



# **Family Planning Competency-Based Training**

**Basic Course Handbook  
for Service Providers**



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## ACRONYMS

<b>AIDS</b>	Acquired Immune Deficiency Syndrome
<b>AO</b>	Administrative Order
<b>AOG</b>	Age of Gestation
<b>ARH</b>	Adolescent Reproductive Health
<b>ARMM</b>	Autonomous Region of Muslim Mindanao
<b>ARV</b>	Antiretroviral Drugs
<b>ASC</b>	Ambulatory Surgical Clinic
<b>ASL</b>	Authorized Stock Level
<b>BBT</b>	Basal Body Temperature
<b>BHW</b>	<i>Barangay</i> Health Worker
<b>BHS</b>	<i>Barangay</i> Health Station
<b>BIP</b>	Basic Infertile Pattern
<b>BMD</b>	Bone Mass Density
<b>BMI</b>	Body Mass Index
<b>BOM</b>	Billings Ovulation Method
<b>BP</b>	Blood Pressure
<b>BTL</b>	Bilateral Tubal Ligation
<b>BSPO</b>	<i>Barangay</i> Supply Point Officer
<b>CBHCO</b>	Community-based Health Care Organization
<b>CBMIS</b>	Community-based Monitoring Information System
<b>CBT</b>	Competency-based Training
<b>CDLMIS</b>	Contraceptive Distribution Logistics Management Information System
<b>CHD</b>	Center for Health Development (formerly Regional Health Office)
<b>CHO</b>	City Health Office
<b>CIC</b>	Combined Injectable Contraceptive
<b>CO</b>	Central Office
<b>COC</b>	Combined Oral Contraceptive
<b>COF</b>	Contraceptive Order Form
<b>CON</b>	Condom
<b>CPR</b>	Contraceptive Prevalence Rate
<b>CPS</b>	Contraceptive Prevalence Survey
<b>CR</b>	Cardiac Rate
<b>CSR</b>	Contraceptive Self-Reliance
<b>DMPA</b>	Depot Medroxyprogesterone Acetate
<b>DOH</b>	Department of Health
<b>DSWD</b>	Department of Social Welfare and Development
<b>DTUR</b>	Dispensed To User Record
<b>DVT/PE</b>	Deep Vein Thrombosis/Pulmonary Embolism
<b>EDR</b>	Early Days Rule
<b>EE</b>	Ethinyl Estradiol
<b>FAB</b>	Fertility Awareness-Based Method
<b>FEFO</b>	First-to-expire, First-out
<b>FHSIS</b>	Field Health Services Information System
<b>FP</b>	Family Planning

<b>FPS</b>	Family Planning Survey
<b>FSH</b>	Follicle-Stimulating Hormone
<b>HBV</b>	Hepatitis B Virus
<b>HCG</b>	Human Chorionic Gonadotropin
<b>HH</b>	Household
<b>HIV</b>	Human Immunodeficiency Virus
<b>HLD</b>	High Level Disinfection
<b>HMO</b>	Health Maintenance Organization
<b>HPV</b>	Human Papillomavirus
<b>ICPD</b>	International Conference on Population and Development
<b>ICV</b>	Informed Choice and Voluntarism
<b>IE</b>	Internal Examination
<b>IEC</b>	Information, Education, and Communication
<b>ILHZ</b>	Interlocal Health Zone
<b>IM</b>	Intramuscular
<b>IMAP</b>	Integrated Midwives' Association of the Philippines
<b>IUD</b>	Intrauterine Device
<b>IUS</b>	Intrauterine System
<b>LAM</b>	Lactational Amenorrhea Method
<b>LAPM</b>	Long-Acting Permanent Methods
<b>LCE</b>	Local Chief Executive
<b>LGU</b>	Local Government Unit
<b>LH</b>	Luteinizing Hormone
<b>LMP</b>	Last Menstrual Period
<b>LNG</b>	Levonorgestrel
<b>MNCHN</b>	Maternal, Newborn, and Child Health and Nutrition
<b>MCP</b>	Maternity Care Package
<b>MDG</b>	Millennium Development Goals
<b>MEC</b>	Medical Eligibility Criteria
<b>MIS</b>	Management Information System
<b>MOA</b>	Memorandum of Agreement
<b>MTPDP</b>	Medium-Term Philippine Development Plan
<b>MWRA</b>	Married Women of Reproductive Age
<b>NDHS</b>	National Demographic and Health Survey
<b>NDS</b>	National Demographic Survey
<b>NEDA</b>	National Economic Development Authority
<b>NET-EN</b>	Norethisterone Enantate
<b>NFP</b>	Natural Family Planning
<b>NGA</b>	National Government Agency
<b>NGO</b>	Non-Government Organization
<b>NOH</b>	National Objectives for Health
<b>NSD</b>	Normal Spontaneous Delivery
<b>NSV</b>	No-Scalpel Vasectomy
<b>OB-GYNE</b>	Obstetrics-Gynecology
<b>OC</b>	Oral Contraceptive

<b>PE</b>	Physical Examination
<b>PGR</b>	Population Growth Rate
<b>PFPP</b>	Philippine Family Planning Program
<b>PHIC</b>	Philippine Health Insurance Corporation (PhilHealth)
<b>PHO</b>	Provincial Health Office
<b>PID</b>	Pelvic Inflammatory Disease
<b>PLGM</b>	Philippine League of Government Midwives
<b>PMAC</b>	Prevention and Management of Abortion and its Complications
<b>PMP</b>	Previous Menstrual Period
<b>PNDF</b>	Philippine National Drug Formulary
<b>POC</b>	Progestin-only Contraceptive
<b>POI</b>	Progestin-only Injectable
<b>POP</b>	Progestin-only Pill
<b>POPCOM</b>	Population Commission
<b>POPDEV</b>	Population and Development
<b>PPO</b>	Provincial Population Office
<b>PR</b>	Pulse Rate
<b>PRC</b>	Professional Regulation Commission
<b>PRE</b>	Population, Resources, and Environment
<b>PROM</b>	Premature Rupture of Membranes
<b>RH</b>	Reproductive Health
<b>RHU</b>	Rural Health Unit
<b>RIV</b>	Requisition and Issue Voucher
<b>RPFS</b>	Republic of the Philippines Fertility Survey
<b>RTI</b>	Reproductive Tract Infections
<b>RUV</b>	Relative Unit Value
<b>SDM</b>	Standard Days Method
<b>STI</b>	Sexually Transmitted Infections
<b>STM</b>	Sympto-thermal Method
<b>TCL</b>	Target Client List
<b>TDM</b>	Two-Day Method
<b>TFR</b>	Total Fertility Rate
<b>TNA</b>	Training Needs Assessment
<b>TWG</b>	Technical Working Group
<b>USAID</b>	United States Agency for International Development
<b>VAWC</b>	Violence Against Women and Children
<b>VSC</b>	Voluntary Surgical Contraception
<b>WCPU</b>	Women and Child Protection Unit
<b>WHO</b>	World Health Organization

## FOREWORD

The Department of Health (DOH) has consistently improved training for health service providers to enhance their capabilities to deliver quality family planning (FP) services. In line with this commitment to achieve continuing quality improvement, the DOH together with partner agencies reviewed and updated the Family Planning Competency Based Training (FPCBT) Modules to keep pace with the new trends and developments in family planning.

This revised version of the FPCBT Manual is aligned with the 2006 FP Clinical Standards Manual and is consistent with current developments in responsible parenting policies. It adopts modern training approaches towards further enhancing the knowledge, skills, and attitude of service providers.

The overall objective of the training manual is to enable health service providers to safely administer and dispense FP services to, and share accurate information on the different modern FP methods with clients. It aims to improve the quality of FP services delivered by providers in both public, non-government organizations, and private health facilities. It contains up-to-date FP information drawn from actual experiences of family planning experts, and backed up by evidence-based medical information and effective FP practices recommended by highly credible international references, particularly the Medical Eligibility Criteria (MEC) for Contraceptive Use and Selected Practice Recommendations (SPR) of the World Health Organization.

The revised manual introduces an integrated, streamlined, and performance-based training design that builds on the motivation and commitment of the frontline service providers. The DOH hopes that all health service providers undergo the FPCBT to ensure the delivery of FP services that are consistent with and supportive of the country's commitments to the Millennium Development Goals and the Philippine Development Plan.

I strongly encourage the effective dissemination and utilization of this manual across the country as one of the tools towards achieving improved quality of health care.



**ENRIQUE T. ONA, MD, FPCS, FACS**  
Secretary of Health

## ACKNOWLEDGEMENTS

The DOH recognizes and expresses its full appreciation to all those who participated in the development, revision, pre-testing, final review, and editing of the manuals.

In particular, the DOH would like to thank the following:

- The United States Agency for International Development (USAID) in providing technical assistance in the overall process of developing the manual.
- The Technical Working Group whose members came from various sectors and agencies, who not only unselfishly shared their technical expertise and experiences but also took time out of their busy schedules and concurrent work to enhance, pretest, edit, and finalize the training manual.
- The individuals who were contracted for the development, pre-test, design, and layout of the manual.
- The FP trainers from the different CHDs and Local Government Units who provided technical inputs and insights and shared their experiences in conducting training activities at the local level. These FP trainers also served as facilitators during the pre-testing together with a group of health service providers.

The DOH is also grateful to those who contributed in one way or another in producing this training manual but whose names have not been mentioned.



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## INTRODUCTION

The integrated, modified family planning training system is performance-based which develops the knowledge, attitudes, and skills of participants on the requirements of quality FP service provision. The training system implements a basic approach that exposes participants to levels of training based on certain criteria which qualify them to the next higher level of training.

A higher level training course will develop more specialized skills in the intrauterine device, bilateral tubal ligation by minilap under local anesthesia and no scalpel vasectomy, and provision of natural family planning. Participants to this level of training must be professionally qualified to perform the skills taught in the respective course, have undergone the basic course, have satisfactorily integrated the skills learned in their provision of health services, and have the ability and opportunity to increase the client load for the service(s) they will be trained in.

In support of this training system and as a response to the request from the regional and provincial program managers and private health practitioners, HealthGov, PRISM, HPDP, SHIELD, IRHP, Dr. Jose Fabella Memorial Hospital and selected trainers from the CHDs provided technical assistance to DOH-NCDPC in revising the training materials. The revision will strengthen the training system and improve service provider performance ensuring high quality of family planning services.

The DOH-NCDPC assisted by HealthGov and other USAID Cooperating Agencies conducted two consultative workshops which were the initial activities in the revision of the training materials. These paved the way to the development of the 2010 FPCBT Basic Course Handbook. The DOH-NCDPC also formed a TWG to oversee the process of revising and pilot testing the revised training materials. The TWG conducted an orientation of public and private sector trainers and developed a system for rolling out the training for frontline health service providers.

The materials of this basic course are consistent with new developments in program policies and contraceptive technology, updates in the modern training approaches, and aligned with the 2006 FP Clinical Standards Manual. After two consultative workshops followed by several meetings with the FPCBT TWG to ensure efficiency of the curriculum, the 2010 version of the FPCBT Basic Course is made available for implementation.

## Schedule of Activities

TIME	MODULES/SESSIONS
<b>Day 0</b>	
	Arrival of facilitators and participants Facilitator's meeting
<b>8:00-10:00 AM</b>	<ul style="list-style-type: none"> <li>• Registration</li> <li>• Opening Ceremonies               <ul style="list-style-type: none"> <li>✓ Invocation</li> <li>✓ National Anthem</li> <li>✓ Welcome Remarks</li> </ul> </li> <li>• Introduction of Participants</li> <li>• Pre-test</li> <li>• Leveling of Expectations</li> <li>• Overview and Mechanics of the Course</li> </ul>
<b>10:00-11:00</b>	<b>Module 1: The Philippine FP Program</b> ✓ Session 1: Overview of the PFPP
<b>11:00-11:30</b>	✓ Session 2: Family Planning and Reproductive Health
<b>11:30-12:00</b>	✓ Session 3: Maternal High-Risk Factors
<b>12:00-1:00 PM</b>	<b>LUNCH BREAK</b>
<b>1:00-1:30</b>	<b>Module 1: The Philippine FP Program (continued)</b> ✓ Session 4: Health Benefits of FP
<b>1:30-2:30</b>	<b>Module 2: Human Reproductive Anatomy and Physiology</b> ✓ Session 1: The Female Reproductive Anatomy and Physiology
<b>2:30-3:00</b>	✓ Session 2: The Male Reproductive Anatomy and Physiology
<b>3:00-3:30</b>	✓ Session 3: The Concept of Fertility and Joint Fertility
<b>3:30-4:30</b>	<b>Module 3: FP Client Assessment</b> ✓ Session 1: The FP Service Record in Client Assessment
<b>4:30-5:30</b>	✓ Session 2: WHO Medical Eligibility Criteria for Contraceptive Use
<b>5:30-6:30</b>	Facilitator's Meeting
<b>8:00-8:30 AM</b>	Recap of Day 1
<b>8:30-9:15</b>	<b>Module 4: Infection Prevention in FP Services</b> ✓ Session 1: The Disease Transmission Cycle and Infection Prevention Definitions
<b>9:15-10:30</b>	✓ Session 2: Infection Prevention Measures
<b>10:30-11:30</b>	<b>Module 5: Fertility Awareness-Based Methods</b> ✓ Session 1: Fertility Awareness-Based Methods
<b>11:30-12:00</b>	✓ Session 2: Lactational Amenorrhea Method
<b>12:00-1:00 PM</b>	<b>LUNCH BREAK</b>
<b>1:00-3:00</b>	<b>Module 6: Hormonal Contraceptive Methods</b> ✓ Session 1: Low Dose Combined Oral Contraceptives
<b>3:00-3:30</b>	✓ Session 2: Other Combined Contraceptives
<b>3:30-4:00</b>	✓ Session 3: Progestin-only Pills



4:00-5:30		✓ Session 4: Progestin-only Injectable
5:30-6:30		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 2
8:30-9:30		<b>Module 7: Male Condom</b> ✓ Session 1: Male Condom
9:30-10:00		<b>Module 8: Long-acting and Permanent Methods</b> ✓ Session 1: Intrauterine Device
10:00-11:00		✓ Session 2: Permanent Methods
11:00-12:00		<b>Module 9: FP for Special Populations</b>
12:00-1:00	PM	<b>LUNCH BREAK</b>
1:00-1:30		<b>Module 10: Counseling for FP</b> ✓ Session 1: Values Clarification
1:30-3:00		✓ Session 2: Informed Choice and Voluntarism
3:00-4:00		✓ Session 3: Types of Communication in FP/RH
4:00-6:00		✓ Session 4: Effective Communication Skills
6:00-7:00		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 3
8:30-11:30		<b>Module 10: Counseling for FP (continued)</b> ✓ Session 5: Steps in Counseling Using the GATHER Approach
11:30-12:30	PM	<b>LUNCH BREAK</b>
12:30-5:30		<b>Module 10: Counseling for FP (continued)</b> ✓ Role Play Practice: Steps in Counseling Using the GATHER Approach
5:30-6:00		<b>Module 10: Counseling for FP (continued)</b> ✓ Plenary: Summary of Role Play Practice
6:00-7:00		Facilitator's Meeting
8:00-8:30	AM	Recap of Day 4
8:30-9:00		<b>Module 11: Management of a Family Planning Clinic</b> ✓ Session 1: Managing for Quality
9:00-9:30		✓ Session 2: Facility-Based FP Services
9:30-10:30		✓ Session 3: Management Support System
10:30-11:00		✓ Session 4: Monitoring and Evaluation
11:00-11:30		✓ Session 5: Service Delivery Networks
11:30-12:30	PM	<b>LUNCH BREAK</b>
12:30-5:00		Action Planning ✓ Introduction ✓ Development of Action Plans ✓ Plenary: Presentation of Selected Action Plans
5:00-6:00		Closing Activities ✓ Post-test ✓ Course Evaluation ✓ Closing Remarks
6:00-7:00		Facilitator's Meeting on Next Steps



# MODULE 1



## The Philippine Family Planning Program

Session 1: Overview of the Philippine Family Planning Program

Session 2: Family Planning and Reproductive Health

Session 3: Maternal High-Risk Factors

Session 4: Health Benefits of Family Planning



# MODULE 1: THE PHILIPPINE FAMILY PLANNING PROGRAM



## MODULE OVERVIEW

This module provides information on the Philippine Family Planning Program (PFPP) and its evolution since it started more than 38 years ago. It will explain the general health status of the population and the Family Planning (FP) program coverage over the past years. Policies and strategies for nationwide implementation and the benchmarks that the program aims for on Family Planning practice will also be discussed. The module includes the integration of FP with other Reproductive Health elements as well as the benefits of Family Planning. The module will also discuss the maternal high-risk factors to put into perspective the importance of ensuring quality FP services. The need to make FP services accessible and available to all women and men of reproductive age for the reduction of maternal and child mortality will also be emphasized.



## MODULE OBJECTIVES

At the end of the module, the participants will:

1. Understand the Philippine Family Planning Program as an intervention to improve the health of all Filipinos with special attention to women and children.
2. Relate Family Planning to the reduction of maternal and child mortality.



## MODULE SESSIONS

<b>Session 1</b>	Overview of the Philippine Family Planning Program
<b>Session 2</b>	Family Planning and Reproductive Health
<b>Session 3</b>	Maternal High-Risk Factors
<b>Session 4</b>	Health Benefits of Family Planning

## SESSION 1

### OVERVIEW OF THE PHILIPPINE FAMILY PLANNING PROGRAM

#### LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Explain the evolution of the Philippine FP Program (PFPP).
2. Describe the PFPP in terms of its vision, mission, goal, and objectives.
3. Explain the four pillars of the PFPP.
4. Explain the implementing guidelines and policies of the PFPP as stipulated in Administrative Order (AO) 50-A, series 2001, otherwise known as the National FP Policy.
5. Enumerate the FP program methods.
6. Enumerate the benchmarks on the implementation of a FP program.
7. Explain the health status and FP situation as it relates to the attainment of the Millennium Development Goals (MDGs) on maternal mortality, under-five mortality, population growth rate, total fertility rate, FP unmet need, and contraceptive prevalence rate.
8. Identify activities towards the improvement and attainment of program benchmarks.

#### NARRATIVE

##### THE EVOLUTION OF THE PHILIPPINE FP PROGRAM

The FP Program has been implemented for about 38 years, which started from a demographic perspective to a health intervention-oriented program. In the year 1970 to 1985, PFPP started as a family planning service delivery component to achieve fertility reduction by a contraceptive-oriented approach. From 1986 to 1993, the program was reoriented from mere fertility reduction to a health intervention by improving the health of women and children.

From 1994 to 1999, the family planning program underwent another shift that emphasized integration with other RH programs giving importance to recognizing choice and rights of FP users. This shift was in line with the country's commitments made in the International Conference on Population and Development (ICPD), held in Cairo in 1994, and the Fourth World Conference on Women, held in Beijing in 1995. During this period, the Philippines has adopted and developed a policy framework in Reproductive Health (RH) with the goal of providing universal access to RH services with family planning as the flagship program. Implicit in the policy is the right of men and women to be informed and to have access to safe, effective, affordable, and acceptable family planning methods of their choice including the right to access appropriate health care services that will enable women to go safely through pregnancy and childbirth, and provide couples the freedom to decide if, when, and how often to do so.

In the period between the year 2000 to the present, the national FP policy, AO NO. 50-A, s.2001, was formulated to prescribe the key policies of FP services in the country, which is "family planning as a means towards responsible parenthood". Likewise, to signify the government's commitment to the MDGs on the improvement of maternal and child health and nutrition and reduction of maternal and child mortality, the Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy was introduced in 2008.

DOH also issued AO No. 005, series of 2011 to ensure Quality Standards in the Delivery of FP Program and Services through Compliance to Informed Choice and Voluntarism.

## THE PHILIPPINE FAMILY PLANNING PROGRAM (PFPP)

### VISION:

To empower women and men to live healthy, productive, and fulfilling lives with the right to achieve their desired family size through quality, medically sound, and legally permissible FP methods.

- Quality: there are six facets of FP quality care: choice of method, technical competence of providers, informing and counseling clients, interpersonal relations, mechanisms to encourage continuation and appropriateness and acceptability of services.
- Medically sound: sound medical treatment is defined as the use of medical knowledge or means to cure or prevent a medical disorder, preserve life, or relieve distressing symptoms.
- Legally permissible: all FP interventions must be legal and must not violate any existing Philippine law.

### MISSION:

The DOH, in partnership with the LGUs, NGOs, private sector, and communities shall ensure the availability of FP information and services to men and women who need them.

### GOAL:

To provide universal access to FP information and services whenever and wherever these are needed.

### OBJECTIVES:

1. The FP Program addresses the need to help couples and individuals achieve their desired family size within the context of responsible parenthood and improve their reproductive health to attain sustainable development.
2. It aims to ensure that quality FP services are available in DOH-retained hospitals, LGU-managed health facilities, NGOs, and the private sector.

### GUIDING PRINCIPLES OF THE PFPP:

Family Planning Program services are to be delivered within the context of the following principles:

1. *Respect for the sanctity of life.* Family Planning aims to prevent abortion and therefore can save the lives of both women and children.
2. *Respect for human rights.* Family Planning services will be made available using only medically and legally permissible methods appropriate to the health status of the client. Family Planning services shall be provided regardless of the client's sex, number of children, sexual orientation, moral background, occupation, socio-economic status, cultural and religious belief.
3. *The freedom of choice and voluntary decision.* Couples and individuals will make family planning decisions based on informed choice including their own moral, cultural or religious beliefs.
4. *Respect for the rights of clients to determine their desired family size.* Couples and individuals have the basic right to decide freely and responsibly the number and spacing of their children.

Couples and individuals are free to decide and choose the FP methods they will use based on informed choice. They will exercise responsible parenthood in accordance to their religious and ethical values and cultural background, subject to conformity with universally recognized international human rights.

This means that in any FP method service delivery, providers must give good counseling and ready access to contraceptive options, free of any provider bias for or against particular methods, so that clients can exercise their rights to make informed and voluntary decisions based on accurate and up-to-date information.

Counseling helps clients choose and correctly use any contraceptive method and reassures a positive impact on method adoption, continuation, and client satisfaction. It enables clients to achieve their reproductive goals and good health outcomes (adopted from the Ten Guiding Principles for LAPM Service Programs, ACQUIRE/Engender Health, 2007).

## FP POLICIES AND STRATEGIES

The **National FP Policy (Administrative Order No. 50-A, s. 2001)**, prescribes the key policies for FP services focused on modern FP methods including natural FP. Policy statements that guide FP program promotion and implementation are the following:

1. Family Planning as a health intervention to promote the overall health of all Filipinos particularly women and children by:
  - preventing high-risk pregnancies;
  - preventing unwanted/unplanned pregnancies;
  - reducing maternal deaths; and
  - responding to unmet needs of women.
2. Family Planning as a means towards responsible parenthood. Planning for the future reflects the will and the ability to respond to the needs of the family and children.
3. FP information and services will be provided based on voluntary and informed choice for all women and men of reproductive age regardless of age, number of children, marital status, religious beliefs, and cultural values.
4. Only medically safe and legally acceptable FP methods shall be made available in all public, NGOs, and private health facilities.
5. Quality care must be promoted and ensured in providing FP services. Privacy and confidentiality should be strictly observed in the provision of services at all times.
6. Efforts must be undertaken to orient clients on fertility awareness as the basic information to fully understand and appreciate FP.
7. Multi-agency participation is essential. Involvement of the private sector, academe, church, media, community, and other stakeholders must be encouraged at all levels of operation.
8. FP services, in the context of the RH approach, must be integrated with the delivery of other basic health services.
9. Sustainability of FP services and commodities must be promoted through the localization and adoption of the Contraceptive Self-Reliance (CSR) strategy (i.e., market segmentation and LGU empowerment, etc).

### STRATEGIES:

1. Focus service delivery to the urban and rural poor;
2. Re-establish/strengthen the FP outreach program;
3. Strengthen FP provision in regions with high unmet need;
4. Promote frontline participation of hospitals;
5. Mainstream modern natural FP;
6. Promote and implement CSR strategy to include other non-commodity based methods (e.g. BTL, Vasectomy, Fertility Awareness-Based Methods);
7. Integration of FP with other RH services (i.e., maternal, neonatal, child and nutrition services, adolescent health services, etc.);
8. Ensuring quality care through compliance to informed choice and voluntarism principles;
9. Capacitate high volume providers.

## COMPONENTS

- Service Delivery
- Logistics Management
- Information, Education and Communication and Advocacy
- Monitoring and Evaluation
- Research and Development
- Management Information System
- Training

## FP PROGRAM METHODS

### Modern methods

- ✓ Permanent methods
  - Female sterilization/Bilateral Tubal Ligation
  - Male sterilization/Vasectomy
- ✓ Temporary Methods
  - Supply methods
    - Pills
    - Intrauterine Device
    - Injectable
    - Male condom
  - Fertility Awareness-Based Method
    - Cervical Mucus/Billings Ovulation Method
    - Basal Body Temperature
    - Sympto-thermal Method
    - Standard Days Method
    - Lactational Amenorrhea Method

## THE HEALTH AND FP SITUATION IN THE PHILIPPINES

### MATERNAL, INFANT AND UNDER-FIVE MORTALITY

The Philippines was one of the 179 member states of the United Nations which reaffirmed its commitment to peace, security, poverty alleviation, reproductive health, and equality of men and women.

Two of the MDGs are reduction in maternal and child mortality, which is a concern of FP service providers. This can be addressed through family planning as it can help women who are at risk during pregnancy and birthing. The country has shown improvements in the following:

- Maternal mortality ratio decreased from 209 (NDHS, 1993), to 162 maternal deaths per 100,000 livebirths (FPS, 2006). The MDG is 52 maternal deaths per 100,000 livebirths by 2015.
- Mortality rate of under-five children decreased from 54 (NDHS, 1993) to 40 (NDHS, 2003) per 1000 livebirths to 32 deaths per 1000 livebirths (FPS, 2006). The MDG is 26 deaths per 1000 livebirths by 2015.
- Infant mortality rates declined from 34 (NDHS, 1993) to 29 deaths per 1000 livebirths (NDHS, 2003). The MDG is 19 deaths per 1000 livebirths by 2015.



## THE PHILIPPINE POPULATION IN RELATION TO FP

- The Philippine population stood at 94.01 million in 2010 (NSO Projected Population, 2010) and is expected to grow annually at 2.04%. Philippine population is expected to double in 29 years.
- Total Fertility Rate declined very slowly from 3.5 children per woman (NDHS, 2003) to 3.2 children per woman (FPS, 2006). The program aims to achieve a 2.1 TFR by 2010. With a 3.2 TFR, there is one excess child per woman from the target.
- FP unmet need was from 17.3% (2003) to 15.7% (FPS, 2006). The program aims to reduce this by half (8.6%) by 2010.
- Total CPR has increased from 15.4% (1968) to 48.9% (NDHS, 2003) to 50.6 (FPS, 2006). The MDG for total CPR is 80% by 2010.
- Modern FP methods use has increased from 33.4% (NDHS, 2003) to 35.9% (FPS, 2006). The MDG is 60% CPR for modern methods in 2010.

## NATIONAL BENCHMARK FOR MEASURING ADOPTION OF FP PRACTICES (2003-2010)

- Reduced Population Growth Rate (%) - 2.3 (2003) to 1.9 (2010)
- Reduced Total Fertility Rate (%) - 3.5 (2003) to 2.1 (2010)
- Increased Total Contraceptive Prevalence Rate (%) - 48.9 (2003) to 80 (2010)
- Increased use of modern FP (%) - 33.4 (2003) to 60 (2010)
- Reduced FP unmet need (%) - 17.3 (2003) to 8.6 (2010)

## SESSION 2

### FAMILY PLANNING AND REPRODUCTIVE HEALTH



#### LEARNING OBJECTIVES:

At the end of the session, the participants will be able to:

1. Explain the Administrative Order (AO) on Reproductive Health (RH).
2. Explain what is RH.
3. Enumerate the 10 elements of RH.
4. Explain how FP can be integrated with the other RH elements.
5. Explain the Maternal, Newborn, and Child Health and Nutrition (MNCHN) strategy.



#### NARRATIVE

##### REPRODUCTIVE HEALTH POLICY

The Philippines is a signatory to the 1994 International Conference on Population and Development (ICPD) Program of Action. In 1998, DOH issued **AO 1-A establishing the Philippine RH program**, which defined the RH service package consisting of 10 elements to include FP.

This was further strengthened through the issuance of **AO 43, s.1999 adopting the RH policy to integrate RH** services in all health facilities as part of a basic package of health services and thus ensuring a more efficient and effective referral system from primary to tertiary, public and private facilities.

##### WHAT IS REPRODUCTIVE HEALTH?

Reproductive Health is defined as a state of “complete physical, mental and social well-being, and not merely the absence of disease or infirmity in all matters relating to the reproductive health system and to its functions and processes” (UN ICPD, 1994).

Reproductive health care is defined as the constellation of methods, techniques, and services that contribute to reproductive health and well-being by preventing and solving reproductive health problems.

##### TEN ELEMENTS OF REPRODUCTIVE HEALTH

The following are the 10 elements of reproductive health:

1. Family Planning
2. Maternal and Child Health and Nutrition
3. Prevention and Management of Reproductive Tract Infections (RTIs) including Sexually Transmitted Infections (STIs), and HIV/AIDS
4. Adolescent Reproductive Health
5. Prevention and Management of Abortion and Its Complications
6. Prevention and Management of Breast and Reproductive Tract Cancers and other Gynecological Conditions
7. Education and Counseling on Sexuality and Sexual Health
8. Men’s Reproductive Health and Involvement
9. Violence against Women and Children
10. Prevention and Management of Infertility and Sexual Dysfunctions

## LINKING FP TO THE OTHER RH ELEMENTS

Clients consulting for a particular service may have other unmet RH needs that should also be provided. This client-centeredness of care is the cornerstone in the provision of quality, comprehensive RH package of services. This simply means that no client will leave the facility with a need not addressed. This is also termed as the “one stop shop” on health care.

Family planning, as an integral element of Reproductive Health, can be provided to everyone in the reproductive age group with other RH services. Family Planning is foremost in the attainment of reproductive health as it allows couples to decide freely on the number and spacing of their children. It can be linked to other RH elements.

### 1. Maternal and Child Health and Nutrition

Central to the attainment of optimum maternal and child health is proper birth spacing of at least three years. This period provides ample time for mothers to regain their health and to properly care for their newborns. Through the use of safe and effective FP methods, the risks of pregnancy among the “too young”, “too old”, “too frequent”, and “too many” can be avoided.

Pregnant women may have unmet need for FP. These women will benefit from being informed of FP services available in their localities.

Breastfeeding mothers have specific FP needs specially methods that do not affect the quality and quantity of breast milk.

### 2. Prevention and Management of RTIs, including STIs, HIV/AIDS

Individuals with FP needs are sexually active which makes them at risk for STIs like HIV/AIDS.

Family planning clients who are at risk of contracting STIs need dual protection through the use of a FP method such as condom which provides protection against STIs.

Risk assessment for STIs is part of determining a client’s eligibility for IUD use.

### 3. Prevention and Management of Abortion and Its Complications

Abortions are a result of unplanned pregnancies. One of the major causes of maternal deaths is due to the complications of unsafe abortion. Women who resort to abortion have unmet needs for family planning.

Family planning provides men and women with options for preventing unplanned pregnancies which may result in abortion. Proper management of complications of abortion includes medical treatment and the provision of FP services (i.e., counseling and the chosen method).

#### **4. Prevention and Management of Breast and Reproductive Tract Cancers and other Gynecological Conditions**

Provision of FP services presents an opportunity for screening and early detection of breast and reproductive tract cancers.

Combined oral contraceptives are proven to reduce the risk of ovarian and endometrial cancers. Progestin-only contraceptives have a high protective effect against endometrial cancers.

#### **5. Education and Counseling on Sexuality and Sexual Health**

An understanding of basic concepts on fertility deepens the appreciation of gender roles and enhances the relationship between sexual partners.

Fertility management and sexuality education are essential to sexual health.

Family planning counseling and provision of accurate information on sexuality helps reduce unplanned pregnancies.

#### **6. Men's Reproductive Health and Involvement**

Men are crucial halves in the attainment of a couple's reproductive intentions and should be involved in family planning.

Male involvement is critical to acceptance and continuous use of family planning methods. This can be in the form of:

- ✓ supporting their partner's use of FP
- ✓ being acceptors themselves
- ✓ performing family obligations and other shared responsibilities such as child rearing

Men have their own specific health needs for FP that a comprehensive RH service should provide for.

#### **7. Adolescent Reproductive Health**

Adolescents have the potential to be sexually active and need to be advised and counseled about safe and responsible sexual practices, including FP.

Orientation on fertility awareness and counseling are basic services which will help promote responsible sexuality among adolescents. Responsible sexuality will help reduce unplanned pregnancies and RTIs particularly sexually transmitted infections like HIV/AIDS.

#### **8. Prevention and Management of Infertility and Sexual Dysfunctions**

Fertility awareness during FP counseling may provide the opportunity to discuss infertility and sexual dysfunction problems, which are normally difficult topics to bring out in the open.

FP is not only for delaying pregnancies but also for achieving fertility through fertility awareness orientation, counseling, and referral to appropriate facilities.

## 9. Violence Against Women and Children

FP use may be a sensitive issue in a family affected by a gender-related violence (i.e., women who are beaten up because they do not want to get pregnant). Health providers need to be tactful while ensuring that client needs are met.

Domestic violence, mostly with women as the victims, is now recognized as an important public health issue. Sexual violence is one of the most common forms. This provides an opportunity to discuss and promote FP.

### THE INTEGRATED MATERNAL, NEWBORN, CHILD HEALTH AND NUTRITION (MNCHN) STRATEGY

The Integrated MNCHN Strategy (DOH AO 2008-0029) was instituted in September 2008 to address the need to reduce both maternal and infant mortality rates as part of the MDGs for the Philippines.

The strategy includes the quality provision of family planning methods of choice and meeting the unmet needs for family planning services and information.

#### **GOAL:**

Rapidly reduce maternal and neonatal mortality through local implementation of an integrated MNCHN strategy.

#### **OBJECTIVES:**

- Develop, adopt, promote, implement, and evaluate an integrated MNCHN strategy for the rapid reduction of maternal and neonatal mortality;
- Engage all province-wide or city-wide health systems to adopt and implement the integrated MNCHN strategy;
- Provide targeted support to province-wide or city-wide health systems and specific population groups where the maternal and neonatal mortality problem is most severe; and,
- Achieve national MNCHN program targets for the following key indicators by 2010:
  - Increase modern contraceptive prevalence rate from 35.9% (FPS, 2006) to 60%;
  - Increase percentage of pregnant women having at least four antenatal care visits from 70% (NDHS, 2003) to 80%;
  - Increase percentage of skilled birth attendants and facility-based births from 40% (NDHS, 2003) to 80%; and,
  - Increase percentage of fully immunized children from 70% (NDHS, 2003) to 95%.

#### **Immediate Results of the MNCHN Strategy:**

- Every pregnancy is wanted, planned, and supported;
- Every pregnancy is adequately managed throughout its course;
- Every delivery is facility-based and managed by skilled birth attendants; and,
- Every mother-and-newborn pair secures proper postpartum and postnatal care with smooth transitions to the women's health care program for the mother and child survival package for the newborn.

## SESSION 3

### MATERNAL HIGH-RISK FACTORS

#### LEARNING OBJECTIVE

At the end of the session, the participants will be able to:

Discuss the maternal high risk factors in pregnancy and childbirth and its complications to mothers and infants.

#### NARRATIVE

Maternal high-risk factors refer to:

- Too young (mothers who are below 18 years of age),
- Too old (mothers who are 35 years old and above),
- Too many (mothers who have four or more pregnancies),
- Too close (birth interval of less than three years) and,
- Too ill (mothers having chronic diseases or disorders).

Mother's age at birth, birth order, and birth interval can affect a child's chances of survival. These are major factors in increasing maternal and infant mortality.

#### 1. "Too Young"

Pregnancy complications of mothers who at young age (below 18 yrs of age) include the following:

- Hemorrhage/Anemia
- Toxemia
- Iron Deficiency Anemia
- Miscarriage/Stillbirth
- Prolonged Labor

A teen-age mother is prone to these complications because her reproductive system is not yet fully developed, and pregnancy interrupts her body's normal course of growth and development. These complications are compounded by the heavy social and economic responsibilities of parenthood for which they are rarely ready.

Infants of mothers who are too young are in danger of the following:

- Low birth weight
- Birth-related defects
- Prematurity
- High incidence of fetal death and morbidity

#### 2. "Too Old"

Pregnancy complications of mothers who are at advanced age (35 years old and above) includes the following:

- Hemorrhage
- Prolonged Labor
- Toxemia

As a woman's age advances, the muscles of her uterus also become less firm, making pregnancy and childbirth more difficult.

Infants born to older women are also at a much greater risk of having the following birth defects:

- Heart defects
- Birth defects (i.e., cleft palate and lip)
- Down's syndrome
- Higher incidence of stillbirths and fetal deaths

If childbirth could be postponed until the "too young" mother is old enough, and averted in mothers who are "too old" and "too ill," the impact on both maternal and infant mortality would be significant.

### 3. Birth Number ("Too Many")

- Women who have had four or more deliveries are more likely to experience problems during pregnancy and labor and to require Caesarean section (which is often not readily available or not performed early enough).
- This group has a significantly higher risk of miscarriage and perinatal mortality than women undergoing their second or third delivery.

### 4. Birth Interval ("Too Close")

- Complications to mothers of birth intervals of less than three years include:
  - ✓ Anemia and malnutrition
  - ✓ Increased vulnerability and illnesses
  - ✓ Physical stress
- Child birth interval of at least three years is good enough to ensure enough opportunity for the mother to completely recover her health and nutritional status.
- Babies born less than three years after early weaning of the child from the mother's breast which often times may result to:
  - ✓ Child diarrheal disease and malnutrition
  - ✓ Low birthweight
  - ✓ High infant deaths which is 1-1.5 times more likely to happen
- When birth interval is more than three years, children become more resistant to infections and communicable diseases.

### 5. Too ill or unhealthy or with medical condition

Women with chronic medical conditions like tuberculosis, cardiac disease, mental health condition, and cancer or malignancies require treatment and therefore need to postpone or limit pregnancy through family planning.

- Pregnancy complicates physiological processes of treatment and rehabilitation.
- Pregnancy adds burden to a body already burdened by disease.

This also poses danger to the infant due to the adverse effects of medications being used to treat the disease including congenital malformations and stillbirth.

### Key Messages

1. Family Planning is a health intervention that promotes the health of women and children and reduces maternal and infant morbidity and mortality.
2. The PFPP is promoted and implemented based on four pillars namely, responsible parenthood, respect for life, birth spacing of at least three years, and informed choice.
3. FP saves lives and is pro-quality life!

## HEALTH BENEFITS OF FAMILY PLANNING

 **LEARNING OBJECTIVE**

At the end of the session, the participants must be able to:

Identify the health benefits of family planning to mothers, children, and fathers.

 **NARRATIVE**
**A. Benefits to Mothers**

- Significant Reduction in Maternal Mortality and Morbidity
  - Using an effective FP method reduces maternal deaths by preventing high risk pregnancies among women who are too young, too old, or too ill to bear children safely.
  - Maternal deaths can be prevented if unwanted pregnancies are avoided and pregnancies are spaced by at least three years.
  - FP prevents closely spaced pregnancies that leads to and worsen conditions such as anemia and maternal malnutrition
  
- Non-Contraceptive Health Benefits of Hormonal Contraceptives
  - Studies show that combined oral contraceptives provide significant non-contraceptive health benefits. They are known to prevent/reduce the incidence of the following diseases and conditions:
    - a. Ectopic pregnancy
    - b. Ovarian cancer
    - c. Endometrial cancer
    - d. Ovarian cysts
    - e. Benign breast disease
    - f. Excessive menstrual bleeding and associated anemia
    - g. Menstrual cramping, pain, and discomfort
  - All FP methods help women with HIV avoid pregnancy thus avoid bearing HIV-infected children.

**B. Benefits to Infants and Children**

- Reduction in Infant and Child Mortality and Morbidity
  - Globally, an estimated 14.5 million infants and children under age five die every year, mainly from respiratory and diarrheal diseases complicated by malnutrition.
  - Recent studies indicate that the lowest risks for fetal death, pre-term delivery, being undersized for gestational age, neonatal death, and low birth weight occur when births are spaced from three to five years (Demographic and Health Surveys, 2002).
  - Properly spaced children at least three years will be given the love, attention, care and time from mothers and fathers attending to their growth and development.
  - Fewer children in the family will provide more opportunities for adequate food, clothing, good education, and good health for the children.
  - Breastfeeding can protect infants against diarrheal and other infectious disease as well as protect mothers from postpartum hemorrhage.



### **C. Benefits to Fathers**

- Provides fathers who are suffering from chronic illnesses (e.g. Diabetes, Hypertension) enough time for treatment and recovery from those illnesses
- Lightens his burdens and responsibilities in supporting his family since he will only be providing few children he can afford to support
- Enables him to give his children a good home, a good education, and a better future
- Gives time for his own personal achievement
- Enables him to have time and opportunity to relate with his wife and play with his children
- Affords him extra resources and enough time to actively participate in community program and projects.



# MODULE 2



## Human Reproductive Anatomy and Physiology

Session 1: The Female Reproductive System

Session 2: The Male Reproductive System

Session 3: The Concept of Fertility and Joint Fertility



## MODULE 2: HUMAN REPRODUCTIVE ANATOMY AND PHYSIOLOGY



### MODULE OVERVIEW

This module provides an overview of the basic anatomy and physiology of both male and female reproductive systems. The knowledge gained from this module will give service providers a better understanding of the various family planning methods - their different modes of action, the connection with, and the effects on the human reproductive anatomy and physiology.



### MODULE OBJECTIVES

The objective of this module is to explain the human reproductive anatomy and physiology as basic knowledge for the effective delivery of family planning methods.



### MODULE SESSIONS

The module contains the following sessions:

<b>Session 1</b>	The Female Reproductive System
<b>Session 2</b>	The Male Reproductive System
<b>Session 3</b>	The Concept of Fertility and Joint Fertility

# SESSION 1

## THE FEMALE REPRODUCTIVE SYSTEM

### LEARNING OBJECTIVES

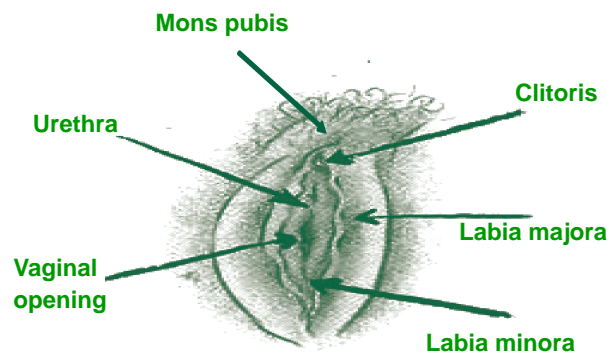
At the end of the session, the participants will be able to:

1. Identify the parts of the external and internal female reproductive system.
2. Discuss the functions of the parts of the female reproductive system.
3. Describe the physiological changes that occur during a woman's menstrual cycle.
4. Relate the human reproductive anatomy and physiology to the mechanisms of action of modern FP methods.

### NARRATIVE

#### THE FEMALE EXTERNAL REPRODUCTIVE ANATOMY

The **vaginal opening** serves as the entrance to the vaginal canal or birth canal. The vaginal opening is elastic and flexible as it widens during sexual excitement, to allow the entrance of the penis; and during childbirth, to allow the passage of the baby during delivery. It also allows the flow of menstrual blood from the uterine cavity to the exterior.



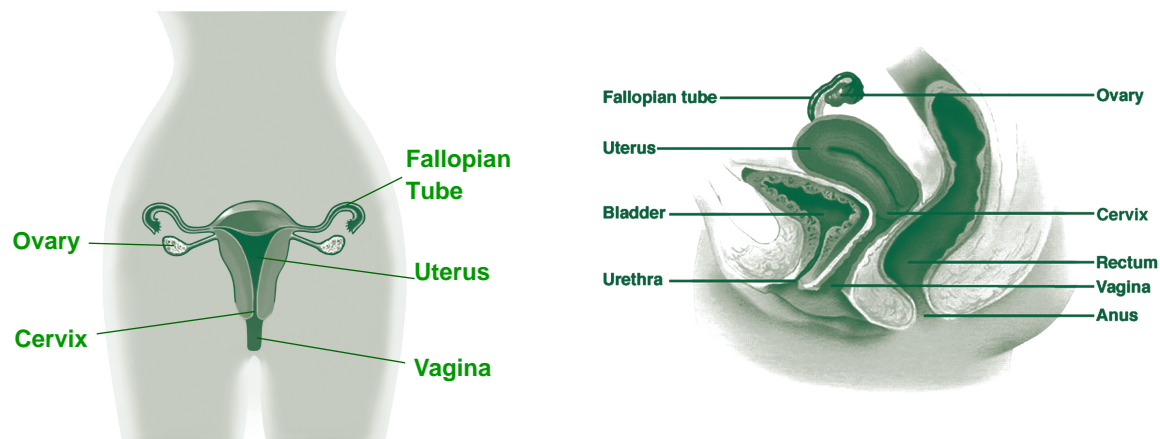
## 2.2

On either side of the vaginal opening are two sets of vaginal lips that protect the vaginal opening. The outer lips are called the **labia majora**, which are covered by pubic hair while the inner lips, are the **labia minora**, which are not covered with hair. The **vulva** refers to both labia majora and minora.

Above, the vagina is the urinary opening called the **urethra**. This is a tubular structure through which urine leaves the body.

The **clitoris** is a peanut-sized structure located above the urinary opening. The clitoris is a sensitive organ that when stimulated brings forth sexual arousal for many women.

The **mons pubis** is a pad of fatty tissue that covers the pubic bone area. The mons pubis is a protective structure that is covered with pubic hair and serves as a cushion during sexual intercourse. It also helps protect the internal reproductive organs.



## FEMALE INTERNAL REPRODUCTIVE ANATOMY

The **uterus** is a hollow, muscular organ that lies between the bladder and the rectum, where implantation of fertilized ovum and eventually pregnancy takes place. A lining called **endometrium** covers the cavity of the uterus.

During the menstrual cycle, the amount of blood in the endometrium increases to help sustain and nourish pregnancy. If pregnancy does not occur, this sloughs off and results to **menstruation**.

Menstrual blood leaves the uterus through the **cervix**. The cervix usually looks like a small round ball seen during speculum examination. The cervix has an opening that allows the entry of sperm for fertilization to take place.

Glandular cells line the cervical canal and produce cervical mucus under the influence of the hormone estrogen. The sperm depend on the consistency of the cervical mucus for their survival and transport. During the fertile period, the mucus is thin and watery allowing the sperm to easily pass through the cervix. During the infertile period, the mucus is said to be thick and sticky making the sperm difficult to pass the cervix to the uterus. During labor, the cervix also dilates to allow the passage of the baby during delivery through the **vaginal canal**.

The **fallopian tubes** are tubular structures that are attached to sides of the body of the uterus. Close to its fimbriated (fan-shaped) opening are two pearly white structures called ovaries. The fallopian tubes receive the mature egg from the ovaries and it is here where fertilization takes place.

The ovaries are the woman's primary sex glands where important hormones, estrogen and progesterone, are produced. These hormones function to prepare the endometrium to receive a fertilized ovum.

A woman has more than seven million potential eggs (primary oocytes) while still a fetus. By birth, the number will fall to one or two million, and by puberty to about 300,000. Only 300 to 400 eggs reach maturity. During the woman's fertile period, one egg matures and will be released from the ovary. This is called the ovulation period.

After the egg has been released from the ovary, it enters one of the fallopian tubes where fertilization takes place. Fertilization is the process of the union of the sperm and egg.

- An egg may be fertilized for up to 24 hours (one day) after it is released.
- If the sperm and egg do not meet within 24 hours, the egg is usually absorbed in the reproductive system.

If pregnancy does not take place, menstruation will occur in about two weeks after the egg leaves the ovary.

## THE MENSTRUAL CYCLE

The menstrual cycle begins on the first day of menstrual bleeding and ends on the day before menstrual bleeding begins again.

The length of a woman's menstrual cycle can normally vary by a few days from cycle to cycle. A menstrual cycle is usually 26 to 35 days long, but some women may have shorter or longer cycles and this can be normal for them.

Menstrual bleeding normally lasts from three to five days.

### The Phases of the Menstrual Cycle

The menstrual cycle has three phases:

#### 1. *Pre-Ovulatory Phase*

- On the first day of the menstrual cycle, estrogen and progesterone levels are low. This causes the shedding of the endometrium as menstrual bleeding.
- The low levels of estrogen and progesterone stimulates the brain to produce Follicle-Stimulating Hormone (FSH). This hormone, as it is called, stimulates the follicles in the ovary to mature. One of these follicles will later further mature to be released during ovulation.
- The maturing follicles in the ovary produce estrogen. As the follicles mature further, the estrogen levels increase.
- Estrogen causes:
  - ✓ endometrium to thicken by cell multiplication and proliferation
  - ✓ production of mucus to become increasingly wet and lubricative

## 2.4

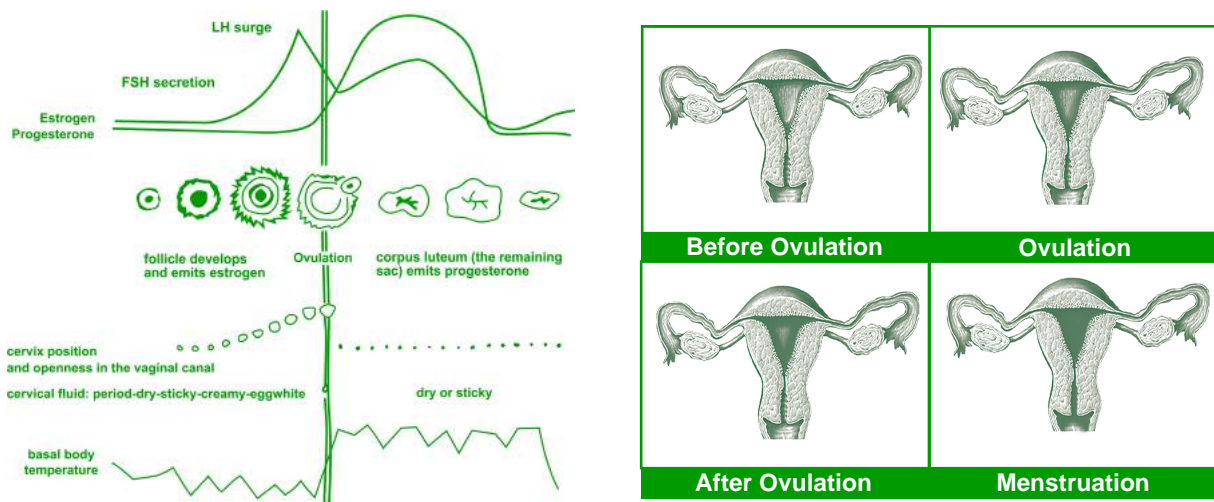
#### 2. *Ovulatory Phase*

- When estrogen levels peak, the brain is stimulated to produce Luteinizing Hormones (LH). This sudden increase of luteinizing hormones causes the release of the mature ovum, a process which is called **ovulation**.
- Ovulation usually occurs 12-16 days before the onset of the next menses.
- Once ovulation occurs and the egg has gone into the fallopian tube, it can be fertilized by the male sperm for only up to one day (24 hours).
- During this phase:
  - The lining of the uterus continues to thicken.
  - The egg is mature and is finally released.

- The cervical mucus is wet, slippery, stretchy, and clear.
- There is a feeling of vaginal wetness.
- The cervix is soft and open.

### 3. Post-Ovulatory Phase

- After ovulation, the remaining follicles that underwent initial maturation are transformed into the corpus luteum.
- The corpus luteum in the ovary produces estrogen in smaller amounts and progesterone in greater amounts. This causes a drop in estrogen levels with higher levels of progesterone.
- Progesterone causes the following changes in the woman's reproductive system:
  - The cervical mucus becomes pasty and is no longer slippery and stretchy.
  - The vagina feels dry (this type of mucus does not allow the sperm to travel into the uterus and prevents the sperm from living for more than a few minutes to a few hours).
  - The cervix becomes firm; the cervical opening closes so that sperm cannot pass through to the uterus.
  - The basal body temperature increases and remains high for the rest of the cycle.
- When there is no fertilization, the corpus luteum regresses. As the corpus luteum regresses, the production of progesterone and estrogen decreases.
- When estrogen and progesterone levels are low, menstruation occurs.



When fertilization occurs, the fertilized egg produces the Human Chorionic Gonadotropin (HCG) hormone.



### **Effects of HCG:**

- The corpus luteum is maintained so that the estrogen and progesterone production is sustained.
- Due to the sustained levels of estrogen and progesterone, the endometrium is maintained and menstruation does not happen.
- The presence of HCG causes the pregnancy test to read positive.

### **FP AND PHYSIOLOGICAL CHANGES IN A WOMAN**

- Why are women on hormonal contraceptives not ovulating?  
Women taking the hormonal contraceptives have consistent high levels of estrogen and/or progesterone. The brain is not stimulated to produce FSH so that no follicles mature for ovulation.
- Why are most women on the progestin-only injectable, like DMPA, not having menses?  
The endometrium is not developed because the estrogen effect (i.e., priming of the endometrium) is surpassed by the higher progestin levels. So there is no endometrium to shed off.
- Why is the temperature higher after ovulation?  
After ovulation, progesterone levels are high. Progesterone is thermogenic (i.e., giving high temperatures). The increased levels of progesterone, observed as an increase in basal body temperature, signifies that ovulation has already occurred.
- Why does the cervical mucus thicken in women using progestin-only contraceptives?  
Progesterone causes the cervical mucus to thicken.

## SESSION 2

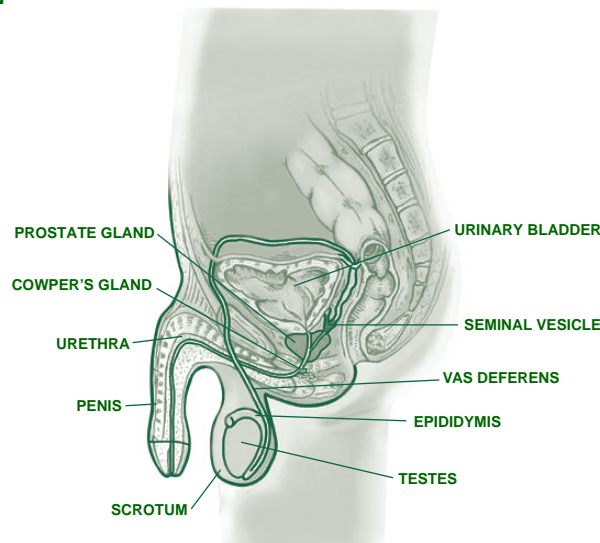
### THE MALE REPRODUCTIVE SYSTEM

#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Identify the parts of external and internal male reproductive system.
2. Explain the functions of the parts of the male reproductive system.

#### NARRATIVE



#### THE MALE EXTERNAL REPRODUCTIVE ANATOMY

The **penis** is the male organ for copulation. It is made up of spongy erectile tissues. When a man becomes sexually excited, it becomes erect; it stiffens and grows both in width and length. An erect penis is about five to seven inches long and about an inch or an inch-and-a-half in diameter.

The **scrotal sac or scrotum** is the wrinkled skin pouch, which contains and protects the testes or testicles. The scrotum controls the temperature of the testicles, which is normally about 6°C lower than the body temperature, ideal for sperm production.

#### THE MALE INTERNAL REPRODUCTIVE ANATOMY

- A man is fertile everyday from puberty (age eight to 12) and for the rest of his life.
- The **testes** are the pair of male sex glands that produce sperm and testosterone. Sperm is the male sex cells. Testosterone is the major male hormone responsible for the development of sperm and secondary male sex characteristics.
- Normal sperms analysis: count: 60 million/ml; motility: 60%; morphology: 30% or more of normal morphology; volume: 1-6ml per ejaculate; ph: 7.2 to 7.8; liquefaction- less than 20 minutes.
- Under optimal conditions, the life span of the sperm is up to three to five days.
- Once sperm are produced, they travel to the epididymis, where they start to mature. The **epididymis** are small tubes at the base of the testes.

