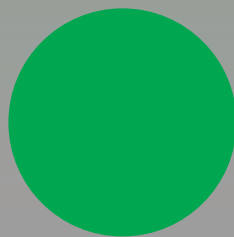




FAMILY PLANNING TRAINING MANUAL

**For Tier 2 Patent Proprietary
Medicine Vendors**

Participant's Guide



Safe and Trusted

2019 EDITION





FEDERAL MINISTRY OF HEALTH

TIER 2 PATENT PROPRIETARY MEDICINE VENDORS (PPMV_s)

PARTICIPANT'S GUIDE

**ON
FAMILY PLANNING SERVICES**

SEPTEMBER, 2019

Foreword

In Nigeria, the contribution of PPMV)s in improving access to medicine supply, attainment of Universal Health Coverage and reduction of maternal mortality is on the increase and cannot be underestimated. The focus of this Training Manual on Family Planning services in Nigeria is to provide standards and guidelines for the Tier 2 Patent Proprietary s Medicine Vendors (PPMV)s. The Task Shifting Task Sharing Policy in Nigeria has laid a good foundation of accessibility of Family Planning contraceptives through PPMV)s and contributed immensely to Universal Health Coverage. This participants manual also intends to update the knowledge and skills of providers to enhance appropriate and adequate dissemination of information for services on Contraceptives.

The process leading to the development of this participant’s manual was inclusive and painstaking with relevant technical stakeholders making necessary inputs to the process. Prominent stakeholders involved in the process include representatives of Federal Ministry of Health, Pharmacists Council of Nigeria (PCN), Nursing and Midwifery Council of Nigeria (NMCN) , Medical & Dental Council of Nigeria (MDCN), Community Health Practitioners Regulatory Board (CHPRB Planned Parenthood Federation of Nigeria (PPFN) , Marie Stopes International Organisation Nigeria (MSION), UNFPA, JHPIEGO, JSI, NURHI2, ARFH, SFH, Society of Obstetrics & Gynecology of Nigeria (SOGON), , National Association of Nigerian Nurses and Midwives (NANNM),) and Association of Community Health Practitioners of Nigeria. National Association of Patent Proprietary of Medicines (NAPPMED).

We acknowledge the input of all the contributors and National Experts most especially those who laid the foundation of accessibility of Family Planning contraceptives through PPMV)s and Task Shifting and Sharing in Nigeria. We especially appreciate partners who continue to ensure that this vision is kept alive, as well as the technical and financial support of IntegratE Project.

This document serves the purpose of ensuring that the Family Planning services are of high standard across the country. The mandates of all the stakeholders are brought into alignment with Government’s aspirations for the Universal Health Coverage and wellbeing of its people.

I recommend this document, which will contribute to reduction of maternal mortality in Nigeria, to all Health Care Workers and organizations involved in preventing and addressing maternal mortality through regular and adequate use of contraceptives in Nigeria.

Dr. Ehanire Osagie

Honourable Minister of Health

September , 2019

Acknowledgement

The combined effort of the Federal Government of Nigeria and partners towards accelerating the reduction of maternal mortality and morbidity in Nigeria is greatly appreciated. A key strategy in this process is to strengthen the capacity of different cadres of public and private health care providers in the provision of Family Planning services through Second Tier PPMVs in Nigeria. The Federal Ministry of Health in collaboration with IntegratE Project and technical stakeholders have developed this manual to be used by the participants on Family Planning Service provision.

We therefore appreciate the technical and financial support of IntegratE Project and other partners in the development process of this manual.

Special thanks to Dr. Kayode Afolabi, Director and Head Reproductive Health Division of Family Health Department, Federal Ministry of Health and other officers of the Reproductive Health Division for their vision of setting and maintaining standards towards the development of this document.

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September , 2019.

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ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
ANC	Antenatal Care
ART	Antiretroviral Therapy
ARV	Antiretroviral
BCC	Behaviours Communication Programme
CBO	Community Based Organization
CHO	Community Health Officer
CiSHAN	Civil Society on HIV/AIDS in Nigeria
CSO	Community Serving Organization
ELISA	Enzyme Linked Immunosorbent Assay
FMOH	Federal Ministry of Health
FMWA	Federal Ministry of Women Affairs
GF9	Global Fund Round 9
GON	Government of Nigeria
HCP	Health Care Provider
HCT	HIV Counselling and Testing
HIV	Human Immunodeficiency Virus
IDU	Injection Drug Users
IEC	Information Education and Communication
LACA	Local Agency for the Control on AIDS
LFA	Local Funding Agency
LGA	Local Government Area
MARP	Most at Risk Populations
M&E	Monitoring and Evaluation
MIS	Management Information System

