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CHAPTER FIVE

Family Planning

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All people have the right to family planning services and information

1 Introduction

Family planning (FP) allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.

The use of FP methods has the potential to avert 32% of all maternal deaths and nearly 10% of childhood deaths, while at the same time decreasing rates of poverty and hunger.[*]

[*] Cleland, John, et al. "Family planning: the unfinished agenda." *The Lancet.* The Lancet Sexual and Reproductive Health Series, October 2006. http://www.who.int/reproductivehealth/publications/general/lancet_3.pdf.

Family Planning

Additionally, the use of FP methods contributes to women's empowerment, schooling and economic stability. Due to the health risks of pregnancy, sexually transmitted infections (STIs), including the human immunodeficiency virus (HIV), and unsafe abortion, unprotected and unsafe sex is the second most important risk factor for disability and death in the world's poorest communities. FP methods are safe, effective and inexpensive to provide.

2 Objectives

The objectives of this chapter are to:

- provide guidance for RH programme managers and service providers on FP needs, methods, effectiveness and their appropriateness in humanitarian settings;
- describe factors necessary to establish FP services, including needs assessments, coordination, planning, implementation, monitoring and review.

3 Programming

The affected population, both males and females, must be involved in all aspects of FP programming, including volunteerism and choice. Religious and community leaders should also be involved to ensure that services are culturally appropriate.

The situation in the affected population's region or country of origin is an important factor influencing expectations, perceived needs and demand for family planning. Laws, infrastructure, religious and ethical values, cultural backgrounds and the competencies and skills of health-care providers from the host country have an important effect on the services that can be offered.

At the onset of the humanitarian response, some women may seek to continue using a contraceptive method that they used before the crisis. Although comprehensive FP programming is not part of the Minimum Initial Service Package (MISP), it is important to make basic contraceptive methods available to meet women's demands for continued family planning. Condoms should be made available from the start of the response to prevent transmission of STIs, including HIV, and unwanted pregnancy (see Chapter 2: Minimum Initial Service Package).

Once the situation stabilizes, women (and their partners) may want to start, change or discontinue a contraceptive method. FP counselling must precede FP method provision and must realistically reflect the methods available since a full range of FP services may not be available until later in the programme.

Every FP client has the right to confidentiality and privacy and to voluntarily choose a method. Contraceptive methods are commonly used by women; however, men are frequently the decision-makers within the family. Hence, men should be given appropriate information and encouraged to take an active role in the FP decision-making process. This will help ensure that joint responsibility is taken for FP decisions and maximize acceptance of the programme within the community. An exception would be where involving the man would compromise the safety of the woman.

Protocols used to manage FP services in the region or country of origin may be dif-

ferent from those used in the host country. Host country protocols need to be followed, although some negotiation, taking into account international standards, may be necessary where differences exist.

3.1 Needs assessment

In coordination with other health actors through the health cluster coordination mechanism collect background information on reproductive health (RH) from the affected community. Sources for this information include the Ministry of Health (MOH), UNAIDS, UNFPA, WHO, religious and community leaders and other governmental and nongovernmental agencies that work in reproductive health and/or family planning. Agency headquarters or regional offices can assist you in obtaining this information.

Conduct a review of national, multilateral or bilateral FP agencies and/or programmes in place prior to the crisis or in the country of origin in case of displacement, in order to find opportunities for collaboration and to identify any differences in protocols that need to be resolved. Any services that are made available must be available to both the affected population and the host community.

To understand the need and demand for family planning among the affected population:

- Investigate community and cultural beliefs and attitudes towards contraception.
- Assess potential providers' competencies of contraception provision, including traditional methods.
- Gather information on contraceptive prevalence by method.
- Verify availability of supplies and continuity of supplies.
- Determine availability and functionality of existing facilities.

Prohibitions, religious beliefs or the refusal to recognize women's reproductive rights may provoke opposition to family planning. Seek the support of the community and community and religious leaders for an Information, Education and Communication (IEC) campaign emphasizing birth spacing, safe motherhood and the health of women. Also involve members of the community (men, women and adolescents) and community leaders in setting up FP services. Without their support, the FP services programme might risk community censure.

Hold discussions with men, women (including leaders, traditional healers, traditional birth attendants (TBAs)), adolescents and local organizations to obtain suggestions on the locations of service delivery points; timing of services at the health facilities; and level of privacy and confidentiality needed to ensure maximum use and acceptability. Hold discussions with men and women separately depending on cultural and local norms (e.g. focus group of a local women's group).

RH programme managers and service providers must also be familiar with national legislation and policies in the countries in which they are working on the following issues related to family planning:

- What are the laws and policies on access to family planning information and services?
  - Are there laws or policies relating to universal access to FP information and services?
  - Are there laws or policies restricting access of some people (adolescents,

Emergency Contraceptive Pills (ECPs) are a back-up method for contraceptive emergencies, which women can use within the first five days after unprotected intercourse to prevent an unwanted pregnancy. Service providers must be aware that ECPs do not cause abortion. ECPs prevent ovulation and are not effective once the process of implantation has begun. ECPs do not affect an already existing pregnancy.* (See also paragraph 3.9.5 below and Chapter 2, paragraph 3.2.3.)

* *Emergency Contraception, Fact sheet N°244*, WHO, revised October 2005.

unmarried women, etc.) to FP information or services?
- Are there laws or policies on the provision of emergency contraceptive pills (ECPs)? How are ECPs made available to women?

- Are there requirements for marital, parental or guardian approval for delivery of FP information and services to adolescents? Is the evolving capacity and best interest of adolescents taken into consideration in laws or policies regulating adolescents' access to FP information and services?
- Are there spousal approval or other status requirements (age, number of children) for women to undergo sterilization or access other kinds of FP services?

3.2 High-quality family planning services

High-quality FP services meet individuals' and couples' needs at every stage of their reproductive lives through providing opportunities for making informed decisions, a range of methods

Box 21: High-quality Family Planning

High-quality FP means that:

- Services are convenient, accessible and acceptable to clients.
- Confidentiality of information and physical privacy is ensured.
- Providers are trained and competent to provide appropriate counselling to clients and take sufficient time to do so.
- Providers have the necessary technical skills and have access to service delivery guidelines, protocols and a sustainable supply of FP commodities.
- A range of FP methods is available.
- Clients' needs are assessed.
- Informed choice is ensured: complete and accurate information about available methods is offered.
- Method-specific counselling is conducted.
- Standards recommended by national or international protocols are maintained.
- All procedures are performed by trained personnel according to service delivery guidelines.
- Clients are resupplied with their method of choice in a timely manner, management of complications is ensured and when a client wants to switch methods, alternative options are offered.
- A logistics system is in place to ensure a sustainable supply of FP commodities.

to chose from, safe procedures and continuity of services. Service providers should provide clients with accurate and complete information, allowing women and men to voluntarily select a method that suits their needs.