- When a man ejaculates, the sperm leave the epididymis and travel through a pair of tubes called the **vas deferens**, also known as sperm ducts.
- The vas deferens allows the passage of sperm to the **seminal vesicles**, the glands that produce a fluid that enters the vas deferens to nourish the sperm. The vas deferens are the tubes that get cut during vasectomy.
- After the fluid from the seminal vesicles mixes with the sperm, this mixture continues to travel through the vas deferens to the **prostate gland**, which is situated at the base of the **urinary bladder** that surrounds part of the urethra. This gland produces a thin, milky, and alkaline fluid, which forms part of the semen.
- Semen with sperm travel out of the man's body through the **urethra**, the tube that runs through the center of the penis. In males, the passage way for urine and sperm are the same. A man cannot urinate and release semen at the same time.
- Before the semen leaves the man's reproductive system, the **Cowper's gland** releases a small amount of fluid. This fluid further makes the seminal fluid alkaline so that sperm are not destroyed as it passes the urethra during ejaculation.

## SESSION 3

### THE CONCEPT OF FERTILITY AND JOINT FERTILITY

#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Explain the concept of fertility and joint fertility.

#### NARRATIVE

**Fertility** is the capacity of the woman to conceive and bear a child and the capacity of a man to have a woman conceive.

When we refer to **joint fertility**, we focus on both male and female fertility, not separately, but in a joint or combined perspective. Joint fertility involves contributions from both the male (sperm) and the female (egg) resulting to the conception of a child.

#### Male Fertility

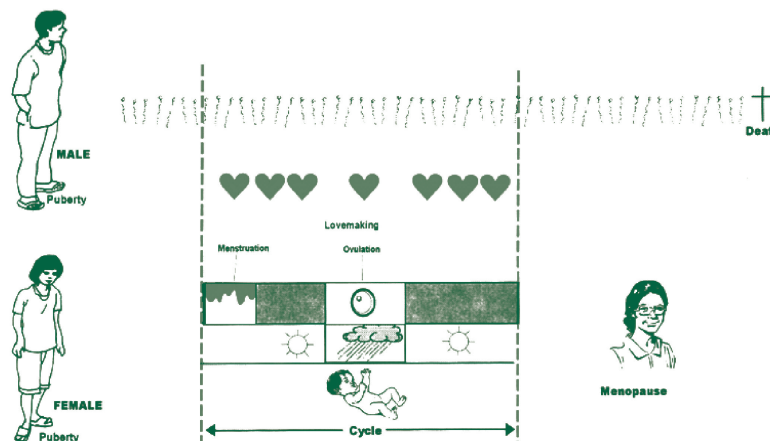
- Males, after they reach puberty, are always fertile and are able to make females pregnant at any time.
- Male fertility ends at death.

#### Female Fertility

- Unlike males, females are fertile only on certain days within a menstrual cycle, which is during ovulation. On other days, they are infertile.
- Fertilization occurs when there are sperm cells available to fertilize the ovum at the time of ovulation.
- Female fertility ends at menopause which occurs at 50 years of age (at an average).

Joint or combined fertility involves the united and equal contribution of the male and female in the decision and ability to have a child.

#### JOINT FERTILITY DIAGRAM



## PUBERTY

Puberty refers to the process of physical changes by which a child's body becomes an adult body capable of reproduction. In a strict sense, this refers to the bodily changes of sexual maturation. Puberty is initiated by hormone signals from the brain to the gonads (the ovaries and testes). In response, the gonads produce a variety of hormones that stimulate the growth, function, or transformation of the brain, bones, muscle, skin, breasts, and reproductive organs. During puberty, major differences of size, shape, composition, and function develop in many body structures and systems. The most obvious of these are referred to as secondary sex characteristics.

### SIGNS OF PUBERTY

#### *IN FEMALES*

Girls begin the process of puberty about one to two years earlier than boys. The process begins at the age of nine to 14 years.

#### 1. Breast development

The first physical sign of puberty in females is usually a firm, tender lump under the center of the areola(e) of one or both breasts, occurring on average at about 10.5 years of age. Within six to 12 months, the swelling has clearly begun in both sides, softened, and can be felt and seen extending beyond the edges of the areolae. By another 12 months, the breasts are approaching mature size and shape, with areolae and papillae forming a secondary mound. In most young women, this mound disappears into the contour of the mature breast.

#### 2. Pubic hair

Pubic hair is often the second change of puberty noticed in females. The pubic hair is usually visible first along the labia. Within another six to 12 months, the hair is too many to count and appear on the pubic mound as well. Later, the pubic hair densely fill the "pubic triangle," and spread to the thighs and sometimes as abdominal hair upward towards the navel.

#### 3. Vagina, uterus, ovaries

The mucosal surface of the vagina also changes in response to increasing levels of estrogen, becoming thicker and a duller pink in color (in contrast to the brighter red of the prepubertal vaginal mucosa). Whitish secretions (physiologic leukorrhea) are a normal effect of estrogen as well. In the next two years following the development of the breast, the uterus, and ovaries increase in size, and follicles in the ovaries reach larger sizes. The ovaries usually contain small follicular cysts visible by ultrasound.

#### 4. Menstruation and fertility

The first menstrual bleeding is referred to as menarche, and typically occurs about two years after the first signs of breast development. The average age of menarche is about 11.75 years. Menses (menstrual periods) are not always regular and monthly in the first two years after menarche. Ovulation is necessary for fertility, but may or may not accompany the earliest menses. In post menarchal girls, about 80% of the cycles are anovulatory in the first year after menarche (about 13 years), 50% in the third (about 15 years) and 10% in the sixth year (about 18 years).

During this period, also in response to rising levels of estrogen, the lower half of the pelvis relaxes and thus the hips widen (providing a larger birth canal). Fat tissue increases to a greater percentage of the body composition than in males, especially in the typical female distribution of breasts, hips, buttocks, thighs, upper arms, and pubis.

Progressive differences in fat distribution as well as sex differences in local skeletal growth contribute to the typical female body shape by the end of puberty. At age 10, the average girl has 6% more body fat than the average boy, but by the end of puberty, the average difference is nearly 50%.

## 5. Body odor and acne

Rising levels of androgens can change the fatty acid composition of perspiration, resulting in a more "adult" body odor. This often precedes breast and pubic hair development by a year or more. Another androgen effect is increased secretion of oil (sebum) from the skin. This change increases the susceptibility to acne, a characteristic affliction of puberty in its severity.

## IN MALES

Boys begin the process of puberty at about 10 to 17 years old. The following are the physical changes during puberty:

### 1. Testicular size, function, and fertility

This is the first physical manifestation of puberty in males. The testes start producing testosterone and sperm. Sperm can be detected in the morning urine of most boys after the first year of pubertal changes (and occasionally earlier). Potential fertility is reached at about 13 years old in boys, but full fertility will not be gained until 14-16 years of age, although some go through the process faster, reaching it only a year later.

### 2. Pubic hair

Pubic hair often appears on a boy shortly after the genitalia begin to grow. The pubic hair is usually first visible at the dorsal (abdominal) base of the penis. After another six to 12 months, the hair become more dense and fills the "pubic triangle". Hair also spreads to the thighs and upward towards the navel as part of the developing abdominal hair.

### 3. Body and facial hair

In the months and years following the appearance of pubic hair, other areas of skin which respond to androgens (testosterone) develop heavier hair in roughly the following sequence: underarm (axillary) hair, perianal hair, upper lip hair, sideburn (preauricular) hair, periareolar hair, and the rest of the beard area. Arm, leg, chest, abdominal, and back hair become heavier more gradually.

There is a large range in amount of body hair among adult men, and significant differences in timing and quantity of hair growth among different ethnic groups.[13]

Chest hair may appear during puberty or years after. Not all men have chest hair.

### 4. Voice change

Under the influence of androgen, the voice box, or larynx, grows in both sexes. This growth is far more prominent in boys, causing the male voice to drop and deepen, sometimes abruptly but rarely "overnight," about one octave. Full adult pitch is attained on the average, by the age of 15.

### 5. Male musculature and body shape

By the end of puberty, adult men have heavier bones and nearly twice as much skeletal muscle.

### 6. Body odor and acne

Rising levels of androgens can change the fatty acid composition of perspiration, resulting in a more "adult" body odor. Another androgen effect is increased secretion of oil (sebum) from the skin and the resultant variable amounts of acne. Acne can not be prevented or diminished easily, but it typically fully diminishes at the end of puberty.



# MODULE 3



## FP Client Assessment

Session 1: The FP Service Record or FP Form 1 in Client Assessment

Session 2: WHO Medical Eligibility Criteria for Contraceptive Use





# MODULE 3: FP CLIENT ASSESSMENT



## MODULE OVERVIEW

In all primary health care units, RH services should be available and provided. It is the service provider's responsibility to assess the reproductive health status of the clients.

The health provider should therefore have the necessary knowledge and skills to adequately and accurately assess the health needs, as well as the health status of clients seeking to improve the quality of their lives.

Client assessment is the first stage common to any health care service provision and an important step prior to provision of FP services. The client's FP needs and data on medical status and conditions are obtained to ensure that they are medically eligible for their chosen FP method.



## MODULE OBJECTIVES

At the end of this module, participants will be able to perform a complete FP client assessment based on evidence-based global standards.



## MODULE SESSIONS

This module will cover the following:

<b>Session 1</b>	The FP Service Record in Client Assessment
<b>Session 2</b>	WHO Medical Eligibility Criteria for Contraceptive Use

# SESSION 1

## THE FP SERVICE RECORD IN CLIENT ASSESSMENT



### LEARNING OBJECTIVES

At the end of this session, participants will be able to:

1. Define client assessment.
2. Explain the purpose of client assessment in FP.
3. Describe the steps of FP client assessment.
4. Describe the FP Service Record or FP Form 1 with its components.
5. Demonstrate use of the FP Service Record.
6. Explain the guidelines on physical examination in FP service provision.
7. Enumerate the steps in physical examination of FP clients.
8. Explain the purpose of laboratory examination in FP service provision.
9. Describe commonly performed laboratory examination in FP service provision.



### NARRATIVE

**Client assessment** is the process by which the health worker learns about the health status, the FP needs, and the eligibility of the client for contraceptive use. The first step to assessing a client is to take the client's clinical history.

Data about the client's health are gathered through medical history taking, physical examination, and needed laboratory examination which is analyzed to see if the client is in good health or needs further evaluation and management and/or referral. It is a **MUST** that all clients who attend FP/ RH clinics undergo assessment.

#### Purpose

##### **Client assessment is important as it:**

- Establishes the client's health status.
- Determines the client's eligibility for using a contraceptive method.
- Determines whether the client is in good health, needs further examination and management including closer follow-up and/or referral.
- Identifies the need for additional procedures and/or laboratory examination.

##### **Steps in Client Assessment:**

The following are the specific steps in client assessment:

1. Note that for each step, client comfort and privacy should always be considered.
  - a. Greet client cordially.
  - b. Establish rapport with the client.
  - c. Establish the purpose of the visit.
  - d. Explain to the client procedures to be performed (including physical and/ or laboratory examinations, if needed).
  - e. Encourage the client to ask questions openly/freely.
2. Take and record client 's health history using the Family Planning Service Record Form 1. (FP Form 1)

3. Discuss with the client the:
  - a. Findings based on the history.
  - b. Need to perform further examination like physical and/or laboratory examination, if necessary.
  - c. Need for referral for laboratory examination or further management, if necessary.
  - d. Need and schedule of follow-up visit(s).

Only those procedures that are essential as recommended by the WHO (applicability of procedures and examinations for contraceptive use) should be performed. Additional examinations (i.e., physical or laboratory) are performed to validate abnormal findings during client assessment.

**Example:**

It is not necessary to do a complete physical examination including a pelvic exam on a client requesting for a condom. However, if there is a complaint of urethral discharge, a pelvic exam and collection of urethral discharge for smear should be performed. In this case, the additional examination is performed because of the signs of infection and not for determining his suitability for using the condom.

## CLIENT HISTORY-TAKING

Client history-taking is the process of gathering data by interviewing the client about past and present medical/reproductive health status. Obtaining the client's history during the initial visit is important in identifying needs and factors or conditions that may affect suitability for using the FP method(s). It is, therefore, the responsibility of the service provider to be able to elicit such information prior to the provision of a method.

Client history-taking enables the service provider to:

1. Assess the client's reproductive health status and identify the RH needs of the client.
2. Identify risk factors or areas for precaution in the use of an FP method.
3. Properly record and verify data gathered in FP Form 1.

### FP Form 1

The FP Form 1 lists the possible illnesses relevant to possible FP method use. Family Planning visits are not due to illness, thus the following information are requisite in the context of FP method use whether initial or follow up visits.

#### A. Personal Data

1. Complete name of client
2. For proper identification and documentation, take complete name of client including middle name. Note that under the present Family Code of the Philippines, an unmarried pregnant woman (this includes live-in partners) retains her maiden name.
3. Name of husband/partner/guardian
  - This is in cases of emergency or for purposes of guardianship or consent.
4. Client's age, sex, marital status, date and place of birth
5. Religion, occupation, average family monthly income
  - To determine client's preferences and practices
  - To determine financial capacity for needed examinations, feasibility of using cheaper forms/methods
6. Educational attainment
  - To be able to adjust level of instruction and communication

- To determine ability to follow complicated instructions/ precautions
7. Address
- To be able to determine if client can have good follow up or visit clients when necessary
  - In cases of emergencies

## B. Medical History

This includes the following information:

- Past illnesses
- Accidents/injuries
- Allergies
- Habits (smoking, drinking, substance abuse, etc.)
- Family history

This includes the following information:

- Health status of immediate family members and living relatives
- Risk factor for cancer, heart disease, diabetes, hypertension, kidney disease

## C. Reproductive History

### 1) Menstrual History

- Menarche = age of onset of menstruation
- LMP (Last Menstrual Period) = first day of last menstrual period, including the usual number of days of menstrual flow, character of flow (scanty, moderate, or heavy), and accompanying symptoms
- PMP (Previous Menstrual Period) = first day of menstrual period prior to the mentioned LMP. This is important to establish accuracy of mentioned LMP, and to establish regularity or irregularity of menstrual periods
- Usually, this is the best time to inform clients that “regularity” of menstrual flow is not based on the menstrual flow occurring in the same day or week of every month. Rather, it is based on the number of days between the two LMPs (first day of two menstrual periods). The normal average interval number of days is 25-35 days.

For example, it may happen that a woman with the following menstrual periods will appear to have very irregular menses but is actually having her menses regularly:

- 2nd week of January (say, January 7);
- 1st week of February (February 2);
- then again in February but in the last week (February 28);
- then in the third week of March (March 21).

### 2) OB History

Completing the **OB score** is one way of evaluating the obstetric history of the client which provides information relevant to FP method use (birth spacing and/or birth limiting). The **OB score** measures the gravidity (G), parity (P) of a woman. **Gravidity (G)** refers to number of pregnancies borne by the mother, irrespective of the pregnancy outcome. **Parity (P)** refers to the number of pregnancies reaching viability (>20 weeks AOG). Other relevant information needed are:

- Full-term pregnancies
- Pre-term pregnancies
- Abortions or miscarriages (ectopic/ molar)
- Current living children

### 3) FP History

- FP method currently being used
  - ✓ Duration of use
  - ✓ Satisfaction with use
- FP method previously used
  - ✓ Duration of use
  - ✓ Reason/s for discontinuation or shifting
- Reproductive goals/ intents
  - ✓ To achieve/maintain desired number of children
  - ✓ To limit or to space

### 4) Risk for Sexually-transmitted Infections (STIs)

The following are reasons for assessing an FP client's risk for STIs:

- FP clients are sexually active people who need to know about factors which put them at risk for STIs.
- If the client is likely to get STIs, the client needs a supply of condoms and counseling about risks, symptoms, and treatment. Counseling includes correct and consistent use of condoms.
- FP clients with a high individual risk for STIs may need to be referred to facilities providing STI services (i.e., counseling and/or treatment).
- IUD should not be provided to clients with high risks for STI.

A basic screening history for STI risk should be included in the history-taking which should include the following:

1. Presence of abnormal vaginal and or urethral discharge.
2. Abnormal vaginal bleeding with the last two menstrual periods.
3. Pain or burning sensation during urination.
4. History of genital tract problem such as vaginal discharge, ulcers or skin lesions around the genital area.
5. Partners of the client who have been treated for a genital tract problem in the last three months.
6. Having more than one sex partner in the last two months and/or their sex partner having other sex partner/s.

### 5) Violence Against Women

It is important to assess a potential FP client's exposure to gender violence because her continued use of an FP method may be affected by the kind of support she gets from a "cruel" husband. The use of a contraceptive may subject the client to violent opposition from an oppressive partner. In such cases, methods that do not require cooperation of the partner (e.g. FAB method, condom) and that are private (e.g. injectables) are more appropriate. The service provider needs to ask the following questions:

- How is your relationship with your husband/partner?
- Does he know about your coming to the clinic?
- Is he willing to cooperate or support you in using an FP method?

There may be a need to refer the client to the nearest Women's Crisis Center where she can be helped.

When faced with clients who complain of side effects and complications, or who have reproductive concerns, the following information should be obtained:

## D. Present Health or Concern

Ask the client about possible:

1. Present complaint or concern
2. Onset, nature, and duration of present complaint or concern
3. Accompanying symptoms and precipitating/aggravating factors
4. Measures or medications taken to relieve symptoms and precipitating/aggravating factors
5. Prior consultation or medication

## PHYSICAL EXAMINATION (PE)

### Purpose of a Physical Examination

A general physical examination is not necessary at all times in ensuring the SAFE USE of a FP method. The WHO Applicability of procedures can serve as the guide that will tell which of the procedures or examinations may be necessary.

Physical examination when necessary will also help the FP service provider to:

- Confirm abnormal conditions suspected or noted during the client history-taking.
- Evaluate the health of the client while she/he uses an FP method to make sure she/he has not developed conditions which need precautions to the use of the contraceptive method.
- Confirm complications from side effects which may have arisen from the use of an FP method.

There are two golden rules to remember when conducting the physical examination:

- a. Proceed from head to toe.
- b. Inspect first, palpate later.

There are basically four general steps in conducting a general physical examination:

### 1. Take vital signs

- a. Blood Pressure
- b. Pulse Rate
- c. Respiratory Rate
- d. Temperature

### 2. Prepare client

- a. Make the client comfortable.
- b. If doing an internal exam: Asking client to void/empty bladder and wash perineum.
- c. Assure privacy and confidentiality.
- d. Explain the procedures or what is going to happen and why.

### 3. Prepare needed instruments and supplies

- a. Prepare the instruments and supplies ahead of the actual PE especially when there is no knowledgeable assistant around.

### 4. Conduct the physical examination

- a. If the health provider is a male, the female client may request a companion during the physical examination.

## OTHER PHYSICAL EXAMINATION THAT MAY BE DONE WHEN NECESSARY

### Breast Examination

According to the applicability in WHO MEC, a breast exam does not contribute to the safe and effective use of any contraceptive method. However, in the light of providing quality reproductive health care, a breast examination can be done during initial visit of all new clients and yearly as part of a general checkup.

### Abdominal Examination

1. Abdominal examination is done to check for tenderness, organ enlargements, or masses.
2. Tenderness in one or both lower quadrants may suggest the presence of pelvic inflammatory disease (PID).
3. In non-pregnant women, the uterus is not palpable by this examination. An abdominal mass may suggest tumor or malignancy.

### Pelvic Examination

1. Pelvic examination is done to detect any pelvic abnormality or pathologic condition that may be a precaution to the use of a specific FP method (i.e., IUD, BTL).
2. It is also done to obtain specimen/s for laboratory examination, which may be necessary in providing RH/FP care. These examination include:
  - a. Pap smear
  - b. Wet vaginal smear for trichomoniasis, moniliasis, or bacterial vaginosis
  - c. Gram staining for gonorrhea and chlamydia

## LABORATORY EXAMINATION

In some cases, findings in the history taking or physical examination (PE) may have to be confirmed or worked out through the use of selected laboratory tests. Laboratory tests are **NOT ALWAYS REQUIRED** (refer to WHO Applicability chart) but are only performed when needed. Every FP service provider must be familiar with these tests and how to interpret their results so that s/he is knowledgeable about: (1) when to request the tests; and (2) how these tests can help him/her best manage the client's case.

### Hemoglobin determination

Hemoglobin determination will tell whether a person has anemia or not.

The normal ranges for hemoglobin depend on the age and, beginning in adolescence, the sex of the person. The normal ranges are:

- Adult males: 14-18 gm/dl
- Adult women: 12-16 gm/dl

## Other Laboratory Examination

There are other laboratory examination requested in FP/RH services:

- Wet Smear - to find the causative agent of existing vaginitis- monilia, trichomonas or gardnerella
- Gram Stain - to determine the microorganism causing the STI - gonococci or chlamydia
- Pap Smear - cervical secretions collected examined under a microscope in order to look for pre-malignant or malignant changes
- Acetic Acid - abnormal areas of the cervix are viewed by applying acetic acid to the cervix



## SESSION 2

### WHO MEDICAL ELIGIBILITY CRITERIA (WHO MEC) FOR CONTRACEPTIVE USE



#### LEARNING OBJECTIVES

At the end of this session, participants must be able to:

1. Describe the WHO Medical Eligibility Criteria for contraceptive use.
2. Define the four categories of the WHO MEC for temporary methods.
3. Explain the recommendations for eligibility for the MEC categories for the permanent and FAB methods.
4. Discuss the WHO MEC on “Applicability of Various Procedures for Contraceptive Use”.
5. Discuss how to be reasonably sure that the woman is not pregnant using the checklist.



#### NARRATIVE

WHO MEC is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria developed from evidence based standards.

The WHO MEC is recommended for assessing clients who may want to start or continue using a method. It gives recommendations based on the latest clinical evidence available on the safety of the methods for people with certain health conditions. On the basis of these recommendations, possible conditions of clients wanting to initiate or continue using a contraceptive method are classified under one of the following four categories listed below.

The four categories of the **WHO MEC** are:

- Category 1:** A condition for which there is **NO RESTRICTION** on the use of contraceptive method. **PROVIDE** the **METHOD**.
- Category 2:** A condition where **THE ADVANTAGES** of using the method generally **OUTWEIGH** the theoretical or proven **RISKS**. This indicates that the method can be **GENERALLY** used, but that **CAREFUL FOLLOW-UP** may be required.
- Category 3:** A condition where the **THEORETICAL OR PROVEN RISKS** usually **OUTWEIGH** the **ADVANTAGES** of using the method. Use of this method **IS NOT RECOMMENDED UNLESS OTHER MORE APPROPRIATE METHODS ARE NOT AVAILABLE** or **ACCEPTABLE**.
- Category 4:** A condition, which represents an **UNACCEPTABLE HEALTH RISK** if the contraceptive method is used. **DO NOT PROVIDE** the method.

WHO Category	With Clinical Judgment	With Limited Clinical Judgment
1	Use the method in any circumstances	Use the method
2	Generally use the method	Use the method
3	Use of the method not usually recommended unless other, more appropriate methods are not available or acceptable	Do not use the method
4	Method not to be used	Do not use the method

Below are the Summary Tables for each of the permanent and FAB methods:

### Simplified MEC Categories for Permanent Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny sterilization to a person with this condition.
C (Caution)	The procedure is normally conducted in a routine setting, but with extra preparation and precautions.
D (Delay)	The procedure is delayed until the condition is evaluated and/or corrected. Alternative temporary methods of contraception should be provided.
S (Special/Refer)	The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia, and other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anesthesia regimen is also needed. Alternative temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

### Simplified MEC Categories for Fertility Awareness-Based Methods

Category	Eligibility Criteria
A (Accept)	There is no medical reason to deny the particular FAB method to a woman in this circumstance.
C (Caution)	The method is normally provided in a routine setting, but with extra preparation and precautions. For FAB methods, this usually means that special counseling may be needed to ensure correct use of the method by a woman in this circumstance.
D (Delay)	Use of this method should be delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be offered.
NA	Not Applicable

## 3.10

## Programmatic implications of the WHO MEC

Programmatic issues that need to be addressed include:

- Informed choice,
- Elements of quality of care,
- Essential screening procedures for administering the methods,
- Provider training and skills,
- Referral and follow up for contraceptive use as appropriate.

In the application of the eligibility criteria to programs, service delivery practices that are essential for the safe use of the contraceptive should be distinguished from practices that may be appropriate for good health care but are not related to the use of the method. The promotion of good health care practices unrelated to safe contraception should be considered neither as a prerequisite nor as an obstacle to the provision of a contraceptive method, but rather as complementary to it.

## WHO MEC Wheel for Contraceptive Use

The WHO MEC Wheel contains the medical eligibility criteria for starting the use of contraceptive methods. It is an abridged version of the Medical Eligibility Criteria for Contraceptive Use, Third edition (2004). It guides FP service providers to determine if a woman presenting with a known medical or physical condition is suitable for safe and effective use of various contraceptive methods.

The wheel includes recommendations on initiating use of six common types of contraceptives:

1. Combined pills (low dose combined oral contraceptives, with 35 < ethinylestradiol)
2. Combined injectable contraceptives (Cyclofem and Mesigyna)
3. Progestin-only pills
4. Progestin-only injectables, DMPA (once every three months injectable) and NET-EN (once every two months injectable)
5. Progestogen-only implants (Norplant, Jadelle, and Implanon)
6. Copper-bearing IUD

The guidance in the wheel applies to initiation of contraceptive methods. Recommendations for continuation of method use and if a woman develops a medical condition while using the method can be found in the MEC guideline.

## Applicability of various procedures or test for contraceptive use

Some examination or procedures may be done before providing a method of contraception. Those with known medical problems or other special conditions may need additional examination or tests before being deemed appropriate candidates for a particular method of contraception.

The applicability of various procedures or tests for contraceptive use is part of the WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004. It focuses on the relationship of the procedures or tests to the safe initiation of a contraceptive method. They are not intended to address the appropriateness of these examinations or tests in other circumstances. For example, some of the procedures or tests that are not deemed necessary for safe and effective contraceptive use may be appropriate for good preventive health care or for diagnosing or assessing suspected medical conditions.

The Applicability Chart below shows the required exam for selected methods. Check the WHO MEC Tool (see table below) on a particular physical examination and/or laboratory exam for a specific FP Method.

For most FP methods, there is no need for an examination.

**Table 13. Applicability\* of various procedures or tests for contraceptives methods.**

Specific Situation	COC	CIC	POP	POI	Implants	IUD	Condom	BTL	Vasectomy
Breast exam by provider	C	C	C	C	C	C	C	C	NA
Pelvic/Genital exam	C	C	C	C	C	A	C	A	A
Cervical cancer screening	C	C	C	C	C	C	C	C	NA
Routine lab tests	C	C	C	C	C	C	C	C	C
Hemoglobin test	C	C	C	C	C	B	C	B	C
STI risk assessment: Medical History&PE	C	C	C	C	C	A <sup>1</sup>	C <sup>2</sup>	C	C
STI/HIV screening: Lab tests	C	C	C	C	C	B <sup>1</sup>	C <sup>2</sup>	C	C
BP screening	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	<sup>3</sup>	C	C	A	C <sup>4</sup>

Adapted from: WHO Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004

- \*Class A = essential and mandatory in all circumstances for safe and effective use of the contraceptive method
- Class B = contributes substantially to safe and effective use, but implementation may be considered within the public health and/or service context. The risk of not performing an examination or test should be balanced against the benefits of making the contraceptive methods available.
- Class C = does not contribute substantially to safe and effective use of the contraceptive method.

### 3.12

#### Notes

The Medical Eligibility Criteria for Contraceptive Use, Third Edition, 2004 states that:

<sup>1</sup> If a woman has a very high individual likelihood of exposure to gonorrhea or chlamydial infection, she should generally not have an IUD inserted unless other methods are not available or not acceptable. If she has a current purulent cervicitis or gonorrhea or chlamydial infection, then she should not have an IUD inserted until these conditions are resolved and she is otherwise medically eligible.

<sup>2</sup> Women at high risk of HIV infection should not use spermicides containing nonoxynol-9. Using diaphragms and cervical caps with nonoxynol-9 is not usually recommended for women at high risk of HIV infection unless other more appropriate methods are not available or not acceptable. The contraceptive effectiveness of diaphragms and cervical caps without nonoxynol-9 has been insufficiently studied and should be assumed to be less than that of diaphragms and cervical caps with nonoxynol-9.

<sup>3</sup> It is desirable to have blood pressure measurements taken before initiation of COCs, CICs, POPs, POIs, and implants. However, blood pressure measurements are unavailable in many settings, pregnancy morbidity and mortality risks are high, and hormonal methods among the few methods widely available. In such settings, women should not be denied the use of hormonal methods simply because their blood pressure cannot be measured.

<sup>4</sup> For procedures performed using local anesthesia with ephedrine.

## Determining if a woman is NOT pregnant

A woman should not use an FP method while she is pregnant except for condoms which should be used as a protection against STI.

A health provider can usually tell if a woman is not pregnant by asking the following questions. Pregnancy test and physical examination are usually not needed.

It is reasonably certain that a woman is not pregnant if:

- Her menstrual period started within the last seven days.
- She gave birth within the last four weeks.
- She had an abortion or miscarriage within the last seven days.
- She gave birth within the last six months, is breastfeeding often, and has not had a menstrual period.

The diagram (found next page) summarizes and provides an algorithm of how a service provider can be reasonably sure that a potential FP client is not pregnant. It also provides recommendation for actions.

If the woman has had sex and her last period was five weeks ago or more, pregnancy cannot be ruled out. Even if she used an effective contraception (except DMPA), consider early signs of pregnancy.

- Delayed menstrual period
- Breast tenderness
- Nausea
- Vomiting
- Weight change
- Frequent tiredness
- Mood changes
- Changed eating habits
- Frequent urination

Late Signs of Pregnancy: *(If it has been more than 12 weeks since her last menstrual period)*

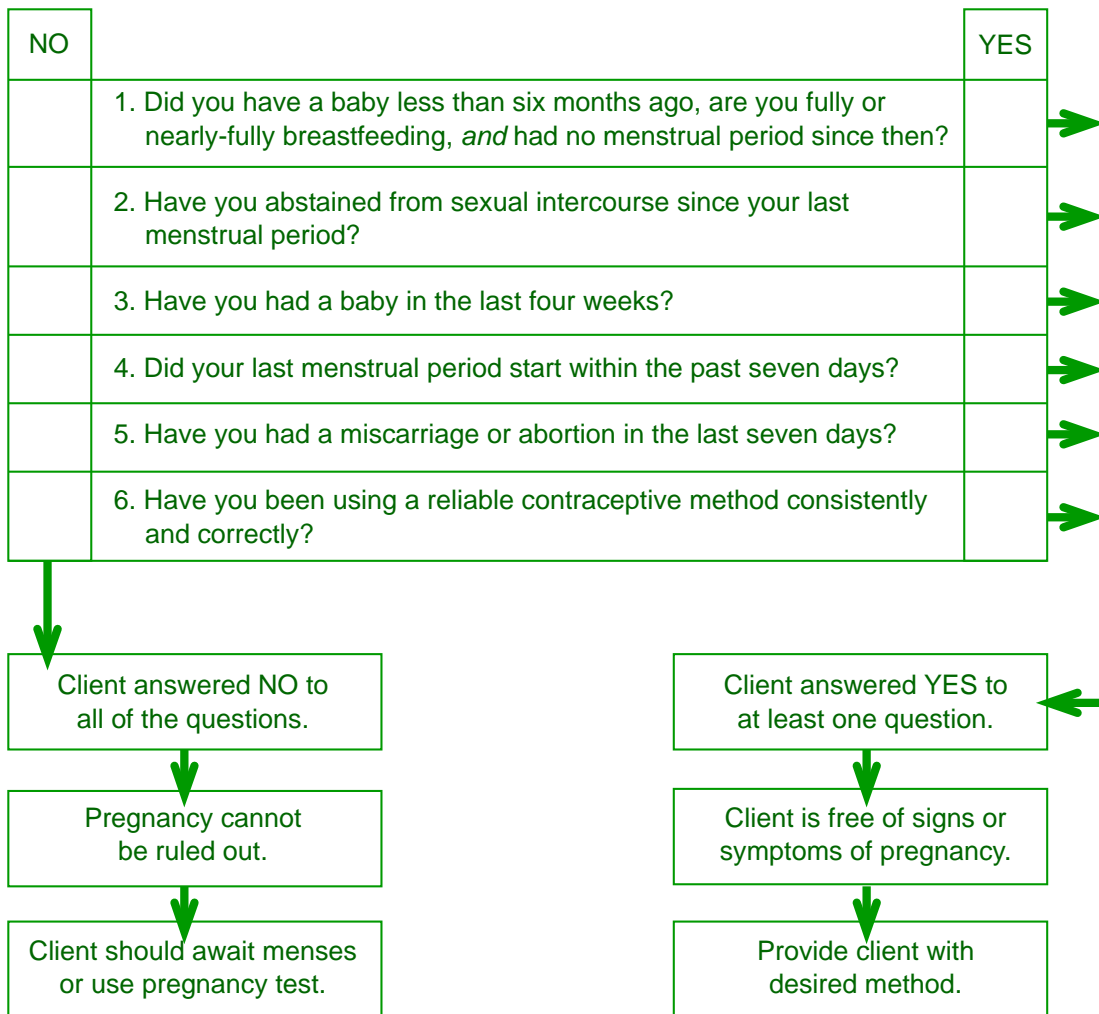
- Larger breasts
- Darker nipples
- More vaginal discharge
- Enlarged abdomen
- Movements of a baby

If she exhibited several of these signs, she may be pregnant. Confirm by doing a physical examination.

If her answers cannot rule out pregnancy, she should either have a pregnancy test, if available, or wait until her next menstrual period before starting a method. Give her condoms to use until then, with instructions and advice on how to use them.

## How to be Reasonably Sure a Client is Not Pregnant

If the client answers YES to any question, proceed to the first box directly below the YES column



### SUMMARY AND KEY LEARNING POINTS

**3.14** The health provider needs to have the necessary knowledge and skills to be able to adequately and accurately assess the health needs, as well as the health status, of clients seeking to improve the quality of their lives.

Client assessment is the first stage common to any health care service, and an important step prior to provision of FP services.

Client's FP needs and data on medical status & conditions are obtained to ensure that she/he is medically eligible for the chosen FP method. Client assessment involves the following components:

- History-taking
- If needed: physical and laboratory examination

The WHO Medical Eligibility Criteria is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria.



# MODULE 4



## Infection Prevention in Family Planning Services

Session 1: The Disease Transmission Cycle and Infection  
Prevention Definitions

Session 2: Infection Prevention Measures





# MODULE 4: INFECTION PREVENTION IN FAMILY PLANNING SERVICES



## MODULE OVERVIEW

Infection prevention is an important element of quality service provision. Correct infection prevention techniques during the provision of FP services is crucial to the safety of both clients and service providers. The purpose of this module is for service providers to practice appropriate infection prevention techniques.



## MODULE OBJECTIVES

At the end of this module, participants will be able to understand the appropriate infection prevention practices to reduce the risk of disease transmission during the provision of FP services.

<b>Session 1:</b>	The Disease Transmission Cycle and Infection Prevention Definitions
<b>Session 2:</b>	Infection Prevention Measures

# SESSION 1

## THE DISEASE TRANSMISSION CYCLE



### LEARNING OBJECTIVES

At the end of the session, participants will be able to:

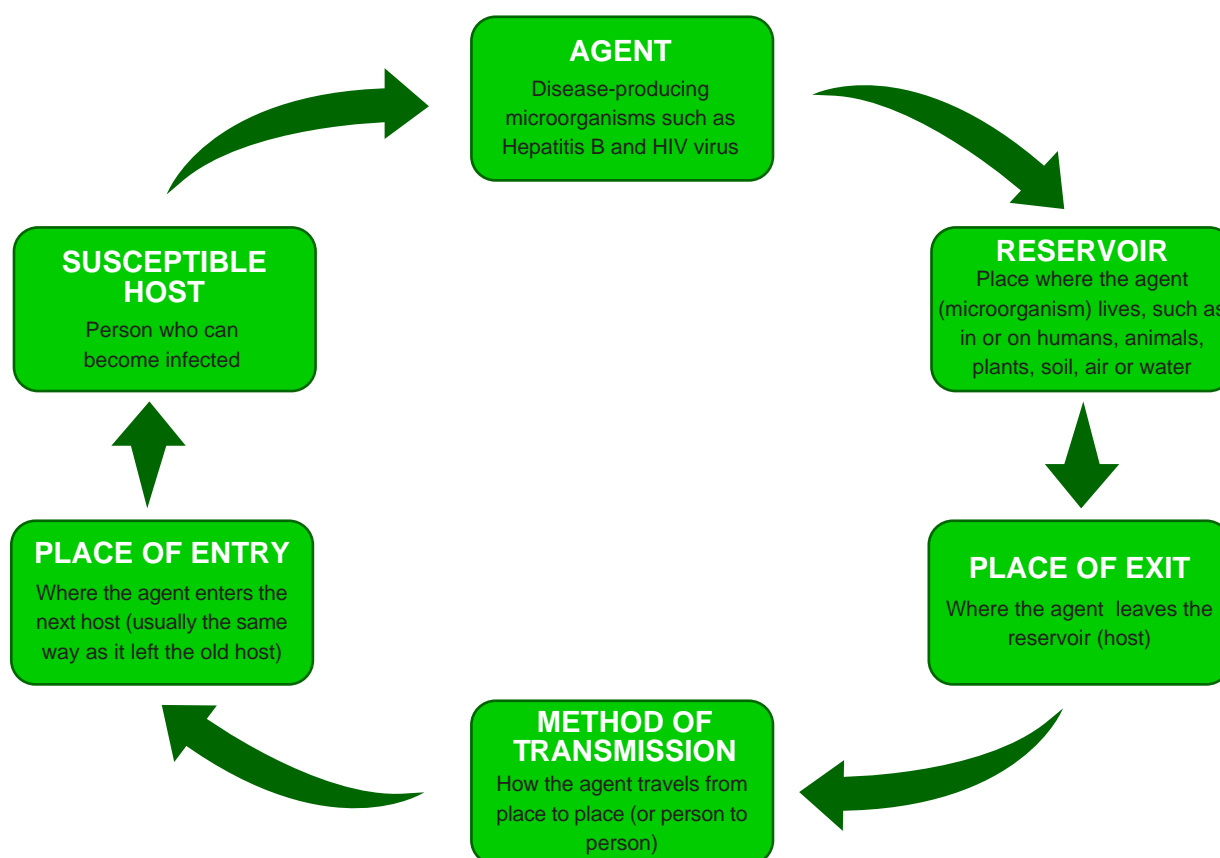
1. Discuss the disease transmission cycle.
2. Explain infection prevention as it relates to family planning service provision.
3. Define infection prevention terms and processes.



### NARRATIVE

Infection prevention in family planning refers to the prevention of the spread of infection during the provision of FP services. It aims to protect both the clients and providers from the spread of infectious diseases. Infection prevention procedures are simple, effective, and inexpensive.

The diagram below illustrates the transmission and proliferation of infection.



- The **agent** refers to the infectious microorganisms (germs) which can cause disease such as:

\*Bacteria = staphylococcus, clostridia tetani which causes tetanus

\*Viruses = Hepatitis B, HIV

\*Fungi and parasites

- Where the agent lives is the **reservoir**. This can be humans, animals, plants, soil, air or water. In humans, the reservoir is usually blood, body fluids, and tissues.

- The **place of exit** is the manner by which the agent leaves the reservoir and is transmitted from place to place or person to person.
- The **mode of transmission** could be through:
  1. Contact - direct transfer of microorganisms through touch, sexual intercourse, fecal/oral transmission, and droplets.
  2. Vehicle - materials that serves as a means of transfer of the microorganisms. This can be blood (HIV, HBV), water (cholera, shigella), food (salmonella) or instruments and other items used during the procedures.
  3. Airborne - carried by air currents (measles, TB)
  4. Vector - invertebrate animals can transmit microorganisms (mosquito for malaria and yellow fever)
- The **place of entry** is the manner by which the agent enters another host. Usually, the mode of entry is the same way that the agent left the old host. The organisms can be passed on through mucous membranes or broken skin, such as cuts and scratches, and puncture wounds from needle sticks with used needles.
- The next person who gets infected is the **susceptible host**. To prevent diseases caused by the agent (organisms that cause infection), the cycle must be broken at any point. Breaking the cycle at any point requires infection prevention measures, which will be discussed in more detail later.

## DEFINITION OF TERMS

**Protective barriers** are physical, mechanical or chemical processes, which help prevent the spread of infectious microorganisms from client to client, clinic staff to client and vice versa due to lack of infection prevention practices or from contaminated instruments or equipment.

Infection prevention relies on barriers between the host and microorganisms.

**Asepsis and aseptic** techniques are procedures used in health care settings to describe the combination of efforts made to prevent entry of microorganisms into any area of the body where they are likely to cause infection. The goal of asepsis is to reduce microorganisms on animate (living) surfaces (skin and tissue) and inanimate objects (surgical instruments) to a safe level or to eliminate the microorganisms completely. Examples are handwashing, surgical scrub, use of antiseptics, use of properly processed instruments, and the use of gloves.

**Antisepsis** is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues through a chemical agent (antiseptic). One example is the use of povidone-iodine applied as an antiseptic solution on the cervix before IUD insertion.

**Decontamination** is the process that makes inanimate (non-living) objects safer for handling by staff before cleaning by soaking in disinfectant like 0.5% chlorine solution. Such objects include large objects (e.g. examination tables) and surgical instruments and gloves contaminated with blood or body fluids (i.e., BTL or vasectomy instruments).

**Cleaning** is the process of physically removing all visible blood, bodily fluids, or foreign material such as dust or soil from skin or inanimate objects. Wash or scrub with a brush with liquid soap or detergent and water. Avoid bar soap or powdered soap, which can stay on the equipment. Rinse and dry. While cleaning, wear utility gloves and personal protective equipment like goggles, masks, aprons, and enclosed shoes.

**Disinfection** is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects. High-level disinfection (HLD), through boiling, by steaming or with chemicals such as chlorine, gluteraldehydes, and formaldehydes, eliminates most microorganisms except some bacterial endospores. HLD is done with instruments or supplies such as vaginal specula, uterine sounds, and gloves for pelvic examination.

**Sterilization** is the process that kills all infectious microorganisms, including bacterial endospores, with a high-pressure steam autoclave, a dry-heat oven, chemicals or radiation. Sterilize instruments such as scalpels and needles that touch tissue beneath the skin.

## SESSION 2

### INFECTION PREVENTION MEASURES

#### LEARNING OBJECTIVES

At the end of this session, participants will be able to:

1. Explain the principle of standard precaution.
2. Discuss the "protective barriers" which disrupt the transmission of infection such as:
  - a. Hand washing
  - b. Using gloves
  - c. Using antiseptics
  - d. Processing instruments and other items
  - e. Proper management of wastes
3. Develop a plan to ensure proper waste management in respective facilities.

#### NARRATIVE

##### STANDARD PRECAUTIONS

Standard precautions are designed for the safety and care of all people in a health care facility – whether a hospitalized patient, a woman receiving IUD services or a health care worker. As a lot of people with blood-borne viral infections (i.e., hepatitis B [HBV] or C [HCV], HIV) do not feel or look ill, standard precautions are to be applied consistently, regardless of the (known or unknown) health status of those who are providing or receiving care.

When applied consistently, standard precautions act as protective barriers between microorganisms and individuals, and are considered as highly effective means of preventing the spread of infection.

The following considerations and actions help to form such barriers, as well as provide the means for implementing the standard precautions:

- **Consider every person** (client or staff) as potentially infectious and susceptible to infection.
- **Wash hands** – the most important procedure for preventing cross-contamination (person to person or contaminated object to person).
- **Wear gloves** (on both hands) before touching anything wet, broken skin, mucous membranes, blood or other body fluids (secretions and excretions), soiled instruments, and contaminated waste materials or for performing invasive procedures.
- **Use physical barriers** (protective goggles, face masks, and aprons) if splashes and spills of blood or other body fluids are possible (e.g. when cleaning instruments and other items).
- Use **antiseptic agents** for cleansing skin or mucous membranes before surgery, cleaning wounds, or doing hand rubs or surgical hand scrubs with an alcohol-based antiseptic product.
- Use **safe work practices** such as not recapping or bending needles, safely passing sharp instruments, and suturing (when appropriate) with blunt needles.
- Safely **dispose of infectious waste materials** to protect those who handle them and prevent injury or spread of infection to the community.
- Finally, **process instruments, gloves, and other items** after use by first decontaminating and thoroughly cleaning them, and then either sterilizing or high-level disinfecting (HLD) them, using recommended procedures. Again, in the context of IUD services, HLD is the recommended method of final processing.

## PROTECTIVE BARRIERS

Having a physical, mechanical or chemical "barrier" between microorganisms and an individual (i.e., client, patient, and health worker) is an effective means of preventing the spread of disease. The barrier serves to break the disease transmission cycle. Protective barriers are designed to prevent the spread of infection from person to person, and from equipment, instruments, and environmental surfaces to people and vice versa.

Barriers include the following:

1. Hand washing
2. Wearing gloves
3. Using antiseptic solutions
4. Processing of instruments

## HAND WASHING

Hand washing is the SIMPLEST, BASIC and MOST IMPORTANT infection prevention procedure in any clinic. It removes many microorganisms from the skin, helping to prevent transmission of infection from person to person.

### 1. When to do hand washing

#### Before

- the day's work
- examining a client
- administering injections or drawing blood
- performing a procedure (IUD insertion and removal or pelvic exam)
- handling clean, disinfected, or sterilized supplies for storage
- putting on sterile gloves
- going home

#### After

- any situation in which the hands may be contaminated, such as handling instruments or touching body secretions or excretions
- examining a client
- removing gloves
- personal use of toilet
- blowing nose, sneezing, or coughing

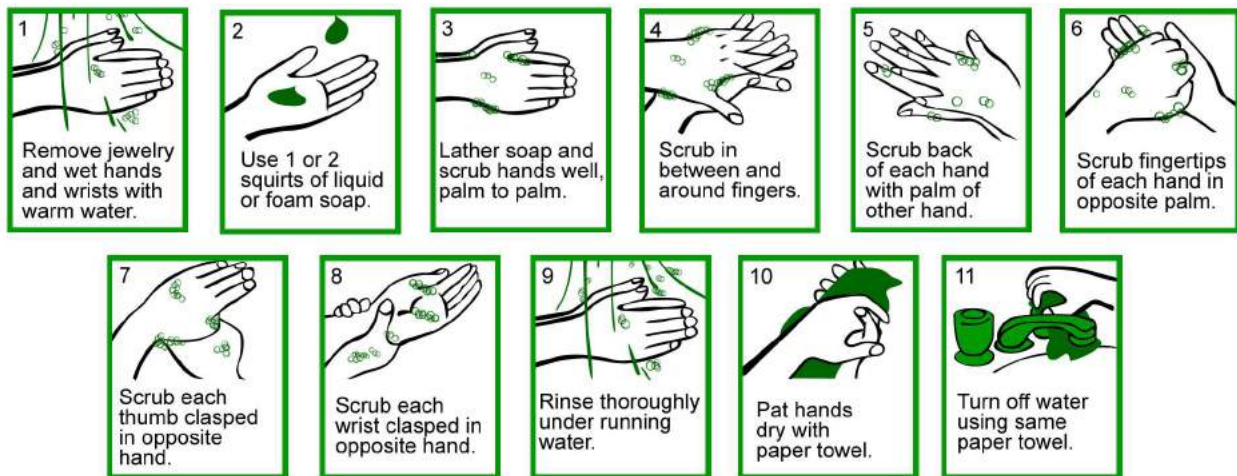
### 2. Supplies needed for hand washing

- Clean water (water may be running or from a bucket, but it must be clean)
- Soap (bar or liquid)
- Soap dish that drains and keeps the soap dry (bar)
- Clean, dry towel
- Plastic container with faucet

### 3. Steps of hand washing

- Remove jewelry and wet hands and wrists with water.
- Use one or two squirts of liquid or foam soap.
- Lather soap and scrub hands, palm to palm.

- Scrub in between and around fingers.
- Scrub back of each hand with palm of the other hand.
- Scrub fingertips of each hand in opposite palm.
- Scrub each thumb clasped in opposite hand.
- Scrub each wrist clasped in opposite hand.
- Rinse thoroughly under running water.
- Turn off water using paper towel.



## Hand washing tips

Important considerations during handwashing:

- If there is no running water, use a dipper (*tabo*) to pour water on the hands at the beginning and when rinsing.
- Position the hands and wrists downward as you wet them so that the water flows down.
- If using bar soap, rinse the soap before putting it back in the soap dish.
- Avoid touching the sink as it is probably contaminated.
- Wash hands for 15-30 seconds.
- Point hands down when rinsing them with running water.
- Air-dry hands or dry with an unused, dry portion of a clean cotton towel not used by others.
- Use the towel or a paper towel to turn off the faucet.
- If water is not available, 70% of isopropyl alcohol can be used if hands are not visibly soiled.

## USING GLOVES

Gloves are used to protect the health care provider from contact with potentially infectious substances and to protect the client or patient from infections that might be present on the skin of the health care provider.

### The Three Kinds of Gloves

1. **Surgical gloves** – used when there is contact with the bloodstream or with tissue under the skin such as surgical procedures, pelvic examination or women in labor.
2. **Single use examination gloves** – used when there is contact with intact mucous membranes or when the primary purpose of gloving is to reduce the provider's risk of exposure (e.g. routine pelvic examination). These gloves should be disposed after one use.
3. **Utility or heavy duty household gloves** – used for handling contaminated items, medical or chemical waste, and performing housekeeping activities.

## ANTISEPTICS

Antiseptics are chemicals, which kill or inhibit a lot, though not all, microorganisms while causing little damage to tissue. Cleaning the client's skin with antiseptic solution is an important infection prevention measure.

Antiseptic solutions should be used in the following situations:

- Skin or vaginal preparations for procedures such as minilaparotomy, laparoscopy, vasectomy, IUD insertion, and injections.
- Handwashing with 70% alcohol before touching clients who are unusually susceptible to infection (e.g. newborns or immune suppressed persons).

*Note:*

- *Alcohol should never be used on mucous membranes because it irritates the membranes.*
- *Antiseptics should not be used as disinfectants.*

## COMMONLY USED ANTISEPTICS

### Iodine and Iodophor Solutions

Povidone-iodine is the most common iodophor and is available globally.

*Note:* Iodophors manufactured for use as antiseptics are not effective for disinfecting inorganic objects and surfaces. These iodine solutions have significantly less iodine than chemical disinfectants (Rutala, 1996).

Iodophors have a broad spectrum of activity. They kill vegetative bacteria, mycobacterium, viruses and fungi. However, they require up to two minutes of contact time to release free iodine, which is the active chemical. Once released, the free iodine has rapid killing action.

### 70% Alcohol Solution

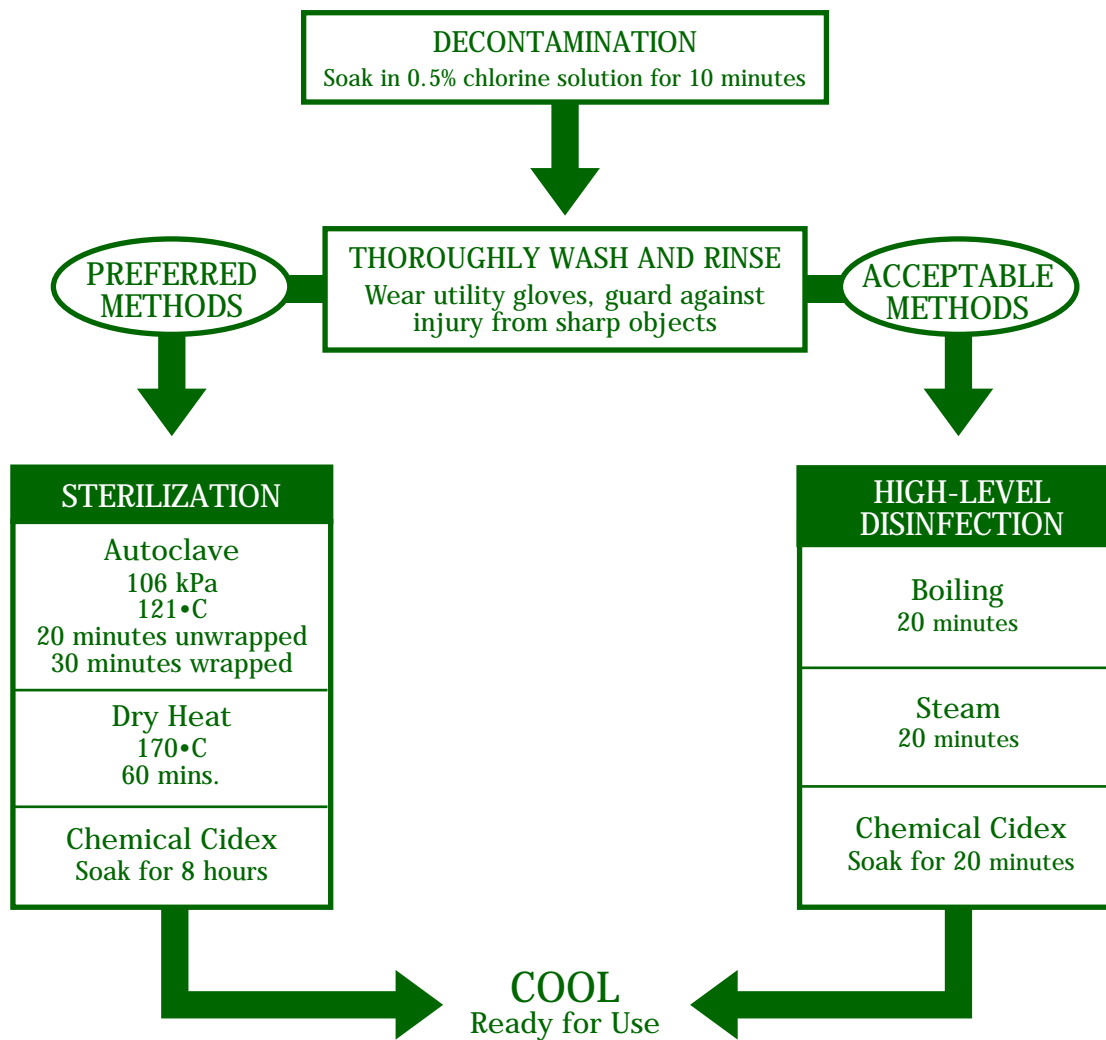
Alcohol functions well to inhibit the growth and reproduction of many microorganisms, including bacteria, fungi, protozoa, and viruses.

Alcohol is a good solvent that dissolves and carries away non-organic impurities that are responsible for things like odor. However, it cannot clean skin that is visibly dirty. Its antiseptic action does cause a burning sensation on open flesh, as anyone who has ever used alcohol to clean a wound can testify.

## PROCESSING OF INSTRUMENTS

- Proper processing of instruments is critical for reducing infection transmission during clinical procedures.
- The four steps for processing instruments and other items include:
  1. decontamination
  2. cleaning
  3. sterilization (preferred) or high-level disinfection (acceptable)
  4. use or storage





*Wrapped sterile packs can be stored for up to one week. Unwrapped items should be stored in a sterile or high-level disinfected container with a tight fitting lid or used immediately.*

#### PREPARING DECONTAMINATING SOLUTION

From concentrated 5% chlorine solution

$$\frac{\text{Parts of water/part of chlorine}}{\% \text{ concentrated chlorine}} = \frac{\% \text{ desired chlorine concentration}}{\% \text{ concentrate of granules}} - 1$$

$$\frac{5}{.5} - 1 = 9 \text{ parts water/part of water}$$

1 part chlorine in 9 parts water

From concentrated chlorine granules containing 30% chlorine

$$\frac{\text{Grams of chlorine powder or granules/ liter of water}}{\% \text{ concentrate of granules}} = \frac{\% \text{ desired concentration} \times 1000}{\% \text{ concentrate of granules}}$$

$$\frac{.5 \times 1000}{30} = .0166 \times 1000 = 16.7 \text{ grams/liter}$$

17 grams of 30% chlorine granules/powder in 1 liter of water

## USE AND DISPOSAL OF SHARPS

In health care settings, injuries from needles and other sharp items are the most common causes of infection from blood-borne pathogens. It is important therefore that sharps are handled with care and disposed properly after use. Below is the list of instances when health care providers can be injured by sharps:

- When health care workers recap, bend, or break hypodermic needles.
- When health care workers are struck by a person carrying unprotected sharps.
- When sharps show up in unexpected places, like between linens.
- During procedures in which health care workers use many sharps, cannot see their hands, or are working in a small, confined space (such as gynecologic procedures).
- When health care providers handle and dispose of wastes that contain used sharps.
- When clients move suddenly during injections.