NACA	National Agency for the Control of AIDS
NARHS	National HIV/AIDS Reproductive Health Survey
NDHS	Nigeria Demographic Health Survey
NEPWHAN	Network of Persons with HIV and AIDS in Nigeria
NGO	Non-Governmental Organization
NNRIMS	Nigerian National Response Information Management System
NPC	National Population Commission
NYSC	National Youth Service Corp
OIs	Opportunistic Infections
OVC	Orphans and Vulnerable Children
PABA	Persons Affected by AIDS
PLWHA	Persons Living with HIV and AIDS
PMTCT	Prevention of Mother to Child Transmission
PR	Principal Recipients
QC	Quality Control
QMS	Quality Management System
RTD	Rapid Test Device
RTI	Reproductive Tract Infections
SR	Secondary Recipient
SDP	Service Delivery Point
SOP	Standard Operating Procedure
STI	Sexually Transmitted Infection
SACA	State Agency for the Control of AIDS
SOPs	Standard Operating Procedures/Standards of Practice
SR	Sub-Recipient
TA	Technical Assistance
TB	Tuberculosis

TSTS	Task Shifting Task Sharing
UNAIDS	Joint United Nations Programme on HIV/AIDS
VCT	Voluntary Counselling and Testing
WHO	World Health Organization

Background and Rationale for Development of Manual

Contraceptives are under-utilized in Nigeria, despite their benefits. According to the most recent National Demographic Health Survey (NDHS) of 2018, only 12% of Women of Reproductive Age (WRA) used a modern contraceptive. This has resulted in high fertility at 5.3 per woman in Nigeria. An unregulated population growth poses several potential developmental challenges not only to Nigeria but also to the neighbouring countries. The Federal Government of Nigeria had earlier responded to this challenge by developing a Family Planning Blueprint Scale-up plan in 2013 and currently being reviewed and set a target to increase Modern Contraceptive Prevalence Rate (mCPR) from its current 12% to 27% by the end of 2020. One of the strategies recommended in the blueprint is increased access to contraceptives through the Proprietary Patent Medicine Vendors (PPMV)

This recommendation is an acknowledgement of the key role that the PPMVs play in Nigeria health care system. PPMVs are a popular source of health care for many reasons: patent medicine shops are available in virtually every community; they offer affordable services; have reliable drug stocks; and have flexible hours of operation. As a result, they are the first point of call for citizens who practice self-care. PPMVs provide a range of services including treatment for malaria, respiratory infections, sale of emergency contraceptives, pills, male and female condoms and injectable contraceptives (Ajuwon et al, 2016).

However, research showed that PPMVs provide low quality services. PPMV stock poor quality medicines, have limited knowledge on drugs resulting in frequent sale of inappropriate drugs (Beyeler et al, 2014), which may contribute to treatment failure and causing unnecessary expenditures for the customers. Clearly, PPMVs need appropriate training if they are to fulfil their role as points of access for high quality family planning services for their clients.

Fortunately, a large proportion of PPMVs have received formal training and many are known to have worked in the health care system as nurses, midwives, Community Health Officer (CHO) and Community Health Extension Workers (CHEW) (Ajuwon et al, 2015). The Federal Ministry of Health (FMoH) could leverage on this advantage as this category of PPMVs would require minimal training to provide good quality family planning services to their clients.

The Pharmacist Council of Nigeria (PCN), the government agency responsible for regulating the practice of PPMVs in the country, has already taken steps in the right direction by creating a three-tier system for PPMV and a Standard Operating Procedure (SOP) for each tier. The three tiers are:

1. Vendors and intending vendors who only possess the ability to read and write having attained the minimum educational qualification of the First School Leaving Certificate.
2. Professionals in the patent medicines business or are intending to be in the business and have one form of health training background or the other such as CHEWs, CHOs, Registered Nurses/Midwives, etc.
3. The pharmacy technicians who yearly apply to retain their names with PCN but are PPMVs or intending to be.

The objectives of the training are to:

1. Improve knowledge of participants on the benefits of family planning
2. Develop communication and counselling skills PPMV need to provide contraceptives to their clients.
3. Improve skills of participants in provision of contraceptives
4. Improve knowledge of participants on the importance of ethical issues in provision of contraceptives
5. Improve skills for record keeping and referral between PM shops and next level of health care system
6. Improve skills for infection control in provision of contraceptive services to clients

MODULE 1

INTRODUCTION

Objectives

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

1. Describe the categories of persons attending the workshop through self-introduction
2. List the objectives of the workshop
3. Identify the ground rules for the workshop

Estimated time: 1 hour

Overview of the session

The main objectives of this session are to introduce the workshop and create a sense of familiarity among trainers and participants.

Methods

- Question and answer
- Brainstorming

CONTENTS

Objectives of the training

The objectives of the training are to:

1. Improve knowledge of participants on the benefits of family planning
2. Develop communication and counselling skills PPMVs need to provide contraceptives to their clients.
3. Improve skills of participants in provision of contraceptives
4. Improve knowledge of participants on the importance of ethical issues in provision of contraceptives.
5. Improve skills for record keeping and referral between PM shops and next level of health care system.
6. Improve skills for infection control in provision of contraceptive services to clients.