3.3 Contraceptive logistics

At the onset of the humanitarian response, ensure service providers can respond to the demand for contraceptive continuation. Basic contraceptive methods are included in the Inter-Agency RH Kits (see Chapter 2: MISP, paragraph 3.5, p. 44). Once the MISP is implemented, clients must have access to FP counselling and services and be provided with the contraceptive method of their choice. Additional contraceptive stocks and a wider range of methods for comprehensive FP programming must be ordered. As soon as possible, move from ordering kits to an integrated logistics system based on demand to ensure sustained availability of a range of methods and to avoid wastage.

Train or hire staff with supply chain management skills to ensure timely ordering and avoid stock-outs. Investigate local supply channels and if these are inadequate, supplies should be obtained through official suppliers or with support from UNFPA, UNHCR or WHO. These agencies can facilitate the purchase of bulk quantities of good-quality contraceptives at low cost to avoid stock-outs. Locate supplies as close to the affected population as possible.

Box 22: Basic Steps to Manage Stocks of Contraceptives

- **Select contraceptive methods.** Base the selection of the range of methods on: past use within the target community and continuing users; providers' skills; local practice, law and culture; and the opportunity to offer clients a choice.

- **Calculate procurement quantities.** Base initial estimates based on local Ministry of Health (MoH) data and later from data generated within the displaced population. Review programming and procurement plans regularly so that quantities can be adjusted to reflect the needs of the population, which may change rapidly in size and composition.

- **Set up a record-keeping system.** Set up a system that collects logistics data from service delivery points and reports monthly or quarterly to the agency responsible for resupply. The data to be collected and reported should include:
  - stock on hand at the facility
  - lost, damaged or expired products, and
  - consumption (rate of consumption of each product).

- **Develop logistics management procedures.** Develop procedures to efficiently manage contraceptive procurement and inventory control (storage, transportation and distribution). Regular reporting and distribution schedules are a critical component of these procedures. Without timely information on supply levels and consumption, distributing adequate quantities of contraceptives to service providers becomes less likely. Avoid under- or over-supply by careful organization of the logistics. Appoint a supervisor (with secondary person in place) who assumes these specific responsibilities.

Sample records and report forms can be found in the resources in the Further Reading Section.

3.4 Opportunities for FP services

Design FP services so that they are accessible and convenient. Implement FP services at health centres, outreach health posts and through community-based distribution (CBD) channels. Some groups, such as adolescents (refer to Chapter 4: Adolescent Reproductive Health, para 3.3) and unmarried women, may need special consideration to feel comfortable using the services and to avoid the risk of stigmatization by the community. Availability of contraceptives at the consultation point is vital: Do not set up services requiring the client to obtain the selected method at a pharmacy or another site. An exception would be surgical procedures that are not available at the consultation point (e.g. voluntary sterilization). Put in place a referral system for clients who make these choices.

> Integrate FP counselling and methods into safe abortion care (SAC), post-abortion care (PAC), STI, HIV, antenatal care (ANC) and postpartum services to create opportunities for clients that may not be reached otherwise.

To ensure integration of FP for more comprehensive services, RH officers, programme managers and FP service providers must implement the following guidance:

- Ensure that FP information is provided during SAC or PAC counselling prior to any procedures and that if the woman is interested, her choice of FP method is made available to her in postprocedure counselling.
- When a woman, man or adolescent comes for care and treatment for STIs, including HIV, ask whether she or he is using a FP method and provide her/him with method-specific counselling and provision for the method of her/his choice. Men are still limited to male condoms and voluntary sterilzation; however, they can be involved in other FP choices with their partner.
- When a woman or girl comes for ANC, ask whether she was using a FP method before she got pregnant and if she would like to restart or start an FP method after delivery.
- When a woman comes for postpartum care services, ask whether she is using an FP method and counsel her based on her needs.

3.5 Human resources

- Organize supervision of FP services with a nurse, midwife or doctor with management experience.
- Identify and hire members of the affected community or local staff from the host community who have skills and experience to provide quality FP services.
- Ensure supervision and training of lay workers who provide CBD. Include the following in their training: how to recognize medical issues that should lead to referral; skills for client follow-up; and how to address contraceptive attitudes and beliefs. Create awareness among community members that the lay worker is supervised by a nurse or doctor, whom a client may see if clinical or counselling care is necessary.

As with all RH services, those involved in providing FP services must respect client confidentiality and show respect for the client's opinion and choices. To ensure continuing contraceptive use and increase FP uptake, providers should be of the same sex and cultural background as clients, and should have strong communication skills.

To ensure administrative, technical and referral support, there must be coordination and cooperation within the health sector/cluster coordination mechanism, the national FP programme and with NGOs and UN agencies involved in family planning. Such cooperation will also increase the sustainability of FP programmes.

3.6 Information, education and communication

Client counselling is an integral part of FP services. Appropriate, culturally acceptable information, education and communication (IEC) materials help individuals and couples make contraceptive choices. Information must include benefits and constraints of different methods, explanation on correct use and emergency methods in case of failure. In addition, materials with graphics and samples of contraceptives to show the client are helpful, particularly in areas with low literacy. As the FP programme expands, ensure that IEC materials are adapted to increase the quality of the services provided. Examples of IEC materials are provided on this manual's accompanying CD-ROM. Prepare versions in local languages or develop homemade materials and models.

3.7 Training of FP service providers

All staff providing FP services must have adequate training on contraceptive methods and counselling, as indicated in the list below. This training should be supplemented by periodic updates. As the FP programme expands, on-the-job training and supervised practice are essential to ensure high-quality performance. Tools and resources for training service providers are provided on the accompanying CD-ROM.

The elements of an adequate training programme for FP service providers include:

1. technical competence (3.7.1);
2. communication and counselling skills (3.7.2);
3. administrative skills (3.7.3).

3.7.1 Technical competence

Providers need to be aware of the following:

- Description of methods, including correct use, advantages, disadvantages and effectiveness (see Table 11: Comparing Oral and Local Application Hormonal Methods, p. 118).
- Mode of action, side-effects and management of side-effects, complications, danger signs
- Instructions for use or administration
- Medical eligibility and drug interactions
- Technical skills relating to the provision of each method, for example, infection prevention, insertion and removal of intrauterine contraceptive device (IUD) or hormonal implant
- Follow-up and resupply requirements, including ordering supplies
- Documentation and record keeping
- Referrals based on clinical decision-making

For methods that require specific technical skills, such as injectable contraceptives, implants, IUDs, male and female voluntary sterilization and the diaphragm, providers need hands-on training in method provision followed by close supervision and experience in counselling for and providing such methods.