## GIVING INJECTIONS

Tell participants some hints to minimize risks when giving injections:

- Always warn the client before giving an injection.
- Always use new or properly processed needle and syringe for every injection.
- Steps for giving injections:
  - \* Wash injection site with soap and water if the area is visibly dirty.
  - \* Swab the area with antiseptic (alcohol solution) in circular motion starting from the intended injection site going outward.
  - \* Allow the alcohol to dry for better efficacy.
  - \* Inform client that you are about to inject

## RECAPPING NEEDLES

- Whenever possible, dispose of needles immediately without recapping them.
- But if recapping is necessary, follow the “one hand technique”.

1. Place the cap on a flat surface and remove hand from the cap.
2. With one hand, hold the syringe and use the needle to scoop up the cap.
3. When the cap covers the needle completely, use the other hand to secure the cap on the needle hub. Be careful to hold the cap at the bottom only (near the hub).

## USE OF MULTIDOSE VIALS

In some clinic settings, direct medications may come in multiple vials (i.e., vaccines, local anesthetic) intended for the use of more than one client. Infections may be transmitted through these vials if proper procedures are not followed. The following are infection prevention tips when using multiple vials:

- Check the vial to be sure there are no leaks or cracks.
- Check the solution to be sure that it is not cloudy and there is no particulate matter.
- Wipe the top of the vial with a cotton swab soaked with 60-70% alcohol. Allow to dry.
- Use a new needle and syringe for each new person.
  - \* Never use a contaminated needle or syringe that has been used previously.
- Do not leave needles in multiple dose vials.

## WASTE MANAGEMENT

Healthcare waste is defined as the total waste stream from a healthcare facility. Most of it (75-90%) is similar to domestic waste, examples of which are paper, plastic packaging, glass, cartons/boxes, etc., that have not been in contact with patients.

A smaller proportion (10-25%) is infectious waste that requires special treatment because of the risks that it poses both to human health and the environment. Exposure to this waste can result in disease or injury.

The purpose of proper waste management:

- Prevents the spread of infections to clinic personnel, clients, visitors, and the community.
- Reduces the risk of accidental injury to staff, clients, and community.
- Reduces bad odors.
- Attracts fewer insects and animals which may be vectors of infectious agents.
- Reduces the possibility of soil or ground water contamination with chemicals or microorganisms.

## TYPES OF WASTES

### 1. General waste

These are non-hazardous wastes that pose no risk of injury or infection. These are similar in nature to household trash. Examples are: paper, boxes, packaging materials, bottles, plastic containers, and food-related trash.

### 2. Hazardous medical waste

Hazardous wastes generated in the rural health unit and birthing homes are classified as:

- Infectious** – all wastes that are susceptible to contain pathogens (or their toxins) in sufficient concentration to cause diseases to a potential host (i.e., excreta, tissue swabs, blood bags, dressings, etc).
- Pathological** – consist of human tissues or fluids (i.e., body parts, blood, blood products and other body fluids, placentas, and product of conception), materials containing fresh or dried blood or body fluids such as bandages and surgical sponges.
- Pharmaceutical** - these are expired, unused, and contaminated pharmaceutical products, drugs and vaccines that are no longer needed. It also includes discarded items used in handling pharmaceuticals such as bottles, or boxes with residue, gloves, masks, connecting tubings, and drug vials.
- Chemicals** - these are the discarded solid, liquid, and gaseous chemicals used in cleaning, housekeeping, and disinfecting procedures.
- Sharps** - items that could cause cuts, puncture wounds, including hypodermic and suture needles, scalpel blades, blood tubes, infusion sets, and other glass items that have been in contact with potentially infectious materials (such as glass slides and coverslips).
- Pressurized containers** – consist of full or emptied containers or aerosol cans with pressurized liquid gas or powdered materials.

Since the disposal of medical waste is frequently a problem, it is useful to develop a medical waste management plan and a staff assigned for the responsibility of waste disposal.

## The Four Aspects of Hazardous (Medical) Waste Management

The management of waste must be consistent from the point of generation to the point of final disposal. The path between these two points can be segmented into four steps.

### 1. Sorting or segregation and containerization

Only a small percentage of the waste generated by a healthcare facility are medical wastes that must be specially handled to reduce the risk of infection or injury. Therefore, sorting the waste at the point where it is generated can greatly reduce the amount that needs special handling.

The correct segregation/sorting of waste at the point of generation relies on a clear identification of the different categories of waste and the separate disposal of the waste in accordance with the categorization chosen. To encourage segregation at source, reusable containers with plastic liners of correct size and thickness are placed as close to the point of generation as possible. They should be properly color coded.

**Black** plastic lining for general, dry, non-infectious waste

**Green** plastic lining for general, wet, non-infectious waste

**Yellow** for infectious/pathological waste

Needles and other sharps pose the greatest risk of injury, and should be disposed in special sharps containers such as heavy cardboard boxes, tin cans with lid and plastic bottles.

### 2. Handling

Handle medical waste as little as possible before disposal. When waste containers are 3/4 full, the liners are closed with plastic strings and are placed in larger containers at the interim storage areas. Always wear heavy utility gloves when handling medical waste. Always wash your hands after handling wastes and after removing your gloves.

### 3. Interim storage

In order to avoid both the accumulation and decomposition of waste, it must be collected on a regular daily basis. Waste should never be stored in the facility for more than one or two days. If it is necessary to store medical waste on-site before final disposal, waste should be placed in an area that is minimally accessible to clinic staff, clients, and visitors.

### 4. Final disposal

**General wastes**, similar to household waste, can be collected by the regular municipal garbage collector and transported into the final dump sites.

#### Solid Medical Waste

There are three options for the disposal of solid medical waste: burning waste, burying waste, and transporting waste to an off-site disposal site.

In our country, burning waste is not applicable because of the Clean Air Act. So the remaining options are:

- a.) burying, that is if there is a space at the back of one's facility to dig a pit;
- b.) and transporting waste to an off-site disposal site. This is done by the waste collector of hospital medical wastes.

### ***Building and using a waste-burial pit***

1. Choose an appropriate site that is at least 50 meters away from any water source to prevent contamination of water source. The site should have proper drainage, be located downhill from the wells, be free of standing water, and be in an area that does not flood. The site should not be located on land that will be used for agriculture or development.
2. Dig a pit one to two meters wide and two to five meters deep. The bottom of the pit should be 1.8 meters above water table.
3. Fence in the area to keep out animals, scavengers, and children.
4. Keep waste covered. Every time waste is added to the pit, cover it with a 10 to 30 cm layer of soil.
5. Seal the pit when the level of waste reaches 30 to 50 cm of the surface of the ground. Fill the pit with dirt, seal it with concrete, and dig another pit.

### **Liquid medical waste**

The following are the procedures when disposing liquid medical wastes:

1. Carefully pour liquid waste down a sink, drain or flushable toilet.
2. Before pouring liquid waste down a sink, drain, or toilet, consider where the drain empties. It is hazardous for liquid waste to run through open gutters that empty onto the grounds of the facility.
3. Rinse the sink, drain, or toilet thoroughly with water to remove residue waste - again avoid splashing. Clean these areas with a disinfectant cleaning solution at the end of the day or more frequently if heavily soiled.
4. Decontaminate the container that held the liquid waste by filling it with 0.5% chlorine solution for 10 minutes before washing.
5. Wash your gloved hands after handling liquid waste before removing gloves.

### **TIPS IN HANDLING WASTES:**

- Always wear utility gloves
- Transport solid contaminated waste in covered, leak proof containers
- Wear utility gloves
- Transport solid contaminated waste in covered containers
- Dispose of all sharp items in puncture resistant containers
- Carefully pour liquid waste down a utility drain or flushable toilet
- Decontaminate gloves and containers before cleaning
- Wash hands after handling infectious waste

## SUMMARY

Creating an infection-free health facility environment protects the clients, clinic staff, and the community from infections. To achieve this, it is important that the rationale for each of the recommended infection prevention processes be clearly understood by clinic staff at all levels - from the supervisor to the health service provider up to the cleaning staff. Since it is not possible to identify infected individuals, standard precaution must be practiced to prevent spread of infection.



# MODULE 5



## Fertility Awareness-Based Methods and Lactational Amenorrhea Method

Session 1: Fertility Awareness-Based Methods

Session 2: Lactational Amenorrhea Method





# MODULE 5: Fertility Awareness-Based Methods and Lactational Amenorrhea Method



## MODULE OVERVIEW

This module discusses the different Natural Family Planning Methods as part of providing a broad range of Family Planning services in the Philippine Family Planning Program. Based on the WHO Medical Eligibility Criteria and the DOH Clinical Standards Manual of 2006, there are six natural family planning methods, also called the Fertility Awareness-Based (FAB) Method.



## MODULE OBJECTIVES

At the end of this module, the participants will be able to understand Fertility-Awareness Based methods (FAB) and Lactational Amenorrhea Method (LAM) as contraceptive methods.



## MODULE SESSIONS

The module contains the following sessions:

<b>Session 1</b>	Fertility Awareness-Based Methods
<b>Session 2</b>	Lactational Amenorrhea Method

## SESSION 1

### FERTILITY AWARENESS-BASED METHODS



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Define FAB Methods.
2. Identify the signs of the fertile and infertile phases of the menstrual cycle.
3. Describe the different FAB methods in terms of mode of action and effectiveness.
4. Instruct women on the use of the SDM.
5. State the advantages and disadvantages of FAB methods.
6. Discuss who can and can not use the FAB methods using the WHO MEC and checklist for FAB Methods.



#### NARRATIVE

**Fertility Awareness-Based methods** are family planning methods that focus on the awareness of the beginning and end of the fertile time of a woman's menstrual cycle.

These methods involve:

- Determination of the fertile and infertile periods of a woman within the menstrual cycle.
- Observation of the signs and symptoms of infertility and fertility during the menstrual cycle.

EFFECTIVENESS: All FAB Methods are above 95% effective.

#### SIGNS OF FERTILITY

There are two main naturally occurring fertility signs that a woman can observe to determine when she can or cannot become pregnant. These are:

1. Changes in the cervical mucus: Cervical mucus can be used to determine the beginning and end of the fertile days.
2. Changes in the basal body temperature: Basal body temperature can be used to determine when ovulation has passed and the fertile days have ended.
3. The first day of menstruation is the sign for keeping track of a woman's menstrual cycle.

#### THE FAB METHODS

1. **CERVICAL MUCUS/BILLINGS OVULATION METHOD (CMM/BOM)** is based on the daily observation of what a woman sees and feels at the vaginal area throughout the day. Cervical mucus changes indicate whether days are fertile or infertile and can be practiced by couples to avoid or achieve pregnancy. On the 4th day after the last day of wetness, all dry days are absolutely infertile days. On dry days following menstruation, couples can engage in sexual intercourse on alternate nights only. With perfect (correct) use, this method is 97% effective. However, with typical use, it is 80% effective. Alternatively, the Two Day Mucus-Based Method Rule states that two dry days (no secretions for two consecutive days) signify that intercourse will not result in pregnancy.
2. **BASAL BODY TEMPERATURE (BBT)** is based on a woman's resting body temperature (i.e., body temperature after three hours of continuous sleep) which is lower before ovulation until it rises to a higher level beginning around the time of ovulation. Her infertile days begin from the fourth day of the high temperature reading to the last day of the cycle. All days from the start of the menstrual cycle up to the third high temperature reading are considered fertile days. With perfect use, this method is 99% effective. With typical use, its effectiveness is 80%.

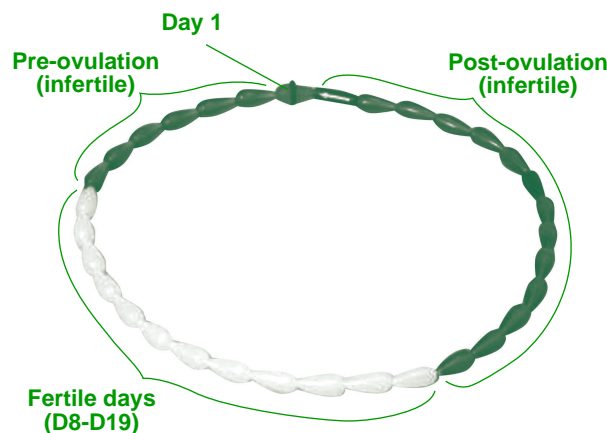
3. **SYMPTO-THERMAL METHOD (STM)** is based on the combined technology of the Basal Body Temperature (e.g. the resting body temperature) and the Cervical Mucus/Billings Ovulation Method (e.g. observations of mucus changes at the vaginal area throughout the day) together with other signs (i.e., breast engorgement, unilateral lower abdominal pain) which indicate that the woman is fertile or infertile. This method is 98% effective as correctly used.
4. **STANDARD DAYS METHOD (SDM)** is based on a calculated fertile and infertile period for menstrual cycle lengths that are 26 to 32 days. Women who are qualified (e.g. with 26 to 32 days menstrual cycles) to use this method are counseled to abstain from sexual intercourse on days 8-19 to avoid pregnancy. Couples on this method use a device, the color-coded “Cycle Beads”, to mark the fertile and infertile days of the menstrual cycle. SDM is 95.25% effective with correct use and 88% with typical use.

### ***How to use the CycleBeads***

Assess the length of the menstrual cycle if it falls within the range of 26–32 days by considering the following information:

- The last menstrual period
  - The previous/past menstrual period
  - When she expects her next menses
- If the cycle length is less than 26 days or more than 32 days, the client cannot use the method.
- If the cycle meets the criteria, provide an SDM card and cyclebeads, which can be used in marking the days of the cycle.

Show the woman the CycleBeads and instruct her on how to use it:



- On the first day of the menstrual cycle (e.g. first day of menstrual bleeding), she puts the ring on the red bead and marks with an “x” the date on the calendar.
- She moves the ring to a bead each day. It is recommended that she moves the ring every morning upon waking up so that she does not forget. The brown beads signify infertile days while the white beads signify fertile days.
- When the ring is on a white bead, she abstains from sexual intercourse.

Draw the client’s attention to the dark brown and black beads. Tell her that if she experiences menstrual bleeding before the dark brown bead, this means that her cycle is short and less than 26 days. If the ring has reached the black bead and she still does not experience menstrual bleeding, then her cycle is more than 32 days. If either happens twice in a year, she cannot reliably use the SDM as her FP method.

## **Women with Special Conditions**

Contraceptive shifters may also use SDM provided that the following criteria are met:

- Shifting from pills
  - Menstrual cycles were within 26-32 days before taking the pill
  - Expects current cycle to be within 26-32 days
- Shifting from injectables
  - At least three months have passed since the last injection
  - Menses have returned
  - Menstrual cycles were within 26-32 days before using injectables
  - Last menstrual cycles were within 26-32 days
- Recently used IUD
  - IUD has been removed
  - Menstrual cycles while using the IUD were within 26 to 32 days
  - Last menstrual cycle was within 26-32 days
- Postpartum and/or Breastfeeding
  - Menstruation has returned
  - Has had at least four normal menstrual periods
  - Expects current cycle to be within 26 to 32 days

### **Advantages of FAB methods:**

- Effective when used correctly and consistently.
- No physical side effects.
- No prescription required.
- Inexpensive; no medication involved.
- No follow-up medical appointments required.
- Better understanding of the couple about their sexual physiology and reproductive functions.
- Shared responsibility for family planning.
- Foster better communication between partners.
- All FAB methods can be used for spacing, limiting, and achieving pregnancy.

### **Disadvantages of FAB methods:**

- May inhibit sexual spontaneity.
- Except for SDM, need extensive training - it takes about two to three cycles to accurately identify the fertile period and how to effectively use it.
- Require consistent and accurate record keeping and close attention to body changes.
- Require periods of abstinence from sexual intercourse, which may be difficult for some couples.
- Require rigid adherence to daily routine of awaking at a fixed time, without any disturbance before taking the temperature (specific for BBT and STM).
- Can be used only by women whose cycles are within 26-32 days (specific for SDM).
- Offer no protection against STI, HIV/AIDS.

## Key Points on the FAB Methods:

- Fertility awareness-based methods require cooperation of both partners.
- A woman or couple using FAB methods must be aware of body changes or keep track of fertile and infertile days according to the rules of the specific FAB method being practiced.
- To avoid pregnancy, the couple should abstain from sexual intercourse during the fertile phase. To achieve pregnancy, the couple can time sexual intercourse during the fertile phase.
- FAB methods have no side effects or health risks.
- SDM can be used by women with 26-32 days menstrual cycles.

## Medical Eligibility Checklist for Fertility Awareness-Based (FAB) Methods

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use any fertility awareness-based method she wants. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have a medical condition that would make pregnancy especially dangerous?  
(Medical Conditions and Method Choice)  
 No  YES She may want to choose a more effective method. If not, stress careful use of fertility awareness-based methods to avoid pregnancy.
2. Do you have irregular menstrual cycles? Vaginal bleeding between periods? Heavy or long monthly bleeding? For younger women: Are your periods just starting? For older women: Have your periods become irregular, or have they stopped?  
 No  YES Predicting her fertile time with only the calendar method may be hard or impossible. She can use basal body temperature (BBT) and/or cervical mucus, or she may prefer another method.
3. Did you recently give birth or have an abortion? Are you breastfeeding? Do you have any other condition that affects the ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, or cervical cancer?  
 No  YES These conditions do not restrict use of fertility awareness-based methods. But these conditions may affect fertility signs, making fertility awareness-based methods hard to use. For this reason, a woman or couple may prefer a different method. If not, they may need more counseling and follow-up to use the method effectively.
4. Have you had any infections or diseases that may change cervical mucus, basal body temperature, or menstrual bleeding, such as vaginal infection or sexually transmitted infection or pelvic inflammatory disease (PID) in the last three months?  
 No  YES These conditions may affect fertility signs, making fertility awareness-based methods hard to use. Once an infection is treated and reinfection is avoided, a woman can use fertility awareness-based methods more easily.
5. Do you take any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic antidepressants, or anti-anxiety therapies?  
 No  YES Predicting her fertile time correctly may be difficult or impossible if she uses only the cervical mucus method. She can use BBT and/or the SDM, or she may prefer another method.

Be sure to explain the health benefits, risks, and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

## CHECKLIST for PROVISION of the SDM

**NAME of COURSE:** \_\_\_\_\_ **Date:** \_\_\_\_\_

Instructions: Put a (v) in the space provided for if the trainee performed the task “satisfactorily”, (x) if the task was performed “unsatisfactorily”, and (NO) if the task was “not observed”.

TASKS	PRACTICES						
	1	2	3	4	5	6	7
1. Once the client has chosen to use the SDM, determines the length of the client’s menstrual cycle by reviewing her last and past menstrual periods and asking when she expects her next menses.							
2. Determines the client’s cycle length by reviewing her menstrual history.							
3. If the cycle meets the criteria, provides the client with a SDM card and cyclebeads.							
4. If the cycle length is less than 26 days or more than 32 days, explains to the client that she cannot use the SDM and helps her choose another method.							
5. If the client has recently used another FP method, determines whether she qualifies based on the following criteria. <ul style="list-style-type: none"> <li>• If recently used the pills, her last two cycles after stopping the pills were within 26-32 days.</li> <li>• If recently used the injectable, her last injection was at least three months ago and that her cycles were within 26-32 days prior to use of the injectable.</li> <li>• If recently used an IUD, her IUD has been removed and her menstrual cycles are within 26-32 days.</li> </ul>							
6. Describes the SDM CycleBeads while showing the client the beads by telling her that: <ul style="list-style-type: none"> <li>• The red bead represents the first day of menstrual bleeding.</li> </ul>							
<ul style="list-style-type: none"> <li>• The brown beads represent the “infertile” days.</li> </ul>							
<ul style="list-style-type: none"> <li>• The white beads (days 8-19) represent the “fertile” days.</li> </ul>							
7. Instructs the client on the use of the SDM by telling her to: <ul style="list-style-type: none"> <li>• Put the ring on the red bead on the first day.</li> </ul>							

TASKS	PRACTICES						
	1	2	3	4	5	6	7
of her menses and mark (with an “x”) this date on the SDM card/calendar.							
<ul style="list-style-type: none"> <li>• Move the ring to a bead each day every morning.</li> </ul>							
8. Tells the client that she should abstain from sexual intercourse on white-bead days if she wants to avoid pregnancy.							
9. Draws the client’s attention to the dark brown and black beads and tells her that: <ul style="list-style-type: none"> <li>• If she experiences menstrual bleeding before the dark brown bead, her cycle is short and less than 26 days.</li> </ul>							
<ul style="list-style-type: none"> <li>• If the ring reaches the black bead and she has not experienced menstrual bleeding, then her cycle is long and more than 32 days.</li> </ul>							
10. Warns the client that if either of the above events happens at least twice in a year, she cannot reliably use the SDM as her FP method.							
11. Asks the client to repeat the instructions on SDM use in her own words.							
12. Corrects or clarifies instructions, as needed.							
13. Asks client what issues or difficulties might arise during fertile days (during white bead days).							
14. Asks client about possible ways she can handle the fertile days.							
15. Asks client for questions and concerns and responds to these.							
16. Tells client to come to the clinic: <ul style="list-style-type: none"> <li>• Within seven days of her next menstrual period bringing with her the CycleBeads, client card, and if possible, her partner.</li> </ul>							



TASKS	PRACTICES						
	1	2	3	4	5	6	7
<ul style="list-style-type: none"> <li>Menses occurs before the dark brown bead or has not occurred upon reaching the black bead.</li> </ul>							
<ul style="list-style-type: none"> <li>After menses for the next three menstrual period.</li> </ul>							
17. Refers the client for methods or services not offered at the counselor's site, if use of the CycleBeads is not appropriate.							
18. Fills out information in the Client Register and record client as New Acceptor.							
19. Provides information materials on the method.							

## LACTATIONAL AMENORRHEA METHOD



## LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the LAM.
2. Explain the criteria for LAM.
3. Explain the mechanism of action, effectiveness, advantages, and disadvantages of LAM.
4. Explain who can use LAM using the LAM algorithm and the MEC checklist.
5. Enumerate the FP methods appropriate for postpartum breastfeeding women.



## NARRATIVE

The Lactational Amenorrhea Method is a contraceptive method that relies on the condition of infertility that results from specific breastfeeding patterns. LAM is the use of breastfeeding as a temporary family planning method. “Lactational”- means related to breastfeeding. “Amenorrhea”- means not having menstrual bleeding.

**There are three criteria that must be met to be able to qualify for the use of LAM:**

1. **The woman exclusively breastfeeds infant.**
  - Exclusively breastfeeding may be interpreted as:
    - a. Exclusive means no supplements of any sort are given. Infant receives no other liquid or food, not even water in addition to breast milk.
    - b. Very small amount (one or two swallows) of water, vitamins or antibiotics as medically prescribed.
    - c. Simply put, the woman should use both breasts to breastfeed her baby on demand with no more than a four-hour interval between any two daytime feeds and no more than a six-hour interval between any two nighttime feeds.
2. **Amenorrhea.** Mother’s monthly bleeding has not returned. In the first weeks postpartum (e.g. in the first 56 days postpartum), there is often continued spotting. This is not considered to be a menstrual period if the woman is fully lactating.
3. **Infant is less than six months old.** If she is fully breastfeeding and her menses have not returned, the effectiveness of LAM diminishes over time. Ovulation resumes in 20% to 50% of women near the end of the six-month postpartum.

*If any of the criteria is not met, it is no longer LAM.*

**MECHANISM OF ACTION**

Works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

**EFFECTIVENESS**

The effectiveness of LAM as consistently followed at 99.5%; if typically used, it is 98%.

Mothers should initiate breastfeeding as soon as possible after birth, and avoid separation from the baby as much as possible. Breastfeed the infant on demand day and night, with no more than a four-hour interval between any two daytime feeds, and no more than a 6-hour interval between any two night time feeds.

### **ADVANTAGES OF LAM**

1. It can be started immediately after delivery.
2. It is economical and easily available.
3. It does not require a prescription.
4. No action is required at the time of intercourse.
5. There are no side effects or precautions to its use.
6. No commodities or supplies are required for clients or for the family planning program.
7. Fosters mother-child bonding.
8. It serves as a bridge to using other methods since LAM is used for a limited time only.
9. It is consistent with religious and cultural practices.

### **DISADVANTAGES OF LAM**

1. Full or nearly full breastfeeding pattern may be difficult for some women to maintain.
2. The duration of the method's effectiveness is limited to a brief six-month postpartum period. If a mother and child are separated for extended periods of time (because the mother works outside the home), the breastfeeding practice required for LAM cannot be followed.
3. There is no protection against sexually transmitted infections, including HIV.
4. In addition, it may be difficult to convince some providers who are unfamiliar with the method that LAM is a reliable contraceptive.

NOTE: If returning to a clinic will be difficult for the client, provide a complementary family planning method for use, when needed. Use condoms with LAM if there is a risk of STI/HIV infection.

### **WHO CAN USE LAM**

The MEC checklist on the use of LAM

## Medical Eligibility Checklist for Lactational Amenorrhea Method (LAM)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use LAM. If she answers YES to any or all of the questions below, follow the instructions.

1. Is your baby six months old or older?  
 No  YES She cannot use LAM. Help her choose another method. If she is breastfeeding, a non-hormonal method is best.
2. Has your menstrual period returned? (Bleeding in the first eight weeks after childbirth does not count.)  
 No  YES After eight weeks since childbirth, if a woman has two straight days of menstrual bleeding, or her menstrual period has returned, she cannot use LAM. Help her choose another method. If she is breastfeeding, a non-hormonal method is best.
3. Have you begun to breastfeed less often? Do you regularly give the baby other food or liquid?  
 No  YES If the baby's feeding pattern has just changed, explain that she must fully or nearly fully breastfeed – day and night – to protect against pregnancy. At least 85% of her baby's feedings should be breastfeeds. If she is not fully or nearly fully breastfeeding, she cannot use LAM as effectively. Help her choose another non-hormonal method.
4. Has a health care provider told you not to breastfeed your baby?  
 No  YES If she is not breastfeeding, she cannot use LAM. Help her choose another method. A woman should not breastfeed if:
  - she is taking mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocriptine, radioactive drugs, lithium, or certain anticoagulants.
  - if her baby has a specific infant metabolic disorder.
  - or she has active viral hepatitis. All others can and should breastfeed for the health benefits.
5. Do you have AIDS? Are you infected with HIV, the virus that causes AIDS?  
 No  YES When infectious diseases are low risk and safe and affordable food for the baby is available, advise her to feed her baby that other food. Help her choose a family planning method other than LAM (some other infectious conditions, such as active viral hepatitis and HIV, can also be transmitted during breastfeeding).

Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

## CHOOSING AN FP METHOD FOR POSTPARTUM BREASTFEEDING WOMEN

The health benefits of breastfeeding for infants have been established. For this reason, the Philippine Maternal, Newborn and Child Health and Nutrition Program has instituted measures to ensure that breastfeeding is promoted in facilities providing maternal and child health services. One such measure is the issuance of the “Milk Code,” which promotes breastfeeding and discourages milk formula for infants.

Pregnant women during their prenatal consultations are counseled for breastfeeding practice immediately after delivery. Maternal and child health service providers are mandated to assist women implement breastfeeding as soon as possible after delivery.

With a high priority on breastfeeding, the table below categorizes the family planning methods as recommendations for breastfeeding postpartum women, who for some reason may not be qualified for LAM.

Categories of Choice of FP methods for postpartum breastfeeding women.	
1st choice: Non-hormonal methods other than LAM	Intrauterine device, condom, tubal ligation, natural family planning, or vasectomy (for the woman’s partner)
2nd choice: Progestin-only methods	DMPA and progestin-only pills (both of which can be initiated after six weeks postpartum)
3rd choice: Methods containing estrogen (only after six months)	Combined oral contraceptives (COCs are recommended only after six months when complementary foods are introduced and the baby is less dependent on breast milk as its sole source of nutrition.) Estrogen can reduce breast milk volume.

5.13

Refer to a Natural Family Planning Provider if the woman prefers to use Natural Family Planning Methods or FAB Methods. The postpartum breastfeeding woman is eligible to use the Breastfeeding Mucus Method, with or without the return of her menses after delivery.

### KEY POINTS ON LAM

- A family planning method based on breastfeeding.
- Can be effective for up to six months after childbirth, as long as monthly bleeding has not returned and the woman is fully or nearly fully breastfeeding.
- Requires breastfeeding often, day and night.



# MODULE 6



## Hormonal Contraceptive Methods

Session 1: Low-dose combined oral contraceptives (Low-Dose COCs)

Session 2: Other combined contraceptives

Session 3: Progestin-only pills (POPs)

Session 4: Progestin-only injectables (POIs)



## MODULE 6: HORMONAL CONTRACEPTIVE METHODS



### MODULE OVERVIEW

There are currently three hormonal contraceptive methods included in the Philippine Family Planning Program. These are oral contraceptives (combined and progestin-only) and the progestin-only injectable.

The **low-dose combined estrogen-progestin pills** are one of the most popular reversible contraceptive combination developed to date. Women worldwide in both developed and developing countries use it safely.

**Progestin-only pills** contain small amount of progestin-only. They are highly recommended oral contraceptives for breastfeeding women because it does not interfere with milk production.

**Progestin-only injectable contraceptives** are also progestin only preparation given intramuscularly.



### MODULE OBJECTIVES

At the end of the module, participants will be able to demonstrate how to safely and effectively provide low-dose combined oral contraceptives (low-dose COCs), progestin-only pills (POPs) and progestin-only injectables (POIs)



### MODULE SESSIONS

The module has the following sessions:

<b>Session 1</b>	Low-dose combined oral contraceptives
<b>Session 2</b>	Other combined contraceptives
<b>Session 3</b>	Progestin-only pills
<b>Session 4</b>	Progestin-only injectables



## SESSION 1

### LOW-DOSE COMBINED ORAL CONTRACEPTIVES

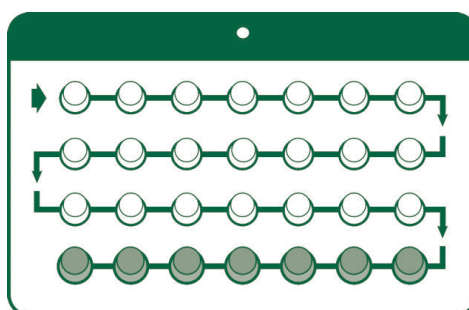
#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe low-dose COCs.
2. Relate the mechanism of action of the COC with the menstrual cycle.
3. Explain the effectiveness of the COC.
4. Enumerate the advantages and disadvantages of the COC.
5. Discuss the possible side effects of the COCs and the management of these.
6. Identify conditions suitable for COCs based on the WHO MEC and checklist.
7. Explain possible side effects (including warning signs) and its appropriate management.
8. Explain the guidelines in providing the COCs, including how to start, what to do for missed pills, and follow-up of clients.
9. Enumerate the “warning signs” of COC use.
10. Manage possible problems on using the COC.
11. Correct myths and misconceptions on the low dose COCs.

#### NARRATIVE

**Low-dose COCs**, otherwise known as pills or oral contraceptives, contain hormones similar to the woman’s natural hormones - estrogen and progesterone. They are taken daily to prevent conception.



**6.2** Most women use low-dose COCs successfully when properly counseled on how to use them and what potential side effects to expect. Service delivery for low-dose COCs can and should be relatively uncomplicated.

Two types of pill packets are available in the Philippines. One type has 28 pills in a packet, with 21 "active" pills containing hormones and seven "inactive or reminder" pills of a different color. The reminder pills do not contain hormones. Another type of pills contain only the 21 "active/hormone containing" tablets.

**Monophasic pills** provide the same amount of estrogen and progesterone in every hormonal pill.

**Biphasic pills** have the first 10 pills with one dosage and the next 11 pills having another level of estrogen and progestin.

**Triphasic pills** have the first seven pills or so with one dosage, the next seven pills have another dosage and the last seven pills with yet another dosage.

All prevent pregnancy in the same way.

Differences in side effects, effectiveness, and continuation appear to be slight.

Other types of hormonal contraceptives are in the form of patch, implant, spray, gel, vaginal ring and intrauterine device.

## Mechanism of Action

Low-dose COCs prevent ovulation by suppressing follicle-stimulating hormone (FSH) and luteinizing hormone (LH). It also causes thickening of the cervical mucus, which makes it difficult for sperm to pass through.

**Low-dose COCs do not disrupt an existing pregnancy.**

## Effectiveness

Low-dose COCs are effective, if perfectly used, 99.7%, as typically used, 92%.

- Many women may not take the pills correctly and risk becoming pregnant. The most common mistakes are starting new packets late and running out of pills.
- The overall continuation rate among low-dose COCs users is low:
  - ✓ 25%-50% of women will stop the low-dose COCs within one year.
  - ✓ Most women stop for non-medical reasons.

### Factors affecting effectiveness:

#### 1. Correct and consistent use.

Low-dose COCs must be taken daily, preferably at the same time of the day or night. Low-dose COCs should be started within the 1st seven days of the menstrual cycle (day 1-7).

If client missed taking the pill, advise them to follow the recommended practice for managing missed pills.

#### 2. Proper storage, observance of shelf life, and expiration date.

Pills should be stored at room temperature with proper ventilation. Too much heat may harden the pills and reduce the bioavailability of the hormone content of the pills.

#### 3. Vomiting or Diarrhea

If vomiting occurs within two hours after taking a pill, she should take another pill from another pack as soon as possible, then keep taking pills as usual. If with vomiting or diarrhea for more than two days, follow instructions for one or two missed pills above. The client is advised to seek consultation for the persistence of vomiting or diarrhea.

#### 4. Drug Interactions

Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-convulsants.

## Advantages of COCs

- Safe as proven by extensive studies
- Reversible, rapid return of fertility
- Convenient, easy to use, no need to do anything at the time of sexual intercourse
- Has significant non-contraceptive benefits
  - Monthly periods regular and predictable
  - Reduces symptoms of gynecologic conditions such as painful menses and endometriosis
  - Reduces the risk for ovarian and endometrial cancer
  - Decreases risk of iron-deficiency anemia
  - Can be used at any age from adolescence to menopause

## Disadvantages of COCs

- Requires regular and dependable supply.
- Client-dependent: effectiveness depends on the client's compliance to the daily routine of taking the pills. Often not used correctly and consistently, which lowers its effectiveness. Strong motivation to take pills correctly is needed.
- Offers no protection against STIs/HIV.
- Not most appropriate choice for lactating women (unless there is no other method available and risk of pregnancy is high) as it can suppress lactation.
- Effectiveness may be lowered when taken with certain drugs such as rifampicin and most anti-convulsants.
- Increased risk to users over 35 years old who smoke and have other health problems.

## WHO CAN USE COCs?

Category 1: Use the method without restriction. The following women can use COCs:

- Have no children yet
- 18-39 years old
- Have just had an abortion or a miscarriage
- Have heavy painful menstrual periods or iron deficiency anemia
- Have irregular menstrual periods
- Have history of ectopic pregnancy
- Post-abortion
- With simple goiter
- With irregular menstrual bleeding/dysmenorrhea
- Have pelvic inflammatory disease (PID - history or current)
- With benign breast disease
- With cervical ectropion/erosion
- With ovarian/endometrial cancer
- With mild non-migrainous headaches
- With varicose veins
- With malaria
- Have thyroid disease
- Have endometriosis
- Have increased STI/HIV risk (advise condom use)
- Have STI (history or current)
- HIV-positive or have AIDS
- Have gestational trophoblastic disease

- Have a history of pregnancy-related diabetes
- Have benign ovarian tumors, uterine fibroids
- Have hepatitis (carriers or not active disease)
- Have tuberculosis, unless taking rifampicin
- Have schistosomiasis

Category 2: Generally use the method but with more than the usual follow-up

- 40 years old or more
- Body mass index of 30 kg/m<sup>2</sup> or more
- Smokes cigarettes but under 35 years old
- Are breastfeeding more than six months postpartum
- Have history of high blood pressure during pregnancy
- Have superficial thrombophlebitis
- With cervical cancer awaiting treatment
- Have diabetes without vascular, kidney, eye or nerve disease
- Have migraine headaches without aura and is under 35 years old
- With unexplained vaginal bleeding before evaluation
- Have a history of deep vein thrombosis or pulmonary embolism (DVT/PE)
- Have undiagnosed breast mass

## WHO CANNOT USE COCs?

Category 3: DO NOT USE the method

- Smoking less than 15 cigarettes a day in a woman aged 35 years or more
- Blood pressure of 140-159/90-99 mm Hg
- Migraine without aura in a woman aged 35 years or more (if migraine develops during use of COCs, it becomes a category 4 contraindication)
- History of breast cancer with no evidence of the disease for five years
- Breastfeeding from six weeks to less than six months postpartum
- Less than 21 days postpartum
- Mild compensated cirrhosis
- History of cholestasis related to past COC use
- Symptomatic gall bladder disease
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants

Category 4: DO NOT USE THE METHOD

- Breastfeeding and less than six weeks postpartum
- Current and history of ischaemic heart disease or stroke
- Smoking 15 or more cigarettes per day in a woman aged 35 years or more
- With BP of 160/100 mm Hg or more
- Hypertension with vascular disease
- Diabetes mellitus with vascular complications (hypertension, nephropathy, retinopathy or neuropathy) of more than 20 years duration
- Past or present evidence of DVT/PE
- Major surgery with prolonged immobilization
- Complicated vascular heart disease
- Breast cancer within the past five years
- Acute viral hepatitis
- Benign or malignant liver tumor
- Severe (decompensated) cirrhosis

## Possible Side Effects and Management

Possible side effects which are common during the first three months of the use of COC are:

- spotting (especially if a woman forgets to take her pills or takes them late)
- amenorrhea
- nausea
- breast tenderness
- headaches

SIDE EFFECTS	POSSIBLE CAUSE(S)	MANAGEMENT
Amenorrhea/ scanty menses	<ul style="list-style-type: none"> <li>• Possible pregnancy</li> <li>• Inadequate endometrial build-up</li> </ul>	<ul style="list-style-type: none"> <li>• Check for pregnancy</li> <li>• Reassurance</li> </ul>
Spotting/breakthrough bleeding	<ul style="list-style-type: none"> <li>• Missed pills</li> <li>• More common with low dose COCs</li> <li>• Taking pills at different times of the day</li> <li>• Vomiting and/or diarrhea within two hours of intake</li> <li>• Drug interaction</li> </ul>	<ul style="list-style-type: none"> <li>• Encourage regular intake of pills at the same time each day</li> <li>• Avoid missing pills</li> <li>• Take another pill from another pack when diarrhea or vomiting occurs within two hours of intake</li> <li>• Change method if taking rifampicin or anti-convulsants</li> </ul>
Nausea	<ul style="list-style-type: none"> <li>• Possible flu or infection</li> <li>• Possible pregnancy</li> <li>• Taking pills on an empty stomach</li> </ul>	<ul style="list-style-type: none"> <li>• Check for flu, infection or pregnancy</li> <li>• Take pills at bedtime or with food</li> </ul>
Headaches	<ul style="list-style-type: none"> <li>• Estrogen effect</li> </ul>	<ul style="list-style-type: none"> <li>• Take analgesics (paracetamol)</li> <li>• Refer if getting worse</li> </ul>
Breast tenderness	<ul style="list-style-type: none"> <li>• Effect of hormones in pills</li> </ul>	<ul style="list-style-type: none"> <li>• Recommend use of supportive bra</li> <li>• Take pain relievers</li> <li>• Try hot or cold compress</li> </ul>

## Warning Signs

6.6

- J** - Jaundice
- A** - Abdominal pain (severe)
- C** - Chest pain
- H** - Headaches (severe)
- E** - Eye problems such as brief loss of vision, seeing flashes of light or zigzag lines
- S** - Severe leg pains

The above signs may not be due to COC use. However, if these signs occur in a client using the COC, she is instructed to immediately seek consultation for proper investigation and management of the underlying problem.

## Procedural points about the delivery of low-dose COCs:

### Guidelines in initiating use of COCs

- Advise the client to take one pill a day regularly, preferably at the same time, even if she is not having sex daily.

- A pack of 21 pills containing the “active” hormones estrogen and progestogen. This requires a seven-day rest period before starting a new pack.
- A 28-day pack would contain seven additional placebo or non-hormone tablets of a different color to enable the woman to finish the pack and start a new one immediately. No rest period required.
- It is best that COCs are taken within the first five days of the menstrual period since conception is virtually nil at this time.
- If a woman started COC after the 7th day of onset of her menses, she should practice abstinence or use back up contraceptive for the next seven days.

**1. What is the best time to start low-dose COCs?**

It is best for the woman to start taking low-dose COCs within the first five days of the menstrual period since conception is virtually nil at this time. If she started to take the pill after the 7th day of her menses, she should abstain or use a back up contraceptive for the next seven days. Low-dose COCs may be started anytime when the service provider can be reasonably sure that the client is not pregnant.

**2. When can low-dose COCs be started postpartum?**

For postpartum women:

- Encourage feeding infant with breastmilk for two years. However, if for whatever reason she wants to stop breastfeeding and use the COC, the following guidelines apply:
- If fully or nearly fully breastfeeding more than six months, and no menses yet
  - ✓ Start at any time for as long as reasonably certain that the woman is not pregnant.
  - ✓ Use back-up for the first seven days of use
- If fully or nearly fully breastfeeding more than six months and menses have returned = start within seven days of menses
- If not breastfeeding = start at three weeks after delivery

**3. May low-dose COCs be started immediately post-abortion?**

After abortion, she may begin low-dose COCs immediately. No back-up contraceptive is needed if she begins within the first seven days following abortion.

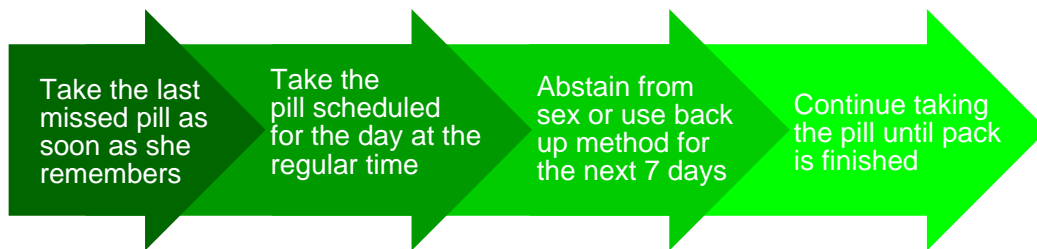
**Missed Pills**

Missed pills are the most common cause of contraceptive failure and COC side effects like spotting and/or withdrawal bleeding. Managing missed pills therefore is a very important aspect that service providers should know and properly implement.

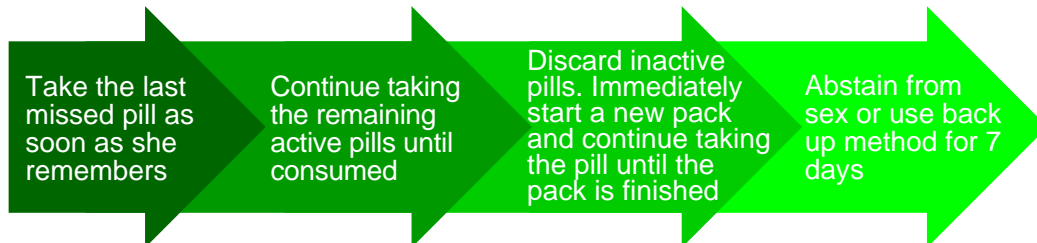
**If a woman misses one or two active COC pill in any day of the first three weeks or starts a pack a day late**



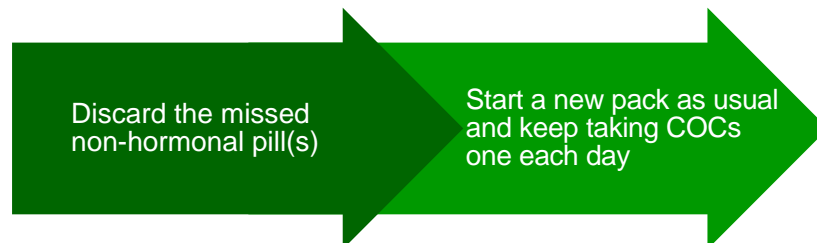
**If a woman misses three or more active COC pills in the first two weeks or starts a pack two or more days late**



**If a woman misses three or more active pills on the third week**



**If a woman misses any non-hormonal pill (any of the last seven pills in a 28-pill pack)**



## Guidelines and instructions for follow-up

Clients should be advised to return to the clinic three months after initiation, then annually thereafter. However, the client should return to the clinic at any time for any problem or questions that may arise.

Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the low-dose COCs.

**6.8** During the annual follow-up, a physical and pelvic examination may be done as a part of good medical practice. Cervical and breast cancer screening are usually undertaken.

Inform client of the appropriate outlets for re-supply of pills. Clients should use the same preparation unless, otherwise advised by the provider.

## Correcting myths and misconceptions

Compliance and continued use of COCs are increased when:

- Clients are properly counseled
- Clients questions and concerns are thoughtfully responded to
- Accurate, detailed, and understandable information is provided



The following are facts on the low-dose COCs:

1. Low-dose COCs appear to have no apparent overall effect on the risk of breast cancer.
2. Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties.
3. Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the Low-dose COCs.
4. Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms.
5. Low-dose COCs are not recommended for breastfeeding women because they can reduce the milk supply.
6. A woman is protected only as long as she takes the pill regularly.
7. COCs do not disrupt an existing pregnancy.
8. COCs do not cause birth defects and will not harm fetus even if the woman becomes pregnant while taking the pill or accidentally starts the pill when she is already pregnant.
9. Most women do not gain or lose weight due to COCs.
10. Generally, COCs do not change the mood or sex drive of a woman.
11. COCs cannot be used as a pregnancy test.
12. COCs are safe for women with varicose veins.
13. COCs can be safely taken by a woman throughout her life.
14. Women younger than age 35 who smoke can use low dose COCs.
15. COCs should be taken at the same time each day to reduce side effects and ensure consistent use.

## KEY MESSAGES

- Low-dose COCs are safe, effective, and reversible. They are some of the most extensively studied medications ever used by human beings. Serious side effects are very rare.
- Low-dose COCs have many non-contraceptive health benefits.
- Low-dose COCs may be used by healthy, non-smoking women throughout their reproductive lives, starting in the teen-age years and into their forties.
- Clients should be provided with enough pills for more than three cycles, provided they have a safe place to store them and the program has enough stocks. Give them more than three cycles only after they have completed a three-month trial period on the Low-dose COCs.
- Low-dose COCs do not protect against STIs and HIV. Women at risk of infection must also be offered condoms.
- Low-dose COCs are not recommended for breastfeeding women because they can reduce the milk supply.



## Medical Eligibility Checklist for Combined Oral Contraceptives (COCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use combined oral contraceptives (COCs). If she answers YES to a question below, follow the instructions.

1. Do you smoke cigarettes and are you 35 or older?

- No  YES      Urge her to stop smoking. If she is 35 or older and will not stop smoking, do not provide COCs. Help her to choose a method without estrogen.

2. Do you have high blood pressure?

- No  YES      If you cannot check blood pressure (BP) and she reports high BP, do not provide COCs. Refer for BP check if possible or help her choose a method without estrogen. If there is no report of high BP, it is okay to provide COCs.

### Check if feasible:

If BP is below 140/90, it is okay to give COCs without further BP readings. If systolic BP is 140 or higher or diastolic BP is 90 or higher, do not provide COCs. Help her choose another method. One BP reading in the range of 140-159/90-99 is not enough to diagnose high BP. Offer condoms for use until she can return for another BP check, or help her choose another method if she prefers. If BP reading at next check is below 140/90, she can use COCs and further BP readings are not necessary. If systolic BP is below 160 or higher or diastolic BP is 100 or higher, she also should not use DMPA or NET-EN.

3. Are you breastfeeding a baby less than six months old?

- No  YES      Can provide COCs now with instruction to start when she stops breastfeeding or six months after childbirth - whichever comes first. If she is not fully or almost fully breastfeeding, give her condoms or spermicide to use until her baby is six months old. Other effective methods are better choices than COCs when a woman is breastfeeding whatever her baby's age.

4. Do you have serious problems with your heart or blood vessels? Have you ever had such problems? If so, what are these problems?

- No  YES      Do not provide COCs if she reports heart attack or heart disease due to blocked arteries, stroke, blood clots (except superficial clots), severe chest pain with unusual shortness of breath, diabetes for more than 20 years, or damage to vision, kidneys, or nervous system caused by diabetes. Help her choose another effective method.

5. Do you have or have you ever had breast cancer?

- No  YES      Do not provide COCs. Help her choose a method without hormones.

6. Do you have jaundice, cirrhosis of the liver, a liver infection or tumor? (Are her eyes or skin unusually yellow?)

- No  YES      Perform physical exam or refer client for PE. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, liver tumor), do not provide COCs. Refer for care as appropriate. Help her choose a method without hormones.

7. Do you often get severe headaches, perhaps on one side or pulsating, that cause nausea and are made worse by light and noise or moving about (migraine headaches)?  
 No  YES      If she is 35 or older, do not provide COCs. Help her choose another method. If she is under age 35, but her vision is distorted or she has trouble speaking or moving before or during these headaches, do not use COCs. Help her choose another method. If she is under age 35 and has migraine headaches without distortion of vision or trouble or moving, she can use COCs.
8. Are you taking medicines for seizures? Are you taking rifampin (rifampicin) or griseofulvin?  
 No  YES      If taking phenytoin, carbamazepine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with COCs or, if she prefers, help her choose another effective method if she is on long-term treatment.
9. Do you think you are pregnant?  
 No  YES      Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until it is reasonably certain that she is not pregnant. Then she can start COCs.
10. Do you have gall bladder disease? Ever had jaundice while taking COCs? Planning surgery that will keep you from walking for a week or more? Had a baby in the past 21 days?  
 No  YES      If she has gall bladder disease now or takes medicine for gall bladder disease, or if she has had jaundice while using COCs, do not provide COCs. Help her choose a method without estrogen. If she is planning to undergo surgery or she just had a baby, she can be provided with COCs with instructions on when to start them.

Be sure to explain the health benefits, risks, and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.

## SESSION 2

### OTHER COMBINED CONTRACEPTIVES



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the contraceptive patch.
2. Explain the effectiveness of the patch.
3. Enumerate the advantages and disadvantages of the contraceptive patch.
4. Discuss the possible side effects of the patch.
5. Identify conditions suitable for use of the patch.
6. Explain the guidelines for providing the patch, including how to start, and what to do for missed patch changes.
7. Describe the combined injectable contraceptives (CIC).
8. Explain the mechanism of action of the CIC.
9. Enumerate the advantages and disadvantages of the CIC.
10. State the effectiveness of the CIC.
11. Discuss the possible side effects of the CIC.
12. Determine conditions suitable or unsuitable for CIC use.
13. Explain how to use the CIC.
14. Enumerate the “warning signs” for CIC use.



#### NARRATIVE

#### CONTRACEPTIVE PATCH



6.12

#### DESCRIPTION

The contraceptive patch is a form of contraceptive applied to the skin. It contains estrogen and progestin similar to the natural hormones in a woman's body and released slowly in the bloodstream.

#### MECHANISM OF ACTION

The contraceptive patch work by:

- inhibiting ovulation
- thickening of the cervical mucus

## ADVANTAGES

Advantages include the following:

- effective (99%)
- no daily pill intake
- regulates menstrual flow such that monthly cycles are regular, lighter, with fewer days of bleeding
- can be stopped at any time by the client
- does not interrupt sex
- increased sexual enjoyment as there is no need to worry about getting pregnant
- convenient and simple to use
- safe
- Has significant non-contraceptive benefits similar to COCs
  - ✓ Monthly periods are regular and predictable
  - ✓ Reduces symptoms of gynecologic conditions such as painful menses and endometriosis
  - ✓ Reduces the risk for ovarian and endometrial cancer
  - ✓ Decreases the risk of iron-deficiency anemia
  - ✓ Can be used at any age from adolescence to menopause

## DISADVANTAGES

There are disadvantages with the use of the contraceptive patch, as follows:

- may be less effective in women with body weight greater than 90 kg
- affects quantity and quality of breastmilk
- need to replace patch weekly
- does not protect against sexually-transmitted infections
- increased risk to users over 35 years old who smoke and have other health problems

## WHO CANNOT USE THE PATCH

Women with the following conditions may not use the patch:

- pregnancy
- smoking and are 35 years old or over
- 35 years old or over and stopped smoking less than a year ago
- breastfeeding
- overweight
- history of thrombosis
- heart disease

Being a combined contraceptive like the COC, the eligibility for use is the same as that of the COC.

## POSSIBLE SIDE EFFECTS

There may be side effects with the use of the contraceptive patch. These are not signs of illness and not all women will experience them. This includes:

- skin irritation or rashes at the site of the patch
- headache
- menstrual bleeding irregularities
- fluid retention
- nausea
- breast tenderness

## HOW TO START

SITUATION	WHEN TO START
Having menses	<ul style="list-style-type: none"><li>• Any day within the first five days of the menstrual cycle (first day is preferable).</li><li>• Any time it is reasonably certain that she is not pregnant. If more than five days since menstrual bleeding started, she can start using the patch but should avoid unprotected sex for the next seven days. Condom use is advisable at this time.</li></ul>
Switching from non-hormonal methods or progestin-only pills	<ul style="list-style-type: none"><li>• Same rule as for women having menses (see situation above)</li></ul>

- Disposing of the patch: Used patches should be placed in the disposal sachet provided and put in a waste bin. They must not be flushed down the toilet.

## MISSED PATCH CHANGES

If client forgets to change the patch at the beginning of a monthly cycle, apply one as soon as remembered. Record this day of the week as the new patch change day and use a back-up method of birth control for the next seven days.

If client forgets to change the patch by one or two days in the middle of a monthly cycle, change patch as soon as remembered. Keep the same patch change day. A back-up method is not required.

If client forgets to change the patch by more than two days in the middle of a cycle, put on a new patch as soon as possible. Begin a new four-week patch cycle with this patch. Record the day of the week and use a back-up method of birth control for the next seven days.

If client forgets to remove the third patch in the cycle, remove it as soon as remembered. Apply a new patch as scheduled to start the next patch cycle. No need to change the regular patch change day or use back up contraception.

6.14

## WARNING SIGNS

The contraceptive patch has the following warning signs similar to the COCs. The client is advised to immediately return to the clinic or consult a physician when any of the following occurs:

- J** - Jaundice
- A** - Abdominal pain (severe)
- C** - Chest pain
- H** - Headaches (severe)
- E** - Eye problems such as brief loss of vision, seeing flashes of light or zigzag lines
- S** - Severe leg pains

The above signs may not be due to contraceptive use.

# COMBINED INJECTABLE

## Description

The combined injectable is a contraceptive containing estrogen and progestin in an injectable form.

The currently available combined injectable in the country contains Norethisterone 50 milligrams (mg) and Estradiol Valerate 5 mg in oily solution.

## Mechanism of Action

The contraceptive effect is primarily on ovulation inhibition and thickening of the cervical mucus.

The contraceptive effect is similar to that achieved by daily intake of the COC.

## Advantages

Advantages are similar to that of the COC with the following additional benefits:

- Does not require daily action. No need to take a pill daily.
- Private. No one else can tell that the woman is using a contraceptive.
- More regular monthly bleeding as compared to DMPA.

## Disadvantages

- Requires injection every month.
- Delayed return to fertility after the woman stops the method. It takes an average of one month for fertility to return.
- Does not protect against sexually transmitted infections (STIs), including HIV.

## Effectiveness

Effectiveness in preventing pregnancy in the first year of use:

- Correct use (no missed or late injections): 99%
- Typical use (some missed or late injections): 97%

## Possible Side Effects

- Changes in monthly bleeding which will lessen within three months of starting injections include:
  - ✓ Lighter and fewer days of bleeding
  - ✓ Irregular bleeding
  - ✓ Infrequent or prolonged bleeding
  - ✓ No monthly bleeding
- Headaches
- Dizziness
- Breast tenderness

## Who Cannot Use

Women with the following conditions are advised not to use the CIC:

- Pregnancy
- Breastfeeding an infant that is less than six months old
- Smoke cigarettes and are 35 years old or older
- Hypertension
- Migraine headaches
- Serious diseases of the liver, heart or blood vessels
- Breast cancer
- Undiagnosed abnormal vaginal bleeding

## How to Use

- First injection is given on the first day of the menstrual cycle.
- Succeeding injections are given every 30+/- three days.
- The injectable must be stored at controlled room temperature (15-30°C). Do not freeze.
- Administration:
  - ✓ Follow infection prevention measures for administering injections.
  - ✓ Slow deep intramuscular injection preferably intragluteal, alternatively into the upper arm.
  - ✓ Place a plaster over the injection site after injection to prevent any reflux of the solution.
- Client instructions
  - ✓ What to expect:

Vaginal bleeding episode will occur within one or two weeks after the first injection. This is normal and if use is continued, bleeding episodes will occur at 30 days interval. Pregnancy should be ruled out if no withdrawal bleeding occurs within 30 days after an injection.
  - ✓ Follow-up
    - Return to the clinic every 30 days for your next injection. Try to come on time.
    - If, for some reason, the next injection was not given after 30 days, abstain from sexual intercourse or use a condom until you get the next injection.
    - Come back to the clinic no matter how late you are. You may still be able to use the injectable.
    - Return to the clinic at any time if:
      - s you develop any of the warning signs
      - s you have any questions or problems
      - s you think you are pregnant

## Warning Signs

The combined injectable contraceptive has the following warning signs similar to the COCs. The client is advised to immediately return to the clinic or consult a physician when any of the following occurs:

- J** - Jaundice
- A** - Abdominal pain (severe)
- C** - Chest pain
- H** - Headaches (severe)
- E** - Eye problems such as brief loss of vision, seeing flashes of light or zigzag lines
- S** - Severe leg pains



### PROGESTIN-ONLY PILLS (POPs)

#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the POPs and commonly available preparations.
2. Relate the mechanism of action of the POP with the menstrual cycle.
3. State the effectiveness of the POP.
4. Enumerate the advantages and disadvantages of the POP.
5. Enumerate the possible side effects of the POP.
6. Explain the management of the possible side effects of the POP.
7. Identify conditions suitable for POPs based on the WHO MEC and checklist.
8. Explain the guidelines in providing the POPs including follow-ups.
9. Correct myths and misconceptions.

