAM, which is 99% effective when used correctly
- Discuss health benefits to the mother and baby of waiting at least 24 months before trying to become pregnant again.
- Discuss return to sexual activity and provide information about return to fertility.

A woman who is not exclusively breastfeeding is able to become pregnant as soon as 4 to 6 weeks after childbirth. An exclusively breastfeeding mother may become pregnant as soon as 6 months postpartum. Advise that, for maximum protection, a woman should not wait until the return of monthly bleeding to start a contraceptive method, but instead she should start as soon as medical guidance allows. So offering and discussing family planning options for postpartum women is important; including long-term and permanent methods according to the client's wishes.

1.4 **When Postpartum Women Can Start Family Planning Methods**?

When a woman should and can start family planning methods after childbirth depends on her breastfeeding status, method of choice and reproductive goals

Table 11.1.Summary of earliest times a client may start family planning after childbirth

Family planning method	Exclusive breast feeding	Partially breast feeding or not breast feeding
Lactational Amenorrhea method	Immediately	Not applicable because it cannot prevent pregnancy
Male or female condoms	Immediately	Immediately
Progestin-only pills	6 weeks after childbirth	Immediately if not breastfeeding 6 weeks after childbirth if partially breastfeeding
Progestin-only injectables		
Implants		
Combined oral contraceptives(COCs)	6 months after childbirth	21 days after childbirth if not breastfeeding 6 months after childbirth if partially breastfeeding
Copper-bearing IUCD	Within 48 hours, otherwise wait 4 weeks	Within 48 hours, otherwise wait 4 weeks

2 .Post abortion Family Planning

Women who have just experienced abortion or who have just been treated for post abortion complications need immediate and easy access to family planning services. Ideally, for post abortion clients, counseling before the procedure can only be an option if the client is not under stress related to the procedure. This allows the client to receive her method of choice immediately after the procedure (immediate post abortion) should she choose a post abortion IUD. However, in this case, the stress that the client is experiencing may impair sound decision making. With such clients, the provider has the responsibility to confirm that they are making an informed, voluntary, and sound decision.

The next appropriate opportunity to counsel such a client is after the procedure but before she leaves the facility. At this point, it may be too late to provide some methods (such as the IUD) at the end of the procedure, but this may help ensure that a client gets her method of choice before discharge or returns later to get it at follow-up.

Factors contributing to repeat unsafe abortions

- Lack of recognition of the problem of unsafe abortion and clients' needs for family planning
- Lack of family planning services for some groups, for example, adolescents
- Family planning services not integrated with post abortion emergency service

2.1 Post abortion Counseling

A woman who has had an abortion needs support. A woman who has faced the double risk of pregnancy and unsafe induced abortion especially needs help and support.

Good counseling gives a post abortion client much needed support. In particular, the counselor should

- Try to understand what the client has been through
- Treat her with respect and avoid judgment and criticism
- Ensure privacy and confidentiality
- Ask if she wants someone she trusts to be present during counseling.

2.2 Post abortion counseling messages

A woman has important choices to make after receiving post abortion care. To make decisions about her health and fertility, she needs to know:

- Fertility returns quickly within 11 days after a first-trimester abortion or miscarriage and within 4 weeks after a second- trimester abortion or miscarriage. Therefore, she needs protection from pregnancy almost immediately.
- She can choose from among many different family planning methods that can be started at once. Methods that women should not use immediately after giving birth pose no special risks after abortion.
- She can wait before choosing a contraceptive method for ongoing use, but she should consider using a backup method in the meantime if she has sex. If a woman decides not to use contraceptives at this time, providers can offer information on available methods and where to obtain them. Also, providers can offer condoms, oral contraceptives, or emergency contraceptive pills for women to take home and use later.
- To avoid infection, she should not have sex until bleeding stops—about 5 to 7 days. If being treated for infection or vaginal or cervical injury, she should wait to have sex again until she has fully healed.
- She should wait at least 6 months before trying to become pregnant. Waiting at least 6 months reduces the chances of low birth weight, premature birth, and mate

2.2.**When to Start Contraceptive Methods after Abortion**

Post abortion, the following methods can be started immediately

- Combined oral contraceptives
- Progestin-only pills
- Progestin-only injectables
- Contraceptive implants
- Male and female condoms
- IUCDs if no infections

2.3 Family planning for young people

Young people embrace the age group 10-24 and in general, they are eligible to use any method of contraception and must have access to a variety of contraceptive choices. Age alone does not constitute a medical reason for denying any method to and specific attributes of the different FP methods shall be discussed during counseling.