Ground Rules

Rules are created to ensure successful conduct of the training. The rules to be set should focus on:

1. Punctuality: Both trainer and participants should be punctual at all sessions.
2. Attendance of sessions: It is compulsory that participants attend all sessions.
3. Use of telephone: Telephones should either be switched off or placed in silent mode to prevent distraction of sessions.
4. Orderliness in answering questions: participants are expected to indicate by show of hand if they have questions; one participant speaks at a time.
5. Other rules that participants may consider appropriate

MODULE 2

OVERVIEW OF FAMILY PLANNING IN NIGERIA

Session 1: Family Planning in Nigeria

Learning objectives

At the end of this session participants should be able to:

1. Describe the concept of FP
2. State the purpose of FP
3. List the benefits of FP
4. Describe the role of Government in FP in Nigeria

Estimate time: 30 minutes

Overview of module

This module provides definition of FP and offers comprehensive information about the features of family planning, use of contraceptives in Nigeria, benefits of FP and the role of Government in promoting FP.

Methodology

- Brainstorming
- Lecture
- Question and answer

CONTENTS

Definition of Family Planning

The WHO defines FP as a process that ‘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’ (WHO, 2010). FP promotes the health and welfare of the entire family and in turn the whole community.

Purpose

Family planning aims at promoting responsible parenthood, population management and improving the quality of life

Importance of Family Planning

Family planning is a primary health strategy with important benefits for both maternal and child health. Family Planning allows individuals and couples to plan and achieve their desired number of children, spacing and timing of their births using modern contraceptive methods and treatment of involuntary infertility. Family Planning is of benefits not only to adopters but also to their family and the nation at large: some of the benefits include:

Man

- Helps him take control and have the number of children he can adequately cater for
- Allows him to have quality time with his family, promoting a closer relationship with them.
- Men will have less anxiety and stress related to unplanned pregnancies
- Promote men’s social well being
- Has less anxiety and stress thus preventing ill health and premature death

Woman

- Allows her to rest between pregnancies in order to regain her health and strength thereby reducing the risk of complications during or after pregnancy
- Gives her time to develop herself and contribute financially to the upkeep of her family
- Allows her to give more time to her husband or partner
- Removes anxiety and stress related to unplanned pregnancies
- She will be able to breast feed for a long period, thus providing her baby with nutritious food and protection from diseases
- By delaying the next pregnancy, she can spend quality time with each child.

Young People

- Promotes healthy behaviours by allowing young persons who wish to prevent, delay or limit pregnancies make informed decision
- Helps them realize their potential and empowers them to make the right choice about their future.

Child

- Able to receive good care and attention from both parents and promotes bonding
- May not be forced into child labour in order to help the family meet financial needs
- Reduction of infant illness and death

- Better health, education, clothing and employment opportunities
- Saves the lives of children by preventing diseases and malnutrition

Family

- Enhances the family's nutrition and wellbeing
- It increases the available financial resources of the family Promotes education of children
- Improves the quality of life
- Long term benefit of breaking the cycle of poverty in the family

Community

- Allows community to plan and manage its resources effectively
- Discourages social delinquencies
- Promotes community development and enhances unity Reduces teenage pregnancy and abortion
-

Nation

- Promotes stability and security in country, peaceful society and basic needs of the people are routinely met
- Improves the nation's health, social and economic indices
- Harness demographic dividends for economic growth and development
- Improves quality of life
- Gives everyone a better opportunity for a good life.

FP in the Context of Maternal Newborn and Child Health

Nigeria's Maternal Mortality is among the highest in the world. To this end, the Government of Nigeria (GoN) has put measures in place to ensure Safe Motherhood.

Safe Motherhood is the creation of an enabling environment for a woman to choose whether she will become pregnant, and if she does, ensuring that she receives care for the prevention and treatment of pregnancy-related complications, has access to skilled birth attendants, emergency obstetrics care and care after birth to prevent death and disability. One of the indicators of safe motherhood is maternal mortality.

Increasing access to and uptake of contraceptives will reduce unintended pregnancies and prevent up to 30% of maternal deaths. FP achieves this through the following ways;

- delaying motherhood,
- discouraging grand-multiparity,
- avoiding closely spaced births, and
- Preventing stressful pregnancies and unsafe abortion.

Family Planning and Fertility Management

Nigeria's Total Fertility Rate is one of the highest in Sub-Saharan Africa. According to the 2013 Nigeria Demographic and Health Survey (NDHS), the Total Fertility Rate (TFR) is 5.5 with a slow trend of reduction. The country's Maternal Mortality is also unacceptably high. The fertility and mortality patterns have resulted in a young population structure, whereby there is a preponderance of young persons in the population. More than two-fifths of the population currently consists of children under the age of 15 years.

According to the 2013 NDHS, the contraceptive prevalence rate (CPR) for Nigeria was 15 percent for any method and 10 percent for modern methods. Low uptake of family planning is a major factor in the fertility pattern and population growth rate.

Factors associated with the low CPR include a culture that is highly supportive of large family size, misconceptions about FP methods, and male child preference, inadequate access to family planning services, poor quality of services and inadequate demand creation efforts.

The Role of Government in Family Planning in Nigeria

The adverse effect of high population growth rate with non- corresponding increase in economic resources is off concern to the Government of Nigeria. In addition, the factors associated with the low contraceptive prevalence levels include a culture that is highly supportive of large family size, misconceptions about family planning methods, and male child preference. Furthermore, the challenges of inadequate access to family planning services, the poor quality of such services and inadequate demand creation efforts also serve to lower the use of contraceptives. In order to ensure that reproductive health commodities are available in Nigeria, the national reproductive health commodity security (RHCS) strategic plan of 2003 has undergone series of reviews, the latest being 2017 – 2021 version.