#### NARRATIVE

There are two kinds of POPs available:

1. 0.5 mg lynesterenol
2. 75 ug desogestrel

Both are available in a 28 tablet package.



#### MECHANISM OF ACTION

6.18

1. Prevents ovulation in about half of menstrual cycles.
2. Causes thickening of the cervical mucus, which make it more difficult for sperm to pass through.

#### EFFECTIVENESS

For breastfeeding women, POPs are very effective:

**99%** for typical use

**99.5%** for perfect use

POPs are less effective for women not breastfeeding.

It is particularly important that POPs be taken at the same time every day. When taken even a few hours late, they lose their effectiveness.

## ADVANTAGES

- Can be used by nursing mothers starting six weeks after childbirth. Quality and quantity of breast milk are not affected.
- No estrogen side effects.
- Women take one pill every day with no break. Easier to understand than taking 21-days combined pills.
- Can be very effective during breastfeeding.
- Lesser risk of progestin-related side effects, such as acne and weight gain, than with low-dose combined oral contraceptives.
- May help prevent:
  - Benign breast disease
  - Endometrial and ovarian cancer
  - Pelvic inflammatory disease

## DISADVANTAGES

- Women who are not breastfeeding experience changes in menstrual bleeding. This include irregular periods, spotting or bleeding between periods (common), and amenorrhea possibly for several months (less common). A few women may have prolonged or heavy menstrual bleeding.
- Less common side effects include headaches and breast tenderness.
- Must be taken at about the same time each day to be effective. For women who are not breastfeeding, even taking a pill more than three hours late increases the risk of pregnancy and missing two or more pills increases the risk greatly.
- Does not protect against STIs/HIV.
- Effectiveness is lowered when certain drugs for epilepsy (phenytoin and barbiturates) or tuberculosis (rifampicin) are taken.

## WHO CAN USE POPs

**Category 1:** Use the method without restriction.

POP<sub>s</sub> can be used by women in any of the following circumstances:

- Breastfeeding six weeks after childbirth
- Smoke cigarettes
- Have no children
- Adolescents and women over 40 years old
- Have just had an abortion or miscarriage
- Have breast disease
- Experiencing heavy painful menstruation, irregular period
- Have thyroid disease
- Have benign ovarian tumor, uterine fibroid
- Have valvular heart disease
- Suffering from STIs and PID

Category 2: Generally use the method but with more than the usual follow-up

- Current history of ischaemic heart disease or stroke (if either develops during POP use, it becomes Category 3)
- History of hypertension where blood pressure cannot be evaluated
- Elevated blood pressure (systolic >160 mm Hg or diastolic >100 mm Hg)
- Hypertension with vascular disease
- Diabetes with or without complications
- History of DVT/PE
- Major surgery with prolonged immobilization
- Mild compensated cirrhosis
- Gall bladder disease
- Undiagnosed breast mass
- Previous ectopic pregnancy
- Known hyperlipidemia
- Irregular, heavy, or prolonged vaginal bleeding or unexpected vaginal bleeding
- Treatment with griseofulvin
- Antiretroviral therapy

## WHO CANNOT USE THE METHOD

**Category 3:** Do not use the method.

- Breast cancer within the past five years

**Category 4:** Do not use the method unless no other appropriate method is available under close supervision.

- Current DVT/PE
- Active viral hepatitis
- Liver tumor (benign or malignant)
- Severe decompensated cirrhosis
- History of breast cancer with no evidence of disease for the last five years
- Breastfeeding and less than six weeks postpartum
- Migraine with an aura or development of migraine without an aura at any age that develops during POP use
- Drug treatment affecting liver enzymes: rifampicin and certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)

## Management of Possible Side Effects of POPs

6.20

### 1. Amenorrhea (No monthly bleeding)

- Reassure that this is normal for breastfeeding women. It is not harmful.
- For non-breastfeeding women, reassure that some women using POPs stop having monthly bleeding but this does not mean that it is harmful. There is no need to lose blood monthly and the woman is not infertile. Blood is not building up inside her (some women are actually happy to be free from monthly bleeding).

### 2. Irregular bleeding (bleeding at unexpected times that bothers the client)

- Reassure that many women using POPs experience irregular bleeding, whether breastfeeding or not. It is not harmful and it lessens or stops after several months of use. However, other possible causes are vomiting/diarrhea and taking anticonvulsants or rifampicin.
- To reduce bleeding, teach her to make up for missed pills properly.
- Consider other underlying conditions unrelated to method use and refer appropriately.

### 3. Ordinary headaches

- Suggest pain relievers (Paracetamol, Aspirin, Ibuprofen)
- Getting worse or occurring more often during POP use, warrants evaluation

### 4. Nausea or dizziness

- Suggest taking POPs at bedtime or with food

## Starting POPs

### Menstruating

- Start within the first five days of the menstrual cycle, preferably on the first day
- At any time during the menstrual cycle if reasonably sure that the woman is not pregnant
  - If not within the first five days of the menstrual cycle = abstain from sex or use a back-up method for the next two days

### Postpartum

- If breastfeeding, start after six weeks postpartum
- If not breastfeeding, can start immediately or at any time within six weeks postpartum.

## Instructions on Use

Once the client has chosen POPs as her preferred contraceptive method, the health provider should:

- Briefly explain how POPs work to prevent pregnancy.
- Show and let client handle a package of pills
  - Explain how to take the pills.
  - Take the first pill on the first day of your period or on any of the next four days.
  - Take one pill everyday, at the same time each day (e.g. between 6pm and 8pm- after an evening meal may be a good time to take the pills).
  - Take the pills non-stop, from one packet to another.
  - Do not miss a day.
  - Have a backup method of contraception (condoms) especially:
    - When you are waiting to start POPs.
    - If you miss a pill, until you restart or until your next period.
    - If you may be at risk of infection from STIs.
- How to manage missed pills
  - Remember to emphasize the importance of not forgetting any pill, even just for a few hours.
  - Advise the client that if she misses one or more pills, she may have spotting or breakthrough bleeding, and more importantly she will be at a greater risk of becoming pregnant.
  - She needs to restart taking the pills as soon as possible.
  - If she missed taking the pills by more than three hours, advise her to abstain from sexual intercourse or use a barrier method of contraception during the first 48 hours after restarting the pills.

- If the client is breastfeeding and amenorrheic and has missed one or more pills by more than three hours, she needs to take one pill as soon as possible and continue to take the pills as usual.
  - If she is less than six months postpartum, no additional contraceptive protection is needed.
- Keep track of your periods while you take POPs. If you have more than 45 days with no period, see your health care provider for an examination and pregnancy test.
- If you have spotting or bleeding between periods, keep taking the pills on schedule. If your bleeding is very heavy, or if you have pain, fever or cramps, return to the clinic. In most cases, the bleeding is not serious and will stop in a few days. Bleeding is especially likely if you have missed a pill. Bleeding will be more common in the first months that you take the pill.
- If you decide to become pregnant, plan to stop your pills two months before you want to get pregnant and use another method like the condom. This gives time for your normal cycle to reestablish itself and makes it easier for your health care provider to determine your pregnancy due date.

## Guidelines and instructions for follow-up

- See your health care provider regularly for routine checkup. Feel free to come to the clinic if you have any questions.
- If you have any problems or questions, you may come back to the clinic anytime.
- If you have any of the following symptoms or problems, come to the clinic:
  - Abdominal pain, tenderness, or fainting (this could be due to an ovarian cyst or ectopic pregnancy). Don't stop taking the pills, but come to the clinic right away.
  - Extremely heavy bleeding (twice as long or twice as much as usual).
  - Any bad headache (that starts or becomes worse after taking POPs).
  - Skin or eyes become yellow.
  - If you think you might be pregnant.

## Correct Myths and Misconceptions about POPs:

- POPs do not affect milk production.
- POPs do not cause birth defects and will not otherwise harm the fetus if a woman becomes pregnant while taking POPs or accidentally takes POPs when she is already pregnant.
- Women who stop using POPs can become pregnant as quickly as women who stop nonhormonal methods.
- POPs do not cause cancer.
- POPs do not affect women's sexual behavior nor cause mood changes.
- POPs reduce the risk of ectopic pregnancy.

## PROGESTIN-ONLY INJECTABLES



### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the Progestin Only Injectables (POIs) and available preparations.
2. Relate the mechanism of action of the POIs with the menstrual cycle.
3. Discuss the effectiveness of POIs.
4. Enumerate the advantages and disadvantages of DMPA.
5. Identify clients who can and cannot use the DMPA using the MEC wheel and checklist.
6. Enumerate the possible side effects of the DMPA.
7. Explain the management of possible side effects of the DMPA.
8. Discuss the guidelines on DMPA provision.
9. Demonstrate how to use the auto-disabled syringe.
10. Demonstrate how to administer the DMPA.
11. Explain the guidelines on return visits and follow-up.
12. Correct myths and misconceptions on the POIs.



### NARRATIVE

It is important that health service providers understand the nature, safety, characteristics and mechanism of action, side effects, and management of side effects of progestin-only injectable.

The progestin-only injectable is a three-month injectable contraceptive. POI contains a synthetic progestin, which resembles the female hormone progesterone. Each standard dose contains 150 mg of the hormone, which is released slowly into the blood stream from the site of intramuscular injection, providing the client/user with a safe and highly effective form of contraception.

POIs commercially available in the Philippines:

1. Depot medroxyprogesterone acetate (DMPA) (part of the Philippine FP program), which is given every three months
2. Norethisterone enanthate (NET-EN), which is given every two months.

### Mechanism of Action

- **Inhibits ovulation** - After a 150 mg injection of DMPA, ovulation does not occur for at least 14 weeks. Levels of the follicle stimulating hormone (FSH) and luteinizing hormone (LH) are lowered and a LH surge does not occur.
- **Thickens the cervical mucus** - The cervical mucus becomes thick, making sperm penetration difficult.

## Effectiveness

Progestin-only injectable is a highly effective contraceptive method. Effectiveness if perfectly used is **99.7%**, if typically used, **97.0%**.

## Safety

Progestin-only injectable is a very safe contraceptive. Like other progestin-only contraceptives, it can be used by women who want a highly effective contraceptive, including those who are breastfeeding or who are not eligible to use estrogen-containing low-dose combined oral contraceptives.

Studies by the World Health Organization (WHO) reassure us that DMPA presents no overall risks for cancer, congenital malformation, or infertility. This research has evaluated more than three million woman-months of DMPA use.

The research also revealed that:

- DMPA, like oral contraceptives, exerts a strong protective effect against endometrial cancer.
- Its use does not increase the risk of breast cancer overall.
- There is no relation between ovarian cancer and the use of DMPA. Researchers had expected that DMPA, like oral contraceptives, would protect women against ovarian cancer.
- DMPA does not affect the risk of developing liver cancer in areas where hepatitis is endemic.

## Advantages

- Reversible
- No need for daily intake
- Does not interfere with sexual intercourse
- Perceived as culturally acceptable by some women
- Private since it is not coitally dependent
- Has no estrogen-related side effects such as nausea, dizziness, nor serious complications such as thrombophlebitis or pulmonary embolism
- Does not affect breastfeeding - quantity and quality of breast milk do not seem to be affected
- Has beneficial non-contraceptive effects:
  - Helps prevent iron-deficiency anemia because of the scanty menses and the consequent amenorrhea
  - May make seizures less frequent in women with epilepsy
  - Reduces the risk of ectopic pregnancies
  - Prevents endometrial cancer



## Disadvantages

- Return to fertility is delayed - on the average, fertility returns for about 10 months from the last injection.
- Requires an injection every two or three months to sustain its effect.
- Does not protect against STI/HIV/AIDS.
- Menstrual irregularity during the first few months of use.
- Amenorrhea; some women get anxious if they do not have menses.
- Not possible to discontinue immediately, until DMPA is cleared from the woman's body.
- There may be a decrease in bone density for long-term users. However, studies show that this condition is reversible after discontinuation and that bone density loss is greater during pregnancy.

## SUITABILITY FOR DMPA

DMPA is an appropriate method for women with the following needs:

- Do not want others to know that she is using a contraceptive.
- Have problems of compliance with oral contraceptive intake.
- Cannot use an estrogen-containing contraceptive.
- Have completed her desired family size, but does not want sterilization.
- Desire an effective long-acting, reversible contraceptive.
- Prefer a method that does not require any preparation before intercourse.
- Want a convenient method.
- Are breastfeeding and wants to use a hormonal method.

## Who can use DMPA?

### Category 1: Use the method without restriction

- 18-45 years old
- Nulliparous or parous
- Breastfeeding (starting as soon as six weeks after childbirth)
- Smoke cigarettes
- Just had an abortion
- History of high blood pressure during pregnancy
- With endometriosis
- With benign trophoblastic disease
- With benign breast disease
- With uterine fibroids/thyroid disease
- With mild headaches
- With iron deficiency anemia
- With varicose veins
- With ovarian/endometrial cancer
- With malaria

### Category 2: Generally use the method but with more than the usual follow-up

- Menarche to less than 18 years old
- More than 45 years old
- History of hypertension where BP cannot be evaluated
- Mild to moderate hypertension (Less than 160/100)
- History of DVT/PE
- Migraine with or without aura
- Valvular heart disease
- Irregular menstrual period
- Cervical cancer awaiting treatment



## Who cannot use DMPA?

### Category 3: DO NOT USE THE METHOD

- With Breast cancer within the past five years

### Category 4: DO NOT USE THE METHOD unless no other appropriate method is available under close supervision by a physician

- With current DVT/PE
- With unexplained vaginal bleeding
- Breastfeeding and less than six weeks after childbirth
- With severe hypertension (more than 160/100 mm Hg)
- With diabetes with vascular disease for more than 20 years
- Current or history of ischaemic heart disease or stroke
- History of breast cancer with no evidence of the disease for the last five years
- Acute viral hepatitis
- Benign and malignant liver tumor

## MANAGEMENT OF POSSIBLE SIDE EFFECTS

Your success in helping your client understand the cause/nature of side effects and complications related to progestin-only injectable and how well you manage such cases will largely determine the client's satisfaction and continuing use of the method.

When side effects are not well managed, many women stop using progestin-only injectable due to fear and misunderstanding.

On very rare occasions, allergic reactions immediately follow an injection of progestin-only injectable.

The possibility of change in menstrual bleeding patterns, include:

- Amenorrhea: reassure the client that amenorrhea is an expected side effect, and that she can expect menstrual cycles to return to normal within six months of discontinuing the POI.
- Menstrual irregularity: Breakthrough bleeding and spotting are common.

## GUIDELINES IN THE PROVISION OF DMPA

### SPECIAL CONSIDERATIONS

- Administering DMPA requires a sterile syringe and a 21-23 gauge needle. Ample supplies of both must be available. Be sure syringes and needles are not removed from DMPA stocks for the administration of other drugs.
- Syringes and needles are manufactured for single use only and must be safely disposed of (in a sharps container, for example), following DMPA administration. Resterilizing needles and syringes may diminish their integrity, resulting in potentially unsafe or ineffective administration.
- Storage conditions are critical to product stability. Particle size in aqueous suspensions like DMPA can change with temperature fluctuations. These changes can affect drug efficacy. Follow manufacturer's storage recommendations.

- Because DMPA is a suspension, the colloid may separate. Shake the vial to return the suspension to a milky white color.
- Apply the normal visual indicators for quality control of direct drugs, i.e., physical damage to carton or product; broken seals; foreign matter inside vial or syringe package; leakage or caking of ingredients.

## **TIMING OF THE FIRST INJECTION**

### ***For “interval” clients***

- Any time it is reasonably certain that the woman is not pregnant.
- Within seven days of the menstrual cycle, the client needs no backup method.
- After seven days of the menstrual cycle, advise the client to use a backup method or to exercise abstinence for the next seven days.

### ***For breastfeeding clients***

- As early as six weeks after delivery
- If menses have resumed, the woman can start direct any time it is reasonably certain that she is not pregnant.

### ***For postpartum, not breastfeeding***

- Immediately or at any time in the first six weeks after childbirth; the client does not need to wait for her menstrual period.
- After six weeks, any time she is reasonably certain that she is not pregnant. If she is not certain, she should avoid sex or use condoms until her first menstrual period or until the possibility of pregnancy has been ruled out.

### ***For post abortion***

- Immediately or within seven days after an abortion
- If later than seven days, any time it is reasonably certain that she is not pregnant. She should avoid sex or use condoms for the next seven days.

## **PREPARING EQUIPMENT, SUPPLIES, AND MATERIALS**

Prepare the following supplies and materials needed for the injection:

- Protection-only direct vial
- Sterile syringe and needle
- Cotton balls
- Locally available antiseptic to clean the skin (70% isopropyl alcohol)

If needles and syringes are to be used more than once, decontaminate, clean, and sterilize them after each use. Presently available are disposable syringes and needles intended for single use.

## **PREPARING THE CLIENT**

- Provide comprehensive counseling for each client.
- Ensure that the client understands method advantages, as well as the side effects of irregular bleeding, minor, and possible delayed return of ovulation.
- Explain the procedure to the client.
- Encourage the client to ask questions to reduce apprehension and anxiety.
- Show her the supplies and materials that will be used.
- Explain that the syringes and needles are sterile.
- Reassure the client before and after the injection.

## STEPS IN ADMINISTERING DMPA

The following steps need to be followed in giving a DMPA injection:

1. Wash hands thoroughly with soap and water and air dry them or use a clean towel.
2. Check vial for contents/dosage. If contents are less than indicated volume, do not use the vial.
3. Roll the vial back and forth between the palms of your hands to mix the solution or shake it lightly. Gently shake the vial as vigorous shaking will make the solution foamy. Failure to mix the solution will permit some of the drug to remain as sediment in the vial, resulting in an inadequate dose and, possibly, lower contraceptive effectiveness.
4. Open the sterile packet of the syringe with needle.  
Use a 21-23 gauge needle, 1-1.5 inches in length, with a two to five ml syringe.
5. Swab the skin at the site of the injection with alcohol or other antiseptic, removing any visible dirt or soil. Allow the antiseptic to dry before giving the injection.
6. Put vial in a flat surface and slightly tilt the vial or hold the vial upside down at eye level while aspirating the solution to be sure that all of the solution is taken out from the vial.
7. Inject deep into the deltoid or gluteal muscle. If administering on the gluteal muscles (buttocks), inject on the upper outer quadrant of the buttocks to prevent hitting the sciatic nerve which may cause paralysis of the legs.
8. Aspirate first to ensure that the needle is not in a vein.
9. Administer the DMPA.
10. Instruct the client not to massage the area after the injection. Massaging may speed the release of progestin and thus shorten the period of efficacy. It may also disperse the DMPA so that it is not properly absorbed.
11. Dispose of needles and syringe in a puncture proof container.
12. Wash hands and dry.

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## THE AUTO-DISABLED SYRINGE (ADS)

The auto-disabled syringe:

- Is a single dose, disposable syringe
- Has a locking mechanism that locks the plunger after a single dose.
- Comes with a detachable needle which cannot be attached to other types of syringe.
- Is designed to prevent re-use.

### Steps on how to use the auto-disabled syringe:

- Check that package seals are not damaged or changed. This ensures that the sterility of the syringe is maintained.
- Do not touch the needle or syringe hub. This contaminates the ADS.
- Do not pull the piston, unless you are drawing the DMPA solution.
- Hold the DMPA vial upright when drawing up the dose.

- Keep the needle in the solution when drawing up the dose.
- Gently pull piston slightly past the 1.0 ml mark when drawing up the dose. Give space for air bubbles while maintaining full dose.
- After drawing up the dose and removing needle from vial, gently push piston to remove excess air.
- Stop when you reach 1.0 ml mark.

## RETURN VISIT

Using progestin-only injectable as a method requires that clients return to the clinic every three months (90 days) for DMPA and every two months (60 days) for Noristerat for the next injection.

Advise every client during counseling and during post-injection instructions about the importance of returning to the clinic on her scheduled date. Give her an appointment card or slip of paper with the date of the appointment written on it.

Instruct the client that if she is more than two weeks late, she should abstain from sexual intercourse or reliably use an additional method until she returns. If you are reasonably assured that she is not at risk of pregnancy, you may give her the next injection. If you are unsure, do a sensitive pregnancy test or ask her to use another method of contraception, and have her return in one month. After one month, you may determine if she is not pregnant, and if not, you may give her the next injection.

The next injection may be given up to four weeks early, if the woman cannot return at the scheduled time. Giving the next injection early is also one form of managing prolonged bleeding or spotting when this occurs within four weeks of the next scheduled visit.

Clients should be instructed to report back to the clinic for any of the following warning signals:

- repeated very painful headaches
- heavy bleeding
- depression
- severe, lower abdominal pain which may be a sign of pregnancy
- pus, prolonged pain, or bleeding at injection site

## STEPS PERFORMED DURING FOLLOW-UP

During each follow up visit, the service provider should perform the following procedures or steps:

1. Interviewing the client:
  - Ask the client whether or not both she and her partner are satisfied with the method.
  - Ask if they have any questions, problems or concerns.
  - Ask if the client has encountered any side effects, such as menstrual irregularities.
2. Take and record BP and weight.

### Satisfied client:

- If the client is satisfied with the method and has no contraindications or precautions to continued use, give the client her next injection.
- Give supportive counseling and continued reassurance to help ensure a high tolerance for menstrual irregularities.
- Remind client to return to the clinic on the scheduled date, or any time she has problems (e.g. side effects) or any condition that may cause dissatisfaction with the method.
- Plan for return or next visit.

**If the client has experienced complications or side effects:**

- If client has developed a complication or troublesome side effect, examine her and gather information about what she experienced.
- Reassure and provide further counseling.
- If it is beyond your capability to manage, refer client to the physician or to the appropriate health service center.
- If the next scheduled injection can be given after the management of the condition or as per physician's advice, then give the injection. If not, advise client to use a temporary back-up method and return for a follow-up visit after she has fully managed/recovered from the side effects or precautions of the method.
- If the client finds the method unacceptable due to the developed condition, then help her choose another method.

**CORRECT INFORMATION ABOUT MYTHS AND MISCONCEPTIONS**

- a. POIs do not cause birth defects and will not harm fetus if a woman becomes pregnant while using them or accidentally starts POIs when she is already pregnant.
- b. POIs do not disrupt an existing pregnancy nor can they be used to cause an abortion.
- c. Bleeding episodes should not be used as a guide for the injection schedule: DMPA should be given every three months regardless of whether a woman has bleeding or not.
- d. POIs are not used to regulate monthly periods especially for those with irregular cycles.
- e. Women younger than 35 who smoke any number of cigarettes and women 35 and older who smoke more than 15 cigarettes a day CAN safely use POIs.
- f. Generally, POIs do not cause change in a woman's mood or sexual drive.
- g. POIs are safe for women with varicose veins. Women with history of DVT/PE should not use POIs.
- h. POIs do not cause a woman to be permanently infertile but there may be a delay in regaining fertility after stopping them; usually it takes around 10 months before they become pregnant.

**SUMMARY:**

- Changes in bleeding patterns are common but not harmful. Typically, irregular bleeding may occur for the first several months, after which, there is no monthly bleeding.
- Return for injections regularly, every three months for DMPA.
- Injections can be as much as two weeks early or late. Clients should come back even if she is late.
- Gradual weight gain is common.
- Return of fertility is often delayed. It takes several months longer on average to become pregnant after stopping POIs than other methods.

## SKILLS CHECKLIST on PROGESTIN-ONLY INJECTABLE ADMINISTRATION

PARTICIPANT \_\_\_\_\_ Course Date \_\_\_\_\_

Instruction: Check the appropriate column for each of the tasks.

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
<b>PRE-INJECTION TASKS</b>					
1. Conducts counseling.					
2. Ensures that the client understands and accepts the possible side effects of the POI.					
3. Explains the injection procedure to the client.					
4. Encourages the client to ask questions and responds to her questions.					
5. Listens attentively to client's response and concerns.					
6. Reassures the client that the needle and syringe used for injection are sterile.					
7. Washes hands thoroughly with soap and water.					
8. Checks vial for contents, dosage, and expiration.					
9. Disperses the suspension by rolling the vial back and forth between the palms of the hands or by gently shaking the vial so that no bubbles are formed in the solution.					
<b>Using the auto-disabled syringe</b>					
10. Checks that package seals of the syringe are not damaged or changed to ensure that sterility of the syringe is maintained.					
11. Takes care that the sterility of the needle is maintained by not touching contaminated surfaces with it.					
12. Holds the DMPA vial upright.					
13. Inserts the needle into the vial and pulls the piston of the syringe to draw the solution.					
14. Keeps the needle in solution when drawing up the dose.					
15. Gently pulls the piston slightly past the 1.0 ml mark when drawing up the dose.					
16. Gives space for air bubbles while maintaining full dose.					

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
17. After drawing up the dose and removing needle from vial, gently pushes the piston to remove excess air.					
18. Stops upon reaching the 1.0 ml mark.					
INJECTION TASKS					
19. Swabs the skin at the site of the injection with alcohol or other antiseptic.					
20. Allows the antiseptic to dry before giving the injection.					
21. Injects deep into the muscle.					
22. Administers the POI.					
23. Instructs the client not to massage the area after the injection.					
24. Disposes of needle and syringe in a puncture proof container.					
25. Washes hands and dry.					

**COMMENTS/RECOMMENDATIONS:**

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Trainer's Signature: \_\_\_\_\_

## Medical Eligibility Checklist for Progestin-Only Contraceptives (POCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use the progestin-only contraceptives. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have or have you ever had breast cancer?  
No YES Do not provide POCs. Help her choose a method without hormones.
2. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)  
No YES Perform physical exam or refer client. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care. Help her choose a method without hormones.
3. Are you breastfeeding a baby less than six months old?  
No YES Can give her POCs now with instruction on when to start - when the baby is six weeks old.
4. Do you have serious problems with your heart or blood vessels? If so, what problems?  
No YES Do not provide POCs if she reports blood clots (except superficial clots). Help her choose another effective method.
5. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)  
No YES Perform physical exam or refer client. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care as appropriate. Help her choose a method without hormones.
6. Are you taking medicine for seizures? Are you taking rifampin (rifampicin) or griseofulvin?  
No YES If she is taking phenytoin, carbamezaphine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with POCs. If she prefers, or if she is on long treatment, help her choose another effective method.
7. Do you think you are pregnant?  
No YES Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, give her condoms or spermicides to use until reasonably certain that she is not pregnant. Then she can start POCs.

Be sure to explain the health benefits, risks, and side effects of the method that the client will use.

Also, point out any conditions that would make the method inadvisable when relevant to the client.





# MODULE 7



## Male Condoms

Session 1: Male Condoms



## MODULE 7: MALE CONDOMS



### MODULE OVERVIEW

This module will cover the male condom as one of the Barrier Methods. Barrier methods include the male condoms, female condoms, diaphragm, cervical caps, and spermicides that mechanically or chemically prevent fertilization or the union of the egg and sperm cell. The male condom is the only barrier method widely available and included in the Philippine FP Program. This will be discussed in more detail in this module.

Condoms are one of the effective family planning methods when used consistently and correctly. It is also an effective method of preventing transmission of HIV and other sexually transmitted infections (STIs).



### MODULE OBJECTIVES

At the end of the module, participants will be able to provide male condoms as an effective contraceptive method as well as a means of protection against the transmission of STIs, including HIV.



### MODULE SESSION

<b>Session 1:</b>	Male Condoms
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# SESSION 1

## MALE CONDOMS

### LEARNING OBJECTIVES

At the end of this module, the participants will be able to:

1. Describe the male condom in terms of its:
  - features
  - mechanism of action
  - advantages and disadvantages
2. Discuss the effectiveness of the condom and the factors that influence this.
3. State client conditions for which the condom is suitable or not based on the WHO Medical Eligibility Criteria.
4. Discuss the guidelines for providing condoms.
5. Demonstrate application of the condom on a penile model.
6. Correct misconceptions about the condom.

### NARRATIVE

The condom is one of the barrier methods. Barrier methods mechanically or chemically prevent fertilization or the union of the egg and sperm cell. The male condom is the only FP method included in the Philippine FP Program that prevents both pregnancy and sexually-transmitted infections (STIs).

#### DESCRIPTION

The condom is a sheath made of thin, latex rubber designed to fit over a man's erect penis.

#### MECHANISM OF ACTION

- Prevents entry of sperm into the vagina.
- Sperm and disease-causing organisms including HIV do not pass through intact latex rubber or polyurethane condoms.
- Some condoms have a spermicidal coating which adds to its effectiveness.

#### EFFECTIVENESS

- Condoms, in order to be effective must be used correctly and consistently. If correctly and consistently used, it is **98%** effective; if typically used, **85%**.

#### Condoms

- Offer dual protection from STI, HIV, and also prevent pregnancy.
- Prevent sexually transmitted infections which include HIV, gonorrhea, syphilis, chlamydia, trichomoniasis, herpes, genital wart virus (HPV). However, condoms cannot prevent sores and warts caused by STIs on the skin not covered by it.
- Reduce the risk of HIV infection by 80%-90%. They can reduce the risk of STIs to a very low level if used correctly and consistently.

The most common condom failures that result in pregnancy or STI transmission are due to user-related causes. Listed below are user-related causes for condom failure:

1. **Inconsistent use**- inconsistent use means condoms are not used in every sexual intercourse.

## 2. Incorrect use

*Common mistakes encountered when using condoms:*

- Unrolling a condom before putting it on (this causes tears or breaks)
- Not “pressing the tip” of the condom
- Tears caused by wearing of rings and fingernails
- Putting a condom on with the rolled rim inward toward the penis instead of away from it
- Stretching/pulling on the condom, which weakens the thin rubber

## 3. Other causes:

- Failure to hold on to the rim of condom when withdrawing, resulting in spills/ leaks; and
- Having intercourse first, then stopping to put condom on before ejaculation.
- Condom Breakage. Condom breaks can occur due to:
  - Inadequate vaginal lubrication
  - Defects in the condom itself
  - Poor or improper storage with exposure to heat, ultraviolet light, and/or humidity
  - Application of certain mineral and vegetable oils as lubricants, which can weaken the latex

Condoms are more likely to break if:

- Used after the expiration date on package
- Seal on the package is broken
- Not produced by a reliable manufacturer
- Stored in high temperature or exposed to sunlight

Inexperienced users tend to report more condom breaks than those who have been taught on how to put it on and those who understand how to use condoms correctly.

## ADVANTAGES

- Protects against sexually transmitted infections, including HIV
- Easy to use
- Usually easy to obtain
- Usually inexpensive
- Safe, effective, and portable
- Helps protect against cervical cancer through prevention of HPV infection
- Allows men to share more responsibility for family planning
- Helps some men with premature ejaculation or to maintain erection
- Convenient for short-term contraception

## DISADVANTAGES

- Coitus-related (must be used during sexual intercourse)
- Some men complain of decreased sensitivity
- Interrupts the sexual act
- Slipping off, tearing, spillage of sperm can occur, especially among inexperienced users
- Allergy to latex (rare)
- Requires high motivation for consistent and correct use
- Deteriorates quickly when storage conditions are poor
- Causes some men difficulty in maintaining erection

## THE WHO MEDICAL ELIGIBILITY CRITERIA FOR CONDOM USE

### Category 1: Use the method without restriction

- Couples who are reliable users and who ask for it.
- Couples who wish to use a backup method when the use of another method is interrupted, e.g. missed pills.
- Couples with high risk of STIs.
- Couples who use it as a temporary method until another method is used or until the method becomes effective (e.g. three months post-vasectomy).
- A woman who is at high risk for or is unwilling to use other contraceptive methods (there are no systemic effects from condom use).
- A woman who is breastfeeding and needs contraception (condoms have no effect on lactation and are a complementary FP method for lactating women who no longer meet LAM criteria).
- When other methods are medically contraindicated to either of the couple or for personal reasons.
- The male condom can help men who have problems with premature ejaculation; it can aid in postponing ejaculation.

### Category 4: Do not use the method

- In general, anyone CAN use condoms safely and effectively if not allergic to latex.
- Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use). The service provider can learn of this condition by asking the client. No tests or examination required.

If the client is at risk of STIs, including HIV, he/she may want to keep using condoms despite the allergy.

## CONDOM STORAGE

1. Store condoms in a cool and dry place out of direct sunlight (heat may weaken latex).
2. Don't use a bad condom.
  - Check the expiration or manufactured date on the box or individual package of condoms. Expiration dates are marked as "Exp."; otherwise, the date is the manufactured date (MFG). Latex condoms should not be used beyond their expiration date or more than five years after the manufactured date. Latex condoms with spermicide should probably be used within two years of the manufactured date.
3. Condoms in damaged packages or ones that show obvious signs of deterioration (e.g. brittleness, stickiness, or discoloration) should not be used regardless of their expiration date.

## 7.4

### HOW TO USE THE CONDOM TIPS

- Do not use condoms that are expired or when the package is perforated.
- Use the condom before the penis comes in contact with the partner's mouth, anus or vagina.
- If the penis is uncircumcised, pull the foreskin back before putting on the condom. Keep the condom on the penis until after intercourse or ejaculation.
- If the condom breaks or falls off during intercourse but before ejaculation, stop and put on a new condom. A new condom can also be used when you have prolonged intercourse or different types of intercourse within a single session (e.g. vaginal and anal).
- Use a new condom from "start to finish" with each act of vaginal, oral or anal intercourse. Do not reuse condoms.
- Take off the condom without spilling semen on the vaginal opening by holding the rim of the condom while withdrawing the penis.

- Adequate lubrication is important in condom use and there are lubricants which can and cannot be used with latex condoms. If lubrication is needed:
  - For latex condoms, use only water-based lubricants like water, lubricants or spermicidal creams, jellies, foam or suppositories.
  - Avoid oil-based lubricants like cold cream, mineral oil, cooking oil, petroleum jelly, body lotions, massage oil, or baby oil that can damage latex condoms.
  - For polyurethane condoms, any type of lubricant can be used.

## STEPS

1. Check package for manufactured or expiration date and perforation.
2. Slide condom to one side of the package and tear the opposite side.  
*Hint: Do not use teeth or sharp object to open the package*
3. Remove condom from package.
4. Unroll condom slightly to make sure it unrolls properly with the rolled ring outward.
5. Place condom on the tip of the erect penis.
6. Pinch the tip of the condom while unrolling condom down to the base of the penis. This will squeeze air out of the tip of the condom and allow space for the ejaculation.
7. After ejaculation, hold on to the condom at the base of the penis while withdrawing penis from the vagina.
8. Withdraw penis while still erect.
9. Remove condom from the penis.
10. Tie and wrap the condom to prevent spills or leaks.
11. Dispose of condom properly.

## Correcting Misconceptions

The use of male condoms:

- Do not make men sterile, impotent or weak.
- Do not decrease men's sex drive.
- Cannot get lost in the woman's body.
- Do not have holes that HIV can pass through.
- Are not laced with HIV.
- Do not cause illness in a woman because they prevent semen or sperm from entering her body.
- Do not cause illness in men because sperm "backs up."
- Are only used by married couples. They are not only for use outside marriage.

## Key learning points

1. Use of condoms encourages men's participation in contraception.
2. When used consistently and correctly, condoms provide effective protection from pregnancy and from sexually transmitted infections.
3. Correct and consistent condom usage protects against HIV and other STIs.
4. Only one medical condition prevents use of condoms and this is if either or both of the sex partners have severe allergy to latex rubber (severe redness, itching, swelling after condom use).
5. Condoms help protect women from cervical cancer and pelvic inflammatory disease (PID).
6. Condoms should always be provided along with another method to any client:
  - Who might be at risk for sexually transmitted infections;
  - Who uses oral contraceptives (in case she forgets to take a pill);
  - Who had a vasectomy (condoms should be used for at least three months after vasectomy and until zero sperm is noted on examination of the semen.
  - Who might need condoms for any reason.



# MODULE 8



## Long-Acting and Permanent Methods (LAPM)

Session 1: Intrauterine Device

Session 2: Permanent Methods





## MODULE 8: LONG-ACTING AND PERMANENT METHODS



### MODULE OVERVIEW

This module will cover both long-acting and permanent methods. There are four contraceptive methods that are categorized as long acting and/or permanent: IUDs, implants, female sterilization, and vasectomy. IUDs and implants are long-acting and temporary. When they are removed, return to fertility is prompt. Female sterilization and vasectomy are permanent methods. In the Philippines, implants are not available so this module will only cover the other three methods.

Session 1 of the module will tackle the knowledge portion of the Intrauterine Device and Session 2 will provide an overview of the Permanent Methods by describing both male and female voluntary surgical contraception (VSC): vasectomy and bilateral tubal ligation (BTL), respectively.

The Intrauterine Device (IUD) is one of the family planning method provided by the Philippine Family Planning Program. Used by 4.1%<sup>1</sup> of women in the Philippines, it is one of the most effective child spacing methods available to women in the country. This method, because it is long-acting, can be used by women who do not want any more children.

Permanent methods next to COCs are the most commonly availed FP methods used by a total of 10.5%<sup>2</sup> married Filipino men and women.



### MODULE OBJECTIVES

At the end of the module, the participants will be able to:

- Understand the long-acting and permanent methods (i.e., IUD, BTL, and vasectomy).
- Identify clients suitable for each of the long-acting and permanent methods.



### MODULE SESSIONS

The module contains the following sessions:

<b>Session 1</b>	Intrauterine Device
<b>Session 2</b>	Permanent Methods

<sup>1</sup> 2006 Family Planning Survey, National Statistics Office

<sup>2</sup> Ibid.

## SESSION 1

### INTRAURINE DEVICE



#### LEARNING OBJECTIVES

At the end of the session, the participants must be able to:

1. Describe the types of IUD available in the Philippines.
2. Describe the TCU380A in terms of its:
  - features
  - mechanism of action
  - effectiveness
  - advantages and disadvantages
3. Explain the possible side effects of IUD use.
4. Explain the WHO Medical Criteria for initiating IUD use.
5. Screen suitability of clients for IUD use employing the Medical Eligibility Checklist for Copper IUD.
6. Explain when the IUD can be inserted.
7. Enumerate the warning signs that indicate complications of IUD.
8. Correct misconceptions on the IUD based on the knowledge acquired on the method.



#### NARRATIVE

##### BASIC INFORMATION ABOUT THE IUD

*The TCU380A*

##### TYPES OF IUD

Common types of IUDs available worldwide are as follows:

- Copper-bearing, which includes the TCU380A (TCu380A, TCU380A with safe load, and TCU200), the Multiload (MLCu250 and Cu375), and the Nova T
- Medicated with a steroid hormone, such as Mirena®, the levonorgestrel-releasing intrauterine system (LNG-IUS)

The main IUD featured in this learning package is the TCU380A (or Copper T), which is:

- widely used
- well known for its effectiveness, ease of insertion and removal, wide margin of safety, acceptability to clients, and low cost
- effective for at least 12 years

## 8.2

### The TCU380A Insertion package

- Each TCU380A comes in a pre-sterilized package that contains the equipment needed to insert the IUD.
- The package includes a clear plastic *inserter tube* with a *blue-depth-gauge*, which can be moved along the length of the tube and functions as a cervical stop.
- A white *plastic rod* is used in conjunction with the inserter tube to place the *TCu380A* in the uterus. The strings and stem of the T will already be inside the inserter tube.
- The package also contains an *identification card* which also serves as a measurement insert.

The TCu380A looks like the letter "T" and contains barium sulfate so that it can be seen by x-ray.

There are small copper bands on each "arm" of the T, which ensure that copper is released high in the fundus of the uterus. The "stem" is also wound with copper wire. A thin polyethylene string is attached to the bottom of the stem to determine correct positioning of the IUD and to ensure easy removal.



**Copper T 380A IUD**



**Copper T 380A IUD inside the Uterus**

### **Mechanism of Action**

Copper-bearing IUDs, such as the Copper T, act primarily by preventing fertilization (Rivera et al., 1999). Copper ions decrease sperm motility and function by altering the uterine and tubal fluid environment, thus preventing sperm from reaching the fallopian tube and fertilizing the egg.

### **Effectiveness**

The IUD is a highly effective form of long-term, reversible contraception, with an associated failure (pregnancy) rate of less than 1% (0.8%) in the first year of use (Trussell, 2004a). In a long-term international study sponsored by the WHO, the average annual failure rate was 0.4% or less, and the average cumulative failure rate over the course of 12 years was 2.2%, which is comparable to that of tubal sterilization (United Nations Development Programme et al., 1997). Service providers can communicate to their family planning clients that the IUD is the most effective, reversible contraceptive currently available.

### **Effective Life**

The latest scientific evidence shows that the TCu380A is effective for at least 12 years (United Nations Development Programme et al. 1997), although the United States Food and Drug Administration (USFDA) has approved it for only 10 years (as of this printing). Clients who have had a Copper T inserted should be advised that it should be replaced or removed 12 years from the date of insertion.

### **Shelf Life**

According to the USFDA, the shelf life of each presterilized Copper T 380A insertion package is seven years. It is important to note that the expiration date on the IUD package refers only to the shelf life of the sterility of the package, and not to the contraceptive effectiveness of the IUD itself. This means that even if an IUD is inserted on the day before the expiration date (provided the package is not torn or damaged), it is still effective for the full lifespan of contraceptive efficacy. In other words, the Copper T 380A would be effective for a full 12 years from that date. On the expiration date, the IUD should be discarded.

## **Advantages**

The IUD has the following advantages:

- Highly effective and very safe
- Reversible and economical
- May be safely used by lactating and immediate postpartum women
- Good choice for women who cannot use other methods
- Long duration of use (up to 12 years for TCU380A)
- Once inserted, they are convenient and extremely easy to use, providing worry-free continuous protection
- Allows privacy and control over her fertility (client does not have to use anything at the time of sexual intercourse)
- Does not interact with medications client may use
- No systemic side effects as its effects are confined to the uterus

## **Disadvantages**

- Requires a pelvic exam to insert the IUD
- Requires a trained health service provider to insert/remove the IUD
- Does not protect against STIs
- Increases the risk of PID for women with STIs
- Device may be expelled, possibly without the woman knowing it (especially for postpartum insertions)

## **Return to Fertility**

A client's fertility returns immediately after an IUD is removed (Andersson et al., 1992). This message should be made clear to clients having an IUD removed. Unless they want to get pregnant, they should have another IUD inserted immediately after removal (if desired and appropriate) or start another contraceptive method.

## **Health Benefits and Potential Health Risks**

Non-hormonal IUDs, such as the Copper T, may protect against endometrial and cervical cancer (Hubacher and Grimes, 2002).

Potential health risks associated with the IUD, which are uncommon or rare, are discussed below.

### **• Uterine perforation**

Perforation of the uterus during IUD insertion has been shown to be rare, with fewer than 1.5 perforations per 1000 insertions occurring in large clinical trials (United Nations Development Programme et al., 1997; Trieman et al., 1995). This minimal risk is associated with level of provider skill and experience (Harrison-Woolrych et al., 2003). When the IUD is inserted by a skilled provider, the risk has been shown to be as low as one per 1000 insertions (WHO, 1987) and one per 770-1600 insertions (Nelson, 2000). If perforation occurs, the risk of serious complications is low and the need for surgical intervention rare (Penney et al., 2004).

### **• Expulsion**

Although IUD failure is rare, expulsion is the most common cause (ARHP, 2004). In the first year of IUD use, 2-8% of women spontaneously expel their IUDs (Trieman et al., 1995). There are several factors that increase the risk of expulsion:

- ✓ Skill and experience of the provider is the most common factor (Chi, 1993). Correct insertion, with the IUD placed high in the uterine fundus, is thought to reduce the chances of expulsion.

✓ **Timing.**

Expulsion is most likely to occur within the first three months post-insertion and is more common in women who are nulliparous, have severe dysmenorrhea, or have heavy menstrual flow (Zhang et al., 1992).

The risk of expulsion is higher (11-25% after 12 months of use) when the IUD is inserted immediately after childbirth (more than 10 minutes but less than 48 hours after delivery of the placenta) (Trieman et al., 1995), and higher when inserted immediately after a second trimester abortion (Grimes, Schulz, and Stanwood, 2002).

• **Infection**

According to latest research, the risk of upper genital tract infection among IUD users is less than 1 %, which is much lower than previously thought. This minimal risk is highest within the first 20 days after IUD insertion, and is related to insertion technique (due to lack of proper infection prevention practices) rather than to the IUD itself (Hatcher et al., 2004). After the first 20 days, the risk of infection among IUD users appears to be comparable to that among non-IUD users (Hatcher et al., 2004).

**Possible Side Effects**

A common side effect of copper-bearing IUDs is menstrual changes. Use of the Copper T has been associated with an increase of up to about 50% in the duration/amount of menstrual bleeding, and this is the most common reason for removal (Penney et al., 2004). Changes in bleeding patterns, such as spotting/light bleeding (between periods), may also occur in the first few weeks. Finally, some women may experience discomfort or cramping during IUD insertion (Grimes, 2004) and for the next several days. Cramping/pain and changes in bleeding amount/patterns usually are not harmful for the client and often subside within the first few months after IUD insertion. Women should be advised of this common side effect before IUD insertion, and assessed for and counseled about it if needed afterward. Non-steroidal anti-inflammatory drugs (NSAID) can lessen symptoms (WHO, 2004b), and good counseling can encourage continued use of the method (Backman et al., 2002).

**Warning Signs**

The service provider should instruct the client to immediately seek consultation when:

- She thinks that she may be pregnant. This is when she has missed a menstrual period and has signs of pregnancy.
- She thinks that the IUD might be out of place. For example, when the strings are missing or the hard plastic of the IUD is felt.
- She has symptoms of infection like increasing or severe pain in the lower abdomen, pain during sexual intercourse, unusual vaginal discharge, fever, chills, nausea and/or vomiting.

The signs of complication can be easily remembered through **PAINS**:

**P**eriod late

**A**bdominal pain

**I**nfection

**N**ot feeling well

**S**trings missing or longer

**Addressing Common Misconceptions About the IUD**

Many misconceptions about the IUD remain despite scientific evidence to the contrary. The following section presents recent research to refute some of these misconceptions, while providing a basis for new recommendations and practices related to IUD.

<p>The IUD <i>does not</i> act as an abortifacient.</p>	<p>Studies suggest that the IUD prevents pregnancy primarily by preventing fertilization rather than inhibiting implantation of the fertilized egg (Rivera et al., 1999). This is particularly true of the copper-bearing IUDs.</p>
<p>The IUD <i>does not</i> increase a client's risk of ectopic pregnancy.</p> <p><b>The absolute number of ectopic pregnancies among IUD users is much lower than that among the general population.</b></p>	<p>The IUD reduces the risk of ectopic pregnancy by preventing pregnancy. Because IUDs are so effective at preventing pregnancy, they also offer excellent protection against ectopic pregnancy. Women who use copper-bearing IUDs are 91% less likely than women using no contraception to have an ectopic pregnancy (Sivin, 1991).</p> <p>The following points should be considered:</p> <ul style="list-style-type: none"> <li>• Less than 1% of IUD users become pregnant, which reduces a woman's risk for ectopic pregnancy.</li> <li>• IUD users are 50% less likely to have an ectopic pregnancy than are women using no contraception.</li> <li>• However, in the unlikely event that an IUD user becomes pregnant, she has equal chances of having an ectopic pregnancy as non-users. Since ectopic pregnancy is a serious condition that requires emergency care, this condition must be considered.</li> <li>• Among IUDs, the TCU380A and Multiload Cu375 are lowest in rates of ectopic pregnancy (WHO, 1987). A long-term study of women using the TCU380A found the rate to be less than one (0.09%) per 100 women a year, and less than one (0.89%) per 100 women at 10 years (Ganacharya, Bhattoa, and Batar, 2003).</li> <li>• Women with a history of ectopic pregnancy can use the IUD with no restrictions.</li> </ul>

## 8.6

<p>The IUD <i>does not</i> cause PID, nor does the IUD need to be removed to treat PID.</p>	<p>Strict randomized controlled trials and literature reviews reveal that PID among IUD users is rare (ARHP, 2004; Grimes, 2000). Early studies that reported a link between PID and IUD use were flawed and poorly designed. Inappropriate groups were used for comparison, infection in IUD users was over-diagnosed, and there was a lack of control for confounding factors (Buchan et al., 1990).</p> <p>Here are some important points about PID and the IUD based on recent research:</p> <ul style="list-style-type: none"> <li>§ During the first three to four weeks after IUD insertion, there is a slight increase in the risk of PID among IUD users compared to non-IUD users, but <b>it is still rare</b> (less than seven per 1000 cases). After that, an IUD user appears to be no more likely to develop PID than a non-IUD user (Farley et al., 1992).</li> <li>§ PID in IUD users is caused by the STIs, gonorrhea and chlamydia, not the IUD itself (Darney, 2001; Grimes, 2000). However, the risk is still very low, with an estimated three cases per 1000 insertions in settings with a high prevalence (10%) of these STIs (Shelton, 2001).</li> <li>§ If PID occurs, the infection can be treated while the IUD is kept in place, if the client so desires. Studies have shown that removing the IUD does not have an impact on the clinical course of the infection. If the infection responds to treatment within 72 hours, the IUD does not need to be removed (WHO, 2004b).</li> <li>§ Randomized controlled trials and cohort studies reveal that the monofilament string does not increase the risk of PID (Grimes, 2000).</li> <li>§ Women who have a history of PID can generally use the IUD (the advantages generally outweigh the risks), provided their current risk for STIs is low.</li> </ul>
<p>The IUD <i>does not</i> cause infertility.</p>	<p>Infertility caused by tubal damage is associated not with IUD use, but with chlamydia (current infection or - as indicated by the presence of antibodies - past infection) (Hubacher et al., 2001). Moreover, there is an immediate return to fertility after an IUD has been removed (Belhadj et al., 1986). In one study, 100% of women who desired pregnancy (97 of 97) conceived within 39 months of IUD removal (Skjeldestad and Bratt, 1988).</p>



<p>The IUD <b>is suitable</b> for use in nulliparous women.</p>	<p>Nulliparous women can generally use the IUD (the advantages generally outweigh the risks). In theory, the smaller size of a nulligravid uterus may increase the risk of expulsion, whereas uterine enlargement, even if due to an abortion, may promote successful IUD use (Hatcher et al., 2004). Expulsion rates tend to be slightly higher in nulliparous women compared to parous women (Grimes, 2004).</p>
<p>The IUD <b>can be</b> safely used by HIV-infected women who are clinically well.</p>	<p>HIV-infected women who are clinically well can generally use the IUD (the advantages generally outweigh the risks). A large study in Nairobi showed that HIV-infected women had no significant increase in the risk of complications, including infection in early months, than HIV negative women (Sinei et al., 2001). In another study of HIV-infected and HIV-negative IUD users with a low risk of STI, no differences were found in overall or infection-related complications between the two groups (Sinei et al., 1998).</p>
<p>The IUD <b>does not</b> increase the risk of HIV transmission.</p>	<p>There is no current evidence that use of the IUD in HIV-infected women leads to increased risk of HIV transmission. Studies have shown that among HIV infected women using the IUD, there is no increase in viral shedding and no statistically significant increase in HIV transmission to male partners (ARHP, 2004; Richardson et al., 1999).</p>
<p>The IUD <b>does not</b> interfere with ARV therapy.</p>	<p>Women who have AIDS, are on ARV therapy, and are clinically well can generally use the IUD (advantages generally outweigh the risks). Because it is a non-hormonal family planning method, the IUD is not affected by liver enzymes and will not interfere with or be affected by ARV therapy (ARHP, 2004; Hatcher et al., 2004).</p>

## Medical Eligibility Checklist for Copper IUDs

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use an IUD if she wants. If she answers YES to a question below, follow the instructions.

1. Do you think you are pregnant?  
 No  YES Assess whether pregnant (see How to tell if a woman is not pregnant). Do not insert IUD. Give her condoms or spermicides to use until reasonably sure that she is not pregnant.
2. In the last three months have you had vaginal bleeding that is unusual for you, particularly between menstrual periods or after sex?  
 No  YES If she has unexplained vaginal bleeding that suggest an underlying medical condition, do not insert IUD until the problem is diagnosed. Evaluate by history and during pelvic exam. Diagnose and treat as appropriate, or refer for medical examination.
3. Did you give birth more than 48 hours but less than four weeks ago?  
 No  YES Delay inserting an IUD until four or more weeks after childbirth. If needed, give her condoms or spermicide to use until then.
4. Do you have infection following childbirth?  
 No  YES If she has puerperal sepsis (genital tract infection during the first 42 days after childbirth), do not insert IUD. Refer for care. Help her choose another effective method.

**Note: Assure confidentiality before asking remaining questions.**

5. Have you had a sexually transmitted infection (STI) or pelvic inflammatory disease (PID) in the last three months? Do you have a STI, PID or any other infection in the female organs now?  
(Signs and symptoms of PID: severe pelvic infection in the female organs)  
 No  YES Do not insert IUD now. Urge her to use condoms for STI protection. Refer or treat client and partner(s). IUD can be inserted three months after use unless reinfection is likely.
6. Do you have an infection following childbirth?  
 No  YES If she has AIDS, is infected with HIV, or is being treated with medicines that make her body less able to fight infections, careful clinical judgment should be made. In general, do not insert IUD unless other methods are not available or acceptable. Whatever methods she chooses, urge her to use condoms. Give her condoms.
7. Do you think you might get an STI in the future? Do you or your partner have more than one sex partner?  
 No  YES If she is at risk of STIs, explain that STIs can lead to infertility. Urge her to use condoms for STI protection. Do not insert IUD. Help her choose another method.

8. Do you have any cancer in the female organs or pelvic tuberculosis?

- No    YES   Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: Do not insert IUD. Treat or refer for care as appropriate. Help her choose another effective method.

*Be sure to explain the health benefits, risks and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.*

## SESSION 2

### PERMANENT METHODS



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe bilateral tubal ligation (BTL) as a method for female sterilization in terms of:
  - what it is
  - mechanism of action
  - effectiveness
  - advantages and disadvantages
2. Explain the possible side effects of BTL.
3. Explain when BTL can be performed.
4. Enumerate the warning signs of complications of BTL.
5. Counteract misconceptions on BTL based on the knowledge acquired on the method.
6. Describe vasectomy as a method for male sterilization.
7. Describe vasectomy in terms of its:
  - mechanism of action
  - effectiveness
  - advantages and disadvantages
8. Explain the possible side effects of vasectomy.
9. Enumerate the warning signs of complications of vasectomy.
10. Counteract misconceptions on vasectomy based on the knowledge acquired on the method.



#### NARRATIVE

##### BILATERAL TUBAL LIGATION

###### DESCRIPTION

- Bilateral tubal ligation (BTL) is known as female sterilization as it provides permanent contraception for women who do not want any more children.
- It is a safe and simple surgical procedure to tie and cut the two fallopian tubes located on both sides of the uterus.

###### MECHANISM OF ACTION

- The service provider makes a small incision in the woman's abdomen and ties and cuts the two fallopian tubes on each side of the uterus. These tubes carry eggs from the ovaries to the uterus.
- With the tubes blocked, the woman's egg cannot meet the man's sperm. The woman continues to have menstrual periods after BTL.

###### EFFECTIVENESS

- BTL is very effective with an effectiveness rate of 99.5%.
- Effectiveness depends partly on how the tubes are blocked, but pregnancy rates are low.

## ADVANTAGES

- Very effective.
- Permanent. A single decision leads to lifelong, safe prevention of pregnancy.
- Nothing to remember, no supplies needed, and no repeated clinic visits required.
- No interference with sex. Does not affect the woman's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- Has no hormonal side effects.
- No effect on breastmilk.
- No known long-term side effects or health risks.
- Can be performed just after a woman gives birth (immediately/within seven days after childbirth).
- For interval cases, can be done six weeks after delivery.
- Can be performed at any day of the menstrual cycle provided the service provider is reasonably sure that the woman is not pregnant.