IEC messages shall be gender and age-oriented and recognize the special needs of young people. Good counseling and support is particularly essential. Ensuring privacy and confidentiality is particularly important. Youth that are not sexually active should get information and education on FP.

3. Combined oral contraceptives (COCs)

COCs are appropriate and safe for young people. Many young people choose a COC because this method has a low failure rate and also offers relief from dysmenorrhea (pain during menstruation). It is a straightforward method that does not interfere with sexual intercourse. This is a good method for you to recommend when it is clearly appropriate for the girl; the particular COC you would suggest will depend on what is available. Some pills are more estrogen dominant and others are more progestin-dominant. A COC with more progestin is helpful for girls who have painful and excessive menstrual bleeding. To decrease failure rate it has to be

taken regularly. You should also encourage condom use in addition to COCs for STI/HIV protection.

3.1 Progestin-only pills (POPs)

POPs are appropriate and safe for young girls. But POPs must be taken daily at approximately the same time every day to be effective in preventing pregnancy, because the progestin levels in the blood peak about two hours after they are taken and then rapidly decline. If a girl is three hours late taking the pill, she will not be protected and so she should use a back-up form of contraception. POPs may not be the best choice for young girls who cannot remember to take POPs at the same time every day. POPs are a good choice for girls who cannot tolerate the estrogen in COCs or have a medical contraindication to the use of COCs.

3.2 Depo-Provera (DMPA) injectable contraceptive

DMPA is a safe and appropriate method for young girls and is particularly good for those who might have difficulty remembering when to take oral contraceptives. Since it may be difficult for young people to remember to return at regular intervals it may be helpful to use a reminder system that encourages clients to return 12 weeks after the previous injection. This allows for a two-week grace period where the injection can still be given up to 14 weeks without fear of pregnancy. DMPA does not protect against STIs/HIV; therefore you should encourage condom use as well.

3.3. Implants

Implants are safe and appropriate for young girls and can be safely used by those who are infected with HIV or have AIDS, or are on antiretroviral (ARV) therapy. However you should urge these women to use condoms with implants.

10.4.5. Intra-uterine contraceptive devices (IUCDs)

IUCDs are appropriate for adolescents in stable, mutually monogamous marriages. Women under the age of 20 who have not given birth appear to have greater risk of expulsion and painful menstruation (monthly periods). After you inform them of the characteristics of IUCDs and counsel them, if adolescents who are married would like to use this method, you should refer them to the nearest health centre for further counseling and service provision.

10.4.6. Condoms

Condoms are safe and appropriate for young people. Because they are available without a prescription and provide protection against STIs/ HIV, they are a good method.

3.1 Family Planning for clients with HIV

FP service providers should respect the right of PLWH and help them to achieve their reproductive needs. Avoiding unwanted pregnancy in HIV positive women using FP is one of the four prongs of preventing mother to child transmission of HIV. Couples with HIV have a wide range of methods from which to choose. HIV-positive clients need continuing protection from other STIs and from HIV re-infection. Correct and consistent condom use, alone or with another method, protects against both pregnancy and infection. Generally, with very limited exceptions, almost any method of contraception can be used by clients with HIV.

3.2Permanent family planning methods

For individuals and couples desiring no more children, permanent family planning provides the most effective protection against pregnancy. It offers the advantage over other contraceptive methods that it is a once-only procedure. The need for continued contraceptive supplies is eliminated. Globally permanent method of contraception is the most popular and commonly used method of contraception, but is the least utilized in Ethiopia

Following effective counseling and improving the availability and quality of service in Permanent methods of contraception, it is possible to improve the acceptability of the methods in the community.