3.7.2 Communication and counselling skills

In this component of training, FP service providers acquire the following skills:

- nonjudgmental attitude towards contraceptive users and nonusers, respecting their choices, dignity, privacy and confidentiality;
- evidence-based and tactful responses to rumours and misconceptions;
- sensitivity to the needs of specific groups (e.g. adolescents, disabled, people living with HIV);
- culturally sensitive, unbiased techniques;
- communication techniques, such as; open interactive dialogue with clients; encouraging clients to speak; active listening; clarifying; asking clients to restate their understanding; acknowledging client feelings; summarizing the discussion;
- documenting method choice.

Train providers in effective communication skills

Box 23: Checklist for Establishing FP Services*
☐ Assessment of attitudes of different groups undertaken
☐ Contraceptive prevalence of country of origin (or in-country)
☐ Contraceptives procured and logistics system in place
☐ FP record-keeping system in place
☐ Active involvement of users of FP services
☐ Involvement of local men, women and community leaders
☐ FP service sites established with participation of affected populations
☐ Service providers trained in FP service delivery as defined by national authority
*Some of these tasks will have to be done simultaneously.

to provide method counselling within a limited time frame. Providers must be trained or updated on the use of educational materials and learn how to identify clients with special needs, such as adolescents, those at high risk of STIs, including HIV, women who are breastfeeding, etc. Role playing will increase providers' competency in approaching different cases.

3.7.3 Administrative skills

Administrative skills include record keeping, inventory control and supervising community-based distributors. Emphasize the specific skills necessary to carry out these tasks, why they are important and how and when to carry them out.

3.8 Family planning service provision

Family planning consultation

The first contact between a provider and client involves:

- registration and taking a reproductive health and medical history;
- physical examination (if indicated by the history), which may include a pelvic examination (e.g. to investigate unexplained vaginal bleeding);
- counselling on available contraceptive methods and the client's preferred choice while considering her/his STI/HIV risk and medical history;
- providing the selected contraceptive method and explanation on its use:
  - Counsel the client on correct use of the contraceptive, including the route of ad-

Dual Protection

Many sexually active people need dual protection: protection against unintended pregnancy and against STIs, including HIV. Those contraceptives that offer the best pregnancy prevention do not protect against STIs. Thus, simultaneous condom use for disease prevention is recommended. Condoms used alone can also prevent both STIs and pregnancy if used correctly and consistently, but are associated with higher pregnancy rates than condoms used together with another contraceptive method.

ministration, what to do in case of missed doses and where to access emergency contraception if needed. In addition, explain possible side-effects and reassure the client that she/he can return to the health facility at any time for management of side-effects or to change methods.

- scheduling a follow-up visit or visit by a lay worker:
  - Give new users a date for the follow-up visit. Such follow-up visits will give the client opportunities to ask questions about contraceptive use and any side-effects that she/he may have experienced. With some methods, such as contraceptive pills, condoms and injectable contraceptives, clients must have regular contact with the CBD service provider or the nurse to obtain the contraceptives. As the user becomes familiar with a method, follow-up visits can be initiated by the user her- or himself. Whatever the frequency of follow-up visits, the client should be assured of immediate access if she/he experiences any difficulties. When arranging follow-up visits, service providers must be sensitive to the literacy level of the client and use appropriate job aids to ensure that information is understood by the client.
- documenting visit in standardized data collection materials and patient records.

National protocols, job aids or checklists may exist. Ensure technical correctness and congruence with international standards.

Pregnancy diagnosis

The diagnosis of pregnancy is important because a provider should not prescribe a FP method for clients who are pregnant. The ability to diagnose early pregnancy will vary depending on resources and settings. Reliable pregnancy tests are very useful, but may not be available. Pelvic examination, if conducted by a skilled provider, is reliable at approximately 8–10 weeks since the first day of the last menstrual period. If neither of these are feasible, the checklist on the following page can be used by service providers to be reasonably sure that the client is not pregnant.

Figure 4: Checklist to Exclude Early Pregnancy

Ask the client questions 1 – 6. As soon as the client answers yes to any question, stop and follow the instructions.

NO	1. Did you have a baby less than 6 months ago, are you fully of nearly exclusively breastfeeding and have you had no menstrual period since the birth?	YES
NO	2. Have you abstained from sexual intercourse since your last menstrual period or delivery?	YES
NO	3. Have you had a baby in the last 4 weeks?	YES
NO	4. Did your last menstrual period start within the past 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	5. Have you had a miscarriage or abortion in the last 7 days (or within the past 12 days if you are planning to use an IUD)?	YES
NO	6. Have you been using a reliable contraceptive method consistently and correctly?	YES

If the client answered no to all of the questions, pregnancy cannot be ruled out. Use a pregnancy test to exclude pregnancy, or client should await menstruation before starting her method of choice.

If the client answered yes to at least one of the questions and she is free of signs and symptoms of pregnancy, provide client with desired method.

Box 24: Contraceptive Considerations for Adolescents
• Although young women are often less tolerant of side-effects, counselling will help adolescents know what to expect and may make them less likely to stop using their methods. • Unmarried adolescents may be at increased risk of STIs and HIV transmission. Counsel on dual protection strategies to reduce the risk of STI infection. • Female adolescents may have less control than older women over having sex and using contraception. This may increase their need for emergency contraception. Counsel all adolescents who seek emergency contraception on FP methods and give them the option to take extra emergency contraception with them. • Young women often prefer methods which they can use without others knowing (such as injectable contraceptives). • Because of the many barriers for adolescents to access health care at facilities, CBD should also target adolescents. For more information refer to Chapter 4: Adolescent Reproductive Health.

3.9 Family planning methods

Service providers must be able to explain the characteristics of each method, how to use it, its effectiveness, safety and side-effects. They must know how the method affects STI and HIV transmission, its appropriateness for clients who have special needs (such as adolescents, clients with acquired immunodeficiency syndrome (AIDS) and breastfeeding women) and the length of time between discontinuation of the method and return to normal fertility. Ensure providers have access to this information for all FP methods available in the setting and are able to use it in accordance with the reproductive goals of each client.