Session 2: Use of contraceptives in Nigeria

Learning objectives

At the end of this session participants should be able to:

1. Describe situation of contraceptives use in Nigeria.
2. List the types of contraceptives used in Nigeria.
3. List role of contraceptive use in maternal survival.

Estimated Time: 40 minutes

Methodology

- Power point presentation
- Brainstorming
- Questions and answers

Materials required

-
- Multimedia projector
- Laptop computer
- Flip Chart
- Makers

CONTENTS

Use of Contraceptives in Nigeria

Despite their numerous benefits, contraceptives are under-utilized in Nigeria. According to the NDHS (2013), contraceptive prevalence rates vary with the age of the woman. The rates are 4.8%, 13.7% and 14% for women aged 15-19, 30-34 and 40-44 age groups, respectively (NPC, 2013). Women's educational levels are positively correlated with CPR. Only 3% of women without education in Nigeria currently use family planning, compared to 37 percent among those with more than secondary education. More women in urban (27%) than rural areas (9%) had used a contraceptive. In addition, available data indicates that there is more knowledge on FP among Nigerians than usage. According to the NDHS (2013) data, 96% of males and 85% of females knew of at least one method of contraceptives. Women with tertiary education have higher knowledge of FP (99.7%) than their counterparts without education (72.3%).

Types of Family Planning Methods

The following are the contraceptive methods used in Nigeria;

- A. Natural methods
- B. Modern methods

- A. Natural methods
 - Abstinence (total or periodical)
 - Coitus interruptus (Withdrawal method)
 - Cycle Beads Standard (Days Method)
 - Lactational Amenorrhea Method/Exclusive breast feeding
 - Fertility Awareness Method (FAM)
 - Basal Body Temperature (BBT)
- B. Modern methods
 - 1. Temporary methods
 - Short term methods (using Emergency contraceptive pills, barriers (male and female condoms), injectable, oral pills, vaginal rings)
 - Emergency Contraceptive Pills
 - Long term methods (implants, IUDs)
 - 2. Permanent methods
 - **Vasectomy**- Male sterilization: means the cutting and tying of the vas deferens (spermatic cord) bilaterally to avoid conveyance of spermatozoa out of the male genitalia.
 - **Bilateral Tubal Ligation**- female sterilization means the cutting and tying of the uterine tubes bilaterally to prevent conveyance and meeting of ova and spermatozoa in order to avoid fertilization.

In order to fully understand the evidence-based interventions for saving the lives of women and their newborns, it is important to first review the sequence of events that may occur before maternal deaths as shown in Figure 1. In general, most women of reproductive age, at some time in their lives, become exposed to pregnancy through unprotected sexual intercourse. In some cases, this is a deliberate action to fulfill man's desire for procreation. When it occurs too early, before full physical maturation of the woman (before 18 years of age), the challenges of the pregnancy and/or childbirth can endanger the life of the woman. Furthermore, if the resultant pregnancy was unplanned, it may lead to unsafe abortion with its attendant complications, including maternal death.

Role of Contraceptive use in Maternal Health

Family Planning plays a key role in the prevention of maternal and neonatal mortality. This is because no woman can die of pregnancy-related causes and/or childbirth if they did not get pregnant in the first place. Numerous publications confirm that widespread use of contraceptives contribute to healthy timing and spacing of pregnancy (HTSP) with decreased maternal and newborn mortality. It is known that irrespective of whether the pregnancy was planned or unplanned, 15% of pregnant women globally will experience one life-threatening complication or the other. The outcome of the management of such a complication is dependent on its early recognition as well as access and the quality of emergency obstetric and newborn care provided.