## DISADVANTAGES

- Requires minor surgery.
- Compared with vasectomy, BTL is:
  - ✓ Slightly more risky
  - ✓ Often more expensive
- Considered to be permanent as reversal surgery is difficult, expensive and success cannot be guaranteed.
- If pregnancy happens (very rare), there is a greater risk for ectopic pregnancy compared to women who have not undergone the procedure.
- Does not protect against STIs including HIV/AIDS.

## POSSIBLE SIDE EFFECTS

There are no long-term side effects of BTL.

- Common side effect: pain over the operative site which diminishes in a day or two.
- Complications of surgery, which include the following, are uncommon:
  - ✓ Infection or bleeding at the incision
  - ✓ Internal infection or bleeding
  - ✓ Injury to internal organs
  - ✓ Anesthesia risk:
    - With local anesthesia alone or with sedation, rare risk of allergic reaction or overdose.
    - With general anesthesia, occasional delayed recovery and side effects. Complications are more severe than with local anesthesia.

## TIMING OF BTL

Timing of performing BTL can either be:

- Postpartum,
- Interval, or
- Post abortion

### 8.12

#### Postpartum BTL

BTL can be performed immediately or within seven days after childbirth. The procedure is not recommended between eight days to six weeks postpartum due to difficulty in accessing the tubes at those times and greater risk for infection.

## Interval

When not associated with a recent pregnancy, BTL can be performed:

- From six weeks after childbirth if it is reasonably certain that the woman is not pregnant.
- Within seven days after the start of the woman's menstrual cycle.
- At any time convenient for the woman if it is reasonably certain that she is not pregnant.

## Post abortion

After a miscarriage, BTL can be performed after 48 hours if miscarriage is uncomplicated (i.e., no signs of infection, no heavy bleeding).

## WARNING SIGNS

Problems affect women's satisfaction with BTL. It is, therefore, important that the service provider attends to clients complaining of the following warning signs of complications and refer her to a facility or health service provider who can assess and manage her complaint.

These warning signs are:

- Bleeding, pain, pus, heat, swelling or redness of the wound that becomes worse or is persistent. These are signs of infection on the incision site.
- High grade fever is a sign of more severe infection.
- Fainting, persistent light-headedness, or extreme dizziness.
- Missed period, which signifies pregnancy.

## VASECTOMY

### DESCRIPTION

- Vasectomy is known as male sterilization as it provides permanent contraception for men who decide they will not want any more children.
- It is a safe, simple, and quick surgical procedure. The procedure can be done in a clinic or office with proper infection prevention practices.
- The procedure involves tying and cutting a segment of the two vas, which carries sperm.
- No scalpel vasectomy is a small puncture on the scrotum (not using a scalpel) to get the vas. This is the DOH-approved procedure for vasectomy.

### MECHANISM OF ACTION

- The service provider makes a puncture in the man's scrotum and ties and cuts the two vas. The vas carries sperm from the testicles.
- Semen is still produced and found in the tubes after the blocked vas.
- With the two vas blocked, there will be no sperm in the semen.

The man continues to have erections and ejaculates semen.

### EFFECTIVENESS

- Vasectomy is very effective at 99.9% for correct use, but slightly lower with typical use at 99.8%.
- More effective when used correctly. This means using condoms or his woman partner using another effective family planning method (e.g. pills, injectable) consistently for at least three months after the procedure and after a semen check showing no sperm has been performed.

### ADVANTAGES

- Very effective.
- Permanent. A single decision leads to lifelong, safe, and effective contraception.
- Nothing to remember except to use condoms or another effective method for at least three months after the procedure.

- No interference with sex. Does not affect the man's ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No supplies to get, and no repeated clinic visits required.
- No known long-term side effects or health risks.
- Compared to BTL, vasectomy is:
  - ◉ More effective
  - ◉ Safer
  - ◉ Easier to perform
  - ◉ Less expensive
  - ◉ Able to be tested for effectiveness at any time
  - ◉ If pregnancy occurs in the man's partner, less likely to be ectopic

### **DISADVANTAGES**

- Requires minor surgery by a specially trained health care provider.
- Not immediately effective. The couple should use another effective family planning method for at least three months after the procedure.
- Must be considered as permanent. Reversal surgery is more difficult, expensive, may not be available in some areas, and success is not guaranteed. Men who may want to have more children in the future should choose a different method.
- Does not protect against STIs including HIV/AIDS.

### **POSSIBLE SIDE EFFECTS**

Common side effects of vasectomy are:

- ✓ Discomfort for two to three days
- ✓ Pain in the scrotum, swelling and bruising which decreases for about two to three days

### **WARNING SIGNS**

Problems affect men's satisfaction with vasectomy. It is, therefore, important that the service provider attends to clients complaining of the following warning signs of complications and refer her to a facility or health service provider who can assess and manage his complaint.

These warning signs are:

- Severe bleeding or blood clots after the procedure
- Redness, heat, swelling, pain at the incision site
- Pus at the incision site
- Pain lasting for months



# MODULE 9



FP for Special Populations





## MODULE 9: FP FOR SPECIAL POPULATIONS



### MODULE OVERVIEW

Providing FP services to special groups that would have specific needs apart from the general population cannot be overemphasized. The unique characteristics of these special populations imply that their family planning methods must be appropriate and responsive to these special needs.



### MODULE OBJECTIVES

At the end of the module the participants will be able to identify appropriate contraceptive methods to meet the specific needs of special populations. The special populations included in the module are the following:

- Adolescents
- Women over 40 years old
- Obese women
- Smokers
- Postpartum and breastfeeding women

These women may be in situations that require different contraceptive methods. Likewise, women with conditions that may make pregnancy an unacceptable health risk should be given the same advice. Because of their relatively higher typical-use failure rates, sole use of barrier methods for contraception and behavior-based methods of contraception may not be the most appropriate choice for them.



### LEARNING OBJECTIVES

At the end of the module, participants will be able to:

1. Describe the reproductive health concerns/conditions of each of the special populations.
2. Discuss the recommended FP methods/practices for each of the special populations.



### NARRATIVE

Providing FP services to special groups that would have specific needs apart from the general population cannot be overemphasized. The unique characteristics of these special populations imply that their family planning methods must be appropriate and responsive to these special needs.

The special populations included in the module are the following:

- **Adolescents**
- **Women over 40 years old**
- **Obese women**
- **Smokers, and**
- **Postpartum and breastfeeding women (as discussed with LAM and Progestin-only pills/injectables)**

These women may be in situations that require different contraceptive methods. Likewise, women with conditions that may make pregnancy an unacceptable health risk should be advised that, because of their relatively higher typical-use failure rates, sole use of barrier methods for contraception and behavior-based methods of contraception may not be the most appropriate choice for them.

## ADOLESCENTS

### Characteristics of Adolescents:

- Adolescence is defined by WHO as the period between the ages 10 to 19 years.
- Adolescents attain biological maturity earlier than in previous generations, but not necessarily accompanied by psychosocial maturity or economic independence.
- Adolescents face several potential problems in relation to their sexual and reproductive health:
  - The consequence of unsafe abortion due to unplanned pregnancy is a serious concern.
    - ✓ An estimated number of abortions in the Philippines is 400,000 per year. Thirty-three percent (33%) of these are contributed by teens (Allan Guttmacher Studies in 2003).
    - ✓ There is a high risk of early (under age 16) childbearing both for the mother and the infant.
    - ✓ About 30 out of 100 deliveries occur among young people. Three out of four pregnancies in young people result to maternal deaths.
  - Diminished opportunities for education and employment, which affect social and cultural development, especially for females.
  - Unprotected sexual intercourse exposes adolescents to a high risk of STIs, including HIV infection.
- The DOH reported that 62 out of 100 reported cases of STIs and 29 out of 100 cases of HIV involved young people.
- Sex Education
  - Develops the adolescents' knowledge and confidence to make decisions related to their sexual behavior, including the decision not to engage in sexual intercourse until they are ready to do so.
  - Should include an orientation on fertility awareness, which is a comprehensive understanding of how one's reproductive system functions and the biological and sociological facts about human fertility. The peer approach (youth-to-youth) is effective in delivering these information.
  - Parents should be assisted to understand and encourage participation in the sex education of their children.
  - Emphasis on responsible sexual behavior is very important among the youth, particularly, male adolescents who need to share such a responsibility for responsible sexual behavior with their female partners.

## 9.2

### OPTIONS

#### ALL CONTRACEPTIVES ARE SAFE FOR USE OF YOUNG PEOPLE

Generally all adolescents are advised to practice ABSTINENCE until they reach the proper age to start a family.

- Fertility awareness-based methods  
For those adolescents who can effectively monitor body changes to determine the woman's fertile period and able to follow the rules as to when to abstain from sex. If not able, consider other FP methods.
- Oral contraceptives
  - ⊙ Low dose COC is a good choice because of high efficacy and low frequency of side effects.
  - ⊙ Emphasis is needed for consistent and proper use of the methods during counseling along with COC side effects.

- **Male condoms**  
One main advantage is its safety. Since they are readily available and accessible in different places and set-up. Education and counseling are important to ensure correct and consistent condom use.
- **Progestin-only injectables**  
For those adolescents having difficulty in using COCs, progestin-only injectables are suitable alternatives.
- **IUD**  
Not a good choice for young women who are at high risk for STIs. IUD can be an option for parous adolescents who require long-term protection against pregnancy and have a low risk of STIs.

## WOMEN OVER 40 YEARS OLD

### Characteristics

Fertility decreases after age 35, but many women in this age group are delaying pregnancy or avoiding pregnancy because of career demands or choice. Hence, there is a need to provide FP information to this population.

Half of pregnancies in this age group are unintentional and international epidemiologic studies show that about two-thirds of these pregnancies are terminated. Pregnancy in this age group is associated with an increased risk of morbidity and mortality.

Most common causes of maternal morbidity are:

- Spontaneous abortion
- Ectopic pregnancy
- Hyperemesis
- Diabetes
- Hemorrhage and infection

There is no contraceptive method that is contraindicated merely by age. Contraceptive needs of women in this age group may be influenced by a desire to stop fertility, frequency of intercourse, need for protection from STI, or a desire for non-contraceptive benefits, such as control of menstrual cycle irregularities or hot flashes, and prevention of gynecologic cancers, and osteoporosis.

### OPTIONS

In the absence of other adverse clinical conditions, combined hormonal contraceptives can be used until menopause.

- **Low dose estrogen oral contraceptives** can be taken by women in this age group, low dose estrogen (less 50 ug estrogen) formulations may be used by healthy non-smoking women until menopause sets in.
- Non-contraceptive effects which women of this age group benefit from are:
  - reduction of the risk for ovarian cancer
  - possible reduction of the risk for colorectal cancer
  - decreased rate of PID
  - reduced effects in functional ovarian cysts
  - prevention of uterine myoma and endometriosis
  - decreased episodes of hot flashes and others

- **Progestin-only injectable contraceptives** can be used by women, especially those who cannot take oral contraceptives for medical reasons.
- **IUDs** are useful for older women with a completed family size in a monogamous relationship who prefer not to have surgical sterilization.
- **Surgical sterilization** is an option if the desired family size is met.
- Typical menstrual pattern of a woman nearing the perimenopausal period is unpredictable. Shorter cycles, irregular bleeding, and other variations may render predicting ovulation very difficult for the woman. However, these women can still use FAB methods like the BBT, Billings Ovulation Method and the sympto-thermal may be practiced.

## OBESE WOMEN

### Characteristics

Obese women are those who have a body mass index of more than 30kg/m<sup>3</sup>. Obesity is an emerging problem because a higher percentage of the population is becoming obese as a result of:

- over-nutrition
- poor eating habits
- inadequate exercise
- inappropriate lifestyle habits

Obese women are also at risk for cardiovascular disease, diabetes, gall bladder disease, some forms of arthritis and certain cancers. Although over-nourished, some obese women are also found to be deficient in calcium, iron, vitamin B, and folic acid.

Obese women are also found to be anovulatory because of higher levels of estrogen stored in their fat cells. Episodes of anovulation tend to increase as women get older and near menopause. However, many obese women still menstruate regularly, are ovulatory, and can become pregnant.

### OPTIONS:

- WHO MEC category 1 for obese women:
  - POP
  - Progestin-only injectable
  - Levonorgestrel IUD/Copper IUD
- WHO MEC category 2 for obese women:
  - COC
  - CIC

**NOTE:** Obese women who use COCs are at an increased risk of venous thrombosis and embolism (VTE) compared with non-users. **HOWEVER**, the absolute risk of VTE remains small.

Women who weigh 70.5 kg or more had a 1.6-fold increased risk of pregnancy while using pills, and a four to five fold increased pregnancy rate if they use low-dose oral contraceptives. Obese women may have difficulty when undergoing surgical ligation. The surgeon should exercise extra caution to prevent complications due to difficulty in accessing the fallopian tubes.

## SMOKERS

### Characteristics

Smoking for women is associated with many health risks as with men. The increasing rate of lung cancer in women has been associated with the corresponding increase in smoking.

Women smokers HAVE INCREASED RISK for:

- cervical cancer
- premature menopause
- impaired fertility
- cardio-vascular disease (myocardial infarction) when women are over 35 years old, so that an estrogen-containing method is not recommended

Women who smoke during PREGNANCY have increased risks of:

- delivering low-birth weight infants
- miscarriages
- still births OR
- infant deaths

### OPTIONS:

- COCs may be taken by women younger than 35 and who are not heavy smokers. If a pill were to be chosen, the best would be the lowest estrogen content to reduce the risk of arterial thrombosis and the lowest androgenicity (to minimize any adverse effects of lipids).
- Other methods which do not contain high estrogenic levels may be recommended to women who smoke.
- Advise women smokers and who ask for advise on any FP method to stop smoking. For three to 12 months after stopping smoking, past smokers will have the same oral contraceptive cardiovascular risk as non-smokers.
- Cigarette smokers OVER AGE 40 face a higher mortality risk with ongoing oral contraceptive use than they would experience by getting pregnant.
- Heavy smokers (more than 15 cigarettes per day) and smokers who are more than 35 years old with an increasing number of cigarettes used per day are at a high risk for cardiovascular disease, especially myocardial infarction and thrombotic and hemorrhagic stroke.
- Smokers who are more than 35 years old CANNOT use COC and CICs. They should avoid estrogen-containing methods.

## POSTPARTUM AND BREASTFEEDING WOMEN

### Characteristics

Pregnancy is a hypercoagulable state. Estrogen increases the risk of venous thrombosis and embolism. As a result, it is generally recommended that postpartum women delay use of estrogen-containing contraceptive until about a month postpartum, when those changes induced by pregnancy would have been resolved. Additionally estrogen should be avoided by breastfeeding mothers because it decreases the quality and quantity of breast milk.

Counseling for postpartum contraception should begin during the pre-natal period. Proper understanding and adequate preparation for certain methods will make the provision of these methods easier soon after delivery.

## OPTIONS:

- Lactational amenorrhea method provides effective protection against pregnancy for up to six months postpartum. If continued protection is desired, recommend another method of contraception, when the LAM criteria indicate a return to fertility.
- Tubal ligation may be performed immediately postpartum, although there are some concerns about the disruption of lactation because of the effects of general anesthesia. However, with local anesthesia, this is not a problem.
- Copper IUDs are also useful since copper does not affect the quality and quantity of breast milk.
- Spermicides and barrier methods have no effect on the ability to breastfeed. The vaginal dryness associated with the postpartum condition may be relieved by some of the lubricating action of some barrier methods.
- DMPA or progestin-only pills may be used. These do not have adverse effects on lactation and may even increase milk volume. They also do not have an effect on child growth and development. However, these should be started after six weeks postpartum by breastfeeding women.
- Estrogen-containing contraceptives can be used if the mother is more than six months postpartum.
- Fertility awareness based methods may be difficult to use during the return to fertility which can extend for many cycles during lactation. The changing fertility symptoms after the first postpartum menses may be especially difficult for new users to identify and may lead to an increased risk for unplanned pregnancy.
- As with other progestin-only methods, the progesterone IUD and the levonorgestrel IUDs are not recommended for use by breastfeeding women until six weeks postpartum.
- Combined hormonal contraceptives (combined pill, patch, injectables) should generally not be used by breastfeeding mothers.

### Six weeks postpartum:

- Estrogen containing contraceptives are not advised.
- There is some theoretical concern that the neonate may be at risk due to exposure to steroid hormones during the first six weeks postpartum.

## 9.6

### • Six weeks to less than six months (primarily breastfeeding):

- Estrogen containing contraceptives are not advised. Use of combined hormonal contraceptives during breastfeeding diminishes the quantity of breast milk, decreases the duration of lactation, and may thus adversely affect the infant's growth.

### • Less than 21 days or three weeks

- There is some theoretical concern regarding the association between combined hormonal contraceptive use up to three weeks postpartum and risk of thrombosis for the mother. Blood coagulation and fibrinolysis are essentially normalized at three weeks postpartum.

### **Key Messages:**

- a) Special populations have particular family planning needs that should be considered when providing them with FP services.
- b) Evidence-based tools (WHO MEC, Medical Eligibility Checklist and MEC Wheel) are useful in determining client's eligibility for using a method especially among populations with special concerns or needs.





# MODULE 10



## Counseling for Family Planning

Session 1: Values Clarification

Session 2: Informed Choice and Voluntarism

Session 3: Types of Communication in FP/RH

Session 4: Effective Communication Skills

Session 5: Steps in Counseling Using the GATHER Approach



# MODULE 10: COUNSELING FOR FAMILY PLANNING



## MODULE OVERVIEW

Counseling plays an important role in providing quality family planning and reproductive health services. Through counseling, providers help clients make and carry out their own decisions or choices about reproductive health and family planning.

Good counseling leads to greater client satisfaction. A satisfied client promotes family planning and clinic services, returns when s/he needs to, and continues to use a chosen method. S/he also continues to patronize other services of the health center.

This module develops the health service provider's skills on counseling. As such, it will strengthen the provider's understanding of values, client's rights, and skills on interpersonal communication as basic capabilities for counseling. The G-A-T-H-E-R approach is an efficient process for FP counseling as it considers clients' rights to well-informed, voluntary decision-making on FP. Counseling skills using the GATHER approach will be developed as there will be opportunities to practice these skills.



## MODULE OBJECTIVES

The objective of this module is to develop the participant's skills on counseling family planning clients.



## MODULE SESSIONS

The module contains the following sessions:

<b>Session 1</b>	Values Clarification
<b>Session 2</b>	Informed Choice and Voluntarism
<b>Session 3</b>	Types of Communication in FP/RH
<b>Session 4</b>	Effective Communication Skills
<b>Session 5</b>	Steps in Counseling Using the GATHER Approach

# SESSION 1

## VALUES CLARIFICATION



### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Define the terms “values” and “attitudes”.
2. Examine his/her own values.
3. Explain how values and attitudes influence the individual’s decision.
4. State the factors that affect clients’ decision making.



### NARRATIVE

#### DEFINITION OF TERMS

A **value** is a belief, idea, principle or standard that is important and treasured by an individual. Values can be influenced by various factors (i.e., education, culture, religion, and personal experiences). It influences an individual’s attitude and behavior. We acquire and change our values based on the experiences we have. Therefore, we acquire new values and may change old ones as influenced by the people we interact with, our education, age, marital status, health, and economic status, number of children, and sometimes by politics.

A value is strengthened by repetition and by adoption in one’s lifestyle. Values enhance our personal growth and development, especially when affirmed by other people. Examples of values are honesty, integrity, honor, higher education, responsible parenthood.

People’s diverse experiences lead them to different conclusions and decisions. The counselor must first be aware of his/her values and understand that others have a right to their own values which they also treasure. As such, the counselor realizes that he/she should not impose his/her own values on the client nor should these interfere with his/her responsibilities as a counselor.

**Attitude** is the observable, outward expression of one’s belief and value.

Examples of attitudes are:

- Doing one’s best to be recognized.
- Doing the right thing at all times (for integrity)
- Caring for his/her children (for responsible parenting)

#### How client’s values affects decision-making

Values are important and may be considered an individual’s treasured possession. They are the principles that people use as a guide in coping with stress in their everyday lives.

Different people may have similar or different values, depending on their experience, education, environment, social exposure, religion, and culture. Values may change through the years but adequate information, exposure, experience, and education may help other people develop desirable values. So that if an individual is given adequate and appropriate information about certain conditions, situations, or practices, he or she will be guided through modeling to adopt new values. This can be true in making decisions regarding family planning.

The following are some common values that a family planning counselor may encounter:

- Rural mothers still prefer bigger families, while urban women are conditioned to have smaller families.
- Value for information and acceptance is seen when clients come to the clinic for FP services after learning of the availability of these services through mass media.
- Since clients highly value health and wellness, adverse rumors and misinformation are feared by most clients.
- The value for quality services translates to better acceptance of FP services.
- Health worker advice plays a vital role in client choices. Health workers are typically their first contact. The majority of clients' decisions are affected to a great extent when a health worker promotes family planning. Clients are likely to make voluntary decisions.
- Accessibility of the health center and the availability of a contraceptive method in a nearby clinic make clients more likely to avail themselves of family planning services.

### **Responsibility of the counselor in client's decision-making**

The counselor should examine his/her values on family planning which he/she wants others to respect. The counselor should understand that clients have their own values which may be contrary to his/her values. And, like him/her, clients want these to be respected.

It is the counselor's responsibility to understand the client's values and help the client make choices suitable to the client's values and priorities.

### **Factors influencing FP decision-making**

These are some of the factors that influence clients in their FP decision-making:

- Age
- Marital status
- Number of children
- Health status
- Economic status
- Religious beliefs
- Relationship with spouse
- Fear of side effects

### **Key Learning Points**

- No two people have the same values and attitudes.
- Understanding our own values can help us better understand and respect the values of the client.
- Reflecting on our own values can help us set limits so we do not influence our clients by sharing and imposing our own personal views.
- There are many factors that influence client's decisions. We must remember that these are the same factors that affect OUR decision-making but influence us in different ways.

## SESSION 2

### INFORMED CHOICE AND VOLUNTARISM



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Describe the basic rights of the client.
2. Define quality care in health care services.
3. Discuss informed choice in terms of its definition, components, and importance.
4. Define voluntarism.
5. Discuss the principles of informed choice and voluntarism.
6. State the importance of informed choice and voluntarism.
7. Discuss informed consent as to its definition, elements, and importance.



#### NARRATIVE

##### Rights of the Client

The goal of health service delivery is quality of care. Since the practice of Family Planning has been recognized as the right of individuals and couples, delivery of quality services is protecting and upholding these rights. These so-called “rights” that are embodied in international covenants and the Philippine Constitution include the client rights to:

- **Information.** Clients have the right to accurate, appropriate, understandable, and clear information related to reproductive health and sexuality, and to health overall. Informational materials for clients (e.g. flyers on FP methods, all-Method poster) should be made available in all parts of the health care facility.
- **Access to service.** Clients have the right to services that are affordable, are available at convenient times and places, are fully accessible with no physical barriers, and have no inappropriate eligibility requirements or social barriers, including discrimination based on sex, age, marital status, fertility, nationality or ethnicity, social class, religion, and sexual orientation.
- **Informed Choice.** Is the right of individuals or couples to make a voluntary, well-considered decision that is based on options, information, and understanding. It is the responsibility of the service provider to confirm that a client has made an informed choice or to help the client reach an informed choice.
- **Safe services.** Clients have the right to safe services, that require skilled providers, attention to infection prevention, and appropriate and effective medical practices. Safe services also mean use of service-delivery guidelines, quality assurance mechanism within the facility, counseling and instructions for clients, and recognition and management of complications related to medical practice.
- **Privacy.** Clients have the right to a private environment during services and counseling. This means that a facility must have an area where clients cannot be seen or heard during counseling, physical examination, and clinical procedures.
- **Confidentiality.** Clients have the right to be assured that personal information shall not be disclosed. This includes maintaining secrecy about the client’s history, results of examination, and counseling and record keeping.

- **Dignity.** Clients have the right to be treated with courtesy, respect, and consideration. The service provider gives utmost attention to the client's need.
- **Comfort.** Clients have the right to be at ease and relaxed while in a health facility for services. Service providers need to ensure that clients are as comfortable as possible during the procedure.
- **Express Opinion.** Clients have the right to express their views on the services being offered. Clients should be encouraged to express their views freely, even when their views differ from those of the service providers.
- **Continuity of Care.** All clients have the right to continuity of services, supplies, referrals, and follow-up necessary to maintain their health. Clients have the right to receive services and supplies for as long as they need it. This can either be through the service provider or by referral.

## The needs of the health care staff

The health care personnel desire to perform their duties well. However, if they lack administrative support and critical resources, they will not be able to deliver the high-quality service to which clients are entitled.

Health care staff need:

- **Information, training, and development** – Health care staff need knowledge, skills, and on-going training, and exposure to professional development opportunities to remain up-to-date in their field and to continuously improve the quality of services they deliver.
- **Supplies, equipment, and infrastructure** – Health care staff need reliable, sufficient inventories of supplies, instruments, and working equipment, as well as the infrastructure necessary to ensure the uninterrupted delivery of high quality services.

## Quality of Care

The provision of quality Family Planning services is the main goal of the Philippine Family Planning Program. This quality of care is important for all service providers and service facilities whether public or private. But how do you know if the service you deliver is of quality?

One parameter of quality service is ensuring that clients' rights are protected and upheld during the provision of services. Since Family Planning is considered as one of the rights of clients, it is the responsibility of the service provider to uphold this right. This concept is ensured during the counseling process where the counselor uses her/his knowledge and skills in providing accurate, adequate, and appropriate information to help clients make a well-informed decision. The whole process ensures that the clients' rights are not violated thus guaranteeing the delivery of quality service which is vital in any health service facility.

The other aspect of quality service is the ability of the service provider to deliver and provide FP services. As such, the delivery of quality service is influenced by a number of factors which the service provider is exposed to. This includes the condition of his/her work environment, the information and training he/she receives, and the equipment and supplies available to him/her.

## Informed Choice

Informed choice requires full information about the risks and benefits of the methods available. Informed choice involves effective access to information on reproductive choices and to the necessary counseling, services, and supplies that help individuals choose and use appropriate family planning methods.

Informed choice helps couples make various reproductive choices, including the possibility of choosing pregnancy.

Informed choice refers to making a decision regarding a particular method or procedure without coercion, undue influence or fraud.

### Five major components of informed choice

- Provision of information to couples and individuals on reproductive choices, including counseling concerning pregnancy, breastfeeding, and infertility.
- Provision of counseling to ensure comprehension of information and to assist with decision-making.
- Provision of appropriate information on a range of family planning methods, including the advantages/disadvantages, and on accessing services and supplies.
- Provision of comprehensive information on the correct usage of the client's chosen method.
- Efforts to ensure that a range of methods is available to the user either through the service provider or through referral to another agency.

Informed choice increases client satisfaction in using a method, decreasing reservations or fears of possible side effects, and ensures continuous usage of the method.

Counseling assures that each client is guided to make a well-informed and voluntary decision that is best suited to his/her individual needs.

## Voluntarism

Voluntarism is decision-making on the choice of a family planning method based on free choice and not obtained by any inducements or forms of coercion.

### Compliance to Informed Choice and Voluntary Decision Principle

The following explains the principle of informed choice and voluntary decision for better understanding and compliance:



Key Points of the Principle	Clarification/Interpretation	Illustrative Examples of non-compliance/ vulnerability
<p>Service providers and <i>Barangay</i> Health Workers (BHWs) should not be subject to individual quotas and targets.</p>	<p>A quota or target is a predetermined number of births, FP acceptors, or acceptors of a particular method that a service provider or BHW is assigned or required to achieve. Indicators for planning, budgeting, and reporting are exempted.</p>	<p>Dr. Achiever decides that the best way to motivate his staff to increase contraceptive prevalence rate in the province is to assign numerical goals for FP new acceptors.</p>
<p>There will be no payment of incentives, bribes, gratuities or financial rewards to (1) any individual in exchange for becoming an FP acceptor, or (2) personnel for achieving a quota or target.</p>	<p>The restriction on provider payment is based on achieving a quota or target expressed as a “predetermined number” (or incentives provided to acceptors in exchange for accepting a particular method). Incentives, bribes, gratuities, financial rewards should not be a form of inducement to accept a particular method.</p>	<p>Local Government Unit A provides a sack of rice and cash to every individual who accepts a permanent family planning method.</p>
<p>No person shall be denied any right or benefit based on their decision not to accept FP.</p>	<p>Health facilities shall not deny any right or benefit, including the access to participate in any program of general welfare or the right of access to health care, as a consequence of the individual’s decision not to accept family planning services.</p>	<p>Local Government Unit B denies access to supplemental food programs for indigents who are not FP acceptors.</p>
<p>Comprehensible information about benefits and risks of the chosen method, including conditions that might render the method in advisable (e.g. contraindications) plus side effects shall be provided.</p> <p>This requirement should be satisfied through counseling, brochures, posters and/or package inserts.</p>	<p>Provide comprehensive information on the range of methods and services or information in order for a particular client to make an informed decision on what method to use.</p>	<p>In a busy health center with one provider, FP clients are routinely given pills without any explanation about common side effects or warning signs of complications. Moreover, clients are not offered access to information on a full range of family planning choices.</p>

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples of non-compliance/ vulnerability)
<p>Broad range of family planning services/methods should be available and a referral system installed for methods/services not offered in the facility.</p>	<p>During counseling, potential FP clients should be made aware of all the modern FP methods. If some methods are not available like IUD and BTL which requires certain level of skills from providers, the provider should be able to refer the clients to a facility where the services are available.</p>	<p>Maria went to Clinic A for FP counseling. Lorna, the midwife of Clinic A, told Maria that they offer IUD insertion, which she can readily avail of. When she agreed, the midwife inserted the IUD, without discussing the health benefits of using the method, conditions that would make the method inadvisable, and known side effects of the method.</p>
<p>Abortion and/or lobbying for abortion as a method of family planning is not allowed.</p>	<p>Practice of abortion is not legal in the country and is in no way accepted as a family planning method. This is stipulated in AO 50-A : National FP Policy, under the guiding principle in the delivery of FP services. Program beneficiaries are not allowed to join advocacy activities lobbying for abortion as a FP method.</p>	<p>Alberta missed her menstruation last month. She asked her friend, Dr. A, if she can have an abortion. Dr. A discreetly performed dilatation and curettage. This was later on discovered because of complications.</p>
<p>Voluntary Surgical Contraception (VSC) as a method of family planning should be provided out of the acceptor's own decision based on a broad range of information without any inducement or coercion. Informed consent forms should be explained and signed by the acceptor prior to the performance of the procedure.</p>	<p>Service providers should ensure that informed consent have been discussed and secured from every VSC acceptors prior to the performance of the procedure. The six elements should be explained to the clients.</p>	<p>A woman, who had a baby two months earlier, comes into a health clinic for VSC. Prior to the procedure, the woman was not informed on the risks and benefits of VSC, the availability of alternative family planning options, the purpose of the operation and irreversibility, and the option to withdraw consent at any time prior to operation. The woman also did not sign an informed consent form for the procedure.</p>

Key Points of the Principle	Clarification/Interpretation	Illustrative Examples of non-compliance/vulnerability
<p>Family planning IEC materials particularly wall chart on FP methods should be available at the facility.</p>	<p>The ICV wall charts which contain all the different modern FP methods on their mechanism of action, advantages and disadvantages, and possible side effects should be prominently displayed in all clinics that provide FP services to enable clients to make an informed choice and voluntary decision-making. The wall charts are available in local languages.</p>	<p>Clinic A was one of the clinics provided with FP IEC materials together with an ICV wall chart, which contains a list of all the FP methods. The Mayor of Municipality Z, however, prevents the service providers to place any materials in the walls of the rural health unit.</p>

## Informed Consent

Informed consent is the written voluntary decision of a client to accept a particular FP method or to undergo a sterilization procedure. It is important that the service provider asks the client to sign in the appropriate (“Acknowledgement”) part of the FP Form 1 before leaving your clinic to attest to informed choice.

For surgical sterilization procedures (i.e., BTL and vasectomy), the client is asked to sign an informed consent form prior to surgery. Below is the Department of Health “Informed Consent Form”. This has been translated in the main dialects of the Philippines to ensure that clients understand its provisions. Take note that spousal consent is not necessary as signature of the spouse is not included in this form. However, the spouse may sign as a witness.

### Importance of Informed Consent

- a. Among clients who prefer temporary or spacing methods:
  - Ensures that the clients receive the information they need to make informed, well-considered decisions regarding fertility.
  - Ensures that the clients makes the decision of their own free will.
  - Helps to assure satisfied and well-informed clients.
  - Reduces the incidence of regrets, thus enhancing the program’s acceptability and prestige.
  
- b. Among clients who have decided to undergo surgical contraception:
  - Diminishes regret after the surgical procedure.
  - Impresses upon clients that they are making an important and irrevocable decision.
  - Serves as evidence of the client’s request and protects against charges of induced or uninformed sterilization.

DEPARTMENT OF HEALTH

INFORMED CONSENT FORM FOR  
VOLUNTARY SURGICAL CONTRACEPTION CLIENTS

I, \_\_\_\_\_ the undersigned, request that a sterilization via  
(client's name)  
\_\_\_\_\_ be performed on my person.  
(specify the procedure)

I make this request of my own free will without having been forced, pressured, or given any special inducement. I understand the following:

1. There are temporary methods of contraception available to me and my partner.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, in addition to benefits, both of which have been explained to me.
4. The procedure should be considered permanent. However, no surgical procedure can be guaranteed to work 100% on all people. There is a small failure rate. If the procedure is successful, I will be unable to have any more children.
5. This surgical procedure will not protect me and my partner from sexually transmitted infections (STIs), including HIV (the virus that causes AIDS).
6. I can decide against the procedure at any time, before the operation is performed (and no medical, health or other benefits or services will be withheld from me as a result).

\_\_\_\_\_  
Signature or mark of client

\_\_\_\_\_  
Date

10.10

\_\_\_\_\_  
Signature of attending physician or delegated assistant

\_\_\_\_\_  
Date

If the client cannot read, a witness of the client's choosing, of the same sex, and speaking the same language must sign the following declaration:

I, the undersigned, attests to the fact that the client has affixed his/her thumbprint or mark in my presence.

\_\_\_\_\_  
Signature of mark of witness

\_\_\_\_\_  
Date

### TYPES OF COMMUNICATION IN FP/RH



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Define information-giving, motivation, and counseling.
2. Differentiate information-giving, motivation, and counseling.
3. Explain the relationship of the three types of FP/RH communication.
4. Explain the importance of counseling.



#### NARRATIVE

##### Definition of Information-giving, Motivation, and Counseling

**Information-giving** is a way of providing people with facts about family planning and the methods. This can be communicated one-on-one, in a group, or on a mass scale. The information may be complete or limited and can be given anywhere. However, there may be some overlaps between promotion and information-giving, depending on how complete and accurate the information is.

Some examples of information-giving:

- nurse in a clinic shows a film on the various contraceptive methods to a group of women who are waiting for medical checkup.
- client is given a brochure on the temporary methods of contraception by a field worker.

Information-giving activities provide facts about methods and can be done in person (either individually or in group) or through print materials and other media. While the information presented may be complete or limited, it must be accurate and correct.

**Motivation** (also known as promotion) includes all efforts to encourage people to practice family planning. It may be interpersonal or it may involve the mass media. The messages should include a wide range of information on family planning and reproductive health concerns that can attract the interest of the general public or a target audience.

Motivational messages are made up of information emphasizing the benefits of a method being promoted. No special setting is required for these activities.

Motivational activities encourage the use of family planning. These activities may be conducted in person or through the media. While they can convey useful information, these activities are usually biased. They often attempt to influence an individual or group to adopt a certain practice or behavior.

Some samples of motivational messages:

- billboard that promotes the use of specific brand of contraception.
- advertisement in a men's magazine that promotes the use of condoms to prevent pregnancy and STI transmission.

**Counseling** is a two-way communication process between the provider and the client. The goal of this communication is to assist the client in making a free and informed decision about his or her fertility. This is done considering the client’s reproductive needs, living situation, opinions, and feelings.

Counseling activities focus on helping individuals make choices about fertility. Counseling goes beyond just giving facts; it enables clients to apply information about family planning to their particular circumstances and to make informed choices. It includes a discussion of the client’s feelings regarding fertility. Counseling always involves two-way communication. The client and the counselor spend time talking, listening, and asking questions.

While motivation and information-giving can be done anywhere, it is important that counseling occur in a private atmosphere since personal information is shared.

### TYPES OF FAMILY PLANNING COMMUNICATION DIAGRAM



### TYPES OF FAMILY PLANNING COMMUNICATION

Type	Goal	Content	Direction	Bias	Location
<b>Motivation or Promotion</b>	Influence an individual or group to adopt a certain practice or behavior.	Advantages of family planning and the methods	One-way	Biased	Anywhere
<b>Information-Giving</b>	Provide facts	Facts about family planning and the methods	One-way	May be biased	Anywhere
<b>Counseling</b>	Assist the client make a free and informed decision	Facts, client’s needs, situation, opinion, and feelings	Two-way	Not biased	Private

## SESSION 4

### EFFECTIVE COMMUNICATION SKILLS



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Identify good non-verbal communication skills.
2. Describe the appropriate tone of voice to be used by a counselor.
3. Ask closed, open, and probing questions effectively.
4. Demonstrate active listening.
5. Describe paraphrasing and clarifying.
6. Use simple language when telling clients about contraceptive methods.



#### NARRATIVE

A health care provider, who aims to be efficient in delivering health services, must have good communication skills.

A good family planning counselor must be an effective communicator. He/She practices all the basic skills necessary for good communication. These are:

- Non-verbal communication
- Tone of voice
- Asking good questions
- Active listening
- Paraphrasing and clarifying
- Simple language

#### **Non-verbal Communication**

In many cases, what we do not say is almost as important as what we say. In other words, our body position and other non-verbal mannerisms communicate feelings to the client. Also, many of these non-verbal behaviors are culturally bound. What may be acceptable in one part of the country may be considered rude in other parts.

#### **Tone of Voice**

Like non-verbal communication, how we say something is almost as important as what we say. Our tone of voice can be used to project feelings and thoughts that can be picked up by the client in either a negative or positive way.

#### **Asking questions**

Asking good question is one of the main functions of a family planning counselor. We ask questions to:

- Know, investigate, clarify, and gain deeper understanding of facts, issues, feelings, and opinions.
- Encourage another person to communicate, elaborate, and be frank about his or her own knowledge, thoughts, and feelings.
- Direct communication towards a certain issue.
- Make a person feel that we are interested in what the client has to say.



Questions can be used to:

- Assess the needs of the client
- Find out what the client already knows about family planning
- Learn how the client feels
- Help the client reach a decision
- Help the client act on a decision

There are three types of questions that a family planning counselor should know:

### • Closed questions

These are questions that can be answered by yes, no, a number, or a few words. Counselors can use closed questions to start sessions, gather data that can indicate areas that need further exploration. Closed questions can be used to get information, such as a medical history. The following are examples of closed questions.

- How old are you?
- Which family planning methods have you used?
- How many children do you want to have?
- When did you decide that you did not want to have any more children?

### • Open Questions

These types of questions have many possible answers. They can encourage the client to talk about her or his thoughts, feelings, knowledge, and beliefs.

These questions often begin with “how” or “what”. The following are examples of open questions.

- What do you know about condoms?
- How do you feel about not having children?
- How did you decide that you are not ready for tubal ligation?
- What does your partner think about you using contraception?

**Note:** “Why” questions may be intimidating or seem judgmental. It is preferable to use “what” as in “what are your reasons for ...” or “what makes you think ...”

### • Probing questions

Probing questions help a counselor clarify the client’s responses to open-ended questions. An example of a probing question is, “Can you tell me how your friend’s experience made you decide to go for DMPA?”

There is some overlap between open-ended questions and probing questions. The difference between these types of questions is clearer in actual discussions with clients when they appear in context. Probing questions follow open questions. Some additional examples are:

- “You said that you were concerned about the potential bleeding associated with DMPA. How would you feel about a method that does not cause menstrual disturbance?”
- “You told me that your husband wants to use a reliable method of contraception. What are your thoughts about bilateral tubal ligation?”



## Active Listening

Listening to another person in a way that communicates understanding, empathy, and interest

## Paraphrasing and Clarifying

As with all communication processes, sometimes one party or the other - either the client or the counselor - wants to make sure that he or she does in fact understand what is being said. This is done by paraphrasing and clarifying.

- Paraphrasing is restating the client's message in a simple manner. Counselors use paraphrasing to make sure that they have understood what a client said and to let the client know that they are trying to understand his or her basic message.

Paraphrasing supports the client and encourages him or her to continue speaking. Example: *Client*: "I want to use the IUD, but my sister said that it travels around your body and sticks to the baby's head."

*Counselor*: "You want to use the IUD but you have concerns about its possible effects on you and your baby?"

Guidelines for Paraphrasing:

1. Listen to the client's basic message.
2. Restate to the client a simple summary of what you believe is the basic message. Do not add any new idea.
3. Observe a cue or ask for response from the client that will confirm or deny the accuracy of the paraphrase.
4. Do not restate negative images clients may have made about themselves in a way that confirms this perception. For example, if the client says "I feel stupid asking this," it is not proper to say "You feel ignorant".

- **Clarifying** is making an educated guess about the client's message for the client to confirm or deny. Like paraphrasing, clarifying is a way of making sure the client's message is understood. The counselor uses clarifying to clear up confusion if a client's response is vague or not understandable.

Example: *Client*: "I am using the pill and I like it, but my sister says that with DMPA, I do not need to remember to take anything."

*Counselor*: "Let me see if I understand you. You are thinking about switching from the pill to DMPA, because DMPA would be more convenient for you."

**Guidelines for clarifying:**

1. Admit that you do not have a clear understanding of what the client is telling you.
2. Restate the client's message as you understand it, asking the client if your interpretation is correct. Ask questions beginning with phrases such as "Do you mean that..." or "Are you saying..."
3. Clients should not be made to feel they have been cut off or have failed to communicate. Therefore, do not use clarifying excessively.

## Using Simple Language

A large part of what a counselor does is provide information so that the client has sufficient knowledge to make an informed decision about his or her contraceptive options. The problem is that the client must get technical medical information about contraception methods or human anatomy and reproductive physiology. As a result, one of the things that a counselor must do is use a language that the client understands.

## SESSION 5

### THE G-A-T-H-E-R APPROACH TO FAMILY PLANNING COUNSELING



#### LEARNING OBJECTIVES

At the end of the session, the participants will be able to:

1. Explain the G-A-T-H-E-R approach to counseling.
2. Describe each step in the G-A-T-H-E-R approach to counseling.
3. Use the approved counseling cue card/flip chart (if available) as an aid when counseling clients.
4. Explain the tasks of the counselor for each of the GATHER steps of counseling.
5. Explain the importance of each of the GATHER steps of counseling.
6. Enumerate the task of the FP counselor during each of the GATHER steps of counseling.
7. Determine that the woman is not pregnant.
8. Assess client's reproductive needs, risks for STIs, status of relationship with partner, and knowledge on FP methods.
9. Use the FP Service Record (or any approved assessment form) as a tool for undertaking assessment.
10. Use appropriate types of questions (i.e., closed, open-ended, probing) during assessment of the client.
11. Describe available family planning (FP) methods based on client's reproductive need.
12. Discuss appropriate FP methods in terms of:
  - mechanism of action
  - effectiveness
  - advantages and disadvantages
  - possible side effects
13. Correct rumors and misconceptions.
14. Identify the reasons for clients' return visits.
15. Demonstrate counseling using the G-A-T-H-E-R approach.



#### NARRATIVE

A simplified concept in family planning counseling is **GATHER**. The acronym stands for **greet, ask/assess, tell, help, explain, and return** for follow-up or **referral**. This is the suggested guide of steps and topics to cover while the provider and client engage in an interactive two-way discussion of the client's needs feelings and risks. The steps help the client go through the process of learning, weighing choices, making decisions, and carrying out these decisions. In the role of helping the client choose a method, the counselor uses a specific set of skills and knowledge for each step.

**GATHER** provides a useful framework that simplifies the counseling process. The counseling process depends on the needs and situation of the client, so that the length and the content of these steps vary.

**GATHER** is an acronym which stands for the six steps of family planning counseling. The acronym serves as a guide for the counselor as she performs counseling.

Not all the steps are applied to all clients in the same way. Each individual client's needs determine the counselor's level of emphasis of each of the steps. Some clients may need a step repeated, while others may need only a brief exposure to a step.

**GATHER** stands for:

- G:** Greet the client.
- A:** Ask the client about herself/himself, assess her/his knowledge, needs and risks (including risks for sexually-transmitted infections like HIV/AIDS).
- T:** Tell the client about family planning methods based on her/his needs and knowledge.
- H:** Help the client choose a method.
- E:** Explain how to use the method.
- R:** Return for follow-up and refer for services.

## The “G” (Greet) Step

This step relates to how a counselor can begin to establish a relationship/rapport with the client during their first meeting. A good relationship develops when both counselor and client share common goals, are open and communicative, and respect and trust each other. This session introduces the norms of counseling which sets the stage for a positive relationship.

The following are the tasks in the **G** step.

- As soon as you meet the client, give her/him your full attention.
- Greet her/him politely, introduce yourself, and make her/him comfortable by offering her/him a seat.
- Ask the reason for her/his visit and how you can help.
- Assure her that anything that is discussed during the session will be kept confidential.

## The “A” (Ask/Assess) Step

The A step which is the second step in the GATHER technique **asks** clients about themselves and **assesses** their reproductive needs, family planning knowledge, STI risks, and relation with partner.

The tasks of the “A” step are:

- Ask the client about self (use FP form I). This will include:
  - General data
  - Medical/Ob-Gyne history
  - Physical examination, if necessary
- Check if there are any existing medical conditions that will not warrant the use of a specific FP method.
- Assess the client’s reproductive need
  - Ask the client if she/he plans to have another baby
  - Ask client when she/he plans to have their next baby
  - Client’s reproductive need can be classified into three categories:

M E T H O D S	REPRODUCTIVE NEEDS		
	Short term (< 3 yrs)	Long term (≥ 3 yrs)	Permanent
	Condom, LAM, FAB methods, Pills, DMPA, IUD	FAB methods, Pills, DMPA, IUD	BTL, Vasectomy, DMPA, IUD

- Ask client's knowledge and previous use of FP
  - ⦿ What do you know about FP?
  - ⦿ Have you used any method in the past? If yes, what method and for how long? Are you satisfied with the method? If no, why?
  - ⦿ Correct any misconceptions if there are.
  
- Assess client's STI risks
  - ⦿ Find out if the client knows or suspects that her/his partner may be engaging in sex with other partners or if the client herself/himself might have other partners by asking indirect questions beginning with:
    - ✓ How is your relationship with your husband/wife/partner? Or ask:
    - ✓ Have you or your partner ever been treated for STIs in the past?
      - For a woman, ask:
        - ⦿ Do you have any of the following?
          - ✓ Unusual discharge from your vagina?
          - ✓ Itching or sores in or around your vagina?
          - ✓ Pain or burning sensation upon urination?
      - For a man, ask:
        - ⦿ Do you have any of the following:
          - ✓ Pain or burning sensation upon urination?
          - ✓ Open sores anywhere in your genital area?
          - ✓ Pus coming from your penis?
          - ✓ Swollen testicles or penis?
    - If the answer is YES to any of the questions above, refer the client for treatment. Talk to the client about the use of condom.
  
- Assesses for Violence Against Women (VAW) - you may ask the following questions:
  - ⦿ How is your relationship with your husband or partner?
  - ⦿ Does he know about your coming here in the clinic?
  - ⦿ Is he willing to cooperate or support you in using FP method?

For any indication of VAW, refer client to the nearest Women's Crisis Center.

- Assess the possibility of pregnancy.
 

The provider can be reasonably sure that the woman is not pregnant if:

  - ⦿ Her menstrual period started within the last seven days
  - ⦿ She gave birth within the last four weeks
  - ⦿ She had an abortion or miscarriage within the last seven days
  - ⦿ She gave birth within the last six months, is fully breastfeeding, and has not yet had a menstrual period
  - ⦿ She has not had sexual intercourse since her last menstrual period
  - ⦿ She uses a modern/reliable family planning method correctly

Even if she has been using a planning family method correctly but her last menstrual period is more than five weeks ago and she had sex, pregnancy cannot be ruled out. An exception is if she is using a progestin-only injectable.

- If not reasonably sure that the woman is not pregnant, the counselor should ask her about signs of pregnancy.

### Early signs of pregnancy

- Late menstrual period
- Breast tenderness
- Nausea
- Vomiting
- Weight gain
- Always tired
- Mood changes
- Changed eating habits
- Urinating more often

### Later signs of pregnancy (more than 12 weeks from last menses)

- Larger breasts
- Darker nipples
- More vaginal discharge
- Enlarging abdomen
- Movements of the baby

- If the woman has had several of these signs, she may be pregnant.
- If the woman's answer or the physical examination cannot rule out pregnancy, she can either:
  - ⦿ Have a pregnancy test or,
  - ⦿ Wait until her next menstrual period before starting a method. In the meantime, her partner can use the condom.
- Assess the client's condition using the FP Service Record to identify the health status of the client and abnormal conditions she may have. Findings of this assessment may then be looked up in the WHO Medical Eligibility Criteria (MEC Wheel or summary table) to determine suitability of the client for using the chosen method.
- *Category 3 and 4* conditions indicate that the method cannot be provided.

### Revisit Clients

The following are the tasks for revisit clients during the "A" step:

- ⦿ Ask if their situation has changed since their last visit
- ⦿ Ask if reproductive needs have changed
- ⦿ Ask them if they have new concerns
- ⦿ Ask them if they have any problems related to their method
- ⦿ Re-assess STI/HIV risk and client's relation with partner

### The "T" (tell) Step

The counselor **tells** a client about the family planning methods suitable for her/him based on her/his reproductive needs and health status. A client who wants to use family planning should know the basic information about the available methods before she/he decides to use one. What she/he needs to know depends on her/his reproductive needs, health status, those that interest her/him, and what she/he already knows about these appropriate methods. These information should have been taken during the previous ask/assess (A step).

The tasks under the T step are:

- Tell the client about the FP methods in terms of:
  - ⦿ What the method is
  - ⦿ How each method works
  - ⦿ The advantages of each method
  - ⦿ The disadvantages of each method
  - ⦿ The possible side effects of each method
- Correct rumors and misconceptions the client may have.
- Use IEC materials such as samples of contraceptives, leaflets, table flip charts, cue cards, etc.

## The “H” (help) Step

After providing the client with the information on FP methods appropriate to his/her reproductive needs and health status, the client is then helped to make voluntary, well-informed decisions. It is the counselor’s role to help clients make sound decisions.

The primary task of the **H step** is to **help** the client make a decision on what FP method he/she would want to use. Other tasks include:

- Ask the client if there is anything he/she did not understand; repeat information as needed.
- Ask client what additional information is needed to help her/him make a decision.
- Ask client what method heard about during the “tell” step that interests him/her the most.
- Determine client’s suitability for his/her chosen method using the specific MEC Checklist for the chosen FP method.
- Ask the client how he/she will tolerate possible side effects of the chosen method.
- If the client decides not to use a method, tell the client about:
  - Possibility of pregnancy
  - Availability of pre-natal services
  - Assure the client that they can return to see you at any given time should they decide to use a FP method.

## The “E” (explain) Step

After a thorough assessment of the client during the “**A**” step, telling the client about appropriate family planning methods during the “**T**” step and helping the client choose a method in the “**H**” step, the client finally chooses a method she/he can use. The counselor then provides the method and explains, the “**E**” step, how to use the method.

The main tasks of the counselor in the E step are the following:

- Explain to the client how to start and use the chosen FP method.
- Explain the warning signs of the chosen FP method and what to do and where to go should she/he experiences any one of these warning signs.
- Confirm client’s understanding of what has been said by asking her/him to repeat what you have said in client’s own words. Correct misunderstandings.
- Provide the method, if appropriate and available.
- Give the clients informational materials on the method chosen

## Revisit Clients

Ask clients to:

- Tell you how she/he uses the present method and the warning signs for the method.
- Repeat instructions on how to use the method and/or the warning signs if what client said were incomplete or incorrect.

## The “R” (refer/revisit) Step

The “R” return/refer step of the **GATHER** is the final and equally important step of the counseling process. During this step, the counselor can potentially do two things: first, the counselor may inform the client about when to return, for both routine and emergency follow-up; and second, the counselor may need to refer a client for evaluation of a medical problem or for a contraceptive method that is not available.

Routine and emergency follow-up are defined as:

- Routine follow-up is defined as a visit that the client makes to get supplies, or have a routine (or scheduled) check-up.
- An emergency follow-up visit is when a client experiences a warning sign or complication. If this should occur, the client should seek medical help immediately.

It is important to emphasize to the client that counseling does not end after she/he has made a decision in choosing a family planning method. The support should be continuous to ensure client’s satisfaction and safety while using the chosen method.

Return/follow-up visits provide support to clients because it is an important opportunity to:

- Reinforce the decision clients have made to plan their family.
- Discuss any problems they are having with their chosen method. Clients’ concerns and complaints should never be dismissed but taken seriously with a supportive attitude.
- Answer questions they may have.
- Explore changes in their current health status or life situation which may indicate a need to switch to another contraceptive method or to stop using any method.

The tasks of the R step are:

- Tell the client when and where to go for routine follow-up.
  - Schedule the next visit before client leaves.
  - Assure that s/he should not hesitate to come back for any problems, specially warning signs.
- Refer client for methods and/or services you do not provide. Provide client with a referral note.

During return/follow-up visits, the counselor:

- Reviews the chart for the details of the health history.
- Asks the client how s/he feels with the method and if s/he has any questions.
- If s/he is having any problems with the method, assesses the nature of the problem and discusses possible solutions.
- If the problem is a side-effect, assesses how severe it is and offers suggestions for managing it or refers the client for treatment.
- If the client is not using the method any more, asks why not (it may be due to problems related to misunderstanding, side-effects or supply).
- If the client still wishes to continue using a contraceptive, answers her/his questions and provides information that will enable her/him to continue with a contraceptive of choice.
- If the client is still using the method, determines if it is being used correctly. Asks the client how s/he is using the method. Re-enforces instructions on the correct use of the method, if necessary.
- Ensures that the client receives re-supplies and an appropriate examination, if necessary.
- Assists the client in selecting another contraceptive method if the client is not satisfied with the chosen method, if her/his situation has changed, or if the method is no longer safe.
- If the client wishes to become pregnant, helps her to stop her method and provides information on the return of fertility. Emphasizes the importance of antenatal care, which the midwife can provide.



***Bear in mind that especially for revisit clients, counseling should be conducted again, using the appropriate GATHER steps. The tasks enumerated above may fall under the different steps of the GATHER Approach.***

## **ROLE PLAY SITUATIONS**

1. A 25-year-old woman with two children wants to wait at least five years before she has another child. She has never used family planning and knows very little about available methods.
2. A 21-year-old with two children wants to wait three years before having another child. She is returning to the clinic for more pills. She started taking pills about a year ago.
3. A 21-year old woman in her second year of post-graduate college has one child, and she wants to have her next child after she finishes her education in three years. She has never used family planning, and she does not know anything about modern methods.
4. A 26-year-old female consulted for an FP method. She prefers to take the pills, and just had her menstruation 10 days ago. She has not engaged in sexual intercourse since her last menses. She also wants to have a child after three years. How will you advise her on starting the pills?
5. A 38-year-old woman who has four children wants no more. She is currently using the pill and has used the injectable in the past. She knows about these two methods but very little about sterilization.
6. A 22-year-old woman with a one-year-old child comes to the clinic to inquire about FP. She wants to postpone pregnancy for two years. She practiced LAM. After discussing appropriate methods with her, she eventually chooses the SDM.
7. A 24-year-old postpartum mother went to the FP clinic for consultation. She is fully breastfeeding her 1st baby for one month. She expresses fear that she will not be able to continue since she is required to report to her office the following week. She prefers to take pills to prevent pregnancy.
8. A 36-year-old mother of five children went to your FP clinic for advice. She had an abortion five days ago. She doesn't want to undergo the same experience and wanted something to protect her from becoming pregnant. The client does not want the pills.
9. A previous client came back to your clinic for advice. She missed her pills for three days and is afraid she will get pregnant. She also had sex with her husband two days ago. What would you tell her as an FP counselor.
10. A woman with two children who has been using the pills for three months goes to the clinic for consultation. She wants to try the injectable as she does not want to take a pill each day.
11. A woman with two children has been taking the pill for two months now. She returns to the clinic with complaints of nausea during pill intake.
12. A woman who had her 4th injection of DMPA has been worried of not having menses for the past two months.