3.9.1 Fertility awareness methods

Effective use of fertility awareness methods requires that a woman knows how to tell when the fertile time in her menstrual cycle begins and ends. These methods include those that rely on symptoms of fertility, such as tracking the basal body temperature or daily cervical secretions (Two-day Method) or calendar-based methods, which rely on keeping track of days of the menstrual cycle (Standard Days Method). Using these methods requires cooperation of both partners.

Fertility awareness methods are particularly appropriate for people who do not wish to use other methods for medical reasons or because of religious or personal beliefs. Service providers should advise couples that these methods do not protect them from STIs, including HIV infections, and, due to their low effectiveness, may not be appropriate when pregnancy would be an unacceptable risk to a woman's health.

3.9.2 Hormonal contraceptives

Hormonal contraceptives contain progestogen alone or in combination with estrogen to prevent a woman from ovulating. They are common, highly effective and easy to use. There are several administrative routes (by mouth, injection, implants, skin patch, etc.), which are discussed in Tables 11 to 13. When a woman chooses a hormonal method, she must be counselled on correct use, what to do in case of a missed dose and possible side-effects, such as changes in menstrual bleeding patterns. Supportive counselling and continued reassurance during follow-up visits will help clients correctly use the method and tolerate common side-effects.

Table 11: Comparing Oral and Local Application Hormonal Methods				
Characteristics	**Combined oral contraceptives (COC, "the pill")**	**Progestogen-only contraceptives (POP, "mini-pill")**	**Combined patch**	**Combined vaginal ring**
Method of use	Pills taken orally	Pills taken orally. Safe for breastfeeding women and their babies	Patch worn on upper outer arm, back, abdomen or buttocks—not on breasts	Ring inserted in the vagina
Contains	Low doses of 2 hormones—a progestogen and an estrogen	Very low doses of a progestogen	Continuously releases 2 hormones—a progestogen and an estrogen	Continuously releases 2 hormones—a progestogen and an estrogen
Frequency of use	Daily for 21 days, followed by a break or pills without hormones for 7 days	Daily. No break between packs	Weekly: Patch is changed every week for 3 weeks. No patch worn 4th week	Monthly: Ring kept in place for 3 weeks and taken out during 4th week
Effectiveness (Pregnancy rate as commonly used)	Depends on user's ability to take a pill every day As commonly used, about 8 pregnancies per 100 women over the first year	Depends on user's ability to take a pill every day at the same time Breastfeeding: About 1 pregnancy per 100 women over the first year Not breastfeeding: About 3 to 10 pregnancies per 100 women over the first year	Requires user's attention once a week. Effectiveness rates under research. May be more effective than COCs	Depends on user keeping the ring in place all day, not leaving it out for more than 3 hours at a time. Effectiveness rates under research. May be more effective than COCs
Bleeding patterns	Typically, irregular bleeding for the first few months and then lighter and more regular bleeding	Typically, in breastfeeding women the pills lengthen the period of no monthly bleeding For nonbreastfeeding women frequent or irregular bleeding is common	Similar to COCs, but irregular bleeding is more common in the first few cycles than with COCs	Similar to COCs, but irregular bleeding is less common than with COCs

Characteristics	Combined oral contraceptives (COC, “the pill”)	Progestogen-only contraceptives (POP, “mini-pill”)	Combined patch	Combined vaginal ring
Average delay in time to pregnancy after stopping method	No delay	No delay	No delay	No delay
Privacy	No physical signs of use but others may find the pills	No physical signs of use but others may find the pills	Patch may be seen by partner or others	Some partners may be able to feel the ring
Other considerations	Verbal consent plus FP counselling with explanation on how to take pills	Verbal consent plus FP counselling with explanation on how to take pills	Verbal consent plus FP counselling with explanation on how patch is used and rotated	Verbal consent plus FP counselling with demonstration on how and when to insert and remove
Provider skills	Trained in FP counselling			
Adapted from: Family Planning A Global Handbook for Providers. *USAID, John’s Hopkins Bloomberg School of Public Health, WHO, 2007.*				

Table 12: Comparing Injectable Methods

Characteristics	DMPA	NET-EN	Monthly Injectable (CIC)
Method of use	Intramuscular (IM) or sub-cutaneous (SC) injection every 3 months	IM injection every 2 months	IM injection every 1 month
Contains	A progestogen—depot medroxyprogesterone acetate	A progestogen—norethisterone enanthate	Two hormones: a proges-togen and an estrogen
Time-limit for repeat injection to be ef-fective if the client comes too early or too late for her ap-pointment	Up to 2 weeks early or 4 weeks late	Up to 2 weeks early or 2 weeks late	Up to 7 days early or 7 days late

<table>
<tr><th>Characteristics</th><th>DMPA</th><th>NET-EN</th><th>Monthly Injectable (CIC)</th></tr>
<tr><td>Injection technique</td><td>Deep intramuscular (IM) injection into the hip, upper arm or buttock

A DMPA subcutaneous (SC) injection exists in uniject syringes

IM and SC injections should be given as intended; otherwise they may not be completely effective</td><td>Deep IM injection into the hip, upper arm or buttock

May be slightly more painful than DMPA</td><td>Deep IM injection into the hip, upper arm, buttock or outer thigh</td></tr>
<tr><td>Bleeding patterns</td><td>Irregular and prolonged bleeding at first, then no bleeding or infrequent bleeding. About 40% of users have no monthly bleeding after 1 year</td><td>Irregular or prolonged bleeding in first 6 months but shorter bleeding episodes than with DMPA

After 6 months bleeding patterns are similar to those with DMPA. 30% of users have no monthly bleeding after 1 year</td><td>Irregular, frequent or prolonged bleeding in first 3 months. Mostly regular bleeding patterns by 1 year. About 2% of users have no monthly bleeding after 1 year</td></tr>
<tr><td>Average weight gain</td><td>1–2 kg per year</td><td>1–2 kg per year</td><td>1 kg per year</td></tr>
<tr><td>Effectiveness
(Pregnancy rate as commonly used)</td><td>About 3 pregnancies per 100 women in the first year</td><td colspan="2">Similar to DMPA</td></tr>
<tr><td>Average delay in time to pregnancy after stopping injections</td><td>On average 10 months after last injection</td><td>On average 6 months after last injection</td><td>On average 5 months after last injection</td></tr>
<tr><td>Other considerations</td><td>FP counselling plus verbal consent plus reminder card for reinjection visit in 12 weeks</td><td>FP counselling plus verbal consent plus reminder card for reinjection in 8 weeks</td><td>Verbal consent plus FP counselling plus reminder card for reinjection in 4 weeks</td></tr>
<tr><td>Provider skills</td><td colspan="3">Trained in FP counselling and administration of injections</td></tr>
<tr><td colspan="4">Adapted from: Family Planning A Global Handbook for Providers. USAID, John's Hopkins Bloomberg School of Public Health, WHO, 2007.</td></tr>
</table>