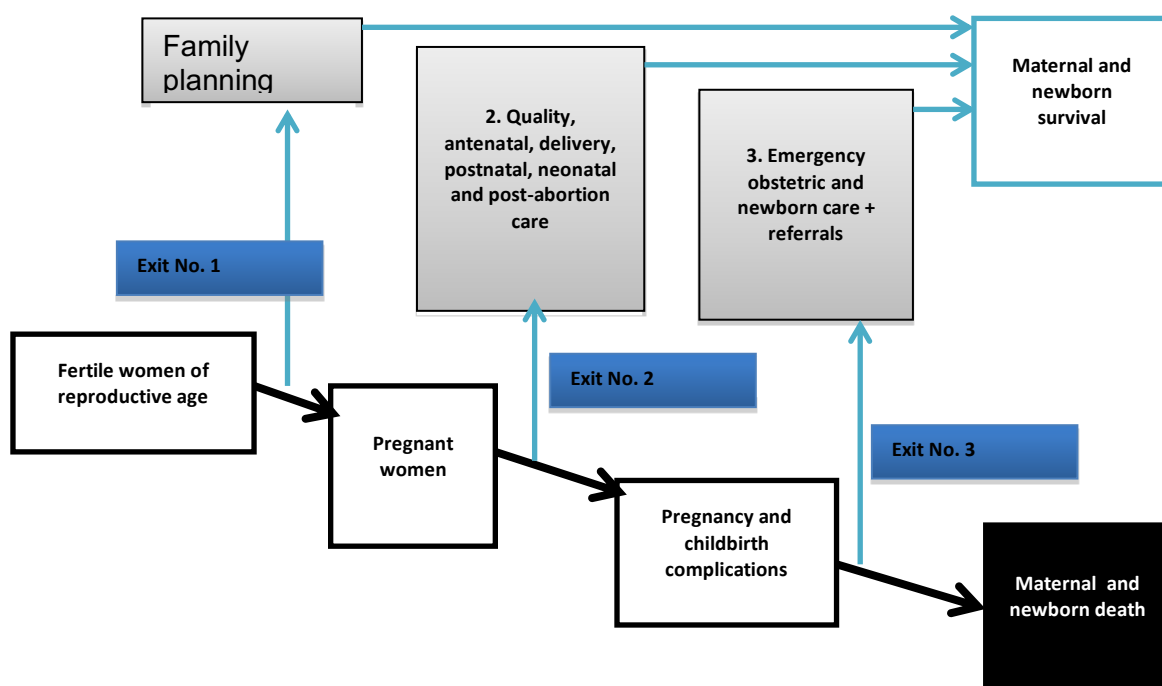


Figure1: Pathway to maternal survival

As healthcare workers, it is our responsibility to seek out opportunities to get women off this slippery pathway to preventable death.

Figure 2 shows the relationship between CPR among Women of Reproductive Age (WRA) and estimated maternal mortality ratios by region in Nigeria. The available data indicates that the Northeast and Northwest regions with the lowest use prevalence of any method of contraception also have the highest maternal mortality ratios (MMRs) nationally. Many factors such as ignorance, culture/traditions, poverty, religious misinterpretation, myths and misconceptions, lack of contraceptive supplies as well as lack of skilled manpower to provide services are thought to be responsible for this situation. According to the NDHS data for 2018, 19% of women had unmet need for family. This simply means that 19% of married women who wish to postpone their next birth or who wish to stop childbearing altogether but are not using contraceptives (NPC, 2019).

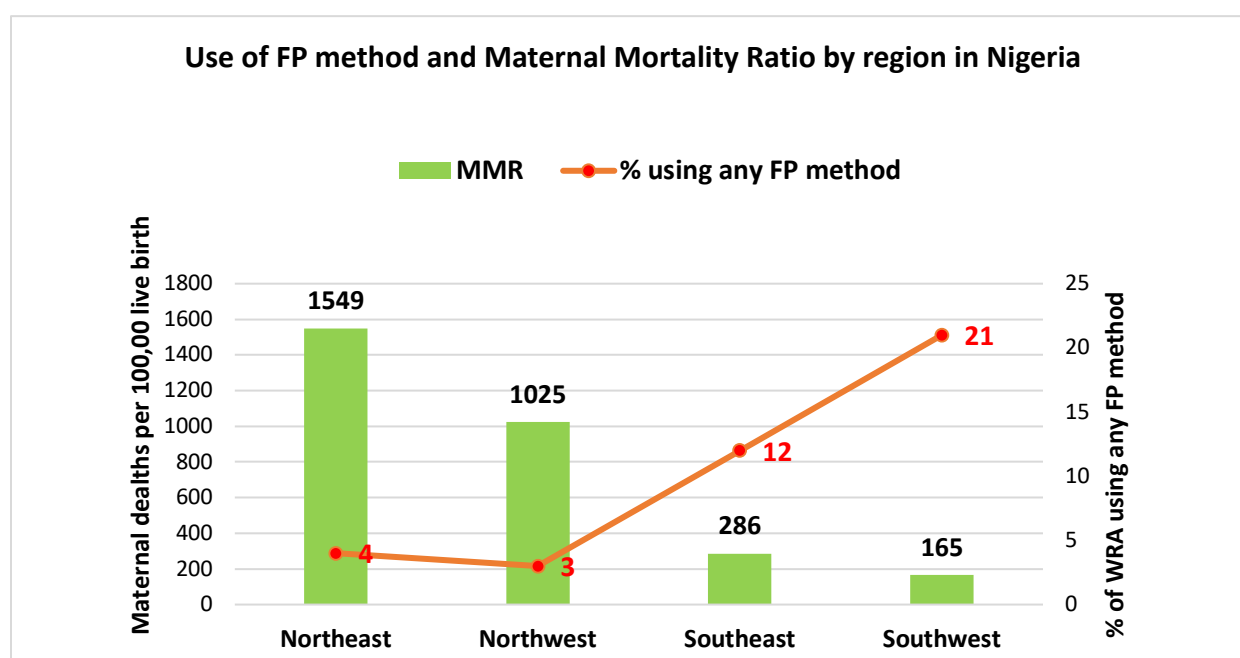


Figure 2: Use of FP methods and Maternal Mortality Ratio in four regions in Nigeria

Furthermore, the 2008 Nigeria Demographic and Health Surveys have shown that the longer the birth interval, the lower the infant and under-5 mortalities. Therefore, the use of FP to space births for at least 2-3 years helps to save the lives of children. Postpartum women should therefore be counseled to wait for at least 2 years after the birth of a child before another pregnancy.