Mechanism of action

The voluntary surgical contraception (VSC) procedure blocks either the sperm ducts (Vasa deferentia) or the oviducts (fallopian or uterine tubes) to prevent the meeting of sperm and ovum, which makes fertilization and pregnancy impossible. The procedure for male is called vasectomy where as for female it called tubal ligation. As part of your family planning counseling you have to include this method as option during your counseling session for family planning methods available

Self-Check -4	Written Test

Directions: Answer all the questions listed below. Use the Answer sheet provided in the next page:

1. Define natural family planning methods and their types
2. What is the special advantage of condom that makes it unique from other methods?
3. What are Contraindication and indication for COC?
4. What do you counsel for women who preferred to use ingestible contraceptive methods?
5. Who is eligible to use implanon?
6. To whom IUCD is indicated?
7. List down situations in which ECPs are needed
8. What is postpartum family planning?

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

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

Answer Sheet

Score = _____

Rating: _____

Name: _____ Date: _____

Operation Sheet 1	Family planning counseling

Steps in counseling

REDI are a useful memory aid to help us to remember the basic steps in the counseling process and to add structure to complex activity. It can be adapted to meet each individual client's needs. Many steps in REDI and GATHER overlap. Rapport building generally corresponds to Greet, with elements of Ask/Assess. Exploration incorporates Ask/Assess and Tell. Decision making includes the Help step and also elements of Ask/Assess and Tell. Implementing the decision includes Help, Explain, and Return Visit

Counseling session:

Phases and steps of REDI

R= Rapport building

E= Exploration

D= Decision making

I= Implementing the decision

Step 1.Rapport Building

- Greet client with respect return
- Make introduction
- Assure confidentiality and privacy
- Explain the need to discuss sensitive and personal issues

Step 2: Exploration

Explore in depth the client's reason for the visit

For new clients:
▶ Explore client's future RH-related plans, current situation, and past experience
▶ Explore client's reproductive history and goals, while explaining healthy timing and spacing of pregnancy
▶ Explore issues related to sexuality
▶ Explore client's history of STIs, including HIV
▶ Explain STI risk and dual protection, and help the client perceive his or her risk for contracting and transmitting STIs
▶ Focus your discussion on the method(s) of interest to client: discuss the client's preferred method, if any, or relevant FP options if no method is preferred, give information as needed, and correct misconceptions
▶ Rule out pregnancy and explore factors related to monthly bleeding, any recent pregnancy and medical conditions

For returning clients:
▶ 1. Explore the client's satisfaction with the current method used. Confirm if clients were given all the options while they made the decision. If not, tell all the available options.
▶ 2. Confirm correct method use
▶ 3. Ask the client about changes in his or her life (i.e., plans about having children, STI

risk and status,

- 4. For dissatisfied clients only: explore the reasons for the client's dissatisfaction or the problems, including the issue, causes, and possible solutions such as switching methods as well as other options

Step 3: Decision Making

- Identify the decisions the client needs to confirm or make (for satisfied clients, check if client needs other services
- Explore relevant options for each decision
- Help the client weigh the benefits, disadvantages, and consequences of each option
- Encourage the client to make his or her own decision

Step 4: Implementing the Decision

- Assist the client in making a concrete and specific plan for carrying out the decision(s) (obtaining and using the FP method chosen, risk reduction for STIs, dual protection, and so on)
- Have the client develop skills to use his or her chosen method and condom
- Identify barriers that the client might face in implementing his or her decision
- Develop strategies to overcome the barriers
- Make a plan for follow-up and/or provide referrals as needed

Operation sheet 2	How to use male condom

1. Use a new condom for each act of sex

2. Check the condom package. Do not use if torn or damaged. Avoid using a condom past the expiration date—do so only if a newer condom is not available. Tear open the package carefully (**Figure 1)**. Do not use fingernails, teeth, or anything that can damage the condom

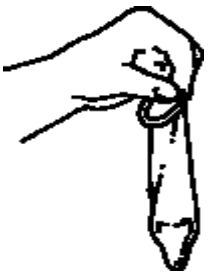
3. Before any physical contact, place the condom on the tip of the erect penis with the rolled side out

If the man is not circumcised, pull the foreskin back. Squeeze the tip of the condom and put it on the end of the hard penis. For the most protection put the condom on before the penis makes any genital, oral, or anal contact.

4. Keep squeezing the tip while unrolling the condom, until it covers the entire penis. The loose part at the end will hold the man's sperm. If you do not leave space for the sperm when it comes out, the condom is more likely to break

5. After the man ejaculates, he should hold on to the rim of the condom and withdraw from the vagina while his penis is still hard.