10.22



## COUNSELING SKILLS PRACTICE CHECKLIST

PARTICIPANT \_\_\_\_\_ COURSE DATE \_\_\_\_\_

**Instruction: Check the appropriate column for each of the tasks.**

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
<b>Interpersonal Communication</b>				
1. Maintains eye contact with the client.				
2. Uses simple language that the client understands.				
3. Uses appropriate tone of voice.				
4. Exhibits positive non-verbal communication.				
5. Uses the cue card effectively.				
6. Asks open-ended, closed, and probing questions effectively.				
7. Listens attentively to client's response and concerns.				
<b>COUNSELING PROCESS</b>				
1. Greets client and introduces herself.				
2. Offers the client a seat.				
3. Asks reason for client's visit.				
4. Respects clients right by:				
– Ensuring confidentiality				
– Providing privacy				
5. Invites client to speak freely.				
<b>New Clients</b>				
6. Uses the FP Form 1 to obtain relevant information.				
7. Assesses the client's reproductive needs (short-term, long-term, permanent)				
8. Asks client if s/he has a method in mind and what s/he knows about the method.				
9. Assesses what the client knows about FP methods.				
10. Asks if client has previously used an FP method and reasons for discontinuing.				
11. If postpartum, assesses the client's willingness to breastfeed.				
12. Assesses reproductive health needs of clients				
• Risk for STIs				
• Gender-based violence (VAW)				
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).				
14. Corrects rumors and misconceptions.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
15. Tells the client about available methods based on her/his knowledge and reproductive needs.  <ul style="list-style-type: none"> <li>• Mode of action</li> <li>• Advantages and disadvantages</li> <li>• STI and HIV prevention</li> <li>• Possible side effects</li> </ul>				
16. Allows the client to choose a method among those previously presented to him/her.				
17. Determines suitability of the chosen method using the method specific MEC checklist.				
18. Helps the client make a decision by asking her how s/he will cope with potential side effects of the chosen method.				
19. Correctly explains to the client how to use the chosen method.				
20. Offers condoms to clients with risk for STIs for dual protection and/or back-up.				
21. Correctly explains the warning signs and what s/he should do if any of these occurs.				
22. Checks at appropriate times if client has understood the information or instructions given.				
23. Asks the client to repeat all instructions in his/her own words.				
24. Tells the client when to return for routine follow-up, if needed.				
25. Refers the client for methods or services not offered at counselor's site.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
<b><i>Return Clients</i></b>				
1. Greets the client and introduces herself, if needed.				
2. Offers the client a seat.				
3. Retrieves client’s records.				
4. Re-assures confidentiality and provides privacy.				
5. Asks if the client’s situation, including her/his reproductive needs, had changed since the last visit.				
6. Asks the client if s/he has problems with the method s/he is using.				
7. If client is satisfied with her/his present method:				
• Asks the client to repeat how s/he uses the method.				
• Asks the client to repeat warning signs of the method s/he is using and emphasizes that immediate consultation should be sought if any of these occurs.				
• Gives client re-supply of the method s/he is using.				
• Tells the client when to return for follow-up, if needed.				
8. If client is not satisfied with the method:				
• Tells the client that there are other methods that s/he can use to meet her/his needs.				
• Tells the client about appropriate methods for her/his reproductive need.				
• Helps the client make a decision by determining how s/he will cope with potential side effects.				
• Explains how to use the chosen method, including what to do for warning signs.				
9. Refers the client for methods or services not offered at her clinic.				

**COMMENTS/RECOMMENDATIONS:**

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**Trainer’s Signature:** \_\_\_\_\_



# MODULE 11



## Management of Family Planning Clinic Services

Session 1: Managing for Quality

Session 2: Facility-Based FP Services

Session 3: Management Support Systems

Session 4: Monitoring and Evaluation

Session 5: Service Delivery Network



## MODULE 11: MANAGEMENT OF FAMILY PLANNING CLINIC SERVICES



### MODULE OVERVIEW

It is important for doctors, nurses, midwives, health supervisors, and other health workers to know the essentials of family planning (FP) clinic services management. Learning how to manage FP services in clinics is an important requisite for providing good quality health care. Standard operating procedures and requirements have to be set and followed toward an effective and efficient management of FP services.



### MODULE OBJECTIVES

At the end of the module, the participants will be able to improve competency in managing FP clinic services to provide quality health care.



### LEARNING OBJECTIVES

At the end of the module, participants will be able to:

1. Describe the reproductive health concerns/conditions of each of the special populations.
2. Discuss the recommended FP methods/practices for each of the special populations.



### MODULE SESSIONS

<b>Session 1</b>	Managing for Quality
<b>Session 2</b>	Facility-Based FP Services
<b>Session 3</b>	Management Support Systems
<b>Session 4</b>	Monitoring and Evaluation
<b>Session 5</b>	Service Delivery Network

# SESSION 1

## MANAGING FOR QUALITY



### LEARNING OBJECTIVES

At the end of the session, participants must be able to:

1. Define quality.
2. Explain the three principles in managing for quality FP service provision.



### NARRATIVE

#### MANAGING FP CLINIC SERVICES WITH QUALITY

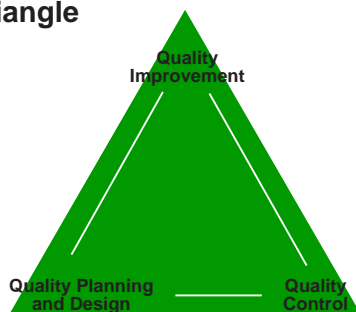
Quality of care is an important aspect in the provision of FP services and quality management should be our goal. In other words, aim for service delivery excellence in providing health care services. Quality should be the goal of any health service provision.

Quality is attaining the maximum well-being for the client considering both the risks and benefits that also results in provider satisfaction.

There are three principles in managing a FP service with quality. These are:

- **Clients come first.** Client-centered care provides what clients everywhere want - respect, understanding, fairness, accurate information, competence, convenience, and results. The best care helps clients achieve their own reproductive goals.

- **Quality Management Triangle**



- Quality planning and design - sets objectives, allocates resources, and establishes guidelines to ensure effectiveness and safety, maximize access, and increase clients' satisfaction.
- Quality control - monitors program activities and staff performance to ensure that they meet quality objectives.
- Quality improvement - seeks to keep raising the level of care - no matter what its current level is - often by forming staff teams to solve problems.

(adapted from Population Reports, Volume XXVI, Number 3 November, 1998)

## Requirements in Delivering Quality FP Clinic Services

Three elements are required to enable a health facility to deliver the appropriate FP services.

These include:

- appropriate **health facility infrastructure** and a conducive environment;
- presence of **competent staff**; and
- **adequate logistics** in terms of functional equipment/instruments and continuous supply of contraceptives and other materials.



## FACILITY-BASED FP SERVICES



### LEARNING OBJECTIVE

At the end of the session, participants will be able to:

1. Identify the components of a facility-based FP service.
2. Explain each of the components of a facility-based FP service.



### NARRATIVE

#### FACILITY-BASED FP SERVICES

The major components of FP services in health facilities should include the following:

##### 1. FP Promotion

- Emphasis on the health benefits of practicing FP;
- Awareness on the links of FP to other health development;
- Giving of correct information about FP and FP methods;
- Provision of full information on the effectiveness, mechanism of action, advantages, and disadvantages or side effects of each FP method to serve as the basis for clients to make their decisions and choices.

##### 2. FP Counseling

FP counseling is a service provided to individual clients through a two-way, face-to-face communication in which the FP service provider helps the identified client make an informed, voluntary decision about her/his fertility and make an informed choice.

##### 3. Provision of FP Methods

These include provision of all medically approved, safe, effective, and legally acceptable modern methods. The following services are provided, as needed:

- Physical assessment of clients including pelvic examination;
- Screening for common and other gynecological problems (e.g. RTIs, STIs, cervical cancer, breast cancer);
- Management/referral for services not available in the facility;
- Simple laboratory procedures.

##### 4. Infection prevention and control

Infection control in FP refers to the prevention of the spread of infection during the provision of FP methods. It aims to protect both the clients and providers from the spread of infectious diseases.

##### 5. Referral of clients

Referral and follow up of clients are additional services that can be given depending on the condition of the clients and the existing capacity of the health facility to address client's needs. Referral encompasses sending a client to or receiving a client sent by other clinics or service providers for any FP or related services that the other clinic can ably deliver.

- What needs to be referred?
  - Difficult IUD removal
  - Other FP services not available in the clinic
  - Voluntary Surgical Sterilization (VSS) services
  - Complicated infertility cases
  - Medical problems
  - RTI and other complicated gynecologic problems
  - Suspicious Pap smears

- Where should clients be referred?
  - Government hospital or clinic
  - Non-government hospital or clinic
- How do you refer?
  - A referral form is filled out indicating the name and condition of the client. In turn, referral centers or hospitals will indicate the action taken with the patient, then send the accomplished form back to the referring unit/center.

## SESSION 3

### MANAGEMENT SUPPORT SYSTEMS



#### LEARNING OBJECTIVES

At the end of the session, participants will be able to:

1. Discuss the different management support systems necessary for efficient and effective delivery of quality FP services.
2. Discuss the various records and reports being used in the health facility.



#### NARRATIVE

To deliver quality FP services, there are management support systems that are needed to be in place. For example, in the provision of FP services which is a basic activity, you need trained staff and adequate logistics.

1. Work And Financial Planning
2. Staff Development
3. Logistics Management
4. Resource Mobilization
5. Management Information System (MIS)

### WORK AND FINANCIAL PLANNING

This is the process of evolving a definitive direction and plan of action to respond to the demand for FP services among identified population groups. It involves the selection of appropriate approaches and interventions in light of the particular condition or situation of the identified groups. Planning must observe the following principles:

- objectives and activities aligned with the vision/goal of the LGU/organization and the overall direction of the National Family Planning Program;
- use of evidence-based information generated through program reviews, records analysis, or updated census information;
- participation of all health staff and other stakeholders (i.e., private sector);
- realistic resources and funding.

#### Guide in Preparing a Work and Financial Plan for FP

##### A. Review of Program Accomplishment and Situation Analysis

1. Conduct health facility self-assessment and identify clinic requirements in terms of staff, training, and logistics - contraceptives based on Contraceptive Self-Reliance, clinic supplies, IEC materials, service record forms
2. Review program accomplishments and needs
  - 2.1 identify strengths or best practices
  - 2.2 identify and summarize gaps/weaknesses

3. Install or update the CBMIS and identify selected population
  - 3.1 those with unmet FP needs
  - 3.2 current FP users
  - 3.3 FP clients who dropped out
4. Prioritize identified clients to be served
  - Priority I: Pregnant/postpartum mothers below 18 years or above 35 years, parity of four or higher, child interval of less than three years, low level of education, poor obstetrics/gynecological history.
  - Priority II: Immediate postpartum, post abortal, lactating mothers of malnourished children below five years.
  - Priority III: Couples suffering from tuberculosis, malaria, heart, and kidney diseases, STI/ HIV/AIDS, and with metabolic diseases such as diabetes mellitus and thyroid disorders.

#### B. Preparing the Work and Financial Plan

1. Set goals and objectives for next year based on assessment results.
2. Identify strategies and activities to realize the objectives.
3. Determine the focal person/staff responsible for the activity.
4. Specify the time frame/schedule of activities.
5. Estimate the amount of resources/funds needed and identified sources.
6. Specify the success indicators to facilitate monitoring of accomplishments.

#### C. Submission of Work and Financial Plan

1. Integrate FP work and financial plans with the health facility's overall annual plan.
2. Submit to the LGU Planning and Development Office and LCE for approval.
3. Request budget allocation or funding support from key stakeholders.

(Source: Adapted from 1997 FP Clinical Standards Manual)

## STAFF DEVELOPMENT

### • Training

Training is the main vehicle for enhancing and ensuring the capability of staff to deliver quality FP services. It is the process of developing staff competencies so they can effectively perform their expected functions and tasks.

All providers of FP services must undergo appropriate training (see Table 4 in participants workbook).

Given the fast turnover of staff in the health facility, it is important that a staff development plan be in place and updated yearly. This must be accompanied by a strong advocacy for budgetary support from local officials and mobilization of funds from other resources.

## • Supervision

This is the process of organizing and overseeing the work of subordinates responsible for performing certain assigned functions and tasks. It is a personal interface between the supervisor and supervisee, which must be undertaken regularly for the effective operation of the program and for sustaining staff morale and commitment.

Supervision is essential for two reasons: (a) to find out what is happening in the actual performance of staff in all aspects of their work, and (b) to renew the enthusiasm of staff for the work they are doing. The overall guiding principles of supervision are to guide, support, and assist the staff in carrying out their assigned tasks well (Table 4).

### Guide in Staff development

#### A. Training of Staff

1. Conduct/update an inventory of the training status of health staff.
2. Conduct training needs analysis (TNA) among staff.
3. Discuss TNA results with staff.
4. Identify gaps in competencies and identify appropriate training courses.
5. Prepare the staff development plan specifying the following:
  - 5.1 name of staff to be trained
  - 5.2 specific training course to attend
  - 5.3 projected schedule for training
  - 5.4 potential sources of funds for training
6. Coordinate with the provincial/city or regional health office for training opportunities for your health staff on specific training courses.
7. Mobilize resources to support staff training.
8. Send staff to training and reassign other staff to take on the trainee's tasks.
9. Monitor the application of knowledge and skills learned during the training program.
10. Maintain training certificates and training records.

#### B. Supervision of Staff

1. Organize the work of clinic staff and volunteer workers responsible for implementing/delivering FP services and general clinic operations, including:
  - 1.1 infection control and good housekeeping
  - 1.2 equipment and supplies maintenance
  - 1.3 provision of service to FP/RH clients
  - 1.4 proper recording and reporting
2. Designate the supervisor of an individual or group of staff who will perform specific tasks and reflect these designations in the organizational chart.
3. Prepare the supervisory plan by:
  - 3.1 identifying staff who need supervision
  - 3.2 prioritizing the specific program area where supervision is necessary
  - 3.3 scheduling when supervision visit/session will be undertaken
4. Implement the supervision.
5. Document the results of the supervision.
6. Give feedback to the supervisee.
7. Develop an action plan with the supervisee to address gaps identified.

## LOGISTICS MANAGEMENT

This is the process of ensuring that the health facility has sufficient FP commodities and supplies to meet the needs of FP clients and has the necessary set of equipment or instruments to use in delivering quality FP services. With the eventual phase out of donated contraceptives from USAID (condoms were phased out beginning 2003, pills completely phased out in 2007 and injectables in 2008), health facilities need to start securing the continuous supply of contraceptives to serve their current and potential FP users. The CSR Strategy (AO no.158 s.2004) issued by DOH stipulates guidelines that LGUs should follow.

The needed logistics and management system encompasses the following concerns:

### A. Forecasting

It is the process of determining the commodity requirements (supplies and other services) of all identified clients. It requires profiling the clients in terms of their capacity to pay to determine the segment, which should continue to benefit from the limited public resources or those who should avail of services from the private sector.

#### Steps in forecasting:

1. Identify the selected groups or clients for whom the LGU or health facility will be providing contraceptives.
2. Establish the desired contraceptive mix for the identified groups.
3. Decide on the following options:
  - Option 1: forecast the total requirement of the whole population based on demographic data such as number of married women of reproductive age (MWRA) with FP unmet need and current users.
  - Option 2: forecast requirements based on the average consumption of the identified population to include potential acceptors.
  - Option 3: forecast requirements needed based on available resources of the LGUs for FP commodities.
4. Determine the amount needed for procurement.

### B. Procurement and financing

Procurement is the process of acquiring commodities from suppliers at affordable prices and ensuring custodial requirements to safeguard the quality of commodities.

Financing is the process by which the health facility decides on how the FP commodity required by identified clients will be resourced. Whether this should be paid out of pocket, given free by the LGU, or through subsidies or sponsorship by concerned stakeholders, or through Philippine Health Insurance Corporation (PhilHealth or PHIC) benefit packages.

## Guide in Procurement and Financing:

1. Consider the different options in financing the FP commodity requirements of clients:

Option 1: allocate budget to procure contraceptives for free distribution.

Option 2: make available contraceptives for sale at cost recovery basis or at margins above cost.

Option 3: allow consigned supplies from social marketing sources or commercial sources to be made available to clients in LGU outlets.

2. Decide which of the following options to adopt in procuring FP commodities:

Option 1: direct and separate purchase by the LGU of FP commodities from national or regional-level suppliers or retained hospitals, or distributors of FP products (e.g. DKT).

Option 2: purchase of FP commodities as part of the regular procurement of drugs/ medicines conducted by the LGU.

Option 3: bulk procurement through the established interlocal health zone (ILHZ) where the LGU belongs or as part of the procurement.

## C. Allocation and distribution

This process involves determining how much and where the various commodities and services will be placed to make them available to different identified clients.

This requires the identification of actual clients to make sure that the commodities are placed in appropriate structures or outlets where they can be easily accessed.

FP commodities from DOH and those procured by LGUs should be allocated and distributed using the CDLMIS Modified Forms as stated in AO 158 s. 2004.

### 11.10

These forms consist of :

- Inventory Report,
- Contraceptive Order Form (COF),
- BHS Contraceptive Order Worksheet,
- Summary Delivery Report,
- Dispense to User Record (DTUR),

(See Appendices 1a-e, Philippine Clinical Standards Manual on Family Planning).

## Guide in Allocation and Distribution:

1. **At health facility level I** (e.g. BHS)

- 1.1 Issue contraceptives directly to clients or to BHWs or other community volunteers.
- 1.2 Determine the quantity to be requested to level II facility (e.g. RHU) using the DTUR and by filling out columns of the BHS worksheets.
- 1.3 Place the order for contraceptives to immediate level (e.g. RHU) using the BHS Worksheet.
- 1.4 Keep the record of issuances of contraceptives made to clients or other workers (e.g. DTUR).

## **2. At levels II-III health facilities (i.e., RHUs/hospital)**

- 2.1 Review and issue the requested supplies reflected in the BHS Worksheet submitted by the facilities.
- 2.2 Keep and maintain the Contraceptive Supplies Folder with copies of CDLMIS Forms of all health facility I units (e.g. BHS) within your coverage.

## **3. At the interlocal health zone or provincial level (if applicable)**

- 3.1 Determine the quantity of contraceptives to give to facilities based on data on the contraceptive order form (COF).
- 3.2 Keep and maintain the Contraceptive Supplies Folder with copies of all CDLMIS Forms (e.g. COF) of all health facilities (RHU/hospital) within your coverage.

## **D. Storage**

This is the process of ensuring that FP commodities are properly kept and maintained in good condition to avoid wastage and maintain their quality.

### **Guidelines for Storage of FP commodities**

1. Clean and disinfect the storage area.
2. Provide adequate lighting and ventilation.
3. Store contraceptives away from direct sunlight, fluorescent lights, and electric motors.
4. Keep contraceptives in original boxes which have protective coatings.
5. Stack cartons at least four inches off the floor and at least one foot away from the outer wall to allow air to circulate freely and to protect the contraceptives from being damaged due to water and other environmental conditions.
6. Maintain updated stock cards.
7. Write the expiration dates on the outside of the cartons and boxes and arrange the cartons in such a way that the supplies which will expire first are used first (FEFO).
8. Secure storage areas from thieves and curious adults and children.



9. Separate and return expired and damaged contraceptives to the delivery teams.
10. Store all supplies of OCs, IUDs, condoms, and injectables in one place to make it easier for the delivery teams to count.

## Functions of the FP worker in logistics management

Given the above processes and requirements in logistics management, the health facility worker must always see to it that supplies are sufficient, that no stock runs out, and that the equipment are in good working condition.

Specifically, the FP worker should (show slide on the functions of FP worker):

1. make a regular inventory of all commodities, supplies, and equipment;
2. allocate and distribute correctly and on time the contraceptives and other supplies (IEC materials, forms, etc.) based on client needs;
3. ensure appropriate storage of contraceptives, other supplies, and equipment;
4. update and maintain records and reports;
5. monitor proper use and care of equipment. There are two types of equipment - the expendable equipment for short-term use, and the non-expendable equipment, which refer to items used for a longer time and therefore need proper care and maintenance.

## RESOURCE MOBILIZATION

Mobilizing additional resources is paramount to the effective and efficient management of FP clinic services.

There are different mechanisms to generate additional resources for FP services.

Generation of additional resources for FP services entail:

- mobilizing the support and participation of the different stakeholders from the national, regional, local, and community levels.
- establishment of sustainable financing schemes for FP services, such as availing of certain Philippine Health Insurance Corporation Benefit Packages where FP services are compensable.

## MANAGEMENT INFORMATION SYSTEM (MIS)

MIS involves the collection, processing, and analysis of program-related information essential in policy-making, planning, and designing interventions appropriate to the needs of selected clients.

**COMMUNITY BASED MANAGEMENT INFORMATION SYSTEM** consists of a set of sequenced and continuous steps that allows health care providers to identify eligible selected clients who do not avail of appropriate health services in a given locality. It provides and prompts alternative service delivery interventions. Since its inception in the mid-1990s, the CBMIS tool has been expanded to cover not only FP but also selected maternal and child health indicators.

## FACILITY-BASED RECORDING AND REPORTING SYSTEM

### A. Recording form for FP

1. FP SERVICE RECORD (FP FORM 1)
  - The basic record form used in the FP program, which corresponds to the individual treatment record form used in other programs.
  - It contains essential information about the client that enables the health worker to provide quality FP service.
  - It is filled out by the service provider and is updated every time the client returns for a follow-up visit.
  
2. TARGET CLIENT LIST FOR FP
  - contains data which helps the health worker plan and carry out patient care and service delivery;
  - facilitates the monitoring and supervision of service delivery activities;
  - facilitates the preparation of reports;
  - provides clinic-level information that can be accessed for future studies.
  
3. SUMMARY TABLE FOR BHS FOR FP
  
4. MONTHLY CONSOLIDATION TABLE FOR RHUs FOR FP

### B. Reporting Forms for FP

1. FHSIS/M1 BHS forms - monthly reporting form that the midwife fills up to report the accomplishments from the first day to the last day of the month and submits to the nurse at the RHU/Main Health Center for consolidation.
  
2. FHSIS/Q1 RHU forms - quarterly reporting form from the municipality/city. It contains the consolidated three months reports of all the BHSs and the RHU/Main Health Center for health service delivery during the quarter.

**11.13**

### C. Other records

- There are forms kept in the health facility which include the CDLMIS recording and inventory forms, supplies ledger cards, and requisition and issue vouchers (RIV), which are important for keeping track of the availability of FP supplies in the health facility. Likewise, NFP charts for NFP users and two-way referral slips used in referring clients when services are not available in the health facility are also available.

**FAMILY PLANNING SERVICE RECORD\***

**SIDE A**

**MEDICAL HISTORY**

**HEENT**  
 Epilepsy/Convulsion/Seizure  
 Severe headache/dizziness  
 Visual disturbance/ blurring of vision  
 Yellowish conjunctiva  
 Enlarged thyroid

**CHEST/HEART**

Severe chest pain  
 Shortness of breath and easy fatiguability  
 Breast/axillary masses  
 Nipple discharges (specify if blood or pus)  
 Systolic of 140 and above  
 Diastolic of 90 and above  
 Family history of CVA (strokes), heart attack, asthma, rheumatic heart diseases

**ABDOMEN**

Mass in the abdomen  
 History of gall bladder disease  
 History of liver disease

**GENITAL**

Mass in the uterus  
 Vaginal discharge  
 Intermenstrual bleeding  
 Postcoital bleeding

**EXTREMITIES**

Severe varicosities  
 Swelling or severe pain in the legs not related to injuries

**SKIN**

Yellowish skin

**HISTORY OF ANY OF THE FOLLOWING**

Smoking  
 Allergies  
 Drug intake (anti-tuberculosis, anti-diabetic, anticonvulsant)  
 STI/HIV/AIDS/PIDS  
 Bleeding tendencies (nose, gums, etc.)  
 Anemia  
 Diabetes

**OBSTERICAL HISTORY**

Number of pregnancies:  
 \_\_\_\_\_ Full Term \_\_\_\_\_ Premature  
 \_\_\_\_\_ Abortion \_\_\_\_\_ Living Children  
 Date of last delivery \_\_\_\_/\_\_\_\_/\_\_\_\_  
 Type of last delivery \_\_\_\_\_  
 Past menstrual period \_\_\_\_\_  
 Last menstrual period \_\_\_\_\_   
 Number of days menses  
 \_\_\_\_\_ Scanty \_\_\_\_\_ Moderate \_\_\_\_\_ Heavy  
 \_\_\_\_\_ Painful \_\_\_\_\_ Regular

**OBSTERICAL HISTORY**

Hydatidiform mole (within the last 12 months)  
 Ectopic pregnancy

**STI RISKS**

With history of multiple partners  
**For Women:**  
 Unusual discharge from vagina  
 Itching or sores in or around vagina  
 Pain or burning sensation  
 Treated for STIs in the past  
**For Men:**  
 Pain or burning sensation  
 Open sores anywhere in genital area  
 Pus coming from penis  
 Swollen testicles or penis  
 Treated for STIs in the past

**PHYSICAL EXAMINATION**

Blood pressure: \_\_\_\_\_ mm/Hg  
 Weight \_\_\_\_\_ kg/lbs  
 Pulse Rate: \_\_\_\_\_ /min

**CONJUNCTIVA**  
 Pale  
 Yellowish

**NECK**  
 Enlarged thyroid  
 Enlarged lymph nodes

**BREAST**  
 Mass Right Breast Left Breast  
 Nipple discharge  
 Skin-orange peel or dimpling  
 Enlarged axillary lymph nodes

**THORAX**  
 Abnormal heart sounds/cardiac rate  
 Abnormal breath sounds/respiratory rate

**ABDOMEN**  
 Enlarged liver  
 Mass  
 Tenderness

**EXTREMITIES**  
 Edema  
 Varicosities

**PELVIC EXAMINATION**

**PERINEUM**  
 Scars  
 Warts  
 Reddish  
 Laceration

**VAGINA**  
 Congested  
 Bartholin's cyst  
 Warts  
 Skene's Gland  
 Discharge  
 Rectocele  
 Cystocele

**CERVIX**  
 Congested  
 Erosion  
 Discharge  
 Polys/cysts  
 Laceration

**Consistency**  
 Firm  
 Soft

**RISKS FOR VIOLENCE AGAINST WOMEN (VAW)**  
 History of domestic violence or VAW  
 Unpleasant relationship with partner  
 Partner does not approve of the visit to FP clinic  
 Partner disagrees to use FP

Referred to:  DSWD  WCPU  NGOs  
 Others (specify: \_\_\_\_\_)

**ACKNOWLEDGEMENT:**  
 This is to certify that the Physician/Nurse/Midwife of the clinic has fully explained to me the different methods available in family planning and I freely choose the \_\_\_\_\_ method.

Client Signature \_\_\_\_\_ Date \_\_\_\_\_

**CLIENT NO.:** \_\_\_\_\_

**NAME OF CLIENT:** \_\_\_\_\_

**NAME OF SPOUSE:** \_\_\_\_\_

**NO. OF LIVING CHILDREN:** \_\_\_\_\_

**PLAN MORE CHILDREN:** \_\_\_\_\_

**METHOD ACCEPTED:**  COC  Patch  POP  Injectable  Condom  IUD  BTL  VSC  LAM  SDM  BBT  Billing/Cervical Mucus/Ovulation Method  Sympto-thermal

**TYPE OF ACCEPTOR:**  New to the Program  Continuing User

**PREVIOUSLY USED METHOD** \_\_\_\_\_

**DATE/TIME** \_\_\_\_\_

**DATE OF BIRTH (mm/dd/yy)** \_\_\_\_\_

**HIGHEST EDUC OCCUPATION** \_\_\_\_\_

**HIGHEST EDUC OCCUPATION** \_\_\_\_\_

**NO. STREET BARANGAY MUNICIPALITY PROVINCE** \_\_\_\_\_

**AVERAGE MONTHLY INCOME:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

**REASON FOR PRACTICING FP:** \_\_\_\_\_

Reminder: Kindly refer to PHYSICIAN for any checked (✓) mark prior to provision of any method for further evaluation.



## Instructions for completing the FP Service Record or FP Form 1

### Side A

1. Fill out or check the required information at the far right of the form:
  - Client number, date and time client was interviewed
  - Client name: her maiden name, family name first, date of birth, education, and occupation
  - Spouse name: family name first, date of birth, education, and occupation
  - Complete address of the client: number of the house, street, *barangay*, municipality, and province
  - Average monthly income in peso
  - Choose “yes” or “no” for the couple’s plan for more children
  - Choose “new” or “continuing/current user” for type of acceptor
  - Number of living children
  - Previously used method
  - Reasons for practicing FP: completed the desired family size, economic, and others
  - Check among the list of FP method, the method accepted
2. Fill in the required information on medical, obstetrical/ gynecological history, physical examination, pelvic examination, client signature, and date.
3. Refer to a physician for any abnormal history/findings prior to provision of any method for further evaluation.

### Side B

1. Fill in the required information at the far left of the form on client number and name, date of birth, education, occupation, and address.
2. On the first column, record the date when the service was delivered to the client.
3. On the second column, record the method accepted/number of supplies given.
4. On the third column, record the following:
  - Medical observations
  - Complaints
  - Services rendered, procedures/interventions done (lab, treatment)
  - Reasons for stopping or changing the methods
  - Laboratory results
5. On the fourth column, record the name of the provider with the corresponding signature.
6. On the fifth column, record the next service date or appointment date.

11.16





## Instructions for Completing the Target Client List (TCL) for Family Planning

The TCL is filled out by health workers when providing services and is updated every time a client comes back for a follow-up visit. It has the following purposes:

1. it helps the health worker plan and carry outpatient care and service delivery,
2. it facilitates the monitoring and supervision of service delivery activities,
3. it facilitates the preparation of reports,
4. it provides clinic-level data that can be accessed for further studies.

In the Right Upper Corner of the TCL form (front page) - put the name of FP method. This page includes listing of all clients who accepted any modern FP method for the first term or new to the program or currently using a specific FP method e.g. pill, so each specific method will have a separate TCL.

Column 1: DATE (OF REGISTRATION) - Indicate in this column the date month, day, and year a client made the first clinic visit or the date when client re-started his/her availment of the FP service.

Column 2: FAMILY SERIAL NUMBER- Indicate in this column the number that corresponds to the number written on the family folder or envelope or individual treatment record. This column will help you to easily facilitate retrieval of the record.

Column 3: CLIENT'S NAME - Write the client's complete name. (given name, middle initial, and family name).

Column 4: ADDRESS - Record the client's present permanent place of residence (number of the house, name of the street, *barangay*, municipality, and province) for monitoring follow-up of clients.

Column 5: AGE - Indicate in this column the age of the female client or wife as of last birthday. In the case of a male client, indicate the age of client's wife.

Column 6: Number of living children—Indicate number of living children.

Column 7: TYPE OF CLIENT AND CODES OF CLIENTS - Write on this column the code of the following client categories.



Code	Type of Client
NA	<ul style="list-style-type: none"> <li>New Acceptor (NA) - A client using a contraceptive method for the first time or who is new to the program.</li> </ul>
CU	<ul style="list-style-type: none"> <li>Current Users (CU) - FP clients who have been carried over from the previous month, adding the new acceptors of the previous month and other acceptors (RS, CC and CM) of the present month minus the dropout of present month. Current users constitute specific FP methods used during the month which include condom, injectables, IUD, LAM, NFP, pills, male sterilization, and female sterilization.</li> </ul>
RS	<ul style="list-style-type: none"> <li>Other Acceptors who are included under current users <ul style="list-style-type: none"> <li>Re-Starter (RS) - These are acceptors who have stopped FP practice for at least one month and have resumed using the same method in the same clinic.</li> </ul> </li> </ul>
CC	- Changing clinic (CC)
CM	- Changing Method (CM)

Column 8: PREVIOUS METHOD - Refers to last method used prior to accepting a new method. Enter in this column the codes as indicated below the front page of Target Client List  
\*\* Previous Method.

Column 9: FOLLOW-UP VISITS - Write the next scheduled date of visit in the appropriate column for the month followed by a slash, e.g. 3-31/. When the client returns for the scheduled visit, write the date at the right of the slash, e.g. 3-31/3-29. A client who is scheduled for a particular month but fails to make the clinic visit will have only one date entered for that particular month.

Column 10: DROPOUT - If a client fails to return for the next service date, he or she is considered a dropout. Enter the date the client became a dropout under column "Date" and indicate the reason under column "Reason." Validate client first prior to dropping out from the record.

Column 11: REMARKS - Indicate in this column the date and reason for every referral made (to other clinics) and referral received (from other clinics), which can be due to medical complications or unavailable family planning services and other significant findings to client care.

**Method Dropouts** (when is a client considered a dropout from the method):

1. LACTATIONAL AMENORRHEA METHOD (LAM)

- has her menses any time within six months postpartum (bleeding or spotting within 56 days postpartum is not considered as menses); or
- practices mixed regular feeding and/or regularly introduces solid food, liquid, vitamins within the first six months or not exclusively breastfeeding her baby or;
- when the child reaches six months old.

2. NATURAL FAMILY PLANNING (NFP)

- Basal Body Temperature Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.

- b. Cervical Mucus or Billings Ovulation Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.
- c. Sympto-thermal Method - If the user fails to chart her own fertile and infertile periods, she is considered a dropout.
- d. Standard Days Method - If the user has no indication of (a) SDM use through beads or (b) knowledge of first day of menstruation or cycle length.

Note: Validate chart monthly if client needs to be dropped.

### 3. PILLS

- If the client
  - fails to return for a re-supply/clinic visit on the scheduled date unless client was validated as getting supplies from other sources other than the clinic;
  - gets supplies and/or transfers to another clinic; the client is considered as a current user in the clinic where she transferred, but is a dropout in her former clinic;
  - desires to stop the pills for any reason.

### 4. INJECTABLE (DMPA)

- If the client
  - fails to return for more than two weeks from the scheduled date of injection unless client was validated getting supply from other sources other than the clinic;
  - gets herself injected with DMPA in another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;
  - stops to receive the injection for any reason.

### 5. INTRAUTERINE DEVICE (IUD)

- If the client
  - does not return to the clinic for checkup for three to six weeks; not later than three months after her first post-insertion menses or has not been followed-up for two years;
  - requests for IUD removal;
  - has had her IUD expelled.

### 6. CONDOM

- If the client
  - fails to return for a re-supply/clinic visit on scheduled visit unless client was validated getting supplies from other sources other than the clinic;
  - gets supplies from another clinic and/or transfers to another clinic; the client is considered a current user in the clinic where she transferred, but is a dropout in her former clinic;
  - stops using the method for any other reason.

### 7. VOLUNTARY SURGICAL CONTRACEPTION

- Tubal ligation - If the client is already menopausal (average: 50 years old);
- Vasectomy - indefinite

#### NOTE TO SERVICE PROVIDERS:

For client using pills, injectables, IUDs, condoms, tubal ligation or vasectomy, validate client first whether she/he is using the method or not before dropping her/him out from the record.

# Summary Table

*for*

# BARANGAY HEALTH STATIONS

NAME OF BHS: \_\_\_\_\_

MUNICIPALITY OF: \_\_\_\_\_

PROVINCE/CITY: \_\_\_\_\_

REGION: \_\_\_\_\_

## FAMILY PLANNING (Part 1 of 2)

INDICATORS	TARGET	JAN	FEB	MAR	1st Q	APR	MAY	JUNE	2nd Q	JULY	AUG	SEPT	3rd Q	OCT	NOV	DEC	4th Q	TOTAL
1. Total New Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		
2. Total Other Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		



# MONTHLY CONSOLIDATION TABLE for RURAL HEALTH UNITS

NAME OF RHU: \_\_\_\_\_

MUNICIPALITY OF: \_\_\_\_\_

PROVINCE/CITY: \_\_\_\_\_

REGION: \_\_\_\_\_



## FAMILY PLANNING (Part 2 of 4)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

INDICATORS	N A M E O F B H S												
2. Total Other Acceptors													
▶ Female Ster/BTL													
▶ Male Ster/Vasectomy													
▶ Pills													
▶ IUD													
▶ Injectables (DMPA)													
▶ NFP-CM													
▶ NFP-BBT													
▶ NFP-STM													
▶ NFP-SDM													
▶ NFP-LAM													
▶ Condom													





## FAMILY PLANNING (Part 4 of 4)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

INDICATORS	N A M E O F B H S											
4. Total Current Users												
▶ Female Ster/BTL												
▶ Male Ster/Vasectomy												
▶ Pills												
▶ IUD												
▶ Injectables (DMPA)												
▶ NFP-CM												
▶ NFP-BBT												
▶ NFP-STM												
▶ NFP-SDM												
▶ NFP-LAM												
▶ Condom												



FHSIS REPORT for the MONTH \_\_\_\_\_ YEAR: \_\_\_\_\_  
 Name of BHS: \_\_\_\_\_  
 Municipality/City of: \_\_\_\_\_  
 Province: \_\_\_\_\_  
 Projected Population of the Year: \_\_\_\_\_  
*For submission to RHU*

FHSIS version 2008

**M1**  
**BHS**

<b>MATERNAL CARE</b>	<b>No.</b>
Pregnant women with 4 or more Prenatal visits	
Pregnant women given 2 doses of Tetanus Toxoid	
Pregnant women given TT2 plus	
Preg.women given complete iron w/folic acid supplementation	
Preg.women given Vitamin A supplementation	
Postpartum women with at least 2 postpartum visits	
Postpartum women given complete iron supplementation	
Postpartum women given Vitamin A supplementation	
PP women initiated breastfeeding w/in 1 hr.after delivery	

<b>FAMILY PLANNING</b>	Current User	Acceptors		Dropout	Current User
	(Begin Mo.)	New	Other		(End Mo.)
a. Female Sterilization/BTL					
b. Male Sterilization/Vasectomy					
c. Pills					
d. IUD					
e. Injectables (DMPA)					
f. NFP-CM					
g. NFP-BBT					
h. NFP-STM					
i. NFP-Standard Days Method					
j. NFP-LAM					
k. Condom					

11.30

## Instructions for completing the FHSIS Report Form/M1-BHS for FP

This report form collects information on family planning methods seen at the BHS during the current month.

### Fill up the M1-BHS form for FP as follows:

- Write on the space provided the total number of current users who have been carried over from the previous month to current users begin month on column (2); the total number of new acceptors of the previous month on column (3); the total number of other acceptors (CC, CM or Restart) of present month for each of the FP methods in column (4); total number of dropout for current month for each method in column (5) and number of current users by the end of month in column (6).

To get the total current users of the specific method at the end of the month, apply this formula.

Current users of the previous month carried over at the beginning of the month plus the new acceptors of the previous months plus the other acceptors (CC, CM or Restart) of the present/current month minus the dropouts of the present month is equal to the current users at the end of the month.

Formula:		Current users of previous month carried over to the beginning of next month	
	+	New acceptors of previous month	
	+	Other acceptors of present month	
	-	Dropouts of present month	
	=	Current users at the end of the month	

e.g. To get current users by the end of the month of January 2010:

		Number of current users carried over from the previous month (end of December 2009) to (January 2010) the beginning of the month	= 20
+		New acceptors of previous month (December 2009)	= 5
+		Other acceptors of present month (January 2010)	= 5
-		Dropouts of present month (January 2010)	= 5
=		Current users at end of the month (January 2010)	= 25

**11.31**

“New Acceptors” include clients who are new to the program.

“Other Acceptors” include changing method (CM); Changing Clinic (CC); Restart (RS), which are considered current users

- For FSTR/BTL - there will be no new acceptors at the BHS and RHU level, only indicate referrals in the box.
- For FSTR/BTL - the female client is considered a current user up to the age of 50 years old, beyond this, the client is considered as dropout to the method.
- For MSTR/Vasectomy - the male client is considered a current user if the client is still alive or living.
- For each dropout from a “Program Method” (e.g. pill or IUD or condom, etc.) during the month, subtract the number of drop-outs from each method.
- For Changing Clinic (CC) - a client who transferred to another clinic but is using the same method. the client should be dropped from the record in the previous clinic and be registered/counted as a current user in the clinic where she/he transferred.

FHSIS Report for the Quarter: \_\_\_\_\_ Year: \_\_\_\_\_  
 Municipality/City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Projected Population of the Year: \_\_\_\_\_



FHSIS v. 2008 - Q Form

<i><b>FAMILY PLANNING</b></i>								
Indicators	Current Users (beginning of the quarter)	Acceptors		Drop-Out	Current Users (End Qtr.)	CPR Col.6/TP x 14.5%	Interpretation	Recommendations/ Actions Taken
		New	Others*					
Col.1	Col.2	Col.3	Col.4	Col.5	Col.6	Col.7	Col.8	Col.9
a. Female Ster/BTL								
b. Male Ster/ Vasectomy								
c. Pills								
d. IUD								
e. Injectables (DMPA)								
f. NFP-CM								
g. NFP-BBT								
h. NFP-STM								
i. NFP-SDM								
j. NFP-LAM								
k. Condom								

\* Others include CM, CC and RS

## For Quarterly Form Q1 - RHU Form for FP

Formula - To get current users by the end of the quarter (end of (EO) March 2010)

January 2010

	Current users at the beginning of the month (January 2010 is a carry over of current users from previous month)-EO December 2009	= 20
+	New acceptors of previous month (December 2009)	= 5 (get from TCL)
+	Other acceptors of present month (January 2010)	= 5 (get from TCL)
-	Dropouts of present month (January 2010)	= 5 (get from TCL)
<hr/>		
=	Current users end of (January 2010)	= 25

February 2010

	Current users beginning of the month (February 2010 is a carry over of current users from previous month)-EO January 2010	= 25
+	New acceptors of previous month (January 2010)	= 10 (get from TCL)
+	Other acceptors of present month (February 2010)	= 10 (get from TCL)
-	Dropouts of present month (February 2010)	= 5
<hr/>		
=	Current users end of (February 2010)	= 40

March 2010

	Current users beginning of the month (March 2010 is a carry over of current users from previous month)-EO February 2010	= 40
+	New acceptors of previous month (February 2010)	= 10 (get from TCL)
+	Other acceptors of present month (March 2010)	= 10 (get from TCL)
-	Dropouts of present month (March 2010)	= 5 (get from TCL)
<hr/>		
=	Current users end of quarter (March 2010)	= 55

## SESSION 4

### MONITORING, EVALUATION AND FOLLOW-UP



#### LEARNING OBJECTIVE

At the end of the session, participants will be able to define monitoring, evaluation, and follow-up.



#### NARRATIVE

Monitoring, evaluation and follow-up are important processes to keep track of the progress and status of program implementation and to assess if the desired outputs and outcomes are being met as planned.

##### • Monitoring

- ✓ Is a routine process used to determine the extent to which a program has been effectively implemented at different levels, in time, and at what cost.
- ✓ May include tracking of inputs and outputs.
- ✓ Uses record-keeping, regular reporting systems, health facility observation, client surveys.
- ✓ Basically an internal activity.
- ✓ Carried out regularly, for example, monthly, quarterly, bi-annually or annually.

##### • Evaluation

- ✓ Episodic assessment of overall achievements; examines what has been achieved or what impact has been made
- ✓ Evaluation can be both internal and external
- ✓ Evaluation links particular outputs or outcomes directly to an intervention
- ✓ Three levels of evaluation:
  1. Process/Output evaluation
  2. Outcome evaluation
  3. Impact evaluation

• **Follow-up** refers to the clinic's responsibility of looking after the needs of clients who had been initially provided with FP or other RH-related services to:

- ✓ find out if clients are satisfied and are correctly using the method they chose;
- ✓ provide appropriate supplies;
- ✓ answer clients' questions and reassure them about the possible/ temporary side effects of using the FP method and other services;

- ✓ check for medical complications and refer them for further medical evaluation needed;
- ✓ find out reasons for discontinuance of the method or failure to comply with scheduled date of visits.



## SESSION 5

### SERVICE DELIVERY NETWORKS



#### LEARNING OBJECTIVE

At the end of the session, participants will be able to discuss the minimum standards for the different levels of FP service outlets.



#### NARRATIVE

FP services are made available to clients through a network of health facilities in both the public and private sector. However, these services vary in comprehensiveness and degree depending on the capacity of the facility. The table below provides the various FP Service Outlets with the minimum standards for each level.

**Table 2. Minimum standards for family planning services outlets.**

FP Service Facility	Minimum Set of FP Services	Minimum Staffing With Training Required	Basic Resource Requirement
<b>Level I</b> Health facility with the capacity to provide fertility awareness-based methods; NFP, SDM, and LAM; condoms, pills, and injectables, with counseling and referral for IUD insertion, BTL, and NSV	<ol style="list-style-type: none"> <li>1. FP promotion</li> <li>2. FP counseling</li> <li>3. Provision of FP methods: pills, injectables, condoms, fertility awareness-based methods: NFP, LAM, SDM</li> <li>4. Referral for IUD, BTL, NSV</li> <li>5. Risk assessment by history</li> <li>6. Management of minor side effects</li> <li>7. Routine check-up of clients</li> <li>8. Follow-up of dropouts</li> <li>9. Referral for major complications of contraceptives</li> </ol>	<p>Midwife and/or nurse trained in:</p> <ul style="list-style-type: none"> <li>- Basic FP or FPCBT Level I</li> <li>- Interpersonal Communication</li> <li>- Counseling</li> <li>- NFP</li> <li>- SDM</li> <li>- Fertility awareness orientation</li> </ul> <p>Recommended Additional courses:</p> <ul style="list-style-type: none"> <li>- CBMIS</li> <li>- Orientation on CSR</li> </ul>	<p>Basic clinic equipment/instruments/supplies: stethoscope, BP apparatus, weighing scale, examination table, gooseneck lamp, instrument tray, adequate supplies of contraceptives at authorized stock levels based on CSR plan: condoms, pills, and injectables, AD or disposable syringes with needles, BBT thermometer, NFP charts, cycle beads, FP form 1, target client list, MEC checklist by FP method, clinic services records, referral slips, CBMIS forms, IEC materials</p>
<b>Level II</b> Health facility with the capacity to provide the above PLUS: IUD insertion and/or NSV Referral for BTL	<p>All service offered in Level I PLUS: Risk assessment by physical exam' IUD insertion No scalpel vasectomy Management of complications Diagnosis and management of RTIs Cancer screening (Acetic acid wash/Pap smear) Counseling on infertility</p>	<p>Nurse and/or midwife trained in: above training courses PLUS: Comprehensive FP Training or FPCBT Level 2 (IUD Skills Training) No-scalpel vasectomy training for physicians</p>	<p>All resources available in Level I PLUS: IUD insertion and removal kit (ovum forceps, uterine sound alligator forceps) Sterilizer or stove with covered pan Sterile gloves, microscope Laboratory facilities for RTI diagnosis Acetic acid wash kit, Pap smear kit, NSV kits (Vas dissecting forceps, Vas fixating clamp), NSV drugs and supplies</p>
<b>Level III</b> Health facility with the capacity to provide Level I and Level II PLUS: BTL	<p>All services offered in Level II PLUS: A team composed of a physician/surgeon, nurse and/or midwife trained in the above courses PLUS: Physician and nurse trained in BTL</p>	<p>Surgical record forms All resources available in Level II PLUS: BTL drugs and supplies operating room, minilap kit, Laparotomy kit Other related equipment, drugs and supplies</p>	<p>Tertiary hospital requirements</p>
<b>Level IV</b> Health facility with the capacity to provide the above and management of major complications	<p>All of the above PLUS: Management of major complications</p>	<p>Basic lab facilities Midwife, nurse, medical specialists, obstetrician-gynecologist, anesthesiologist, general surgeon, and urologist.</p>	<p>Tertiary hospital requirements</p>



# MODULE 12



## Action Planning





### LEARNING OBJECTIVE

At the end of the session, participants will be able to:

- Develop an action plan that will integrate the principles and skills learned in the course to her/his job.



### NARRATIVE

Action planning is the process of planning what needs to be done, when it needs to be done, by whom it needs to be done, and what resources or inputs are needed to do it. It is the process of operationalising strategic objectives.

Most action plans consist of the following elements:

- a statement of what must be achieved (the outputs or result areas);
- a spelling out of the steps or activities that have to be done to achieve what needs to be achieved;
- a time schedule for when each activity must take place and how long it is likely to take (when);
- a clarification of who will be responsible for making sure that each step is successfully completed (who);
- a clarification of the inputs/resources that are needed to implement the activity.

Developing an action plan that indicates how and when new skills will be applied increases the opportunity that training will be translated into action. This ensures that the trainee is able to establish how her/his newly acquired skill would positively contribute to the improvement of her/his performance and how this will impact on program goals and objectives.

The trainer assists the trainees develop an action plan that is realistic, which reflects the principles and skills taught in the course. During the post-training monitoring of the trainees, three to six months after the training, the trainer determines to what extent the action plan has been achieved and assists the trainee in resolving issues that impede the implementation of the action plan.

**ACTION PLAN on FAMILY PLANNING (sample)**  
(State period covered)

**CHD:** \_\_\_\_\_ **Province:** \_\_\_\_\_ **Municipality/City:** \_\_\_\_\_

**Barangay:** \_\_\_\_\_ **Date:** \_\_\_\_\_

**Prepared by:** \_\_\_\_\_

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
<b>A. Service Delivery</b>							
To provide quality FP services, including FP counseling, to all clients specially to those with unmet FP needs.	Identify clients with FP unmet needs using the CBMIS or do a masterlisting of all woman of reproductive age 15-49 y/o who are using and not using any FP methods. If using, to specify the methods.	List of clients in the community with FP unmet needs	Number of clients with FP unmet needs				
	Plan for alternative service delivery interventions for clients with unmet FP needs.(e.g. outreach activity; integrating FP during the activity	Workplan with alternative interventions	Number of outreach activities; health activities integrating FP education/ services				
To provide FP counseling to men and women of reproductive age.	Review the master list of WRA with unmet need and target client list regularly to plan and carry out FP client care. Conduct of Counseling activities and provision of chosen method.	List of clients counseled on FP	Number of clients for FP counseling/ number of clients provided with chosen method				
To capacitate health provider and upgrade health facilities.	<ul style="list-style-type: none"> <li>• Conduct of training for health personnel in various FP courses.</li> <li>• Procure equipm/ instruments (IUD kit, BTL/NSV kit)</li> </ul>						

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
<b>A. Service Delivery</b>							
To maintain a functional two-way referral system.	Map all facilities providing FP service (public and private facilities) for referral of clients needing FP services not available in the clinic (i.e., BTL, vasectomy, IUD insertion), public health facilities.	List of referral facilities for specific FP methods	Regionwide Provincewide Municipalwide				
	Accomplish referral slip for referral of clients	Referral slip of clients made	Number of clients referral for BTL/Vas/IUD insertion in a public/private facilities				
	Follow-up results of referral	Feedback slip on referral made	Number of clients with feedback slip				
<b>B. Logistics Management</b>							
To ensure that health facility has sufficient FP Commodities and Supplies to meet the needs of their current and	<ul style="list-style-type: none"> <li>Forecast/determine commodity requirements of all identified clients for the year.</li> <li>Procurement of FP condition.</li> <li>Determine the segment of clients who should benefit for free commodities and those who</li> </ul>						

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
potential users; equipment/instruments to use in FP provision.	should avail from private sector <ul style="list-style-type: none"> <li>• Allocate budget to procure contraceptives for the poor</li> <li>• Provide equip/instrument for use in FP provision</li> <li>• Making available consigned/commercial FP products in the facility for non-poor</li> </ul>						
	Practice proper storage of FP contributions						
	Inventory control of FP contribution quarterly						
To use CDLMIS in terms of storage, distribution, inventory control, authorized stock level, recording, and reporting using the appropriate forms.	Prepare and submit logistics report						
	Identification of poor and non-poor WRA	List of poor and non-poor WRA					
To segment clients as to who can and who cannot afford to buy their chosen FP methods.							



OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
<b>C. Information, Education and Communication (IEC)</b>							
To ensure availability of FP IEC materials.	Reproduction of IEC materials and distribution						
To organize and conduct FP information activities in the community and clinic.	Conduct regular community health education which includes FP						
<b>D. Advocacy and Resource Mobilization</b>							
Networking with stakeholders (e.g. local officials, civic organizations, NGOs) to ensure availability and sustainability of FP commodities and services.	Lobbying with LCES to get financial support for FP commodities/activities						
	Conduct advocacy activities for the LCES or Benefits of FP in terms of health of their constituents and development of their community						

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT	RESPONSIBLE PERSON
<b>E. Monitoring and Evaluation</b>						
To keep track of the progress of FP related initiatives.	Masterlisting and updating of women and men of reproductive age (15-49 years old)					
	Conduct of Program Implementation Review annually					
	Conduct monitoring visits to the health facilities					
	Follow up drop outs/defaulters					
To evaluate client satisfaction on FP services provided by the facility.	Conduct exit interview with client regarding service provision					
To supervise and monitor BHWs in the provision of FP services, including home/community FP information dissemination.	Monitor and provide TA or Coach BHWs during health education on FP (as needed)					



# Annexes



Basic Course Handbook  
for Service Providers



CODE

## FAMILY PLANNING COMPETENCY-BASED TRAINING Pre-Test

NAME: \_\_\_\_\_ Date: \_\_\_\_\_

### HUMAN REPRODUCTIVE ANATOMY and PHYSIOLOGY

**Instructions: Identify the lettered parts and write on the corresponding letters below.**

A -

D -

G -

B -

E -

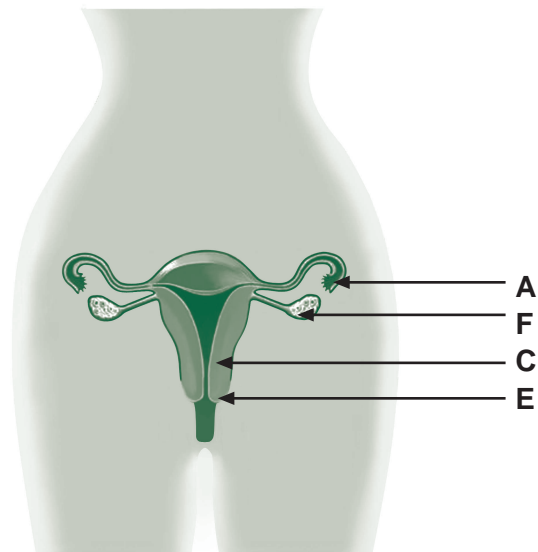
H -

C -

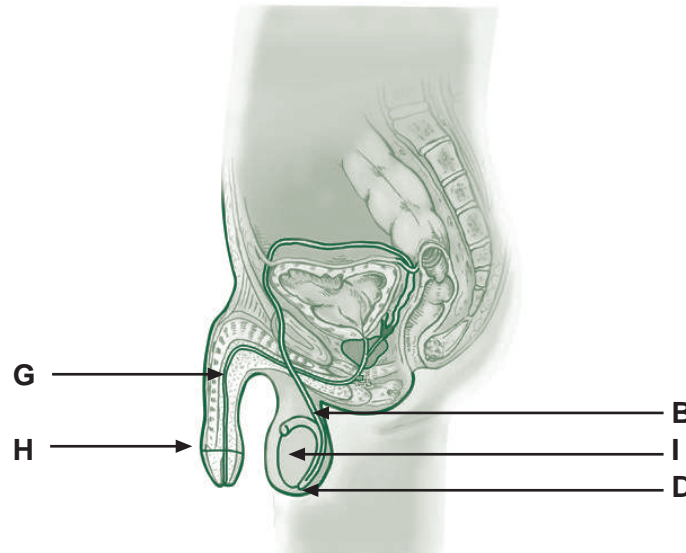
F -

I -

#### FEMALE REPRODUCTIVE SYSTEM



#### MALE REPRODUCTIVE SYSTEM



**Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.**

### **PFPP**

- \_\_\_10. The approach of the National Population Program has been reoriented from a population reduction to a health intervention program.
- \_\_\_11. The four pillars of the Family Planning Program are: a) informed choice b) birth spacing at least 3 years c) respect for life and d) responsible parenthood.
- \_\_\_12. Gender responsiveness, culturally oriented and rights based approaches are the overall guiding principles in designing and implementing RH-related programs/ activities
- \_\_\_13. Family planning services shall be provided regardless of the client's age, sex, number of children, marital status, religious beliefs and cultural values.
- \_\_\_14. One of the major strategies of the Family Planning Program is the promotion and implementation of Contraceptive Self Reliance Initiative.

### **FERTILITY AWARENESS**

- \_\_\_15. A woman can get pregnant on any day of her cycle.
- \_\_\_16. A man after puberty is fertile all the time until death.
- \_\_\_17. A breastfeeding woman who has no menses can get pregnant.