Table 13: Comparing Implants			
Characteristics	**Norplant**	**Norplant Jadelle/Sino-Implant (II)**	**Implanon**
Delivery method	6 capsules inserted under the skin	2 rods inserted under the skin	1 rod inserted under the skin
Contains progestogen	Levonorgestrel	Levonorgestrel	Etonogestrel
Lifespan	Up to 7 years	Up to 4 or 5 years	3 years
Effectiveness (Pregnancy rate in the first year of use)	Pregnancy will occur in only 5 per 10 000 women using implants In women 70–79 kg the method becomes less effective after 5 years of use In women >80 kg the method becomes less effective after 4 years of use	Pregnancy will occur in only 5 per 10 000 women using implants In women >80 kg this method becomes less effective after 4 years of use	Pregnancy will occur in only 5 per 10 000 women using implants Weight has no known impact on effectiveness
Bleeding patterns	In the first few months lighter and fewer days of bleeding or irregular bleeding that lasts more than 8 days or infrequent or no bleeding After about one year lighter and fewer days of bleeding, irregular and infrequent bleeding		Implanon users are more likely to have infrequent or no monthly bleeding
Average delay in time to pregnancy after implants are removed	No delay	No delay	No delay
Availability	Being phased out; Norplant are no longer being inserted	Expected to replace Norplant by 2011	Primarily available in Europe and Asia Also approved for use in United States
Other considerations	Removals only and counselling on other methods Verbal consent if providing another method and written consent if providing another implant	FP counselling, verbal and written consent and reminder card for return visit in one week to check site and remove bandage Provide effectiveness card for Jadelle expiration in 5 years or Sino-Implant in 4 years	FP counselling, verbal and written consent and reminder card for return visit in one week to check site and remove bandage Provide effectiveness card for Implanon expiration in 3 years
Provider skills	Trained in FP counselling and insertion and removal of implants		

3.9.3 Barrier methods

Barrier contraceptive methods prevent pregnancy by physically preventing sperm from entering the uterus. The most frequently used barrier methods are male and female condoms (see Table 14). Condoms are the only FP methods that protect against both pregnancy and STIs. (For more information on condoms, see Chapter 9: Sexually Transmitted Infections p. 169.) Other barrier methods, such as spermicides and diaphragms, may be requested by persons who are familiar with them. If requested, every effort should be made to supply these methods. Spermicides are one of the least effective of all contraceptive methods when used alone. Frequent use of spermicides can increase the risk of HIV acquisition in high-risk clients, such as commercial sex workers.

Table 14: Comparing Male and Female Condoms

Characteristics	Male Condoms	Female Condoms
How to wear	Rolled over the man's erect penis Fits the penis tightly	Inserted into the woman's vagina Lines the vagina loosely and therefore does not constrict the penis
When to use	Immediately before sex	Up to 8 hours before sex
Material	Most commonly made of latex (sometimes of synthetic materials or animal membranes*) * Condoms made with animal membranes do not protect against HIV.	Most are made of a thin, synthetic film (polyurethane or nitrile) Some models are made of latex
Sensation during sex	Sexual intercourse may feel less sensitive	The condoms which are made of synthetic film, conduct heat, so sexual intercourse can feel very sensitive and natural
Noise during sex	May make a rubbing noise during sex	May rustle during sex
Lubrication	Users can add lubricants: • water- or silicone-based only • applied to outside of condom	Users can add lubricants: • water-, silicone- or oil-based • before insertion, applied to outside of condom • after insertion, applied to inside of condom or to the penis
Breakage or slippage	Tend to break more often than female condoms	Tend to slip more often than male condoms

Characteristics	Male Condoms	Female Condoms
When to remove	The penis must be withdrawn from the vagina before erection subsides	The penis can remain in vagina after erection subsides Remove the female condom before the woman stands
Area covered	Protects most of the penis and the woman's internal genitalia	Protects both the woman's internal and external genitalia and the base of the penis
Effectiveness (Pregnancy rate as commonly used)	About 15 pregnancies per 100 women whose partners use male condoms over the first year (If used correctly with every act of sex, about 2 pregnancies per 100 women)	About 21 pregnancies per 100 women using female condoms over the first year (If used correctly with every act of sex, about 5 pregnancies per 100 women)
Protection against HIV	When used consistently and correctly, condom use prevents 80% to 95% of HIV transmission that would have occurred without condoms	When used consistently and correctly, female condom use prevents HIV transmission
How to store	Store away from heat, light and dampness	Plastic condoms are not harmed by heat, light or dampness
Re-use	Cannot be re-used	Reuse not recommended
Cost and availability	Generally low cost and wide availability	Usually more expensive and less widely available than male condoms
Other considerations	Counsel and demonstrate on how and when to apply and remove (ideally with penis model)	Counsel and demonstrate on how and when to apply and remove (ideally with vagina model)
Provider skills	Trained in FP counselling, demonstration and redemonstration	

3.9.4 Intrauterine devices (IUDs)

Intrauterine devices (IUDs) are small, flexible plastic devices that contain either copper or a progestogen. A specifically trained health-care provider inserts it into a woman's uterus through her vagina and cervix, using proper infection-prevention procedures (including a "no-touch" insertion technique). IUDs are among the most effective methods in preventing pregnancy.

IUDs and STIs. By itself, the IUD does not cause pelvic inflammatory disease (PID). IUD insertion when a woman has gonorrhoea or chlamydia may occasionally lead to PID, therefore this should be avoided. If a client's situation places her at very high individual risk of infection, she generally should not have an IUD inserted. When laboratory screening for gonorrhoea and chlamydia is unavailable (see Chapter 9: STIs), service providers should ask the client to consider her own risk and to think about whether she might have an STI. If she considers herself at high risk of acquiring an STI, she should be counselled on alternative FP methods. In special circumstances, if other, more appropriate methods are not available or not acceptable, service providers should consider presumptively treating her with a full curative dose of antibiotics effective against both gonorrhoea and chlamydia and inserting the IUD after she finishes treatment.

If a woman develops a new STI after her IUD has been inserted, she is not especially at risk of developing PID because of the IUD. She can continue to use the IUD while she is being treated for the STI. Removing the IUD has no benefit and may leave her at risk of unwanted pregnancy. She should be counselled on condom use and other strategies to avoid STIs in the future.