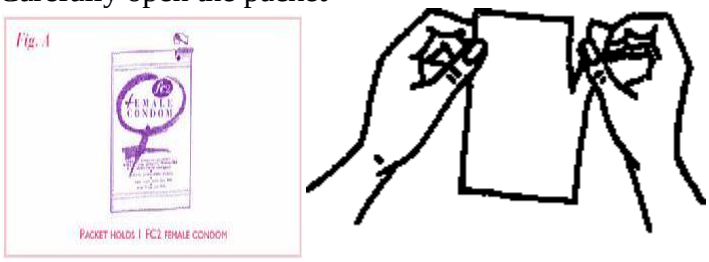
6. Take off the condom. Do not let sperm spill or leak. If having sex again or switching from one sex act to another, use a new condom.



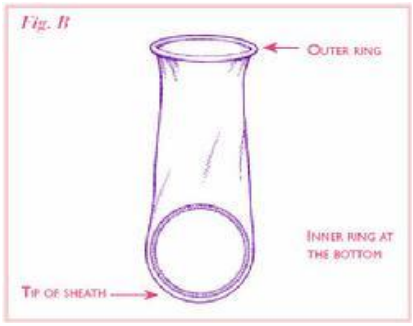
7. Tie the condom shut and dispose of it away from children and animals

Operation sheet 3	How to use female condom

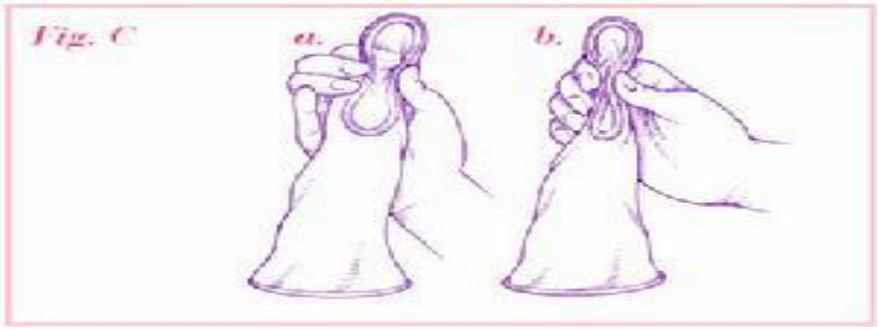
1. Carefully open the packet



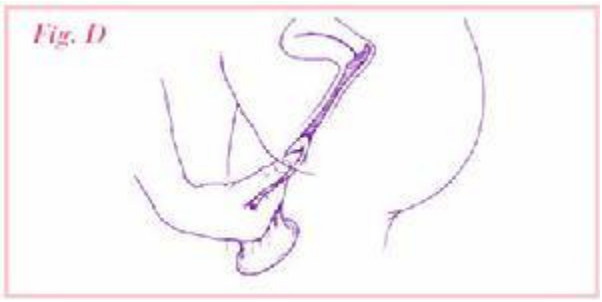
2. Find the inner ring, which is at the closed end of the condom.



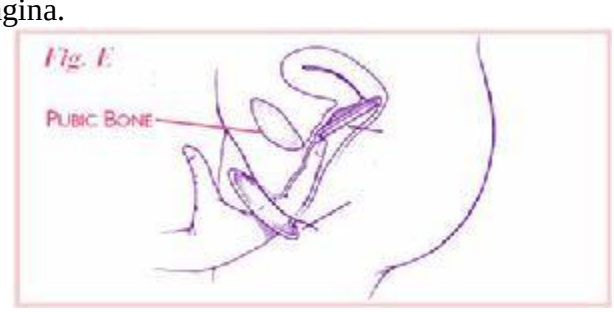
3. Squeeze the inner ring together.