### **FP CLIENT ASSESSMENT**

- \_\_\_18. According to WHO MEC all clients wanting to use a family planning method should undergo a physical examination.
- \_\_\_19. It is mandatory that clients choosing bilateral tubal ligation (BTL) have laboratory examinations like hemoglobin determination and complete blood count.
- \_\_\_20. The WHO Medical Eligibility Criteria is an available reference tool for assessing clients on their eligibility for initiating and continuing the use of a specific contraceptive method based on certain criteria.

### **INFECTION PREVENTION**

- \_\_\_21. During client interaction, handwashing is necessary even if the client does not require an examination or treatment.
- \_\_\_22. Used instruments that have been decontaminated and thoroughly cleaned can be sterilized by boiling them in water for 20 minutes.
- \_\_\_23. Wiping the skin with an antiseptic before an injection has no added benefit.

### **FERTILITY AWARENESS-BASED METHODS**

- \_\_\_24. Fertility awareness based methods can be used only to avoid pregnancy.
- \_\_\_25. Any woman, regardless of the length of her cycle, can use SDM.
- \_\_\_26. The 3 conditions necessary to practice Lactational Amenorrhea Method are: breastfeeding on demand without supplementation, no return of menses, and a 7-month old child.

### **HORMONAL METHODS**

- \_\_\_27. Women who are 40 years old and older cannot use the low dose COCs.
- \_\_\_28. COCs are safe for women with superficial varicose veins.
- \_\_\_29. All the pills in the 28-day POP package contain hormones.

### **LONG-ACTING and PERMANENT METHODS**

- \_\_\_30. The IUD is inserted only during menstruation.
- \_\_\_31. After vasectomy, the couple needs to use another reliable FP method for at least the next 3 months.
- \_\_\_32. Tubal ligation can be performed immediately after delivery.

## **BARRIER METHODS**

- \_\_\_ 33. Condoms prevent sexually transmitted diseases to include HIV, gonorrhea, syphilis, chlamydia, and trichomoniasis.
- \_\_\_ 34. The condom is a barrier method that prevents entry of sperm into the vagina.

## **SPECIAL POPULATIONS**

- \_\_\_ 35. Sex education among the adolescents is not recommended as this may give them a distorted knowledge and attitude on sexual behavior.
- \_\_\_ 36. Counseling for postpartum contraception should be performed during labor and reinforced after delivery.

## **CLINIC MANAGEMENT**

- \_\_\_ 37. Monitoring can be done at any period of time to determine if a health program is being implemented.
- \_\_\_ 38. Evaluation links particular outputs and outcomes directly to an intervention as mandated by the objectives of the program.
- \_\_\_ 39. Setting targets for the purpose of determining logistical requirements is a violation of informed choice and voluntarism.
- \_\_\_ 40. Provision of a broad range of FP methods means that all the methods are available in the facility, including voluntary surgical services.

CODE

## FAMILY PLANNING COMPETENCY-BASED TRAINING Post-Test

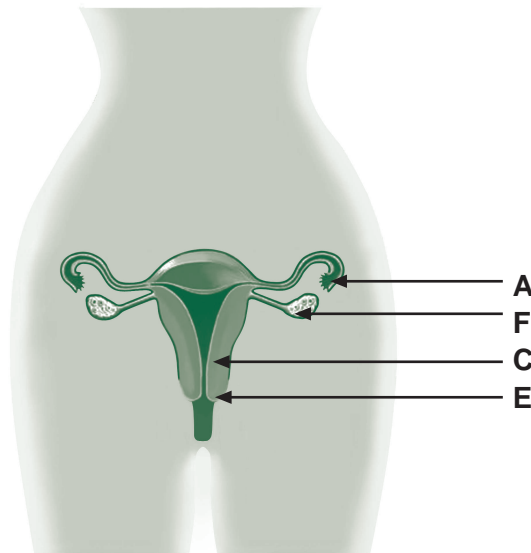
NAME: \_\_\_\_\_ Date: \_\_\_\_\_

### HUMAN REPRODUCTIVE ANATOMY and PHYSIOLOGY

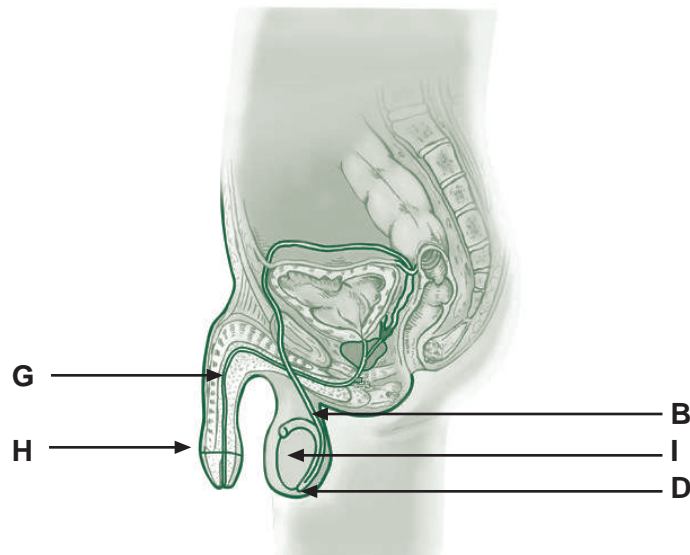
**Instructions: Identify the lettered parts and write on the corresponding letters below.**

- |     |     |     |
|-----|-----|-----|
| A - | D - | G - |
| B - | E - | H - |
| C - | F - | I - |

#### FEMALE REPRODUCTIVE SYSTEM



#### MALE REPRODUCTIVE SYSTEM





**Instructions: Write T on the space provided for if the answer is TRUE and F if FALSE.**

#### **PFPP**

- \_\_\_ 10. The approach of the National Population Program has been reoriented from population reduction to a health intervention program.
- \_\_\_ 11. The four pillars of the Family Planning Program are: a) informed choice b) birth spacing at least three years c) respect for life and, d) responsible parenthood.
- \_\_\_ 12. Gender responsiveness, culturally oriented, and rights based approaches are the overall guiding principles in designing and implementing RH-related programs/activities.
- \_\_\_ 13. Family planning services shall be provided regardless of the client's age, sex, number of children, marital status, religious beliefs, and cultural values.
- \_\_\_ 14. One of the major strategies of the Family Planning Program is the promotion and implementation of Contraceptive Self Reliance Initiative.

#### **FERTILITY AWARENESS**

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- \_\_\_ 39. Setting targets for the purpose of determining logistical requirements is a violation of informed choice and voluntarism.
- \_\_\_ 40. Provision of a broad range of FP methods means that all the methods are available in the facility, including voluntary surgical services.

## POST-COURSE EVALUATION

Please give your rating by putting a check on the box using the following scale:

1. Strongly Agree    2. Agree    3. Not Sure    4. Disagree    5. Strongly Disagree

### A. Objectives are:

	1	2	3	4	5
a. Relevant to the course					
b. Relevant to my work setting					
c. Specific and reasonable					
d. Attained					

### B. Content was:

	1	2	3	4	5
a. Consistent with objectives					
b. Properly organized/sequenced					
c. Adequately discussed					

### C. Workshops/Exercises were

	1	2	3	4	5
a. Consistent with objectives					
b. Properly organized/sequenced					
c. Adequately discussed					

Please give your rating by putting a check on the box using the following scale:

- 1- Excellent    2 - Very Good    3 - Good    4 - Fair    5 - Poor

### D. Administration

	1	2	3	4	5
1. The quality of the accommodation.					
2. The quality of food.					
3. The quality of food service.					
4. The overall rating for the venue staff.					

	1	2	3	4	5
5. The facilitation of handouts/exercise materials.					
6. The degree of service by the administrative staff (registration, facilitation of participants' needs)					

**E. What aspects of the course did you? (use back for more space)**

- a. Like best
- b. Like least

**F. What did the teacher or training team do that were? (use back for more space)**

- a. Most helpful
- b. Least helpful

**G. What suggestions can you give to improve this training program?(use back for more space)**

## WHO MEC Summary Table

SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY								
PREGNANCY	NA*	NA*	NA*	NA*	NA*	NA*	4*	4*
<b>AGE</b>	Menarche to <40=1  ≥40=2	Menarche to <40=1  ≥40=2		Menarche to <18=1  18-45=1  >45=1	Menarche to <18=2  18-45=1  >45=2	Menarche to <18=1  18-45=1  >45=1	Menarche to <20=2  ≥20=1	Menarche to <20=2  ≥20=1
<b>PARITY</b>								
a) Nulliparous	1	1	1	1	1	1	2	2
b) Parous	1	1	1	1	1	1	1	1
<b>BREASTFEEDING</b>								
a) < 6 weeks postpartum	4	4	4	3*	3*	3*		
b) 6 weeks to < 6 months (primarily breastfeeding)	3	3	3	1	1	1		
c) ≥ 6 months postpartum	2	2	2	1	1	1		
<b>POSTPARTUM</b> (non-breastfeeding women)								
a) < 21 days	3	3	3	1	1	1		
b) ≥ 21 days	1	1	1	1	1	1		
<b>POSTPARTUM</b> (breastfeeding or non-breastfeeding women, including post-caesarean section)								
a) < 48 hours							2	3
b) ≥ 48 hours to <4 weeks							3	3
c) ≥ 4 weeks							1	1
d) Puerperal sepsis							4	4
<b>POST-ABORTION</b>								
a) First trimester	1*	1*	1*	1*	1*	1*	1*	1*
b) Second trimester	1	1	1	1	1	1	2	2
c) Immediate post-septic abortion	1	1	1	1	1	1	4	4
<b>PAST ECTOPIC PREGNANCY</b>	1	1	1	2	1	1	1	1

\* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
<b>HISTORY OF PELVIC SURGERY</b> (including caesarean section) (see also postpartum section)	1	1	1	1	1	1	1	1
<b>SMOKING</b>								
a) Age < 35	2*	2	2	1	1	1	1	1
b) Age ≥ 35								
(i) <15 cigarettes/day	3*	2	3	1	1	1	1	1
(ii) ≥15 cigarettes/day	4*	3	4	1	1	1	1	1
<b>OBESITY</b> ≥30 kg/m <sup>2</sup> body mass index (BMI)	2	2	2	1	1	1	1	1
<b>BLOOD PRESSURE MEASUREMENT UNAVAILABLE</b>	NA*	NA*	NA*	NA*	NA*	NA*	NA*	NA*
<b>CARDIOVASCULAR DISEASE</b>								
<b>MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE</b> (such as older age, smoking, diabetes and hypertension)	3/4*	3/4*	3/4*	2*	3*	2*	1	2
<b>HYPERTENSION</b>								
a) History of hypertension where blood pressure CANNOT be evaluated (including hypertension during pregnancy)	3*	3*	3*	2*	2*	2*	1	2
b) Adequately controlled hypertension, where blood pressure CAN be evaluated	3*	3*	3*	1*	2*	1*	1	1
c) Elevated blood pressure levels (properly taken measurements)								
(i) systolic 140-159 or diastolic 90-99	3	3	3	1	2	1	1	1
(ii) systolic >160 or diastolic >100	4	4	4	2	3	2	1	2
d) Vascular disease	4	4	4	2	3	2	1	2

\* Please consult the tables in the text for a clarification to this classification



SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
<b>HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY</b> (where current blood pressure is measurable and normal)	2	2	2	1	1	1	1	1
<b>DEEP VEIN THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)</b>								
a) History of DVT/PE	4	4	4	2	2	2	1	2
b) Current DVT/PE	4	4	4	3	3	3	1	3
c) Family history (first-degree relatives)	2	2	2	1	1	1	1	1
d) Major surgery								
(i) with prolonged immobilization	4	4	4	2	2	2	1	2
(ii) without prolonged immobilization	2	2	2	1	1	1	1	1
e) Minor surgery without immobilization	1	1	1	1	1	1	1	1
<b>KNOWN THROMBOGENIC MUTATIONS</b> (e.g. Factor V Leiden; Prothrombin mutation; Protein S, Protein C and Antithrombin deficiencies)	4*	4*	4*	2*	2*	2*	1*	2*
<b>SUPERFICIAL VEIN THROMBOSIS</b>								
a) Varicose veins	1	1	1	1	1	1	1	1
b) Superficial thrombophlebitis	2	2	2	1	1	1	1	1
<b>CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE</b>				I   C		I   C		I   C
	4	4	4	2   3	3	2   3	1	2   3
<b>STROKE</b> (history of cerebrovascular accident)				I   C		I   C		
	4	4	4	2   3	3	2   3	1	2
<b>KNOWN HYPERLIPIDAEMIAS</b> (screening is NOT necessary for safe use of contraceptive methods)	2/3*	2/3*	2/3*	2*	2*	2*	1*	2*

\* Please consult the tables in the text for a clarification to this classification

SUMMARY TABLES																
CONDITION	COC		CIC		P/R		POP		DMPA NET-EN		LNG/ ETG Implants		Cu-IUD	LNG-IUD		
I = Initiation, C = Continuation																
<b>VALVULAR HEART DISEASE</b>																
a) Uncomplicated	2		2		2		1		1		1		1	1		
b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	4		4		4		1		1		1		2*	2*		
<b>NEUROLOGIC CONDITIONS</b>																
<b>HEADACHES</b>																
	I	C	I	C	I	C	I	C	I	C	I	C		I	C	
a) Non-migrainous (mild or severe)	1*	2*	1*	2*	1*	2*	1*	1*	1*	1*	1*	1*	1*	1*	1*	
b) Migraine																
(i) without aura																
Age <35	2*	3*	2*	3*	2*	3*	1*	2*	2*	2*	2*	2*	1*	2*	2*	
Age ≥35	3*	4*	3*	4*	3*	4*	1*	2*	2*	2*	2*	2*	1*	2*	2*	
(ii) with aura (at any age)	4*	4*	4*	4*	4*	4*	2*	3*	2*	3*	2*	3*	1*	2*	3*	
<b>EPILEPSY</b>																
	1*		1*		1*		1*		1*		1*		1	1		
<b>DEPRESSIVE DISORDERS</b>																
<b>DEPRESSIVE DISORDERS</b>																
	1*		1*		1*		1*		1*		1*		1*	1*		
<b>REPRODUCTIVE TRACT INFECTIONS AND DISORDERS</b>																
<b>VAGINAL BLEEDING PATTERNS</b>																
														I	C	
a) Irregular pattern <i>without</i> heavy bleeding	1		1		1		2		2		2		1	1	1	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	1*		1*		1*		2*		2*		2*		2*	1*	2*	
<b>UNEXPLAINED VAGINAL BLEEDING (suspicious for serious condition)</b>																
														I	C	
Before evaluation	2*		2*		2*		2*		3*		3*		4*	2*	4*	2*
<b>ENDOMETRIOSIS</b>																
	1		1		1		1		1		1		2	1		
<b>BENIGN OVARIAN TUMOURS (including cysts)</b>																
	1		1		1		1		1		1		1	1		

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SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
<b>SEVERE DYSMENORRHOEA</b>	1	1	1	1	1	1	2	1
<b>TROPHOBLAST DISEASE</b>								
a) Benign gestational trophoblastic disease	1	1	1	1	1	1	3	3
b) Malignant gestational trophoblastic disease	1	1	1	1	1	1	4	4
<b>CERVICAL ECTROPION</b>	1	1	1	1	1	1	1	1
<b>CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)</b>	2	2	2	1	2	2	1	2
<b>CERVICAL CANCER (awaiting treatment)</b>							I C	I C
	2	2	2	1	2	2	4 2	4 2
<b>BREAST DISEASE</b>								
a) Undiagnosed mass	2*	2*	2*	2*	2*	2*	1	2
b) Benign breast disease	1	1	1	1	1	1	1	1
c) Family history of cancer	1	1	1	1	1	1	1	1
d) Cancer								
(i) current	4	4	4	4	4	4	1	4
(ii) past and no evidence of current disease for 5 years	3	3	3	3	3	3	1	3
<b>ENDOMETRIAL CANCER</b>							I C	I C
	1	1	1	1	1	1	4 2	4 2
<b>OVARIAN CANCER</b>							I C	I C
	1	1	1	1	1	1	3 2	3 2
<b>UTERINE FIBROIDS</b>								
a) Without distortion of the uterine cavity	1	1	1	1	1	1	1	1
b) With distortion of the uterine cavity	1	1	1	1	1	1	4	4
<b>ANATOMICAL ABNORMALITIES</b>								
a) That distort the uterine cavity							4	4
b) That do not distort the uterine cavity							2	2

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SUMMARY TABLES											
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD			
I = Initiation, C = Continuation											
<b>PELVIC INFLAMMATORY DISEASE (PID)</b>											
a) Past PID (assuming no current risk factors of STIs)							I	C	I	C	
(i) with subsequent pregnancy	1	1	1	1	1	1	1	1	1	1	
(ii) without subsequent pregnancy	1	1	1	1	1	1	2	2	2	2	
b) PID - current	1	1	1	1	1	1	4	2*	4	2*	
<b>STIs</b>							I	C	I	C	
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	1	1	1	1	1	1	4	2*	4	2*	
b) Other STIs (excluding HIV and hepatitis)	1	1	1	1	1	1	2	2	2	2	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	1	1	1	1	1	1	2	2	2	2	
d) Increased risk of STIs	1	1	1	1	1	1	2/3*	2	2/3*	2	
<b>HIV/AIDS</b>											
<b>HIGH RISK OF HIV</b>							I	C	I	C	
	1	1	1	1	1	1	2	2	2	2	
<b>HIV-INFECTED</b>	1	1	1	1	1	1	2	2	2	2	
<b>AIDS</b>	1*	1*	1*	1*	1*	1*	3	2*	3	2*	
Clinically well on ARV therapy	See ANTIRETROVIRAL THERAPY below							2	2	2	2
<b>OTHER INFECTIONS</b>											
<b>SCHISTOSOMIASIS</b>											
a) Uncomplicated	1	1	1	1	1	1	1	1	1	1	
b) Fibrosis of the liver	1	1	1	1	1	1	1	1	1	1	
<b>TUBERCULOSIS</b>							I	C	I	C	
a) Non-pelvic	1*	1*	1*	1*	1*	1*	1	1	1	1	
b) Known pelvic	1*	1*	1*	1	1	1	4	3	4	3	
<b>MALARIA</b>	1	1	1	1	1	1	1	1	1	1	

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SUMMARY TABLES								
CONDITION	COC	CIC	P/R	POP	DMPA NET-EN	LNG/ ETG Implants	Cu-IUD	LNG-IUD
I = Initiation, C = Continuation								
<b>ENDOCRINE CONDITIONS</b>								
<b>DIABETES</b>								
a) History of gestational disease	1	1	1	1	1	1	1	1
b) Non-vascular disease								
(i) non-insulin dependent	2	2	2	2	2	2	1	2
(ii) insulin dependent	2	2	2	2	2	2	1	2
c) Nephropathy/ retinopathy/ neuropathy	3/4*	3/4*	3/4*	2	3	2	1	2
d) Other vascular disease or diabetes of >20 years' duration	3/4*	3/4*	3/4*	2	3	2	1	2
<b>THYROID DISORDERS</b>								
a) Simple goitre	1	1	1	1	1	1	1	1
b) Hyperthyroid	1	1	1	1	1	1	1	1
c) Hypothyroid	1	1	1	1	1	1	1	1
<b>GASTROINTESTINAL CONDITIONS</b>								
<b>GALL-BLADDER DISEASE</b>								
a) Symptomatic								
(i) treated by cholecystectomy	2	2	2	2	2	2	1	2
(ii) medically treated	3	2	3	2	2	2	1	2
(iii) current	3	2	3	2	2	2	1	2
b) Asymptomatic	2	2	2	2	2	2	1	2
<b>HISTORY OF CHOLESTASIS</b>								
a) Pregnancy-related	2	2	2	1	1	1	1	1
b) Past COC-related	3	2	3	2	2	2	1	2
<b>VIRAL HEPATITIS</b>								
a) Active	4	3/4*	4*	3	3	3	1	3
c) Carrier	1	1	1	1	1	1	1	1
<b>CIRRHOSIS</b>								
a) Mild (compensated)	3	2	3	2	2	2	1	2
b) Severe (decompensated)	4	3	4	3	3	3	1	3

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SUMMARY TABLES								
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I = Initiation, C = Continuation								
<b>LIVER TUMOURS</b>								
a) Benign (adenoma)	4	3	4	3	3	3	1	3
b) Malignant (hepatoma)	4	3/4	4	3	3	3	1	3
<b>ANAEMIAS</b>								
<b>THALASSAEMIA</b>	1	1	1	1	1	1	2	1
<b>SICKLE CELL DISEASE</b>	2	2	2	1	1	1	2	1
<b>IRON-DEFICIENCY ANAEMIA</b>	1	1	1	1	1	1	2	1
<b>DRUG INTERACTIONS</b>								
<b>DRUGS WHICH AFFECT LIVER ENZYMES</b>								
a) Rifampicin	3*	2*	3*	3*	2*	3*	1	1
b) Certain anticonvulsants (phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine)	3*	2*	3*	3*	2	3	1	1
<b>ANTIBIOTICS (excluding rifampicin)</b>								
a) Griseofulvin	2	1	2	2	1	2	1	1
b) Other antibiotics	1	1	1	1	1	1	1	1
<b>ANTIRETROVIRAL THERAPY</b>								
							I	C
	2*	2*	2*	2*	2*	2*	2/3*	2
							I	C
							2/3*	2

\* Please consult the tables in the text for a clarification to this classification

## A. Female surgical sterilization

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
<b>PERSONAL CHARACTERISTICS AND REPRODUCTIVE HISTORY</b>			
<b>PREGNANCY</b>	D		
<b>YOUNG AGE*</b>	C	<p><b>Clarification:</b> Young women, like all women, should be counselled about the permanency of sterilization and the availability of alternative, long-term, highly effective methods.</p> <p><b>Evidence:</b> Studies show that up to 20% of women sterilized at a young age later regret this decision, and that young age is one of the strongest predictors of regret (including request for reversal information and obtaining reversal) that can be identified before sterilization.<sup>1-19</sup></p>	
<b>PARITY*</b>			
a) Nulliparous	A		
b) Parous	A		
<b>BREASTFEEDING</b>	A		
<b>POSTPARTUM*</b>			
a) < 7 days	A		
7 to < 42 days	D		
≥ 42 days	A		
b) Pre-eclampsia/ eclampsia			
(i) mild pre-eclampsia	A		
(ii) severe pre-eclampsia/ eclampsia	D		
c) Prolonged rupture of membranes: 24 hours or more	D		
d) Puerperal sepsis, intrapartum or puerperal fever	D		
e) Severe antepartum or postpartum haemorrhage	D		
f) Severe trauma to the genital tract: cervical or vaginal tear at time of delivery	D		

\* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE
<b>POSTPARTUM (Cont'd)</b>		
g) Uterine rupture or perforation	S	<b>Clarification:</b> If exploratory surgery or laparoscopy is conducted and the patient is stable, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
<b>POST-ABORTION*</b>		
a) Uncomplicated	A	
b) Post-abortal sepsis or fever	D	
c) Severe post-abortal haemorrhage	D	
d) Severe trauma to the genital tract: cervical or vaginal tear at time of abortion	D	
e) Uterine perforation	S	<b>Clarification:</b> If exploratory surgery or laparoscopy is conducted, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved.
f) Acute haematometra	D	
<b>PAST ECTOPIC PREGNANCY</b>	A	
<b>SMOKING</b>		
a) Age < 35 years	A	
b) Age ≥ 35 years		
(i) <15 cigarettes/day	A	
(ii) ≥15 cigarettes/day	A	
<b>OBESITY</b> ≥ 30 kg/m <sup>2</sup> body mass index (BMI)	C	<b>Clarification:</b> The procedure may be more difficult. There is an increased risk of wound infection and disruption. Obese women may have limited respiratory function and may be more likely to require general anaesthesia. <b>Evidence:</b> Women who were obese were more likely to have complications when undergoing sterilization. <sup>20-23</sup>

\* See also additional comments at end of table



<b>FEMALE SURGICAL STERILIZATION</b>	Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
<b>CONDITION</b>	<b>CATEGORY</b>	<b>CLARIFICATIONS/EVIDENCE</b>
<b>CARDIOVASCULAR DISEASE</b>		
<b>MULTIPLE RISK FACTORS FOR ARTERIAL CARDIOVASCULAR DISEASE*</b> (such as older age, smoking, diabetes and hypertension)	S	
<b>HYPERTENSION</b>		
For all categories of hypertension, classifications are based on the assumption that no other risk factors for cardiovascular disease exist. When multiple risk factors do exist, risk of cardiovascular disease may increase substantially. A single reading of blood pressure level is not sufficient to classify a woman as hypertensive.		
a) Hypertension, adequately controlled	C	<b>Clarification:</b> Elevated blood pressure should be controlled before surgery. There are increased anaesthesia-related risks and an increased risk of cardiac arrhythmia with uncontrolled hypertension. Careful monitoring of blood pressure intraoperatively is particularly necessary in this situation.
b) Elevated blood pressure levels (properly taken measurements)		
(i) systolic 140-159 or diastolic 90-99	C	
(ii) systolic $\geq$ 160 or diastolic $\geq$ 100	S	
c) Vascular disease	S	
<b>HISTORY OF HIGH BLOOD PRESSURE DURING PREGNANCY</b> (where current blood pressure is measurable and normal)	A	
<b>DEEP VENOUS THROMBOSIS (DVT)/ PULMONARY EMBOLISM (PE)</b>		<b>Clarification:</b> To reduce the risk of DVT/PE, early ambulation is recommended.
a) History of DVT/PE	A	
b) Current DVT/PE	D	
c) Family history of DVT/PE (first-degree relatives)	A	

\* See also additional comments at end of table

<b>FEMALE SURGICAL STERILIZATION</b>		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
<b>CONDITION</b>	<b>CATEGORY</b>	<b>CLARIFICATIONS/EVIDENCE</b>
<b>DEEP VEIN THROMBOSIS (DVT)/PULMONARY EMBOLISM (PE) (Cont'd)</b>		
d) Major surgery (i) with prolonged immobilization (ii) without prolonged immobilization e) Minor surgery without immobilization	D A A	
<b>KNOWN THROMBOGENIC MUTATIONS</b> (e.g., Factor V Leiden; Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)	A	<b>Clarification:</b> Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
<b>SUPERFICIAL VEIN THROMBOSIS</b> a) Varicose veins b) Superficial thrombophlebitis	A A	
<b>CURRENT AND HISTORY OF ISCHAEMIC HEART DISEASE*</b> a) Current ischaemic heart disease b) History of ischaemic heart disease	D C	
<b>STROKE</b> (history of cerebrovascular accident)	C	
<b>KNOWN HYPERLIPIDAEMIAS</b>	A	<b>Clarification:</b> Routine screening is not appropriate because of the rarity of the conditions and the high cost of screening.
<b>VALVULAR HEART DISEASE</b> a) Uncomplicated b) Complicated (pulmonary hypertension, atrial fibrillation, history of subacute bacterial endocarditis)	C S	<b>Clarification:</b> The woman requires prophylactic antibiotics. <b>Clarification:</b> The woman is at high risk for complications associated with anaesthesia and surgery. If the woman has atrial fibrillation that has not been successfully managed or current subacute bacterial endocarditis, the procedure should be delayed.

\* See also additional comments at end of table



<b>FEMALE SURGICAL STERILIZATION</b>		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
<b>CONDITION</b>	<b>CATEGORY</b>	<b>CLARIFICATIONS/EVIDENCE</b>
<b>NEUROLOGIC CONDITIONS</b>		
<b>HEADACHES</b>		
a) Non-migrainous (mild or severe)	A	
b) Migraine		
(i) without aura		
Age < 35	A	
Age ≥ 35	A	
(ii) with aura (at any age)	A	
<b>EPILEPSY</b>	C	
<b>DEPRESSIVE DISORDERS</b>		
<b>DEPRESSIVE DISORDERS</b>	C	
<b>REPRODUCTIVE TRACT INFECTIONS AND DISORDERS</b>		
<b>VAGINAL BLEEDING PATTERNS</b>		
a) Irregular pattern <i>without</i> heavy bleeding	A	
b) Heavy or prolonged bleeding (includes regular and irregular patterns)	A	
<b>UNEXPLAINED VAGINAL BLEEDING</b> (suspicious for serious condition)		
Before evaluation	D	<b>Clarification:</b> The condition must be evaluated before the procedure is performed.
<b>ENDOMETRIOSIS</b>	S	
<b>BENIGN OVARIAN TUMOURS</b> (including cysts)	A	
<b>SEVERE DYSMENORRHOEA</b>	A	

\* See also additional comments at end of table

FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
<b>TROPHOBLAST DISEASE</b>			
a) Benign gestational trophoblastic disease	A		
b) Malignant gestational trophoblastic disease	D		
<b>CERVICAL ECTROPION</b>	A		
<b>CERVICAL INTRAEPITHELIAL NEOPLASIA (CIN)</b>	A		
<b>CERVICAL CANCER*</b> (awaiting treatment)	D		
<b>BREAST DISEASE</b>			
a) Undiagnosed mass	A		
b) Benign breast disease	A		
c) Family history of cancer	A		
d) Breast cancer			
(i) current	C		
(ii) past and no evidence of current disease for 5 years	A		
<b>ENDOMETRIAL CANCER*</b>	D		
<b>OVARIAN CANCER*</b>	D		
<b>UTERINE FIBROIDS*</b>			
a) Without distortion of the uterine cavity	C		
b) With distortion of the uterine cavity	C		
<b>PELVIC INFLAMMATORY DISEASE (PID)*</b>			
a) Past PID (assuming no current risk factors for STIs)			<b>Clarification:</b> A careful pelvic examination must be performed to rule out recurrent or persistent infection and to determine the mobility of the uterus.
(i) with subsequent pregnancy	A		
(ii) without subsequent pregnancy	C		
b) PID - current	D		

\* See also additional comments at end of table



<b>FEMALE SURGICAL STERILIZATION</b>		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.
<b>CONDITION</b>	<b>CATEGORY</b>	<b>CLARIFICATIONS/EVIDENCE</b>
<b>STIs*</b>		
a) Current purulent cervicitis or chlamydial infection or gonorrhoea	D	<b>Clarification:</b> If no symptoms persist following treatment, sterilization may be performed.
b) Other STIs (excluding HIV and hepatitis)	A	
c) Vaginitis (including trichomonas vaginalis and bacterial vaginosis)	A	
d) Increased risk of STIs	A	
<b>HIV/AIDS</b>		
<b>HIGH RISK OF HIV</b>	A	<b>Clarification:</b> No routine screening is needed. Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures. The use of condoms is recommended following sterilization.
<b>HIV-INFECTED</b>	A	
<b>AIDS</b>	S	<b>Clarification:</b> The presence of an AIDS-related illness may require that the procedure be delayed.
<b>OTHER INFECTIONS</b>		
<b>SCHISTOSOMIASIS</b>		
a) Uncomplicated	A	<b>Clarification:</b> Liver function may need to be evaluated.
b) Fibrosis of liver	C	
<b>TUBERCULOSIS</b>		
a) Non-pelvic	A	
b) Known pelvic	S	
<b>MALARIA</b>		
	A	
<b>ENDOCRINE CONDITIONS</b>		
<b>DIABETES*</b>		
a) History of gestational disease	A	<b>Clarification:</b> If blood glucose is not well controlled, referral to a higher-level facility is recommended.
b) Non-vascular disease:		
(i) non-insulin dependent	C	<b>Clarification:</b> There is a possible decrease in healing and an increased risk of wound infection. Use of prophylactic antibiotics is recommended. <b>Evidence:</b> Diabetic women were more likely to have complications when undergoing sterilization. <sup>22</sup>
(ii) insulin dependent	C	
c) Nephropathy/retinopathy/neuropathy	S	

\* See also additional comments at end of table

<b>FEMALE SURGICAL STERILIZATION</b>		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
<b>CONDITION</b>	<b>CATEGORY</b>	<b>CLARIFICATIONS/EVIDENCE</b>	
<b>DIABETES (Cont'd)</b>			
d) Other vascular disease or diabetes of > 20 years' duration	S		
<b>THYROID DISORDERS*</b>			
a) Simple goitre	A		
b) Hyperthyroid	S		
c) Hypothyroid	C		
<b>GASTROINTESTINAL CONDITIONS</b>			
<b>GALL-BLADDER DISEASE</b>			
a) Symptomatic	A		
(i) treated by cholecystectomy			
(ii) medically treated			
(iii) current	D		
b) Asymptomatic	A		
<b>HISTORY OF CHOLESTASIS</b>			
a) Pregnancy-related	A		
b) Past COC-related	A		
<b>VIRAL HEPATITIS*</b>			
a) Active	D	<b>Clarification:</b> Appropriate infection prevention procedures, including universal precautions, must be carefully observed with all surgical procedures.	
b) Carrier	A		
<b>CIRRHOSIS</b>			
a) Mild (compensated)	C	<b>Clarification:</b> Liver function and clotting might be altered. Liver function should be evaluated.	
b) Severe (decompensated)	S		
<b>LIVER TUMOURS</b>			
a) Benign (adenoma)	C	<b>Clarification:</b> Liver function and clotting might be altered. Liver function should be evaluated.	
b) Malignant (hepatoma)	C		
<b>ANAEMIAS</b>			
<b>THALASSAEMIA</b>	C		
<b>SICKLE-CELL DISEASE*</b>	C		

\* See also additional comments at end of table



FEMALE SURGICAL STERILIZATION		Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
CONDITION	CATEGORY	CLARIFICATIONS/EVIDENCE	
<b>IRON-DEFICIENCY ANAEMIA</b> a) Hb < 7g/dl b) Hb ≥ 7 to < 10g/dl	D C	<b>Clarification:</b> The underlying disease should be identified. Both preoperative Hb level and operative blood loss are important factors in women with anaemia. If peripheral perfusion is inadequate, this may decrease wound healing.	
<b>OTHER CONDITIONS RELEVANT ONLY FOR FEMALE SURGICAL STERILIZATION</b>			
<b>LOCAL INFECTION</b> Abdominal skin infection	D	<b>Clarification:</b> There is an increased risk of postoperative infection.	
<b>COAGULATION DISORDERS*</b>	S		
<b>RESPIRATORY DISEASES*</b> a) Acute (bronchitis, pneumonia) b) Chronic (i) asthma (ii) bronchitis (iii) emphysema (iv) lung infection	D S S S S	<b>Clarification:</b> The procedure should be delayed until the condition is corrected. There are increases in anaesthesia-related and other perioperative risks.	
<b>SYSTEMIC INFECTION OR GASTROENTERITIS*</b>	D		
<b>FIXED UTERUS DUE TO PREVIOUS SURGERY OR INFECTION*</b>	S		
<b>ABDOMINAL WALL OR UMBILICAL HERNIA</b>	S	<b>Clarification:</b> Hernia repair and tubal sterilization should be performed concurrently, if possible.	
<b>DIAPHRAGMATIC HERNIA*</b>	C		
<b>KIDNEY DISEASE*</b>	C		
<b>SEVERE NUTRITIONAL DEFICIENCIES*</b>	C		
<b>PREVIOUS ABDOMINAL OR PELVIC SURGERY</b>	C	<b>Evidence:</b> Women with previous abdominal or pelvic surgery were more likely to have complications when undergoing sterilization. <sup>21, 22, 24-26</sup>	

\* See also additional comments at end of table

<b>FEMALE SURGICAL STERILIZATION</b>	Sterilization does not protect against STI/HIV. If there is risk of STI/HIV (including during the postpartum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.	
<b>CONDITION</b>	<b>CATEGORY</b>	<b>CLARIFICATIONS/EVIDENCE</b>
<b>STERILIZATION CONCURRENT WITH ABDOMINAL SURGERY</b>		
a) Elective	C	
b) Emergency (without previous counselling)	D	
c) Infectious condition	D	
<b>STERILIZATION CONCURRENT WITH CAESAREAN SECTION*</b>	A	

\* See also additional comments at end of table

## Medical Eligibility Checklist for Fertility Awareness-Based (FAB) Methods

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use any fertility awareness-based method she wants. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have a medical condition that would make pregnancy especially dangerous?  
(Medical Conditions and Method Choice).  
 No  YES      She may want to choose a more effective method. If not, stress careful use of fertility awareness-based methods to avoid pregnancy.
2. Do you have irregular menstrual cycles? Vaginal bleeding between periods? Heavy or long monthly bleeding? For younger women: Are your periods just starting? For older women: Have your periods become irregular, or have they stopped?  
 No  YES      Predicting her fertile time with only the calendar method may be hard or impossible. She can use basal body temperature (BBT) and/or cervical mucus, or she may prefer another method.
3. Did you recently give birth or have an abortion? Are you breastfeeding? Do you have any other condition that affects the ovaries or menstrual bleeding, such as stroke, serious liver disease, hyperthyroid, or cervical cancer?  
 No  YES      These conditions do not restrict use of fertility awareness-based methods. But these conditions may affect fertility signs, making fertility awareness-based methods hard to use. For this reason, a woman or couple may prefer a different method. If not, they may need more counseling and follow-up to use the method effectively.
4. Have you had any infections or diseases that may change cervical mucus, basal body temperature, or menstrual bleeding, such as vaginal infections or sexually transmitted infections (STI), pelvic inflammatory disease (PID) in the last three months?  
 No  YES      These conditions may affect fertility signs, making fertility awareness based methods hard to use. Once an infection is treated and reinfection is avoided, however, a woman can use fertility awareness-based methods more easily.
5. Do you take any drugs that affect cervical mucus, such as mood-altering drugs, lithium, tricyclic antidepressants, or antianxiety therapies?  
 No  YES      Predicting her fertile time correctly may be difficult or impossible using only the cervical mucus method. She may use BBT and/or the SDM, or she may prefer another method.

*Be sure to explain the health benefits, risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable pertaining to the client.*

## Medical Eligibility Checklist for Lactational Amenorrhea Method (LAM)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use LAM. If she answers YES to a question below, follow the instructions.

1. Is your baby six months old or older?

No  YES

She cannot use LAM. Help her choose another method. If she is breastfeeding, a nonhormonal method is best.

2. Has your menstrual period returned? (Bleeding in the first eight weeks after childbirth does not count.)

No  YES

After eight weeks since childbirth, if a woman has two straight days of menstrual bleeding, or her menstrual period has returned, she cannot use LAM. Help her choose another method. If she is breastfeeding, a nonhormonal method is best.

3. Have you begun to breastfeed less often? Do you regularly give the baby other food or liquid?

No  YES

If the baby's feeding pattern has just changed, explain that she must fully or nearly fully breastfeed – day and night – to protect against pregnancy. At least 85% of her baby's feedings should be breastfeeds. If she is not fully or nearly fully breastfeeding, she cannot use LAM as effectively. Help her choose another nonhormonal method.

4. Has a health care provider told you not to breastfeed your baby?

No  YES

If she is not breastfeeding, she cannot use LAM. Help her choose another method. A woman should not breastfeed if she is taking mood-altering drugs, reserpine, ergotamine, antimetabolites, cyclosporine, cortisone, bromocriptine, radioactive drugs, lithium, or certain anticoagulants, if her baby has a specific infant metabolic disorder, or if she has active viral hepatitis, breastfeeding is also inadvisable. All others can and should breastfeed for the health benefits.

5. Do you have AIDS? Are you infected with HIV, the virus that causes AIDS?

No  YES

Where infectious diseases kill many babies, she could be encouraged to breastfeed. However, HIV may be passed on to the baby in breast milk. When infectious diseases are a low risk and safe and affordable food for the baby is available, advise her to feed her baby other food. Help her choose a family planning method other than LAM (some other infectious conditions, such as active viral hepatitis, can also be transmitted during breastfeeding.)

*Be sure to explain the health benefits, risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.*



## Medical Eligibility Checklist for Combined Oral Contraceptives (COCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use combined oral contraceptives (COCs). If she answers YES to a question below, follow the instructions.

1. Do you smoke cigarettes and are you 35 or older?

- No  YES      Urge her to stop smoking. If she is 35 or older and will not stop smoking, do not provide COCs. Help her to choose a method without estrogen.

2. Do you have high blood pressure?

- No  YES      If you cannot check blood pressure (BP) and she reports high BP, do not provide COCs. Refer for BP check if possible or help her choose a method without estrogen. If there is no report of high BP, it is okay to provide COCs.

### Check if feasible:

If BP is below 140/90, it is okay to give COCs without further BP readings. If systolic BP is 140 or higher or diastolic BP is 90 or higher, do not provide COCs. Help her choose another method. (One BP reading in the range of 140-159/90-99 is not enough to diagnose high BP. Offer condoms or spermicide for use until she can return for another BP check, or help her choose another method if she prefers. If BP reading at next check is below 140/90, she can use COCs and further BP readings are not necessary.) If systolic BP is below 160 or higher or diastolic BP is 100 or higher, she also should not use DMPA or NET-EN.

3. Are you breastfeeding a baby less than six months old?

- No  YES      Can provide COCs now with instruction to start when she stops breastfeeding or six months after childbirth – whichever comes first. IF she is not fully or almost fully breastfeeding, also give her condoms or spermicide to use until her baby is six months old. Other effective methods are better choices than COCs when a woman is breastfeeding whatever her baby's age.

4. Do you have serious problems with your heart or blood vessels? Have you ever had such problems? If so, what problems?

- No  YES      Do not provide COCs if she reports heart attack or heart disease due to blocked arteries, stroke, blood clots (except superficial clots), severe chest pain with unusual shortness of breath, diabetes for more than 20 years, or damage to vision, kidneys, or nervous system caused by diabetes. Help her choose another effective method.

5. Do you have or have you ever had breast cancer?

- No  YES      Do not provide COCs. Help her choose a method without hormones.

6. Do you have jaundice, cirrhosis of the liver, a liver infection or tumor? (Are her eyes or skin unusually yellow?)

- No  YES      Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, liver tumor), do not provide COCs. Refer for care as appropriate. Help her choose a method without hormones.

7. Do you often get severe headaches, perhaps on one side or pulsating, that cause nausea and are made worse by light and noise or moving about (migraine headaches)?  
 No  YES      If she is 35 or older, do not provide COCs. Help her choose another method. If she is under age 35, but her vision is distorted or she has trouble speaking or moving before or during these headaches, do not use COCs. Help her choose another method. If she is under age 35 and has migraine headaches without distortion of vision or trouble or moving, she can use COCs.
8. Are you taking medicines for seizures? Are you taking rifampin (rifampicin) or griseofulvin?  
 No  YES      If taking phenytoin, carbamazepine, barbiturates or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with COCs or, if she prefers, help her choose another effective method if she is on long-term treatment.
9. Do you think you are pregnant?  
 No  YES      Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, give her condoms or spermicide to use until it is reasonably certain that she is not pregnant. Then she can start COCs.
10. Do you have gall bladder disease? Ever had jaundice while taking COCs? Planning surgery that will keep you from walking for a week or more? Had a baby in the past 21 days?  
 No  YES      If she has gall bladder disease now or takes medicine for gall bladder disease, or if she has had jaundice while using COCs, do not provide COCs. Help her choose a method without estrogen. If she is planning surgery or she just had a baby, can provide COCs with instruction on when to start them later.

*Be sure to explain the health benefits, risks, and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.*

## Medical Eligibility Checklist for Progestin-Only Contraceptives (POCs)

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use the progestin-only contraceptives.. If she answers YES to a question below, follow the instructions. No conditions restrict use of these methods, but some conditions can make them harder to use effectively.

1. Do you have or have you ever had breast cancer?  
No YES Do not provide POCs. Help her choose a method without hormones.
2. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)  
No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care. Help her choose a method without hormones.
3. Are you breastfeeding a baby less than six months old?  
No YES Can give her POCs now with instruction on when to start – when the baby is six weeks old.
4. Do you have serious problems with your heart or blood vessels? If so, what problems?  
No YES Do not provide POCs if she reports blood clots (except superficial clots). Help her choose another effective method.
5. Do you have jaundice, cirrhosis of the liver, a liver infection, or tumor? (Are her eyes or skin unusually yellow?)  
No YES Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, live tumor), do not provide POCs. Refer for care as appropriate. Help her choose a method without hormones.
6. Are you taking medicine for seizures? Are you taking rifampin (rifampicin) or griseofulvin?  
No YES If she is taking phenytoin, carbamazepine, barbiturates, or primidone for seizures or rifampin or griseofulvin, provide condoms to use along with POCs. If she prefers, or if she is on long treatment, help her choose another effective method.
7. Do you think you are pregnant?  
No YES Assess whether pregnant (see How to tell if a woman is not pregnant). If she might be pregnant, also give her condoms or spermicide to use until reasonably certain that she is not pregnant. Then she can start POCs.

*Be sure to explain the health benefits, risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.*

## Medical Eligibility Checklist for Copper IUDs

Ask the client the questions below. If she answers NO to ALL of the questions, then she CAN use an IUD if she wants. If she answers YES to a question below, follow the instructions.

1. Do you think you are pregnant?  
 No  YES Assess whether pregnant (see How to tell if a woman is not pregnant). Do not insert IUD. Give her condoms or spermicide to use until reasonably sure that she is not pregnant.
2. In the last three months, have you had vaginal bleeding that is unusual for you, particularly between periods or after sex?  
 No  YES If she has unexplained vaginal bleeding that suggests an underlying medical condition, do not insert IUD until the problem is diagnosed. Evaluate by history and during pelvic exam. Diagnose and treat as appropriate, or refer.
3. Have you given birth more than 48 hours but less than four weeks ago?  
 No  YES Delay inserting an IUD until four or more weeks after childbirth. If needed, give her condoms or spermicide to use until then.
4. Do you have infection following childbirth?  
 No  YES If she has puerperal sepsis (genital tract infection during the first 42 days after childbirth), do not insert IUD. Refer for care. Help her choose another effective method.

**Note: Assure confidentiality before asking remaining questions.**

5. Have you had a sexually transmitted infection (STI) or pelvic inflammatory disease (PID) in the last three months? Do you have an STI, PID or any other infection in the female organs now?  
(Signs and symptoms of PID: severe pelvic infection in the female organs)  
 No  YES Do not insert IUD now. Urge her to use condoms for STI protection. Refer or treat client and partner(s). IUD can be inserted three months after use unless re-infection is likely.
6. Do you have an infection following childbirth?  
 No  YES If she has AIDS, is infected with HIV, or is being treated with medicines that make her body less able to fight infections, careful clinical judgment should be made. In general, do not insert IUD unless other methods are not available or acceptable. Whatever methods she chooses, urge her to use condoms. Give her condoms.
7. Do you think you might get an STI in the future? Do you or your partner have more than one sex partner?  
 No  YES If she is at risk of STIs, explain that STIs can lead to infertility. Urge her to use condoms for STI protection. Do not insert IUD. Help her choose another method.

8. Do you have any cancer in the female organs or pelvic tuberculosis?  
No YES Known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; pelvic tuberculosis: Do not insert IUD. Treat or refer for care as appropriate. Help her choose another effective method.

*Be sure to explain the health benefits, risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable when relevant to the client.*

## CHECKLIST FOR PROVISION OF THE SDM

NAME OF COURSE: \_\_\_\_\_ Dates: \_\_\_\_\_

**Instructions:** Put a (v) in the space provided for if the trainee performed the task “satisfactorily”, (x) if the task was performed “unsatisfactorily”, and (NO) if the task was “not observed”.

TASKS	PRACTICES						
	1	2	3	4	5	6	7
1. Once the client has chosen to use the SDM, determines the length of the client’s menstrual cycle by reviewing her last and past menstrual periods and asking when she expects her next menses.							
2. Determines the client’s cycle length by reviewing her menstrual history.							
3. If the cycle meets the criteria, provides the client with a SDM card and CycleBeads.							
4. If the cycle length is less than 26 days or more than 32 days, explains to the client that she cannot use the SDM and helps her choose another method.							
5. If woman has recently used another FP method, determines whether she has the following criteria. <ul style="list-style-type: none"> <li>• If client recently used pills, her last two cycles after stopping the pills were within 26-32 days.</li> <li>• If client recently used injectable, her last injection was at least three months ago and that her cycles were within 26-32 days prior to use of the injectable.</li> <li>• If client recently used IUD, her IUD has been removed and her menstrual cycles are within 26-32 days.</li> </ul>							
6. Describes the SDM CycleBeads while showing the client the beads and telling her that: <ul style="list-style-type: none"> <li>• The red bead represents the first day of menstrual bleeding.</li> </ul>							
<ul style="list-style-type: none"> <li>• The brown beads represent the “infertile” days.</li> </ul>							
<ul style="list-style-type: none"> <li>• The white beads (days 8-19) represent the “fertile” days.</li> </ul>							
7. Instructs the client on the use of the SDM by telling her to: <ul style="list-style-type: none"> <li>• Put the ring on the red bead on the first day</li> </ul>							

TASKS	PRACTICES						
	1	2	3	4	5	6	7
of her menses and mark with an “x” this date on the SDM card/calendar.							
<ul style="list-style-type: none"> <li>• Move the ring to a bead each day every morning.</li> </ul>							
8. Tells the client that she should abstain from sexual intercourse on white-bead days if she wants to avoid pregnancy.							
9. Draws the client’s attention to the dark brown and black beads and tells her that: <ul style="list-style-type: none"> <li>• If she experiences menstrual bleeding before the dark brown bead, her cycle is short and less than 26 days.</li> </ul>							
<ul style="list-style-type: none"> <li>• If the ring reaches the black bead and she has not experienced menstrual bleeding, then her cycle is long and more than 32 days.</li> </ul>							
10. Warns the client that if either of the above events happens at least twice in a year, she cannot reliably use the SDM as her FP method.							
11. Asks the client to repeat the instructions on SDM use in her own words.							
12. Corrects or clarifies instructions, as needed.							
13. Asks client what issues or difficulties might arise during fertile days (during white bead days).							
14. Asks client about possible ways she can handle the fertile days.							
15. Asks client for questions and concerns and responds to these.							
16. Tells the client to come to the clinic: <ul style="list-style-type: none"> <li>• Within seven days of her next menstrual period bringing with her the CycleBeads, client card, and if possible, her partner.</li> </ul>							

TASKS	PRACTICES						
	1	2	3	4	5	6	7
<ul style="list-style-type: none"> <li>Menses occur before the dark brown bead or has not occurred upon reaching the black bead.</li> </ul>							
<ul style="list-style-type: none"> <li>After menses for the next 3 menstrual periods.</li> </ul>							
17. Refers the client for methods or services not offered at the counselor's site, if use of the CycleBeads is not appropriate.							
18. Fills up information in the Client Register and record client as New Acceptor.							
19. Provide information materials on the method.							



## SKILLS CHECKLIST on PROGESTIN-ONLY INJECTABLE ADMINISTRATION

PARTICIPANT: \_\_\_\_\_ Course Date: \_\_\_\_\_

**Instruction: Check the appropriate column for each of the tasks.**

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
<b>PRE-INJECTION TASKS</b>					
1. Conducts counseling.					
2. Ensures that the client understands and accepts the possible side effects of the POI.					
3. Explains the injection procedure to the client.					
4. Encourages the client to ask questions and responds to her questions.					
5. Listens attentively to client's response and concerns.					
6. Reassures the client that the needle and syringe used for injection are sterile.					
7. Washes hands thoroughly with soap and water.					
8. Checks vial for contents, dosage, and expiration.					
9. Disperses the suspension by rolling the vial back and forth between the palms of the hands or by gently shaking the vial so that no bubbles are formed in the solution.					
<b>Using the auto-disabled syringe</b>					
10. Checks that package seals of the syringe are not damaged or changed to ensure that sterility of the syringe is maintained.					
11. Takes care that the sterility of the needle is maintained by not touching contaminated surfaces with it.					
12. Holds the DMPA vial upright.					
13. Inserts the needle into the vial and pulls the piston of the syringe to draw the solution.					
14. Keeps the needle in solution when drawing up the dose.					
15. Gently pulls the piston slightly past the 1.0 ml mark when drawing up the dose.					
16. Gives space for air bubbles while maintaining full dose.					

Key: 2= Yes 0= No	1= Yes, but needs improvement NA= Not applicable	1	2	3	4
17. After drawing up the dose and removing needle from vial, gently pushes the piston to remove excess air.					
18. Stops upon reaching the 1.0 ml mark.					
INJECTION TASKS					
19. Swabs the skin at the site of the injection with alcohol or other antiseptic.					
20. Allows the antiseptic to dry before giving the injection.					
21. Injects deep into the muscle.					
22. Administers the POI.					
23. Instructs the client not to massage the area after the injection.					
24. Disposes of needle and syringe in a puncture proof container.					
25. Washes hands and dry.					

**COMMENTS/RECOMMENDATIONS:**

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Trainer's Signature: \_\_\_\_\_

## COUNSELING SKILLS PRACTICE CHECKLIST

PARTICIPANT: \_\_\_\_\_ COURSE DATE: \_\_\_\_\_

**Instruction: Check the appropriate column for each of the tasks.**

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
<b>Interpersonal Communication</b>				
1. Maintains eye contact with the client.				
2. Uses simple language that the client understands.				
3. Uses appropriate tone of voice.				
4. Exhibits positive non-verbal communication.				
5. Uses the cue card effectively.				
6. Asks open-ended, closed, and probing questions effectively.				
7. Listens attentively to client's response and concerns.				
<b>COUNSELING PROCESS</b>				
1. Greets client and introduces self.				
2. Offers the client a seat.				
3. Asks reason for client's visit.				
4. Respects clients right by:				
– Ensuring confidentiality				
– Providing privacy				
5. Invites client to speak freely.				
<b><i>New Clients</i></b>				
6. Uses the FP Form 1 to obtain relevant information.				
7. Assesses the client's reproductive needs (short-term, long-term, permanent)				
8. Asks client if s/he has a method in mind and what s/he knows about the method.				
9. Assesses what the client knows about FP methods.				
10. Asks if client has previously used an FP method and reason for discontinuing.				
11. If postpartum, assesses the client's willingness to breastfeed.				
12. Assesses reproductive health needs of clients				
• Risk for STIs				
• Gender-based violence (VAW)				
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).				
14. Corrects rumors and misconceptions.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
15. Tells the client about available methods based on her/his knowledge and reproductive needs.  <ul style="list-style-type: none"> <li>• Mode of action</li> <li>• Advantages and disadvantages</li> <li>• STI and HIV prevention</li> <li>• Possible side effects</li> </ul>				
16. Allows the client to choose a method among those previously presented to her/him.				
17. Determines suitability of the chosen method using the method specific MEC checklist.				
18. Helps the client make a decision by asking how s/he will cope with potential side effects of the chosen method.				
19. Correctly explains to the client how to use the chosen method.				
20. Offers condoms to clients with risk for STIs for dual protection and/or back-up.				
21. Correctly explains the warning signs and what s/he should do if any of these occurs.				
22. Checks at appropriate times if client has understood the information or instructions given.				
23. Asks the client to repeat all instructions in her/his own words.				
24. Tells the client when to return for routine follow-up, if needed.				
25. Refers the client for methods or services not offered at counselor's site.				

Key: 2= Yes 1= Yes, but needs improvement 0= No NA= Not applicable	2	1	0	NA
<b><i>Return Clients</i></b>				
1. Greets the client and introduces self, if needed.				
2. Offers the client a seat.				
3. Retrieves client's records.				
4. Re-assures confidentiality and provides privacy.				
5. Asks if the client's situation, including her/his reproductive needs, had changed since the last visit.				
6. Asks the client if s/he has problems with the method s/he is using.				
7. If client is satisfied with her/his present method:				
• Asks the client to repeat how s/he uses the method.				
• Asks the client to repeat warning signs of the method s/he is using and emphasizes that immediate consultation should be sought if any of these occurs.				
• Gives client re-supply of the method s/he is using.				
• Tells the client when to return for follow-up, if needed.				
8. If client is not satisfied with the method:				
• Tells the client that there are other methods that s/he can use to meet her/his needs				
• Tells the client about appropriate methods for her/his reproductive need.				
• Helps the client make a decision by determining how s/he will cope with potential side effects.				
• Explains how to use the chosen method, including what to do for warning signs.				
9. Refers the client for methods or services not offered at the clinic.				