MODULE 3

MALE AND FEMALE REPRODUCTIVE SYSTEM

Session 1: Overview of Male Reproductive System

Learning Objectives

At the end of this session participants should be able to:

1. List the components of the male reproductive system
2. List the function(s) of the components of the male reproductive system

Estimated Time: 35 minutes

Overview of the module

This module is aimed at deepening participants' knowledge and understanding of both male and female reproductive systems and how these relate to the provision of FP services.

Methodology

- Brainstorming
- Power point presentation
- Exercises
- Evaluation

CONTENTS

The Male Reproductive System

It consists of two parts:

The external male reproductive organs consist of:

- The penis and
- The scrotum

The internal male reproductive organs consist of:

- 2 testicles or testes
- 2 epididymis
- 2 vas deferens
- 1 prostate gland
- 1 urethra
- 2 seminal vesicles
- 2 cowpers' glands

A Brief Description of the Male Reproductive System

Penis: The penis is a soft and spongy tissue that lies in front of the scrotum. During erection, the penis becomes hard and stiff as the spongy tissue fills with blood. Erections do occur when a male feels sexually excited.

Scrotum: This is a thin walled soft bag that is covered with wrinkled skin. The scrotum keeps the testicles at just the right temperature for sperm production. In order to maintain the right temperature, the scrotum tightens up and pulls the testicles close to the body when the weather is cold and gets loose and hangs lower down when the weather becomes hot. For most men, one testicle hangs lower than the other, and may be normal.

Testicles/Testes: These are two firms, smooth and egg-shaped organs. Each is about 2.5 cm long, located in each chamber of the scrotum. A white fibrous capsule, the tunica albuginea, contains each testis and each is invaginated anteriorly into a double serous covering, the tunica vaginalis.

They produce the male hormones which regulate growth, sexual development, reproduction.

Blood Supply

The testicular artery arises from the abdominal aorta at the level of the renal vessels. It is a paired artery with one for each of the testes and is the male equivalent of the ovarian artery. The testicular artery anastomoses with the artery supplying the vas deferens and epididymis, which arises from the inferior vesical branch of the internal iliac artery. This cross connection means that ligation of the testicular artery is not necessarily followed by testicular atrophy. The pampiniform plexus of veins becomes a single vessel, the testicular vein in the region of the internal ring. On the right this drains into the inferior vena cava, on the left into the renal vein.

Lymphatic Drainage

The lymphatic drainage of the testis obeys the usual rule; it accompanies the venous drainage and thus passes to the para-aortic lymph nodes at the level of the renal vessels. Free communication occurs between the lymphatics on either side; there is also a plentiful anastomosis with the paraaortic intrathoracic nodes and, in turn, with the cervical nodes, so that spread of malignant disease from the testis to the nodes at the root of the neck is possible.

Nerve supply

The nerve supply of the testis derives from the T10 sympathetic fibres via the renal and aortic plexuses. These convey afferent (pain) fibres—hence referred pain from the testis to the loin.

Structure

The testis is divided into 200–300 lobules each containing one to three *seminiferous tubules*. Each tubule is some 2 feet (62 cm) in length if teased out and is thus obviously coiled and convoluted to pack away within the testis. The tubules anastomose posteriorly into a plexus termed the *rete testis* from which about a dozen fine *efferent ducts* arise, pierce the tunica albuginea at the upper part of the testis and pass into the head of the epididymis, which is formed by these efferent ducts coiled within it.

The efferent ducts fuse to form a considerably convoluted single tube which constitutes the body and tail of the epididymis; unravelled, it is the length of a cricket pitch.

Epididymis

These are two tightly coiled tubes next to the testicles and the vas deferens. They store the sperm produced by the testicles.

Vas Deferens

This tube is 18 in (45 cm) long (a distance which one may remember is also the length of the thoracic duct, the spinal cord and the femur, and the distance from the incisor teeth to the cardiac end of the stomach). The vas passes from the tail of the epididymis to traverse the scrotum, inguinal canal and so comes to lie upon the side wall of the pelvis. Here, it lies immediately below the peritoneum of the lateral wall, extends almost to the ischial tuberosity then turns medially to the base of the bladder. Here it joins the more laterally placed seminal vesicle to form the *ejaculatory duct* which traverses the prostate to open into the prostatic urethra at the verumontanum on either side of the utricle.

Prostate Gland

This is located below the bladder and surrounds the urethra. It is about the size of a large chestnut. It secretes the fluid that helps the sperm (semen) to move during ejaculation

Urethra

The urethra is a tube-like structure about 18 cm long. It runs from the neck of the bladder through the prostate and through the length of the penis. It serves as an outlet for urine, semen and sperm

Seminal Vesicles

These are coiled sacculated tubes 2 in (5 cm) long which can be unraveled to three times that length. They lie, one on each side, extraperitoneally at the bladder base, lateral to the termination

of the vasa. Each has common drainage with its neighbouring vas via the ejaculatory duct (Figure 3). Despite their name, they do not act as receptacles for semen, although their secretion does contribute considerably to the seminal fluid.