4. Put the inner ring in the vagina.



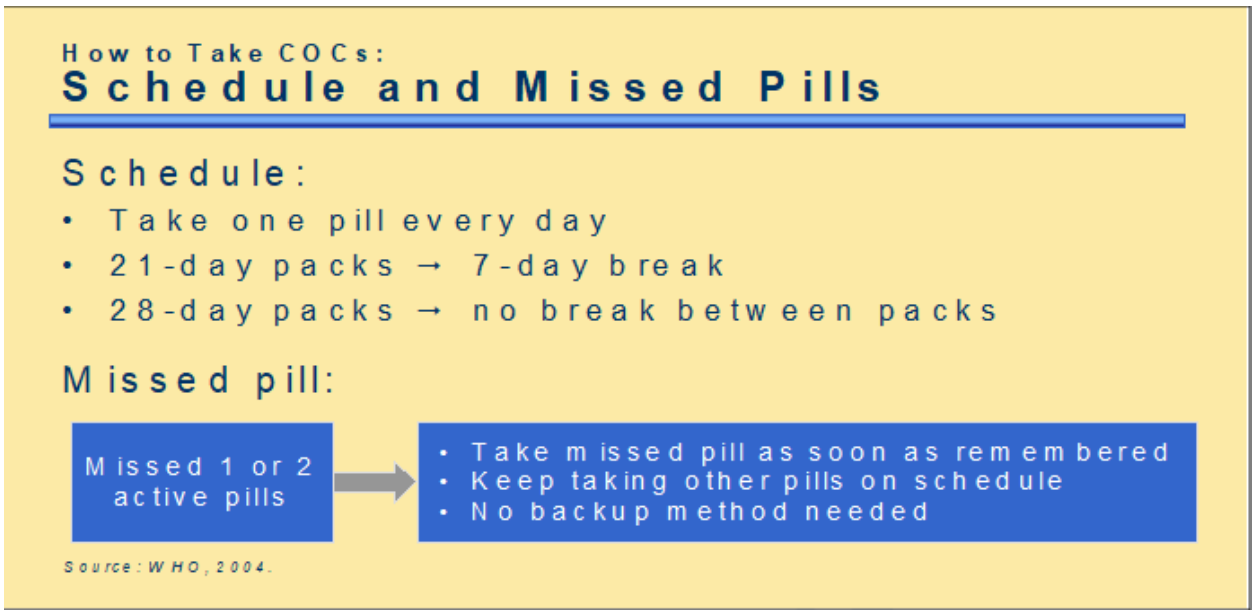
5. Push the inner ring up into your vagina with your finger. The outer ring stays outside the vagina.