**COMMENTS/RECOMMENDATIONS:**

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Trainer's Signature: \_\_\_\_\_

## SUMMARY TABLE FOR BARANGAY HEALTH STATIONS

### FAMILY PLANNING (Part 1 of 2)

INDICATORS	TARGET	JAN	FEB	MAR	1st Q	APR	MAY	JUNE	2nd Q	JULY	AUG	SEPT	3rd Q	OCT	NOV	DEC	4th Q	TOTAL
1. Total New Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		
2. Total Other Acceptors																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		

### FAMILY PLANNING (Part 2 of 2)

INDICATORS	TARGET	JAN	FEB	MAR	1st Q	APR	MAY	JUNE	2nd Q	JULY	AUG	SEPT	3rd Q	OCT	NOV	DEC	4th Q	TOTAL
3. Total Drop-out																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ Condom																		
▶ LAM																		
4. Total Current Users																		
▶ Female Sterilization																		
▶ Male Sterilization																		
▶ Pills																		
▶ IUD																		
▶ Injectables (DMPA)																		
▶ NFP-CM																		
▶ NFP-BBT																		
▶ NFP-LAM																		
▶ NFP-SDM																		
▶ NFP-STM																		
▶ LAM																		
▶ Condom																		

## MONTHLY CONSOLIDATION TABLE FOR RURAL HEALTH UNITS

### FAMILY PLANNING (Part 1 of 4)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

INDICATORS	NAME OF BHS												
1. Total New Acceptors													
▶ Female Ster/BTL													
▶ Male Ster/Vasectomy													
▶ Pills													
▶ IUD													
▶ Injectables (DMPA)													
▶ NFP-CM													
▶ NFP-BBT													
▶ NFP-STM													
▶ NFP-SDM													
▶ NFP-LAM													
▶ Condom													

### FAMILY PLANNING (Part 2 of 4)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

INDICATORS	NAME OF BHS												
2. Total Other Acceptors													
▶ Female Ster/BTL													
▶ Male Ster/Vasectomy													
▶ Pills													
▶ IUD													
▶ Injectables (DMPA)													
▶ NFP-CM													
▶ NFP-BBT													
▶ NFP-STM													
▶ NFP-SDM													
▶ NFP-LAM													
▶ Condom													

### FAMILY PLANNING (Part 3 of 4)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

INDICATORS	N A M E O F B H S														
3. Drop-out															
▶ Female Ster/BTL															
▶ Male Ster/Vasectomy															
▶ Pills															
▶ IUD															
▶ Injectables (DMPA)															
▶ NFP-CM															
▶ NFP-BBT															
▶ NFP-STM															
▶ NFP-SDM															
▶ NFP-LAM															
▶ Condom															



### FAMILY PLANNING (Part 4 of 4)

Month: \_\_\_\_\_ Year: \_\_\_\_\_

INDICATORS	N A M E O F B H S														
4. Total Current Users															
▶ Female Ster/BTL															
▶ Male Ster/Vasectomy															
▶ Pills															
▶ IUD															
▶ Injectables (DMPA)															
▶ NFP-CM															
▶ NFP-BBT															
▶ NFP-STM															
▶ NFP-SDM															
▶ NFP-LAM															
▶ Condom															



## M1/FHSIS Report Form

 	FHSIS REPORT for the MONTH _____ YEAR: _____ Name of BHS: _____ Municipality/City of: _____ Province: _____ Projected Population of the Year: _____ <i>For submission to RHU</i>	FHSIS version 2008 <div style="font-size: 48pt; font-weight: bold; margin: 10px 0;">M1</div> <div style="font-size: 36pt; font-weight: bold;">BHS</div>			
<b>MATERNAL CARE</b>		<b>No.</b>			
Pregnant women with 4 or more Prenatal visits					
Pregnant women given 2 doses of Tetanus Toxoid					
Pregnant women given TT2 plus					
Preg.women given complete iron w/folic acid supplementation					
Preg.women given Vitamin A supplementation					
Postpartum women with at least 2 postpartum visits					
Postpartum women given complete iron supplementation					
Postpartum women given Vitamin A supplementation					
PP women initiated breastfeeding w/in 1 hr.after delivery					
<b>FAMILY PLANNING</b>	Current User (Begin Mo.)	Acceptors		Dropout	Current User (End Mo.)
		New	Other		
a. Female Sterilization/BTL					
b. Male Sterilization/Vasectomy					
c. Pills					
d. IUD					
e. Injectables (DMPA)					
f. NFP-CM					
g. NFP-BBT					
h. NFP-STM					
i. NFP-Standard Days Method					
j. NFP-LAM					
k. Condom					

## Q1 Form for FP

FHSIS Report for the Quarter: \_\_\_\_\_ Year: \_\_\_\_\_  
 Municipality/City: \_\_\_\_\_  
 Province: \_\_\_\_\_ Projected Population of the Year: \_\_\_\_\_



FHSIS v. 2008 - Q Form

<i><b>FAMILY PLANNING</b></i>								
Indicators	Current Users (beginning of the quarter)	Acceptors		Drop-Out	Current Users (End Qtr.)	CPR Col.6/TP x 14.5%	Interpretation	Recommendations/ Actions Taken
		New	Others <sup>a</sup>					
Col.1	Col.2	Col.3	Col.4	Col.5	Col.6	Col.7	Col.8	Col.9
a. Female Ster/BTL								
b. Male Ster/ Vasectomy								
c. Pills								
d. IUD								
e. Injectables (DMPA)								
f. NFP-CM								
g. NFP-BBT								
h. NFP-STM								
i. NFP-SDM								
j. NFP-LAM								
k. Condom								

<sup>a</sup> Others include CM, CC and RS

## ACTION PLAN ON FAMILY PLANNING

CHD: \_\_\_\_\_ Province: \_\_\_\_\_ Municipality/City: \_\_\_\_\_

Barangay: \_\_\_\_\_ Date: \_\_\_\_\_

Prepared by: \_\_\_\_\_

OBJECTIVES	ACTIVITIES	PERFORMANCE INDICATORS	TARGET	TIME FRAME	RESOURCE REQUIREMENT		RESPONSIBLE PERSON
					Items	Cost	
<b>A. Service Delivery</b>							
<b>B. Logistics Management</b>							
<b>C. Information, Education and Communication (IEC)</b>							
<b>D. Advocacy and Resource Mobilization</b>							
<b>E. Monitoring and Evaluation</b>							

## GUIDELINES ON POST-TRAINING FOLLOW-UP AND MONITORING OF BASIC COURSE TRAINEES

### Preparatory Activities

#### 1. One month prior to the visit

Ensure that communication (i.e., letter followed by phone call, if possible) with the head of the trainee's facility, the trainee's supervisor and the trainee to inform them of:

- Purpose of the visit which may be but not limited to:
  - ✓ Determine if the trainee-service provider is able to competently perform the skills taught during the FPCBT Basic Course.
  - ✓ Provide trainee with technical assistance, as necessary.
  - ✓ Identify problems the trainee may have in applying the knowledge and skills learned.
  - ✓ Assist the trainee in finding solutions to these problems.
- Date of the visit.
- What the trainee needs to prepare: FP form 1 of FP clients provided with services after the course, Target Client List, CDLMIS Inventory Report, Referral Slips, BHS Summary Table (green book) and the RHU Summary Table (blue book).
- Arrange for availability of client(s) during the visit.

#### 2. Two weeks prior to the visit

Obtain confirmation of the scheduled visit.

Prepare materials you will need, such as:

- ✓ Performance monitoring checklist (two copies per midwife: a copy to be left with her and another for the monitoring agency)
- ✓ Copy of the letter previously sent informing her/him of your visit
- ✓ Copy of the action plan (developed during the course)

#### 3. Immediately prior to the visit

- Prepare for travel arrangements.

#### 4. Plan to be on time for the site visit.

### During the Follow-up

#### 1. Conduct a courtesy call on the head of the facility.

- Explain the purposes of the follow-up visit which are:
  - o To determine if the trainee-service provider is able to competently perform the skills taught during the FPCBT Basic Course.
  - o To provide trainee with technical assistance, as necessary.
  - o To identify problems the trainee may have in applying the knowledge and skills learned.
  - o To assist the trainee in finding solutions to these problems.

#### 2. Arrange to interview the trainee's immediate supervisor.

The following are some informal interview questions the trainer can ask the supervisor:

- Did the training improve the trainee's work attitude and performance?
- Is the trainee able to effectively provide FP services (e.g. counseling, provision of SDM, pills, DMPA, and condoms)?
- Has there been an increase in the FP client load of the clinic after the trainee's training?
- Has there been an improvement in the quality of services provided by the trainee? In what way?

- Has there been a change in the infection prevention practices in the clinic as practiced by the trainee? In what way?
- Has the trainee been involved in activities to improve the quality of FP services in the facility (e.g. work planning activities, forecasting and allocation of commodity needs, accomplishment of reports, resource mobilization)?
- Were the changes in the trainee's performance and attitude worth the time invested in training?
- Based on observations in the trainee's change of behavior, knowledge, and attitude, what suggestions would she/he have towards the improvement of the course?
- Did the training correct the problem or meet the need for which the training program was designed?
- What recommendations does she/he have for future trainees of the course?

### 3. Interview the trainee and observe her/his performance

- Review the action plan developed during the course. Determine the extent to which the trainee has implemented the action plan.
- Find out whether she/he is able to apply the concepts (e.g. infection prevention, informed consent and voluntarism, managing for quality) and provide FP services as learned in the course.
- Validate performance with records: FP form 1 of FP clients provided with services after the course, Target Client List, CDLMIS Inventory Report (DTUR, *Barangay* Inventory Worksheet), Referral slips, BHS Summary Table (green book) and the RHU Summary Table (blue book).
- If trainee expresses that she/he has not fully applied the concepts and skills learned in the course, ask for the constraints she/he is encountering. Include these as part of the "Issues" that need to be addressed.
- COACH the midwife to reinforce the critical skills learned during training by:
  - o Reviewing the performance monitoring checklist as the basis of the evaluation. Ask if there are any tasks in the checklist that is difficult to perform.
  - o Observing performance on counseling and infection prevention practices.  
Note: Do a role play if no client is available during the visit.
  - o Checking and assisting the trainee on the accomplishment of appropriate forms, as needed.
  - o Providing feedback by commending the trainee on tasks that were performed well followed by recommendations for improvement.
  - o Asking for additional assistance needed to improve performance.
  - o Arrange for schedule of return visit if trainee has not performed satisfactorily and to check if recommendations are implemented.
- Provide feedback on the comments of the supervisor.
- Process the observations by listing items rated as "2" in the "Good Points" portion. Those rated as "1" and "0" under the "Issues" heading. For each of the issues, discuss recommendations for improvement and the agreed time frame for completion of the recommended activities.
- Thank the trainee for her/his cooperation.

### 4. Conduct an exit conference with the supervisor/head of facility.

- Present a summary of the results of the trainee's observation and assistance they can provide in improving the trainee's performance.

#### After the follow-up visit

Prepare the report.

Send copies of the report to appropriate agencies.

## POST-TRAINING MONITORING AND FOLLOW-UP CHECKLIST OF BASIC COURSE GRADUATES

Name of Service Provider: \_\_\_\_\_ Course Dates: \_\_\_\_\_

Address: \_\_\_\_\_

Visited by: \_\_\_\_\_ Date of Visit: \_\_\_\_\_

### OBSERVATION CHECKLIST

**Instruction: Check the appropriate column for each of the items.**

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
<b>PHYSICAL ENVIRONMENT</b>					
<b>THE FACILITY IS ADEQUATELY EQUIPPED AND SUPPLIED AS IT HAS THE FOLLOWING:</b>					
1. Signage that informs clients of services, including FP, provided at the clinic and clinic hours.					
2. Clean and well ventilated client areas free from garbage, pests, and insects.					
3. Waiting area with seats for clients.					
4. All-methods poster displayed in an area where clients can see.					
5. An area for consultation and counseling that:					
– has a table and chairs.					
– provides auditory and visual privacy.					
– has an examination table with Kelly pad.					
– has gooseneck lamp and alternate source for light (i.e., emergency light, flashlight).					
– has sink with running water, liquid or bar soap, and clean, dry towel for washing and drying hands.					
– has locked storage for medicines and supplies.					
– has locked filing cabinet to keep clients' records.					
6. Clean toilet with running water accessible to clients and staff.					
7. Has provisions for infection prevention such as:					
– boiler or sterilizer					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
– gloves (i.e., utility, examination, and sterile)					
– antiseptics (i.e., isopropyl 70% alcohol, betadine)					
– bleach for preparing 0.5% decontaminating solution					
– detergent					
– plastic containers for soaking and cleaning used instruments.					
– covered waste baskets lined with appropriate color coded plastic bags in client areas (i.e., waiting area, consultation room)					
– work area for cleaning instruments, Kelly pad, and mop.					
– access to potable water.					
– color-coded garbage containers for different types of wastes <ul style="list-style-type: none"> <li>✓ Black plastic lining for general, dry, non-infectious waste</li> <li>✓ Green plastic lining for general, wet, non-infectious waste</li> <li>✓ Yellow for infectious/pathological waste</li> </ul>					
– container for sharps.					
– mops and rags					
8. Has an area for interim storage of waste that is minimally accessible to staff, clients, and visitors.					
9. Has the following supplies:					
– cotton					
– gauze					
– pregnancy test					
– family planning supplies: cycle beads, pills (COC, POP), DMPA with syringe, condoms					
<b>TECHNICAL COMPETENCE</b>					
<b>INTERPERSONAL COMMUNICATION</b>					
1. Uses simple language that client understands.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
2. Exhibits positive non-verbal communication.					
3. Uses appropriate tone of voice.					
4. Asks open-ended, closed, and probing questions effectively.					
5. Ensures that clients understand information given by asking follow-up questions.					
6. Listens attentively to client's response and concerns.					
7. Responds to all client's questions and concerns.					
8. Treats the client with respect by informing her/him of procedures to be performed and asking about how she/he feels about it.					
<b>COUNSELING PROCESS</b>					
1. Greets client and introduces self, if needed and asks about the client's feelings.					
2. Offers the client a seat.					
3. Asks reason for client's visit.					
4. Respects clients right by: a. Ensuring confidentiality					
b. Providing privacy					
5. Invites client to speak freely.					
<b>NEW CLIENTS</b>					
6. Uses FP Form 1 to obtain relevant information.					
7. Assesses the client's reproductive needs (short-term, long-term, permanent)					
8. Asks client if s/he has a method in mind and what s/he knows about the method.					
9. Assesses what the client knows about FP methods.					
10. Asks if client has previously used an FP method and reasons for discontinuing.					
11. If postpartum, assesses the client's willingness to breastfeed.					



Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
12. Assesses reproductive health needs of clients	• Risk for STIs				
	• Gender-based violence (VAW)				
13. Checks what possible methods client can use by using the WHO Medical Eligibility Criteria (i.e., wheel or summary table).					
14. Corrects rumors and misconceptions.					
15. Tells the client about available methods based on her/his knowledge and reproductive needs.	• Mode of action • Advantages and disadvantages • STI and HIV prevention • Possible side effects				
16. Allows the client to choose a method among those previously presented to her/him.					
17. Determines suitability of the chosen method using the method specific MEC checklist.					
18. Helps the client make a decision by asking her/him how s/he will cope with potential side effects of the chosen method.					
19. Correctly explains to the client how to use the chosen method.					
20. Offers condoms to clients with risk for STIs for dual protection and/or back-up.					
21. Correctly explains the warning signs and what s/he should do if any of these occurs.					
22. Checks at appropriate times if client has understood the information or instructions given.					
23. Asks the client to repeat all instructions in her/his own words.					
24. Tells the client when to return for routine follow-up, if needed.					
25. Refers the client for methods or services not offered at counselor's site.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
<b>RETURN CLIENTS</b>					
6. Greets the client and introduces herself, if needed.					
7. Offers the client a seat.					
8. Asks if the client's situation, including her/his reproductive needs, had changed since the last visit.					
9. Asks the client if s/he has problems with the method s/he is using.					
10. If client is satisfied with her/his present method:					
• Asks the client to repeat how s/he uses the method.					
• Asks the client to repeat warning signs of the method s/he is using and emphasizes that immediate consultation should be sought if any of these occurs.					
• Gives client re-supply of the method s/he is using.					
• Tells the client when to return for follow-up, if needed.					
11. If client is not satisfied with the method:					
• Tells the client that there are other methods that s/he can use to meet her/his needs.					
• Tells the client about appropriate methods for her/his reproductive need.					
• Helps the client make a decision by determining how s/he will cope with potential side effects.					
• Explains how to use the chosen method, including what to do for warning signs.					
12. Refers the client for methods or services not offered at the clinic.					
<b>CLINIC MANAGEMENT</b>					
<b>WORK PLANNING</b>					
1. Reviews the CBMIS regularly to identify clients with FP unmet needs for planning alternative service delivery interventions in the community.					
2. Reviews the target client list regularly to plan and carry out FP client care and service delivery.					
3. Contributes to the clinic's workplan by developing a plan					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
for the provision of FP services in the community and clinic.					
<b>PROMOTIONAL ACTIVITIES</b>					
4. Uses the opportunity of a clinic visit with a woman to discuss additional issues like FP.					
5. Makes women/couples realize the relationship of FP to their health concerns.					
6. Conducts community education on FP.					
7. Conducts “ <i>Buntis</i> ” parties for pregnant women which includes FP and discusses the possibility of practicing postpartum FP.					
8. Discusses family planning to women of reproductive age in the clinic or community by communicating: <ul style="list-style-type: none"> <li>– that the ideal gap between pregnancies is three years</li> <li>– that there are options depending on her/their situation and needs.</li> <li>– about FP services available in the clinic.</li> </ul>					
<b>REFERRAL</b>					
9. Refers client to other facilities or service providers for services not available in the clinic.					
10. Has identified facilities for referral of specific services not available in the clinic.					
11. Accomplishes referral slips accurately when appropriate.					
12. Follows-up outcome of referrals.					
13. Keeps record of clients referred for FP and other RH services.					
14. Compiles returned referral slips.					
<b>RESOURCE MOBILIZATION</b>					
15. Partners with companies, NGOs, local government executives, and other stakeholders in the community for support and delivery of services.					
16. Networks with other facilities, including private sector delivery points (private birthing homes), for continuation of services and referral.					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
<b>MANAGEMENT INFORMATION SYSTEM</b>					
17. Ensures that all FP users have FP Form 1.					
18. Updates the TCL every time a client comes to the clinic for FP services.					
19. Accomplishes the BHS summary table (green book) and/or the RHU summary table (blue book).					
20. Accomplishes the RHU summary table (blue book).					
21. Supervises BHWs in updating the family profile (part of the CBMIS) to determine FP unmet needs in the community.					
22. Completes the FHSIS by accomplishing the: <ul style="list-style-type: none"> <li>- FP Form 1</li> <li>- TCL</li> <li>- Summary Table for FP Program (i.e., green and blue books)</li> </ul>					
23. Consolidates/lists all clients with FP unmet needs.					
24. Has a system for the submission of reports.					
<b>INFECTION PREVENTION</b>					
25. Keeps the clinic and its surroundings clean.					
26. Washes hands properly and at appropriate times.					
27. Uses gloves correctly and appropriately.					
28. Uses antiseptics and disinfectants correctly.					
29. Follows the three steps for processing equipment/instruments that has contact with body fluids. The steps, in proper order, are: <ul style="list-style-type: none"> <li>- decontamination</li> <li>- washing/cleaning</li> <li>- high-level disinfection</li> </ul>					
30. Maintains single-use injection practice.					
31. Disposes used needles/sharps in a sharps container.					
32. Segregates wastes properly. <ul style="list-style-type: none"> <li>- Black trash bag = general, non-infectious, dry</li> <li>- Green trash bag = general, non-infectious, wet</li> <li>- Yellow trash bag = infectious, pathological</li> </ul>					

Key: 2 = Yes 0 = No	1 = Yes, but needs improvement NA = Not applicable	2	1	0	NA
- Sharps container = sharps					
33. Properly disposes contaminated materials, pathological, and other medical wastes.					
<b>LOGISTICS MANAGEMENT SYSTEM</b>					
34. Estimates FP commodity requirements of the clinic.					
35. Ensures proper storage of FP commodities.					
36. Follows the FEFO principle in using up stocks of commodities.					
37. Returns expired and damaged contraceptives and other supplies to the delivery team.					
38. Reviews/prepares records like the following to determine logistical requirements for FP commodities: – CDLMIS Inventory Report					
– Dispensed to User Report (DTUR)					
– Target Client List (TCL)					
– Supplies Ledger Card					
– Contraceptive Order Form (COF)					
39. Monitors stock levels of FP commodities by maintaining the authorized stock level (ASL) and ensures availability of these commodities at all times.					
40. Checks availability of essential clinic equipment and supplies and reports if any of these are not available or functional.					
41. Submits requirements for commodities and equipment to the procuring level.					
<b>INFORMED CHOICE AND VOLUNTARISM</b>					
42. Ensures that the six elements of informed choice and voluntarism are complied with in the facility: – Availability of a broad range of modern contraceptive methods. – No quota and targets are imposed on the BHWs. – No financial rewards or incentives. – No denial of rights and benefits. – Comprehensible information given to clients. – Informed consent for BTL and NSV are signed.					

## DOH ICV ADMINISTRATIVE ORDER



Republic of the Philippines  
Department of Health  
**OFFICE OF THE SECRETARY**

JUN 23 2011

**ADMINISTRATIVE ORDER**  
No. 2011- 0005

**SUBJECT: Guidelines on Ensuring Quality Standards in the Delivery of Family Planning Program and Services through Compliance to Informed Choice and Voluntarism**

### **I. BACKGROUND and RATIONALE**

In 2001, the Administrative Order- 50-A s.2001, National Family Planning Policy (NFPP) which embodies the Philippines FP program policies has refocused FP as a health intervention that will promote the overall health of all Filipinos by: preventing high-risk and unplanned pregnancies thus reducing maternal deaths, and preventing abortions, responding to the reproductive rights of women with unmet FP needs and promoting responsible parenthood. As such, the management and implementation of the program are specifically guided by the "Four Principles/Pillars of Family Planning" namely: 1) Respect for the sanctity of life; 2) Respect for human rights; 3) The freedom of choice and voluntary decisions (Informed Choice and Voluntarism - ICV); and 4) Respect for the rights of clients to determine their desired family size. These principles uphold the rights of the Filipino people to have access to quality health services, promote the will and abilities of couples and individuals to freely choose which method to use according to their religious beliefs and ethical values and cultural background to enable them to respond to their needs and aspirations in pursuit of a better life

In a memorandum to all regional directors of Centers for Health Development issued on June 29, 2006, the Department of Health (DOH) reiterated its order for national and local health managers and FP service providers to observe, comply and adhere to four FP guiding principles. However, through the years, ICV compliance has not been sustained reflecting the need to strengthen monitoring of implementation and the issuance of guidelines on establishing ICV compliance monitoring and reporting system.

This Order is issued to reiterate observance, compliance and adherence to the prescribed principles in the delivery of accessible quality family planning services.

**CERTIFIED TRUE COPY**

JUN 23 2011

*MAY JEEN AGUIRRE*  
MAY JEEN AGUIRRE  
Chief, Records Section - IMS  
Department of Health



## II. GOAL and OBJECTIVES

### Goal

To provide universal access to quality FP information and services to men and women whenever and wherever needed and enable them to make informed choice and voluntary decision to use modern FP method best suited to his/her needs.

### Objectives

1. To provide policy and program directions on FP service delivery that support informed choice and voluntary decision making;
2. To ensure that health service providers are providing accurate and complete information on family planning methods and services, crucial to informed choice and voluntary decision-making;
3. To increase awareness among men and women of reproductive age of their individual rights to access quality FP services and make choices for themselves; and
4. To establish and implement an effective and efficient monitoring and reporting system on informed choice and voluntary decision making.

## III. COVERAGE and SCOPE

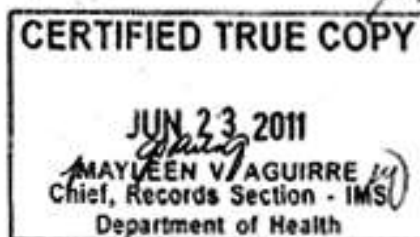
This policy applies to all DOH units and attached agencies such as the Commission on Population (POPCOM) and Philippine Health Insurance Corporation (PHIC), non-government organizations and the private sector.

Compliance to ICV policy requirements shall cover the operations of both public and private health facilities providing FP services under the local government units, and other government agencies in so far as their health service operations are governed by technical guidelines, standards, and policies mandated by DOH.

## IV. DEFINITION of TERMS

### 1. Informed Choice

Effective access to information on a wide range of family planning options and to counseling, services and supplies needed to help individuals choose to obtain or decline services, to seek, obtain and follow up on a referral, or simply to consider the matter further. ICV is when clients freely make their own decision based on accurate and complete information on a broad range of available modern FP methods.



## **2. Voluntarism**

Decision-making on the choice of FP method is based upon the exercise of free choice and not obtained by any special inducements or forms of coercion or misrepresentation.

## **3. FP Target**

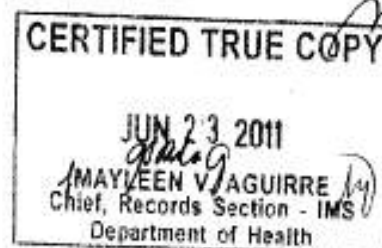
FP target is a quantitative estimate used for determining logistics and budget requirements for planning purposes;

## **4. Incentives**

An incentive is a form of payment in cash or material transferred or provided in order to influence or coerce the acceptance of any family planning method by a client or in recruiting clients to achieve set targets or quota by service providers.

## **V. GENERAL GUIDELINES**

1. The delivery of the family planning program services shall strictly adhere to the principles of:
  - a) Respect for the sanctity of life. Family Planning is aimed at preventing abortions thus saving the lives of women and children
  - b) Respect for human rights. Family Planning services are provided using only medically and legally acceptable methods appropriate to the health status/needs of the client and shall be provided regardless of gender, number of children, religion, sexual orientation, moral background, occupation, socio-economic status, cultural and political affiliation.
  - c) The freedom of choice and voluntary decisions. The Family Planning program enable couples and individuals to make family planning decisions based on informed choice through the provision of complete and accurate information.
  - d) Respect for the right of clients to determine their desired family size. The Family Planning program respects the basic rights of couples and individuals to freely and responsibly decide on the number and spacing of their children.
2. FP services shall adhere to quality standards and shall be part of an integrated core of service package across the continuum of care for men and women of reproductive age, so that missed opportunities in serving the unmet needs of clients will be reduced.
3. Informed choice and voluntarism shall be promoted in all facilities rendering FP services, public or private. Sustained regular quarterly monitoring coupled with facilitative supervision and periodic evaluation of service delivery procedures shall be established to ensure that clients are satisfied and able to make informed choices thus an informed choice and voluntary compliance monitoring system shall be installed at the central, regional and provincial, city/municipal levels of the health care delivery system.



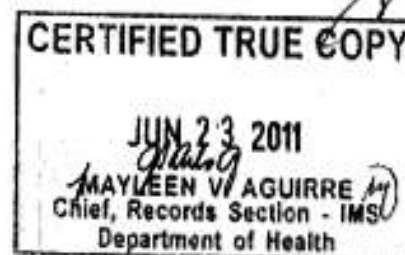


## VI. SPECIFIC GUIDELINES

1. To ensure adherence to the principles of the Family Planning Program and ensure delivery of quality services the following shall be implemented:
  - a) Clients will be provided with correct, evidence-based and comprehensible information on the benefits of the chosen method, including contraindications, and possible side effects. Clients will further be provided clear, unbiased information on the advantages and disadvantages of the various family planning methods and explain correct use of the chosen method.
  - b) Incentives and financial rewards, gratuities, and bribes shall not be provided in exchange of or to influence client's decision for becoming a FP acceptor, or for service provider to achieve a target or quota.
  - c) Clients shall not be denied any right or benefit including the right of access to participate in any program of general welfare or the right of access to health care, as a consequence of client's decision **not to accept** family planning services.
  - d) Clients shall be assured of the availability, accessibility and affordability of a broad range of FP methods to enable them to choose the suitable method they like and to switch when they decide to do so.
  - e) Proper referral systems shall be ensured by creating links with the concerned health facilities (both in the public and private clinics/ hospitals) and other agencies to meet the range of clients' family planning needs.
  - f) Service providers shall not be subjected to target/quota, or other numerical targets of total number of births, number of family planning acceptors, or acceptors of a particular method of family planning that may run contrary to clients' decision. This provision shall not include FP program targets used as quantitative estimates or indicators for planning and budgeting of logistics requirements.
  - g) Service providers shall ensure that informed consent have been secured from every voluntary sterilization (VS) potential acceptor prior to the performance of the procedure.
2. To promote informed choice and voluntary decision making, three types of measures or approaches shall be adopted for implementation. These are:

### A. Measures to promote compliance to ICV

The first approach is creating awareness among potential FP clients, FP public and private service providers including NGOs and local chief executives to strengthen their knowledge, attitude and skills in ensuring compliance to these policies and enable potential clients to have access to



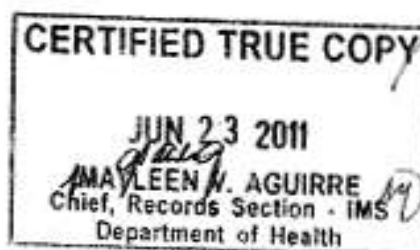
broad range of choice of FP services. The awareness raising activities for particular targeted groups are as follows:

1. Effective dissemination of information on ICV principles to potential clients especially regarding their rights to choose from and access a broad range of FP services. Public and private service providers including NGOs shall ensure that the counseling process reflects the principle of informed choice and leads to family planning decisions that clients make for themselves.
2. Effective dissemination of information on ICV principles to public and private FP service providers and NGOs including Barangay Health Workers (BHWs) as referral agents through:
  - The conduct of orientation training on ICV principles and policy requirements and Compliance Monitoring and Reporting among frontline public and private service providers, NGOs and BHWs on a regular basis;
  - The implementation of the revised Family Planning Competency-Based Training (FPCBT) Level 1 and Level 2 which also contain a comprehensive discussion on ICV thereby increasing the knowledge and improve the skills of frontline service providers in providing quality FP services.
  - Use of FP wall charts which explain all the FP methods. These shall be posted on the most visible area of the facility for the clients to read. Likewise, other IEC materials on the different FP methods shall also be available for the clients to read or take home.
3. Advocacy to Local Chief Executives (LCEs), leader, organizations of private sector providing FP services and NGOs on ICV principles to prevent the provision of incentives among their constituents/clients as this may influence informed choice and voluntary decision making of potential FP clients. Likewise, LCEs should support and ensure the availability of broad range of FP methods by providing logistics and budgetary support to the implementation of the FP program.

#### **B. Compliance Monitoring and Reporting Measures**

Monitoring Compliance shall also be implemented to ensure strict adherence to the ICV requirements in the delivery of FP services. These shall include the following:

1. Periodic ICV compliance monitoring and reporting





The Department of Health-National Center for Disease Prevention and Control (DOH-NCDPC) shall install a functional ICV compliance monitoring and reporting system at all levels: from the DOH-Center for Health Development (DOH-CHD) to the Provincial/City Health Office (PHO/CHO) to ensure ICV compliance at the city/municipal level health service delivery facilities.

ICV compliance monitoring shall be integrated into existing regular field visits. ICV compliance monitoring may also be incorporated during meetings and discussions with provincial, city and municipal health personnel to identify and address potential issues and concerns.

Compliance monitoring results shall be consolidated and reported to appropriate levels quarterly, while monitoring results indicating possible non-compliance shall be immediately reported to the Regional ICV Compliance Committee (Annex A. ICV Compliance Monitoring and Reporting Flow) using the narrative report form for non-compliance (Annex D)

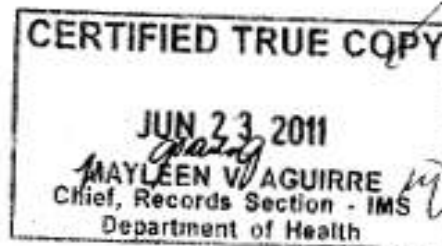
## 2. Use of standard ICV Compliance Monitoring Questionnaires and Reporting Forms

ICV compliance monitoring tool for service providers/service delivery sites and clients [Annex B1 and B2, ICV Compliance Monitoring Questionnaires] and Summary Matrix (Part B) were developed to facilitate the gathering of information pertaining to compliance with the National Family Planning policies of the Department of Health. The service provider and client questionnaires serve as rapid assessment tools.

The results of the service provider and client compliance monitoring shall be reported jointly using the standard reporting forms [Annex C. ICV Reporting Forms]. For instance, where the results from the two tools do not match, cross-checking and validation shall be conducted. In facilities where interviews of clients revealed possible non-compliance but interviews of service providers of the same facility did not reveal any possible non-compliance, there is a need to conduct a validation of the report.

## C. Implementing Corrective Measures

If, during monitoring visits, any service provider or any relevant person (program managers, policy-makers, or the local chief executives) is identified as not compliant to the ICV policy requirement, the following steps shall be undertaken:



1. A report of the non-compliance shall be immediately submitted to the Regional ICV Compliance Committee which upon receiving the report shall immediately mobilize the Regional Validation Team to conduct in-depth investigation.

2. In cases that non-compliance is confirmed, the Validation Team shall propose immediate corrective actions (e.g., ensure that the non-compliant practice ceases, formulation/issuance of appropriate local policies/guidelines addressing the compliance problem and reporting requirements are complied with ) and shall immediately prepare and submit the report on the in-depth investigation together with the proposed corrective action to the CHD Director/Regional ICV Compliance Committee who shall in turn immediately submit the report with recommendations to the NCDPC Director IV for information and possible recommendation of additional corrective action.

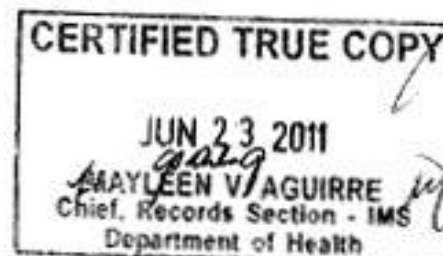
3. In instances where corrective actions for ICV non-compliance require national mandate (e.g., systems strengthening, training, policy changes), the CHD Director through the Regional ICV Compliance Committee shall submit an in-depth investigation report and recommendations to the DOH National ICV Compliance Committee through the DOH-NCDPC Director for immediate action.

4. Proper feedback on the findings of non-compliance with the appropriate recommendations/corrective actions are relayed to, applied and implemented by the health facility concerned. The DOH National ICV Compliance Committee through the FP program manager may conduct further investigation if necessary and/or shall ensure that the committee recommendations for further corrective actions are relayed to the CHD Director for implementation and monitoring.

## VII. IMPLEMENTATION ARRANGEMENT

### 1. At the National Level:

- a. The DOH-NCDPC-Family Health Office (FHO) shall create a National ICV Compliance Committee that shall be responsible for the overall implementation of the FP ICV Compliance Monitoring and Reporting Policy.
- b. The DOH-National ICV Compliance Committee shall strictly monitor the implementation and establishment of ICV compliance monitoring and reporting at the regional, provincial/city levels and shall ensure the regions that essential logistics requirements including the availability of monitoring tools/ instruments are set in place to support the implementation of the ICV compliance monitoring

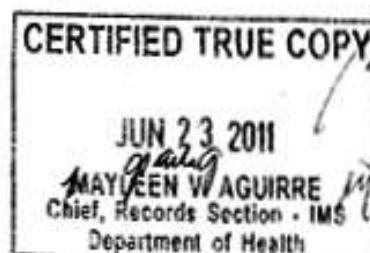




- c. The DOH National ICV Compliance Committee shall be chaired by the DOH-NCPDC Director and shall be composed of representatives from the
  - 1. DOH-NCDPC Family Health Office
  - 2. DOH-BHFS (Bureau of Health Facilities and Services)
  - 3. DOH-BLHD (Bureau of Local Health Development)
- d. DOH-NCDPC-FHO through the FP program manager shall ensure that National ICV Compliance Committee recommended corrective measures are relayed to and implemented by the concerned health facility found to be non compliant to ICV policy standards

**2. At the Regional Level:**

- a. The CHD Director IV shall constitute a Regional ICV Compliance Committee composed of the following:
  - i. Director IV or III as Chair
  - ii. Local Health Assistance Chief as member
  - iii. Family Health Cluster Head as member
- b. The CHD Director IV through Regional ICV Compliance Committee shall be responsible for the strict implementation and adherence of FP service providers and facilities to the FP informed choice and voluntary decision making policy.
- c. The Regional ICV Compliance Committee shall ensure that the CHD and its provinces have installed a functional ICV compliance monitoring and reporting system
- d. The Regional ICV Compliance Committee through the regional FP coordinator shall be responsible for the conduct of orientation training and use of the monitoring tools and reporting forms for the DOH-Representatives and the Provincial/City FP coordinators and technical staff.
- e. The regional FP coordinator shall consolidate all field monitoring reports and shall prepare and submit a semi-annual monitoring report to the Regional ICV Compliance Committee, and the National FP program manager (end of July and end of January of each year). Copies of the semi-annual report shall be provided to the P/CHO.
- f. The CHD Director IV shall create a Validation Team composed of the Regional Family Planning Coordinator and the members of the provincial/city monitoring team which reported the non-compliance. The Validation Team shall review and/or conduct in-depth investigation on reported non-compliance and recommend corrective actions.
- g. The Regional FP coordinator through the Provincial/City Monitoring Team shall regularly monitor and report the status of implementation of the recommended corrective measures where appropriate.
- h. The CHD Director shall ensure that LGUs have the essential logistics requirements including the availability of monitoring tools/ instruments to support the implementation of the ICV compliance monitoring



### 3. At the LGU Level:

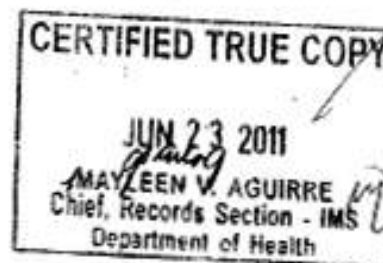
- a. The PHO/CHO through their respective FP coordinator shall be responsible for the functional operation of the provincial/city ICV compliance monitoring and reporting system and the strict adherence and compliance to the Informed Choice and Voluntary decision making policy
- b. The PHO/CHO shall ensure essential logistics requirements including the availability of monitoring tools/ instruments are set in place to support the implementation of the ICV compliance monitoring
- c. The DOH-Representatives with the PHO/CHO FP coordinators/technical staff shall orient all health service providers on compliance monitoring in their respective areas of responsibility.
- d. The PHO/CHO shall designate the Provincial/City Family Planning coordinator as the chair of the Provincial/City ICV Monitoring Team with the DOH-Provincial Team Leader and DOH-Representatives as members
- e. The Provincial/City ICV Compliance Monitoring Team shall monitor ICV compliance in all government and private health facilities providing FP services within their respective territorial jurisdiction (City Health Office, Main Health Centers, Rural Health Units, Barangay Health Stations, and hospitals, private clinics, NGOs providing FP services). ICV compliance monitoring shall be conducted as part of regular monitoring (quarterly) visits or as a separate ICV monitoring visit.
- f. The Provincial/City ICV Compliance Monitoring Team through the Provincial/City FP Coordinator shall consolidate and submit the report to the PHO/CHO and to the Regional ICV Compliance Committee.
- g. FP service delivery facilities' (CHOs, MHCs/RHUs, BHS, and hospitals) head, or the public health nurse/rural health midwife shall ensure that ICV components/elements are strictly implemented by ensuring that FP wall charts are displayed, information are disseminated and pertinent materials and counseling services are provided.

### 4. DOH Attached Agencies (POPCOM and PhilHealth)

- a. Support and advocate compliance to FP informed choice and voluntary decision making policy of the Department of Health
- b. Support CHDs in monitoring and reporting ICV compliance within their respective areas of responsibilities

### 5. NGO/Private Sector

- a. Support and advocate compliance to FP informed choice and voluntary decision making policy of the Department of Health
- b. Support ICV compliance monitoring and reporting within their respective areas of responsibilities



**VIII. REPEALING CLAUSE**

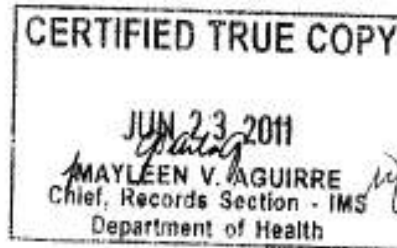
Any provisions of existing policies or issuances found inconsistent with this Order shall be deemed repealed.

**IX. EFFECTIVITY**

This Order shall take effect after fifteen days of publication in a newspaper of national circulation.



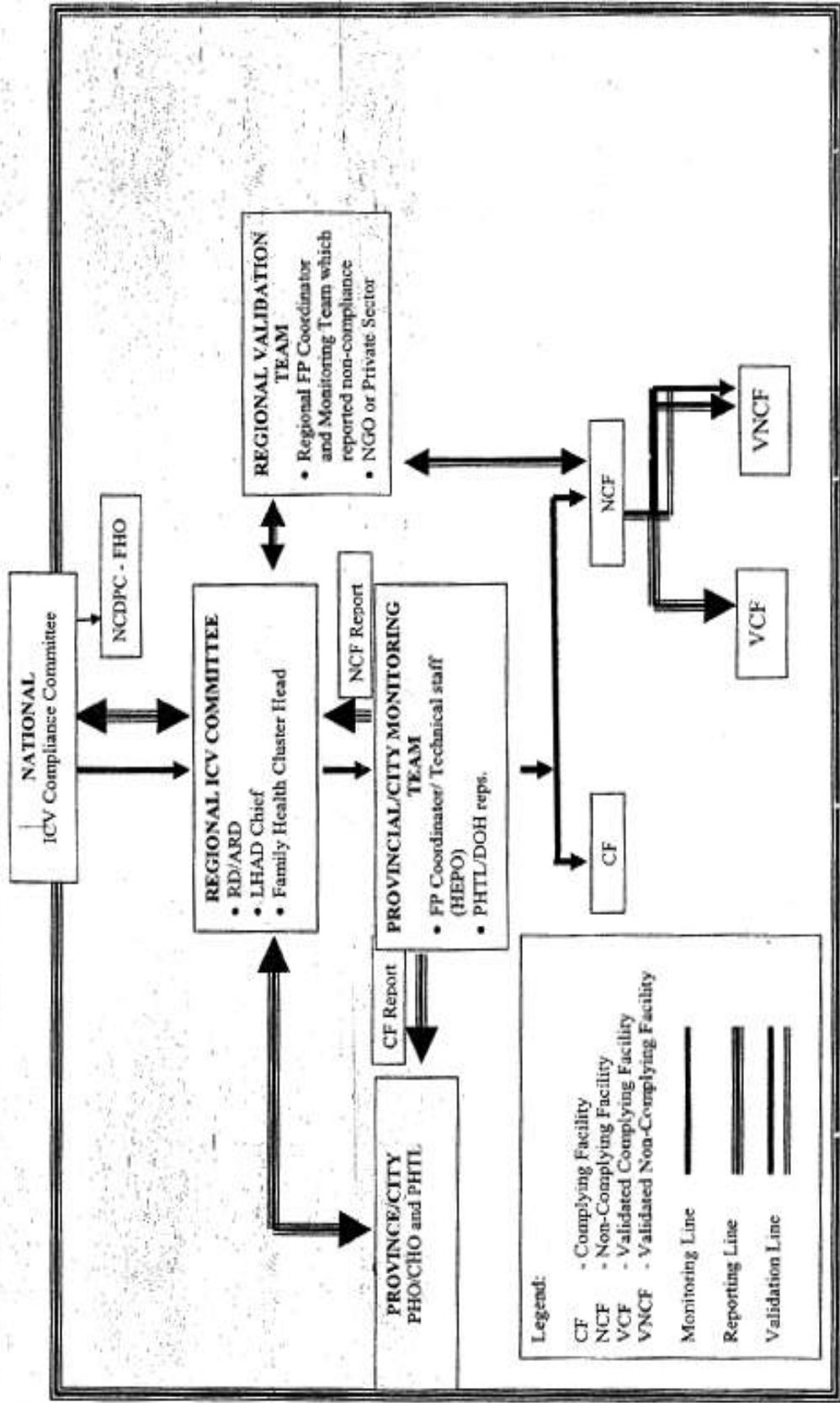
**ENRIQUE T. ONA, MD, FPCS, FACS**  
Secretary of Health





ANNEX A

ICV Compliance Monitoring and Reporting Flow Chart





**ICV Compliance Monitoring tool for Service Providers/Service Delivery Sites****Instructions to Interviewer:**

The purpose of this Assessment Tool is to facilitate the gathering of information related to compliance with the Department of Health legislative and policy requirements to ensure quality of care in family planning service delivery. This tool is intended to serve as a rapid assessment of compliance to the National Family Planning Program policies **by the service providers at service delivery sites or outlets** at the regional, provincial, city, municipal or barangay levels. It is not necessary to follow this tool verbatim, but rather during the course of conversation, to obtain the information requested below, it may be necessary to ask additional questions and probe deeper to obtain details about a given issue. It is the responsibility of the interviewer to continue the in-depth discussion to the point necessary to gather all the necessary information and provide a comprehensive report to the appropriate level of DOH office. If during the use of the tool there is a 'red flag' that indicates non-compliance, it is necessary to report this **immediately** to the appropriate level of DOH office to initiate in-depth investigation. The results of this tool must be reported jointly with the results of the Assessment Tool for Family Planning Clients. If the results obtained by the two tools do not match, further investigation will be required.

When all pertinent questions in the interview have been asked and answered, all feedback and comments have been taken, **BE SURE** to address the service provider's questions, issues or concerns. **DO NOT** leave without addressing issues that you had picked up during the interview.

**How to use this instrument:**

The instrument is divided into 10 sections that examine different aspects of family planning and abortion-related issues and concerns. Each section has several questions which are designed to elicit the information necessary to determine whether there is cause for concern related to that particular issue. Each section contains a space to record answers to the specific questions and a space for additional comments based on the information provided.

This tool is intended to serve as a guide to the interviewer. For record keeping purposes, please fill in the tool immediately following the interview and submit the form to the appropriate entity within your respective office.

**ICV Compliance Monitoring Questionnaire for Service Providers/Service Delivery Sites**

Date : \_\_\_\_\_

Name of Interviewer : \_\_\_\_\_

Position and Office : \_\_\_\_\_

Name of Health Facility : \_\_\_\_\_

Address of health facility : \_\_\_\_\_

Name of individual interviewed : \_\_\_\_\_

Position/Title : \_\_\_\_\_

Interviewees include: Doctors, nurses, midwives and barangay health workers.

**Introduction:**

My name is \_\_\_\_\_ and I work for \_\_\_\_\_ as a \_\_\_\_\_. I am here to collect some information about family planning services in this region/province/ city/ municipality/ barangay. I will ask you some questions about family planning services at this facility. Thank you for your assistance in helping us better understand the family planning services in this facility.

Do you have any questions? Yes  No

**1. Broad range of contraceptive methods available at the health facility**

No.	Question	
1.1	What family planning (FP) methods are currently available and offered to clients in this health facility?  <input type="checkbox"/> Pills <input type="checkbox"/> NFP (what method? _____) <input type="checkbox"/> Injectables <input type="checkbox"/> Bilateral Tubal Ligation (BTL) <input type="checkbox"/> Intra-Uterine Device (IUD) <input type="checkbox"/> Vasectomy <input type="checkbox"/> Condoms <input type="checkbox"/> Other (specify) _____	
1.2	If methods are not available, are clients referred elsewhere?	Yes <input type="checkbox"/> No <input type="checkbox"/>
	If yes, a) what methods _____ and b) where referred? _____	
<b>Comments</b>		

## 2. Numerical Targets

No.	Question	Answer	
		Yes	No
2.1	Do you have planned FP targets/goals?		
2.2	<p><i>If yes, for what purpose/s?</i></p> <p><input type="checkbox"/> Planning</p> <p><input type="checkbox"/> Logistics (forecasting, procurement and distribution)</p> <p><input type="checkbox"/> Performance evaluation</p> <p><input type="checkbox"/> Other, please specify:</p>		
2.3	<p>Are you required to achieve any assigned specific numbers of any of the following?</p> <p><i>If yes, please check all that apply:</i></p> <p>_____ total number of FP acceptors</p> <p>_____ number of acceptors of specific methods as follows:</p> <p>_____ for IUD</p> <p>_____ for injectables</p> <p>_____ for modern NFP (BBT, CM, ST, LAM, SDM)</p> <p>_____ for vasectomy</p> <p>_____ for pills</p> <p>_____ for condoms</p> <p>_____ for tubal ligation</p> <p>_____ for others, specify pls:</p>		
2.4	<p>What happens if you meet your targets?</p> <p>What if you fail to meet your targets?</p>		
<i>Comments</i>			

## 3. Incentives/Financial Rewards

No.	Question	Answer	
		Yes	No
Incentives/Financial rewards for Service Providers/Clients			
3.1	<p>Aside from your salary, do you get paid (money or in kind) for FP services and/or referrals?</p> <p><i>If yes, how much and explain for what?</i></p>		
3.2	Are financial rewards/incentives provided when you achieved your individually assigned predetermined FP numerical targets?		

3.3	Does the facility offer anything to clients in exchange for accepting family planning (e.g., food, money)?		
<i>If yes, how much and for what?</i>			
<i>Comments</i>			

#### 4. Denial of Benefits

No.	Question	Answer	
		Yes	No
4.1	If a client decides not to use family planning, are any benefits or rights withheld from the client or their family?		
4.2	<i>If yes, what is withheld?</i>		
<i>Comments</i>			

#### 5. Comprehensible Information

No.	Question
5.1	What information do you give to clients about the FP method he/she has chosen (check) <input type="checkbox"/> Risks and benefits <input type="checkbox"/> Side effects <input type="checkbox"/> Advantages/Disadvantages <input type="checkbox"/> How to use the methods/procedures <input type="checkbox"/> Conditions that would render method inadvisable?

#### 6. Family Planning IEC Materials Available

No.	Question	Answer	
		Yes	No
6.1	Is there a wall chart with all FP methods visible? ( <i>where is/are posted and in what language?</i> )		
6.2	Are other family planning IEC materials available- flipcharts, brochures, leaflets, etc)		
<i>Comments</i>			



### 7. Abortion

No.	Question	Answer	
		Yes	No
7.1	Have there been times when you were consulted for missed or delayed menstruation?		
7.2	What do you do when such clients ask you to help them regain menstruation?		
7.3	What do you do if pregnancy is confirmed?		
<i>Comments</i>			

### 8. Voluntary Surgical Sterilization (VSS)

No.	Question	Answer	
		Yes	No
8.1	<b>VSS Information Giving</b>		
8.2	Do you provide counseling to clients who want VSS services (BTL/Vasectomy)?		
8.3	Does this health facility have informed consent forms for VSS?		
8.4	Are informed consent forms signed prior to any VSS procedure?		
8.5	<b>Compensation to Clients/Providers services</b>		
8.6	If VSS is provided at this health facility, do VSS clients receive any type of compensation? <i>If so, how much?</i>		
8.7	If VSS is provided at this health facility, are referral agents or service providers paid on a per case basis related to VSS?		
<i>Comments</i>			

### 9. Document Review

No.	Question	Answer	
		Yes	No
<i>Request for permission to review the service provider's service records/statistics (3-6 months) and referral records (ex. FP Form 1, FP clients' logbook; target client list; FHSIS monthly/quarterly reports; O.R. logbook; others). Use the guide</i>			

<i>questions below to determine compliance with FP policies.</i>		
9.1	Are there any sharp increases that might indicate more emphasis on increasing number of acceptors/users of any one particular method (note or record any observations)?	
9.2	Are there any kind of inconsistency in the data (ex. Anything that looks unusual; supply vs. utilization reports)?	

**10. Coercion**

No.	Question	Answer	
		Yes	No
10.1	Is there any evidence of coercion in the family planning program?  If yes, please describe and explain.		

**ICV Compliance Monitoring Tool for FP Clients****Instructions to Interviewer:**

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When all pertinent questions in the interview have been asked and answered, all feedback and comments have been taken, BE SURE to address the FP clients' issues or concerns. DO NOT leave without addressing issues that you had picked up during the interview.

This tool is intended to serve as a guide to the interviewer. For record keeping purposes, please fill in the tool immediately following the interview and submit the form to the appropriate entity within your respective office.

**ICV Compliance Monitoring Questionnaire for Family Planning Clients**

Date \_\_\_\_\_

Name of Interviewer \_\_\_\_\_

Position and Office \_\_\_\_\_

Place of Interview/address \_\_\_\_\_

Client (circle one) : Male                  Female

**Introduction**

My name is \_\_\_\_\_ and I work for \_\_\_\_\_ as a \_\_\_\_\_. I am here to collect some information about the family planning services in this area. I will ask you some questions about the family planning services you have received and your impressions about family planning services in general. The results of our interview and data collection will be used to better understand the current situation in this LGU and to identify areas that might be strengthened or improved. I am not recording your name or any other information that could be linked to you. The responses you give me are confidential and will be summarized with the responses of other clients from different sites around the country. In addition to our discussions with clients, we will also be gathering information from health facility staff.

Do you have any questions? Yes  No

Do you agree to participate in this interview? Yes  No

**1. Client Feedback on the Quality of FP Services**

No.	Question	Answer
1.1	What family planning method are you currently using?	
1.2	Where do you get family planning supplies and/or services?	
	<i>If no, explain?</i>	

**2. Voluntary decision making**

2.1	How did you decide/choose the FP method that you are using now?
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2.2	Who decided/chose the family planning method that you are using now? <input type="checkbox"/> A. Myself <input type="checkbox"/> B. My husband/partner <input type="checkbox"/> C. My in-laws/parents <input type="checkbox"/> D. Others: (pls. specify) _____
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### 3. Knowledge of complete and accurate information on FP method

No.	Question	Answer	
		Yes	No
3.1	Did the service provider share with you the information about the method you selected.  <input type="checkbox"/> advantages/disadvantages <input type="checkbox"/> possible side effects <input type="checkbox"/> how to use the method/procedures <input type="checkbox"/> conditions that made method inadvisable		
3.2	Did the service provider explain what to do and where to go if you experienced side effects?		
3.3	Do you think that you received all of the information necessary to make a decision about your family planning needs?		

### 4. Coercion/Denial of Benefits

No.	Question	Answer	
		Yes	No
4.1	Did you feel any pressure from anyone to use family planning, or to use a particular method?		

### 5. Incentives/Financial Rewards

No.	Question	Answer	
		Yes	No
5.1	Did someone give you anything, in exchange for using family planning or using a particular method (i.e. food, money, gift, access to a particular program)?  <i>If yes, what or how much?</i>		

**1. Voluntary Sterilization (for BTL/NSV Clients only)**

No.	Question	Answer	
		Yes	No
6.1	Before you had the procedure, did you sign a form saying you understand what bilateral tubal ligation (BTL)/vasectomy is about?		
6.2	Did you receive anything (money, food, gift, etc.) for having BTL/vasectomy done?		
	<i>If yes, what or how much?</i>		

**Part B. Summary Matrix of Service Providers/Facilities Monitored and Family Planning Clients Interviewed**

Date Monitored	Name of Facilities	Location of Facilities	Name/Designation of Service Providers	No. of FP Clients Interviewed	Monitored by	Results/Findings (Please be as detailed as possible and indicate separately for service providers and FP Clients)	Steps Taken/ Recommendations (Please be as detailed as possible and indicate separately for service providers and FP Clients)

Total number of Facilities Monitored: \_\_\_\_\_  
 Total number of Service Providers Monitored: \_\_\_\_\_  
 Total number of FP clients interviewed: \_\_\_\_\_

Number of facilities noted to be compliant to policies: \_\_\_\_\_  
 Number of facilities noted to not compliant \_\_\_\_\_

**Part C. General Recommendations and Next Steps**  
*Good points determined during this monitoring:*

\_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_  
*Points to improve on and recommendations/next steps:*  
 \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

Prepared by: \_\_\_\_\_ (Signature over printed name) Designation \_\_\_\_\_ Contact Number \_\_\_\_\_  
 Date: \_\_\_\_\_

**Form 3: ICV Reporting Form for Service Provider/Service Delivery Sites and Clients Monitoring Results**

Center for Health Development: \_\_\_\_\_  
 Province/City: \_\_\_\_\_  
 Date Submitted: \_\_\_\_\_  
 Report for the Month of: \_\_\_\_\_

**Part A: Technical Assistance, Inputs and Other Activities**

Specific Activity (Topic or Content)	Date of Activity	Place of activity	Conducted By Whom	Number of Participants		Remarks
				M	F	

Total Number of Orientation/Training Activities conducted: \_\_\_\_\_  
 Total Number of Participants Trained or Oriented: \_\_\_\_\_  
 Males: \_\_\_\_\_  
 Females: \_\_\_\_\_

**Narrative Report of Non-compliance with FP Policies**

**Date of monitoring:**

**Name of Unit (RHU/Hospital/private clinic, etc)**

**Location/Exact Address of Unit:**

**Reported by:**

**Witnessed by:**

**Complete Name/s of Service Providers or Source of Info:**

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**Nature of the incident/possible non-compliance:**

**Specific FP Policy possibly not complied with:**

**Evidence/result or outcome of the possible non-compliance committed, if any:**

**Action taken by reporter/eyewitness:**

**Printed name and signature of eyewitness or reporter:**

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**Printed name and signature of the FP Compliance Focal Person:**

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**Noted by (Signature of) the Reporter's immediate superior:**

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