Cowpers' Gland: These are two in number situated just below the prostate gland. The function is to secrete special lubricant fluid for the sperm. They also help to remove traces of urine from the urethra so that the acid in the urine will not kill the sperm.

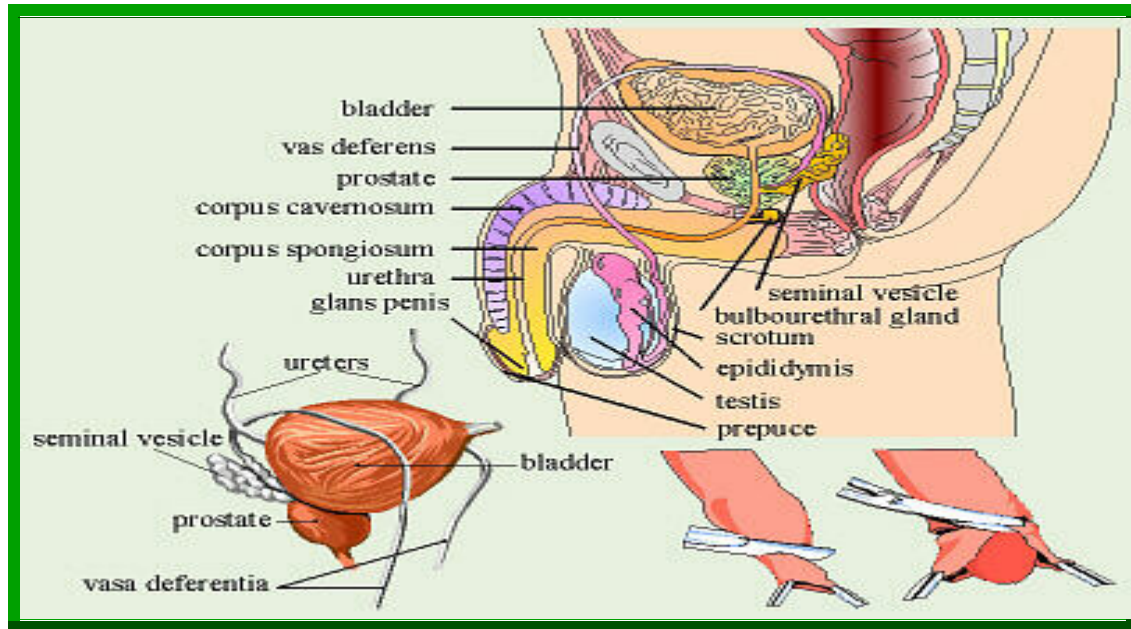


Figure 3: Male Reproductive Organ

Session 2: Female Reproductive System

Learning Objectives

At the end of this session participants should be able to:

1. List the components of the female reproductive system
2. List the function(s) of the components of the female reproductive system
3. Describe the clinical significance of each of different types of female pelvis in relation to childbirth

Estimated time: 60 minutes

Methodology

- Brainstorming
- Power point presentation
- Exercises
- Evaluation

CONTENTS

The Female Reproductive Organs consist of two parts:

The external female reproductive organs consist of different parts (see Figure 4):

- Mons veneris
- Labia majora
- Labia minora
- Prepuce of clitoris
- Clitoris
- Glans of clitoris
- Vestibule
- Vaginal Orifice
- Frenulum of clitoris
- Urethra
- Hymen
- Fossa navicularis
- Fourchette
- Perineum

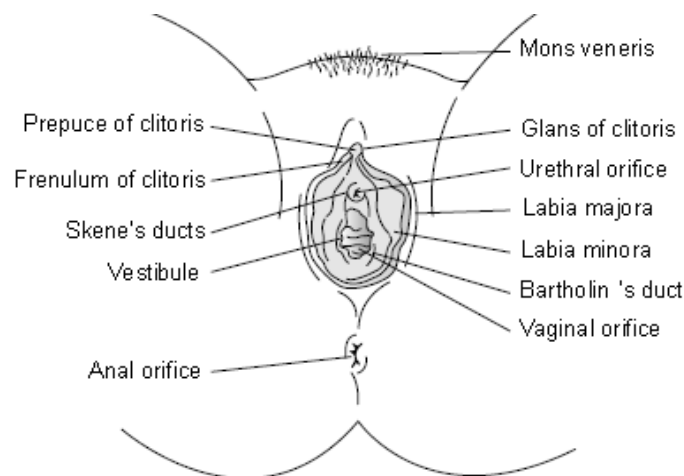


Figure 4: Female external genitalia

The Internal female organs of reproduction consist of many parts (see Figure 5):