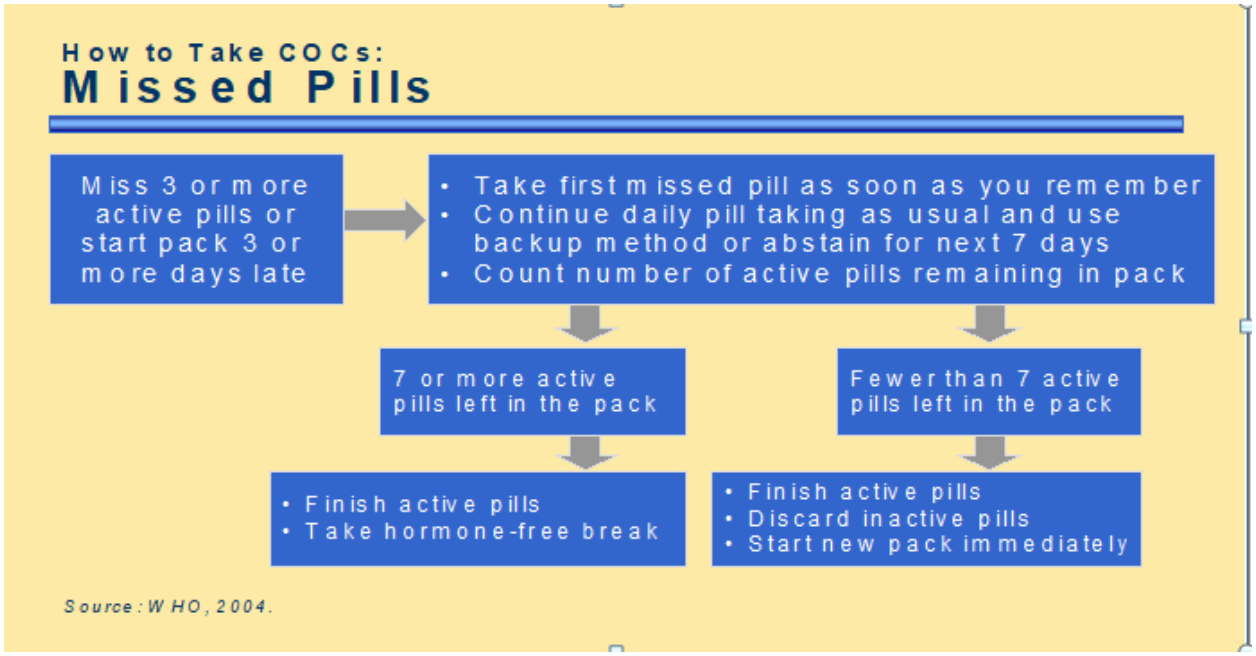


6. When you have sex, guide the penis through the outer ring.

7. Remove the female condom immediately after sex, before you stand up. Squeeze and twist the outer ring to keep the man's sperm inside the pouch. Pull the pouch out gently, and then dispose of it out of reach of children and animals.

- Give your client at least one packet of the same pills that she will use, even if she will be getting her pills elsewhere later.
- Show her which kind of pill packet you are giving her (21 pills or 28 pills).If the pack has 28 pills, point out that the last seven 'remainder' pills are a different color and do not contain hormones.
- Instruct her to follow the direction of the arrows on the packet to take the rest of the pills, one each day (including the remainder pills).
- Give her key instructions on starting the first packet, starting the next packet, and what to do if she misses a pill.
- Ask her to repeat the most important instructions, and show you how she will take her pills, using the pill packet.
- Ask her if she has any questions, fears or concerns, and answer her questions




How to Take COCs:
Missed Pills
Miss 3 or more active pills or start pack 3 or more days late
• Take first missed pill as soon as you remember
• Continue daily pill taking as usual and use backup method or abstain for next 7 days
• Count number of active pills remaining in pack
7 or more active pills left in the pack
Fewer than 7 active pills left in the pack
• Finish active pills
• Take hormone-free break
• Finish active pills
• Discard inactive pills
• Start new pack immediately
Source: WHO, 2004.

Operation sheet 5	Implanon Insertion Procedure:

Implanon Insertion Procedure: Steps of Insertion

Getting Ready

Step 1: Greet client respectfully and with kindness.

Step 2: Review Client Screening Checklist and further evaluate client,

Step 3: Tell client what is going to be done and encourage her to ask questions.

Step 4: Ask about allergies to antiseptic solution and local anesthetic agent.

Step 5: Check to be sure client has thoroughly washed and dried her entire arm.

Step 6: Help position and allow the client on table to lie on her back with her non-dominant arm (the arm, which the woman does not use for carrying pitcher or for writing) on the arm rest of the table turned outwards and bent at the elbow.

Step 7: Determine insertion site at the inner side of the upper arm (non-dominant arm) about 6-8 cm above the elbow

Step 8: Mark the insertion site on arm with a marker/pen (optional)

Step 9: Open sterile Implanon package by pulling apart sheets of the pouch completely without touching the preloaded applicator and place on the work table.

Pre-Insertion Tasks

Step 1: Wash your hand and dry with clean towel or air dry.

Step 2: Put pair of gloves on both hands.

Step 3: Arrange instruments and supplies on tray.

Step 4: Using iodine or betadine solution on gauze & clean the insertion site two times using a circular motion for 8 to 13 cm from center to periphery starting at the site of insertion, and allow to air dry

Step 5: Using a sterile needle and syringe, inject 2 ml of local anesthetic (1% lidocaine without adrenaline) just under the skin along the 'insertion canal' to anesthetize the insertion site, starting first at needle entry point to raise a small wheel. During procedure, one has to make sure that the needle is not in the blood vessels by repeatedly withdrawing on the syringe.

Step 6: Withdraw needle and dispose it in a safety box to prevent accidental needle sticks.

Step 7: Wait 2 to 3 minutes for the anesthesia effect to take place

Insertion of Implanon

Step 1: Carefully remove the sterile disposable applicator carrying Implanon rod from the sterile blister and remove the needle cap/shield.

Step 2: Always hold the applicator in the upward position (i.e. with the needle pointed upwards) until the time of insertion. This precaution is to prevent the implant from dropping out.