Table 15: Comparing IUDs

Characteristics	Copper-bearing IUD	Levonorgestrel IUD
Effectiveness (Pregnancy rate in the first year of use)	Pregnancy will occur in 6 to 8 per 1000 women over the first year	Pregnancy will occur in 2 per 1000 women over the first year
Length of use	Approved for 10 years	Approved for 5 years
Bleeding patterns	Longer and heavier monthly bleeding, irregular bleeding and more cramping or pain during monthly bleeding	More irregular bleeding and spotting in the first few months After one year it is common to have no monthly bleeding Causes less bleeding than copper-bearing IUDs over time
Anaemia	May contribute to iron-deficiency anaemia if a woman already has low iron blood stores before insertion	May help prevent iron-deficiency anaemia
Main reasons for discontinuation	Increased bleeding and pain	No monthly bleeding and hormonal side-effects

Characteristics	Copper-bearing IUD	Levonorgestrel
Average delay in time to pregnancy after IUD is removed	No delay	No delay
Noncontraceptive benefits	May help protect against endometrial cancer	Effective treatment for long and heavy monthly bleeding (alternative to hysterectomy) May also help treat painful monthly bleeding Can be used as the progestogen in hormone replacement therapy
Postpartum use	Can be inserted up to 48 hours postpartum	Can be inserted 4 weeks postpartum
Use as emergency contraception	Can be used within 5 days after unprotected sex	Not recommended
Insertion	Requires specific training but easier to insert than levonorgestrel IUD	Requires specific training and a unique, more difficult insertion technique Women may experience more faintness, pain and nausea or vomiting at insertion than with the copper-bearing IUD
Cost	Less expensive	More expensive
Other considerations	FP counselling, verbal and written consent. Provide explanation how to check strings for clients who wish to do so	
Provider skills	Trained in FP counselling and Cu IUD insertion and removal	Trained in FP counselling and LNG-IUD insertion and removal

3.9.5 Emergency contraception (EC)

(For more information on EC see Chapter 2: MISP, p. 27.)

The two methods of emergency contraception are:

- emergency contraceptive pills (ECP)
- copper IUD.

Emergency contraceptive pills can prevent unwanted pregnancy if used within five days (120 hours) after unprotected sex. ECP should be taken as soon as possible after unprotected intercourse. **They are most effective the sooner they are taken, but can still be effective when taken up to five days after unprotected sex.**

Two formulations are available (see Box 25).

ECPs can safely be used by any woman, even those who cannot use hormonal methods on a continuous basis, as the dose of hormones used is relatively small and the pills are used for

Box 25: Emergency Contraceptive Pill Regimens

The **levonorgestrel-only regimen:** 1.5 mg of levonorgestrel in a single dose (this is the recommended regimen; it is more effective and has fewer side-effects). These pills are specially packed for emergency contraception.

The **combined estrogen-progestogen regimen (Yuzpe):** a dose of 100 microgram ethinyl estradiol plus 0.5 mg of levonorgestrel, taken as soon as possible, followed by the same dose 12 hours later. These pills are either specially packed for emergency contraception or can be taken from regular combined oral contraceptive pill packs.

Levonorgestrel-only (LNG) pills have been shown to be more effective than combined pills for emergency contraception and have significantly fewer side-effects. The levonorgestrel-only regimen is included in WHO's Model List of Essential Medicines.

a short time. ECPs should not be given if there is a confirmed pregnancy. ECPs may be given when pregnancy status is unclear and pregnancy testing is not available, as there is no evidence of harm to the woman or to an existing pregnancy. Use the pregnancy checklist to reasonably rule out pregnancy prior to providing ECP (see Figure 4: Checklist to Exclude Early Pregnancy).

Periodic ECP use is possible, but is not recommended as a method of family planning. However, a request for EC provides an entry point to discuss family planning and counsel the client on continuous contraceptive methods. Utilize that opportunity!

A **copper-bearing IUD** can be inserted up to five days after unprotected intercourse as an emergency contraceptive. When the time of ovulation can be estimated, a copper-bearing IUD can be inserted beyond five days after unprotected intercourse, as long as insertion does not occur more than five days after ovulation.

This may be a good option for a woman who wants to use an IUD for continuing contraception. It is more effective in preventing pregnancy than ECPs.

Ensure that the client is eligible for IUD insertion. If an IUD is inserted as EC after a rape, ensure that full presumptive STI treatment is provided (see Chapter 2: MISP).

3.9.6 Voluntary surgical sterilization

Male (vasectomy) and female (tubal ligation) sterilization are desirable methods of contraception for some clients who have decided to have no more children.

Surgical contraception should only be performed in safe conditions with informed consent of the user, by trained personnel and with the necessary equipment. Sterilization should be available to clients, especially if they are familiar with the method from their region or country of origin and if it is allowed within the host country. This method does not protect against STIs, including HIV.

3.10 Postpartum family planning

A woman is protected from pregnancy in the postpartum period if:

1) she is fully breastfeeding (baby receives only breast milk or, once in a while, some added vitamins, water, juice or other nutrients) or nearly fully breastfeeding (more than three-fourths of all feeds are breast milk); **and**
2) she has not resumed menstruating; **and**
3) she is less than six months postpartum.

This is called the lactational amenorrhoea method (LAM). Its effectiveness, as commonly used, is about two pregnancies per 100 women in the