Step 3: Visually verify the presence of the implant inside the metal part of the cannula (the needle). The implant can be seen as a white tip inside the needle. If the implant protrudes from the needle, return to its original position by tapping against the plastic part of the cannula.

Note: Keep the needle and the implant sterile. Do not touch the needle of the cannula or the implant inside the applicator with anything, including client skin before insertion. If contamination occurs, a new package with a new sterile applicator must be used.

Step 4: Stretch the skin around the insertion site with thumb and index (***Figure8.21***) or pulling the skin with thumb towards the elbow joint.

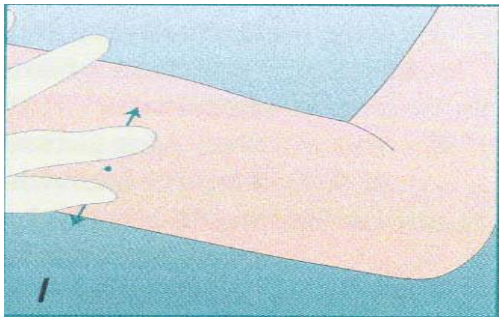


Figure 8.2

Step 5: Insert only the tip of the cannula (needle), slightly angled (~ 20°) (***Figure 8.3***).

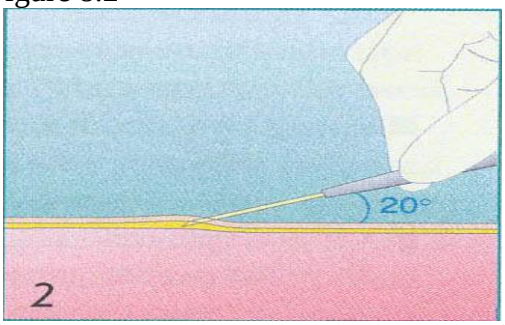


Figure 8.3

Step 6: Release the skin.

Step 7: Tent/elevate the skin and lower the applicator to a horizontal position without touching the skin with parts the needle which you are going to insert subdermal (***Figure 8.4***).

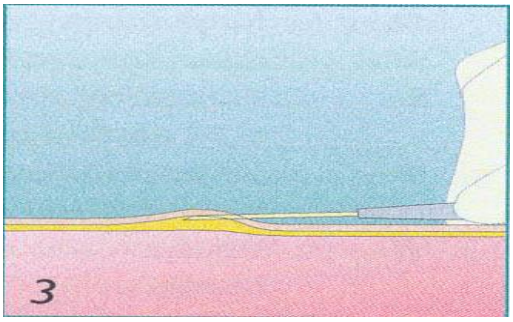


Figure 8.4

Step 8: Lift the skin with the tip of the needle in the sub-dermal connective tissue (***Figure 8.5***).

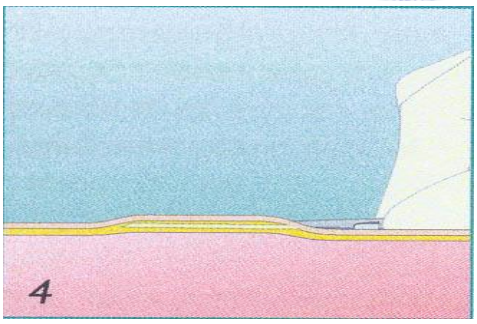


Figure 8.5

Step 9: While lifting the skin gently insert the needle to its full length without using force.

Step 10: Keep the applicator parallel to the surface of the skin.

Note: When the implant is placed too deeply the removal can be difficult.

Step 11: Break the seal of the applicator (***Figure 8.6***).

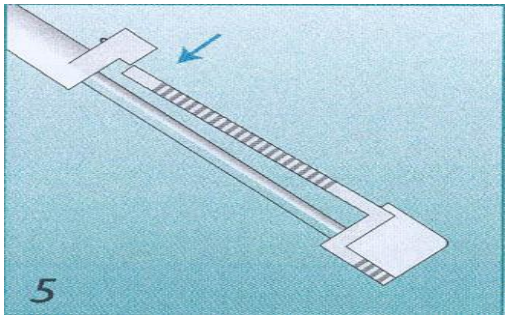


Figure 8.6

Step 12: Turn the **obturator** 90° (***Figure 8.7***).

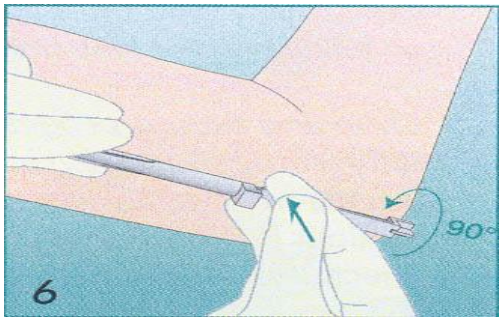


Figure 8.7

Step 13: Fix the obturator with one hand against the arm and with the other hand slowly retract the cannula (needle out of the arm) (***Figure 8.8***).

Note: Never push against the obturator.

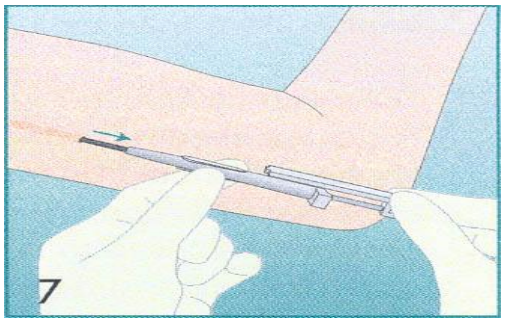


Figure 8.8

Step 14: Check the needle to ensure that the implant is not within the needle. After retraction of the cannula, the grooved tip of the obturator should be visible (***Figure 8.9***).

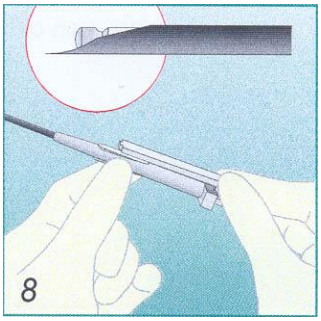


Figure 8.9

Note: Always verify the presence of the implant by palpation**.**

Dispose the applicator in the safety box (Figure 8.10).

Fig.8.10

Step 15: Palpate with the index finger to ensure that the implant is placed/released under the skin

Operation sheet 6	Post-insertion Tasks for Implanon

Post-insertion Tasks

Step 1: Press down on incision with gauzed finger to stop bleeding (if any).

Step 2: Apply first aid plaster and pressure bandage to ensure hemostasis and to prevent bruising.

Step 3: Fill-out the user card and hand it over to the client for follow-up and to facilitate removal of the implant later on.

Step 4: Dispose of waste materials by placing in a leak proof container or plastic bag.

Step 5: Remove gloves by turning inside out & dispose the glove in leak proof container or plastic bag.

Step 6: Wash hands thoroughly with soap and water and dry with clean towel or air dry.

Step 7: Complete client record, including drawing position of capsules.

Operation sheet 7	Post-insertion counseling for Implanon

Post-insertion Counseling

Step 1: Instruct client regarding wound care and make return visit appointment, if needed.

Step 2: Discuss what to do if client experiences any problems following insertion or side effects.

- There may be some bruising and tenderness for the first few days,
- The insertion area should be kept dry for 48 hours, after which the bandage can be removed,
- To see HEWs if any irritation occurs at the site of insertion,
- Re- inform the possible changes in menstrual irregularities which could be no menses or frequent spotting or longer cycle length
- To carry the follow-up card during each visits to the clinic.

Step 3: Assure client she can return at any time to receive advice or medical attention and, if desired, to have the capsules removed.

Step 4: Ask the client to repeat instructions.

Step 5: Answer client's questions.

Step 6: Observe client for at least 5-10 minutes and ask how she feels before her sending home.

LAP Test	Practical Demonstration

Name: _____ Date: _____

Time started: _____ Time finished: _____

Instructions: Assemble all necessary equipments and perform the following tasks within --- hour.

Task 1. Provide counseling for a mother who wants to use family planning

Task 2. Insert inplannon for a client after counseling.

Task 3. Provide oral contraception for a client

List of Reference Materials

- **LEARNING MODULE FOR LEVEL –III HEALTH EXTENSION PROGRAM IN ETHIOPIA ADDIS ABABA, ETHIOPIA 2014**
- **Family health for health extension workers, Jimma University November 2004**