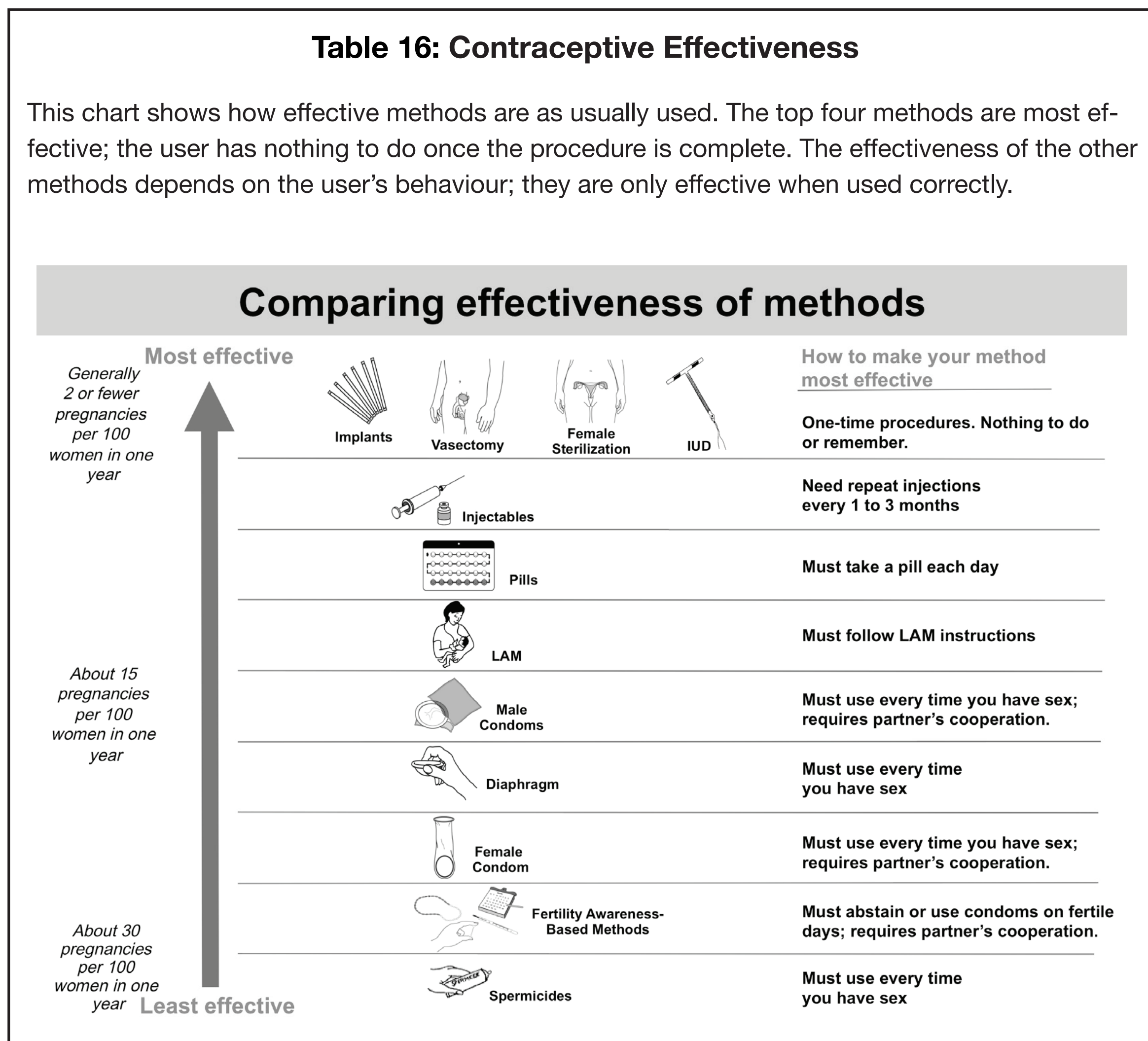
first six months after childbirth. Counsel women using this method to choose another FP method when they approach month-six postpartum or when any of the above criteria change.

Women may initiate the following FP methods safely:

- **Barrier methods:** condoms can be used immediately postpartum.
- **IUD insertion**: IUDs can be inserted either during the first 48 hours after a vaginal or caesarean delivery by a specially trained provider or four weeks postpartum. Insertion of an IUD between 48 hours and four weeks postpartum is not recommended. Expulsion rates are lowest when inserted four weeks or more after delivery or at a time unrelated to pregnancy.
- **Sterilization:** may be performed during the first seven days or six weeks postpartum.
- **Progestogen-only methods (pills, injectables, implants):** may be initiated six weeks postpartum for breastfeeding women, and immediately postpartum for nonbreastfeeding women.
- **Combined methods (pills and injectables):** may be initiated six months postpartum for breastfeeding women and at six weeks postpartum for nonbreastfeeding women.
- **Natural methods (Standard Days Method):** may be initiated when a woman has re-established a regular menstrual cycle.

Table 16: Contraceptive Effectiveness

This chart shows how effective methods are as usually used. The top four methods are most effective; the user has nothing to do once the procedure is complete. The effectiveness of the other methods depends on the user's behaviour; they are only effective when used correctly.



Adapted from: *Decision-making tool for family planning clients and providers*. WHO. 2005. www.who.int/reproductivehealth/publications/family_planning/9241593229/en/index.html

3.11 Family planning for people living with HIV

Encourage condom use for all HIV-positive people to protect them from STIs and to prevent HIV transmission to sexual partners. If an HIV-positive woman desires more effective pregnancy protection, she may wish to use another contraceptive method in addition to condoms.

Women with HIV can use most methods of contraception, with the following considerations:

- An IUD should not be inserted in any woman with a gonorrhoea or chlamydia infection or if a woman is at very high individual risk for these infections. HIV-positive women who are clinically well (whether or not on antiretroviral therapy (ART)) can use an IUD.
- If a woman is taking rifampicin for tuberculosis, she should not use contraceptive pills, the combined patch, the combined ring or implants, as contraceptive effectiveness may be decreased.
- Spermicides, either alone or in combination with barrier methods, should not be used by women with HIV infection or AIDS.
- Women on ART who are using hormonal methods are advised to also use condoms because some antiretroviral drugs (ARVs) reduce the effectiveness of hormonal methods.

Refer to Chapter 10: HIV for more information.

3.12 Infertility

Infertility is the failure to achieve a pregnancy or to give birth to a child after 12 months or more of regular unprotected sexual intercourse. If a woman has never been pregnant before, the disease is primary infertility. If a couple has previously given birth to a child, but currently meets the definition of infertility, this is described as secondary infertility. Infertility has many causes, which can be medical, such as postpartum infection, post-abortion infection, iatrogenic infertility, endometriosis, STIs and other infectious diseases that have caused fallopian tube, vas deferens or epididymal damage, or non-medical. Within a humanitarian setting, secondary and even primary infertility can be the result of stress and major changes in lifestyle.

Worldwide, couples view infertility as a tragedy that carries social, economic and psychological consequences. Infertility is an unmet need in family planning and up to one in four ever-married women of reproductive age in most developing countries suffer from primary and, more significantly, from secondary infertility.

Counselling of couples is critical. Make it clear that infertility is not a woman's problem alone, because between 25% and 50% of infertility may be due to the male partner. Examine the reproductive organs or genitalia of both male and female partners for any structural abnormalities. Where possible, semen analysis is crucial as a basic laboratory test for all infertile couples. Basal body temperature can be a helpful tool as an initial evaluation for ovulation. At a minimum, investigate and, when necessary, treat both partners for medical causes (most specifically STIs) or psychological and emotional problems. Consider and manage issues associated with abnormal body mass index (BMI), diet, cessation of smoking, use of certain medications and pre-existing medical conditions, such as diabetes, heart disease or psychiatric disease. Counsel couples on fertility awareness, menstrual regularity, sexual timing and techniques, as well as STI prevention.

Where these services are available, refer the couple for advanced medical evaluation (such as transvaginal ultrasound, cervical mucus evaluation, postcoital testing, hysterosalpingography, hormone assays) and relevant procedures, such as intrauterine insemination (IUI), surgical interventions and assisted reproduction.

3.13 Male involvement in family planning programmes

Involve men in FP programmes to increase acceptance of the programme within the community and to increase recognition of other RH issues, such as the prevention and treatment of STIs and HIV. Considering men's perspectives and motivation is integral to programme activities. Contraceptive use by men enables them to share the responsibility of family planning with their female partners. FP services may need to be specifically tailored to meet the needs of male users. Activities to encourage men's involvement include couples counselling, condom promotion, special health facility times for men, peer-group sessions and RH information at male social groups.

3.14 Advocacy

RH officers and programme managers should advocate for provision of family planning whenever possible. Knowing the baseline contraceptive use of the host population as well as the displaced population is helpful background information.

Meeting with the local Ministry of Health officials, private donors and other agencies to present data on unmet needs and the potential cost savings and health benefits of providing FP services is an effective advocacy tool.

4 Human rights and legal considerations

4.1 Human rights standards

Under international law, universal access to FP is a human right: all individuals and couples have the "right to decide on the number, spacing and timing of children".* At the 1994 International Conference on Population and Development, governments agreed to make RH care available to all, including a full range of FP services. *The right to the highest attainable standard of health* includes the "right to be informed and to have access to safe, effective, affordable and acceptable methods of FP". **

The right to family planning is closely linked with other human rights:

- Access to contraception will reduce unwanted pregnancies and will help ensure a woman's right to health and right to life.
- Everyone has a right to privacy and the right to equality and nondiscrimination. These rights are sometimes denied in the context of family planning when, for example, someone is denied access to contraception because she or he is not married.
- Everyone has a right to impart and receive information on family planning. This right includes reproductive health and sexuality education for adolescents. Adolescents have a right to access FP services and information. Refusing FP information or contraception to adolescents based on age, marital status or parental or guardian consent may constitute a denial of adolescents' right to health and right to nondiscrimination. (See Chapter 4: Adolescent Reproductive Health for more information.)
- Everyone has a right to enjoy the benefits of scientific progress and its applications. This means that everyone has a right to benefit from developments in contraceptive technology, such as emergency contraception (EC).

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* Convention on the Elimination of All Forms of Discrimination Against Women (CEDAW), art. 16(1).

** Committee on Economic, Social and Cultural Rights, General Comment No. 14, para. 12.

- Coercing people to use a contraceptive method is not family planning and is a violation of international human rights law. For example, forced sterilization without consent violates the right to informed consent, the right to health, the right to security and liberty of the person and the right of individuals to freely decide on the number and spacing of their children.

4.2 Challenges and opportunities

In some cases, service providers may face difficult decisions or dilemmas. They may find that their ability to provide FP information and services is restricted by national legislation, social or cultural norms or medical misconceptions. For example, the following may happen:

- A woman is not provided with FP services without her husband's consent.
- A woman is not permitted to choose to be sterilized without her husband's authorization or she must meet other requirements before she can be sterilized, such as bearing a certain number or children or being of a certain age.
- A woman is refused access to contraception without her husband's authorization.
- A woman is refused access to contraception because she is not married.
- Adolescents are denied IUDs based on the inappropriate medical claim that IUDs will cause infertility unless the patient can demonstrate that she has had a child or is pregnant.
- Women are denied access to emergency contraception because it is wrongly believed to be a form of abortion, which is contrary to local religious and social norms.

Such norms, laws and practices can be in conflict with internationally accepted human rights principles. An RH manager or service provider is likely to face such dilemmas. You must be aware of your agency/organization position on these RH issues and include it as part of your analysis of the situation and possible next steps. When faced with a difficult situation you should first and foremost give priority to the client's safety and health, and your own safety and that of colleagues. Then, you may wish to:

- talk to your supervisor;
- discuss options with your client:
  - For example, if you are unable to provide certain modern methods of contraception to a woman, you can counsel her on natural family planning methods, such as fertility awareness and the lactational amenorrhea method (LAM);
- find out whether your agency is engaged in advocacy on the issue and how you can contribute;
- explore linkages with and referrals to local organizations that might be able to help your client further;
- while respecting the confidentiality of your client, identify with colleagues and other RH providers how to avoid/handle such situations in the future;
- raise these concerns in health coordination meetings.

5 Monitoring

Maintain a daily activity register and individual client forms to record information and offer effective follow-up. In mobile populations, clients may wish to keep a copy of their records. The following information should be recorded on a client form:

- Date
- User name — or, if required for confidentiality, a number code
- User information (age, address, parity)
- Type of user (new, repeat, etc.)
- Method selected (and brand name)
- Side-effects experienced
- Date of next visit (for follow-up)
- Date and reason for discontinuation

Record-keeping forms should be simple and

appropriate for the collected data and staff literacy levels. Use national or local formats that are known by the local staff and the affected population. They can be translated for expatriate staff, if these initially provide the service. Train all staff on maintaining appropriate records and on how the information collected is used in their FP programme.

Indicators to be collected — see Assessment, Monitoring and Review for indicator guidance:

- Indicators to be collected at the health-facility level:
  - proportion of clients offered FP counselling in addition to being given a method of contraception
  - contraceptive prevalence (CP)
    CP is the percentage of women who are using (or whose partner is using) a method of contraception at a given point in time.
- Indicators to be collected at the programme level:
  - the number of FP service delivery points that maintain a minimum of 3 month's supply of OCPs, injectables, IUDs or implants;
  - the number and proportion of providers appropriately implementing family planning services.

6 Further reading

Fact sheet on the safety of levonorgestrel-alone emergency contraceptive pills (LNG ECPs). WHO. 2010. http://whqlibdoc.who.int/hq/2010/WHO_RHR_HRP_10.06_eng.pdf

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The Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs. John Snow Inc./DELIVER, for the U.S. Agency for International Development (USAID), Arlington, VA, 2004. http://deliver.jsi.com/dlvr_content/resources/allpubs/guidelines/LogiHand.pdf

The INFO Project, *USAID's Maximizing Access and Quality Initiative IUD Toolkit*. http://www.maqweb.org/iudtoolkit/index.shtml.

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