- Vagina
- Cervix
- Uterus
- 2 fallopian tubes
- 2 ovaries

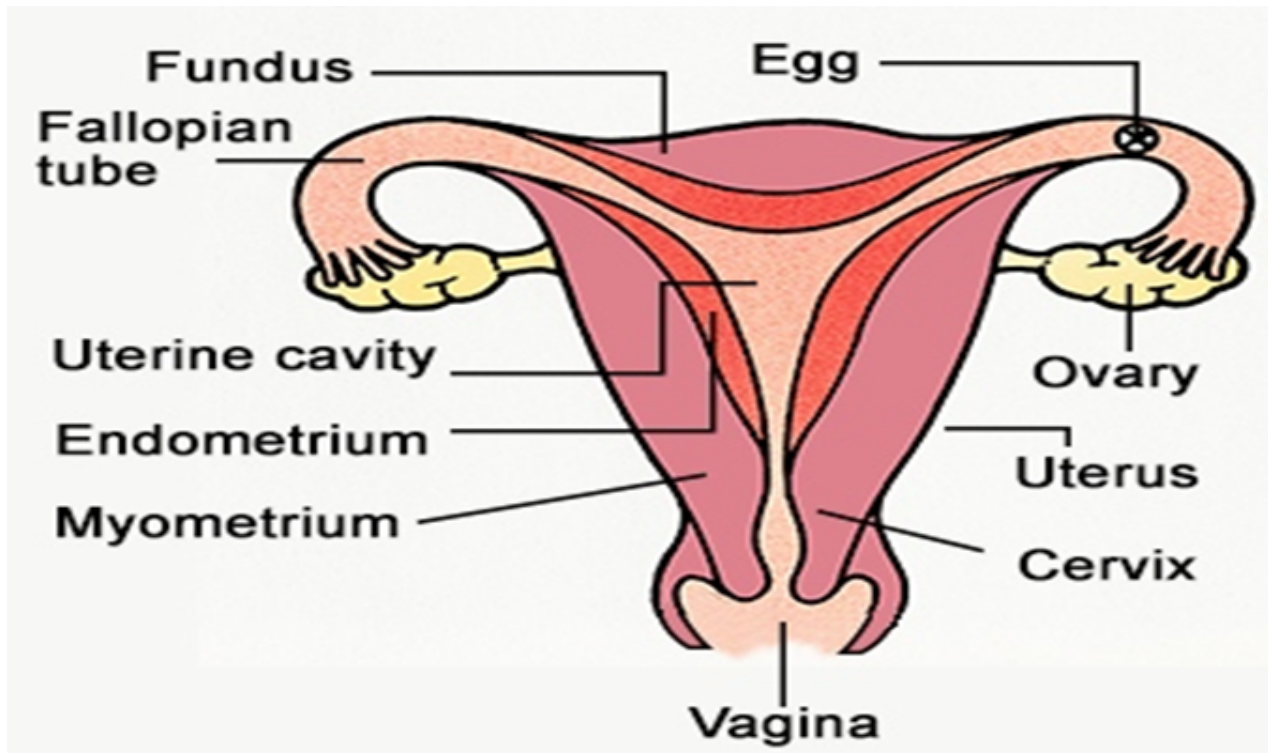


Figure 5: Anatomical relations of the female internal reproductive organs

Female Reproductive System

Description of the female reproductive organs

Mons Veneris: This is the hair bearing skin and fatty pad that overlie the upper part of the symphysis pubes and the lower abdominal muscles. It acts as a coital buffer.

Labia Majora: These are two folds of skin that protect the clitoris, urethra and the vagina. This can be referred to as the outer lips. They are composed of fatty tissue and blood vessels.

Labia Minora (Inner lips): These are two folds that are placed under the labia majora. They are thinner than the outer lips, more vascular and more sensitive.

The labia minora become more purplish in colour with subsequent pregnancy and childbirth. They lose fatty tissue with the advent of the menopause. The labia minora closely protect the clitoris, urethra and the vagina.

Vestibule: The area of smooth skin lying within the minora and in front of the vaginal orifice. The vagina opens into this.

Clitoris: This is the most sensitive part of the female anatomy. It is a small, erect pea- shaped bump located in front of the urethra. It is the centre of sexual sensation for the female.

Urethral Orifice: The Urethra is in the vestibule and under the clitoris. The urethra is the passageway for urine to leave the body.

Vaginal Orifice: This is the opening to the vagina. The vagina is a hollow muscular organ about 7.5 - 10 cm long and located directly under the urethra. Within the vagina is the hymen, which is a delicate skin tissue that may stretch or tear during first sexual intercourse. The vagina links the uterus to the outside of the body. During puberty, the vagina begins to produce some mucus which helps to keep the vagina moist and clean

The vagina

The vagina surrounds the cervix of the uterus, then passes downwards and forwards through the pelvic floor to open into the vestibule. The cervix projects into the anterior part of the vault of the vagina so that the continuous gutter surrounding the cervix is shallow anteriorly (where the vaginal wall is 7.5 cm in length) and is deep posteriorly where the wall is 10 cm long. This continuous gutter is, for convenience of description, divided into the anterior, posterior and lateral *foreskins*.

Relations

- Anteriorly — the base of the bladder and the urethra (which is embedded in the anterior vaginal wall).
- Posteriorly — from below upwards, the anal canal (separated by the perineal body), the rectum and then the peritoneum of the pouch of Douglas which covers the *upper quarter of the posterior vaginal wall*.
- Laterally— levator ani, pelvic fascia and the *ureters*, which lie *immediately above the lateral foreskins*.

Blood supply

Arterial supply is from the internal iliac artery via its vaginal, uterine, internal pudendal and middle rectal branches.

A venous plexus drains via the vaginal vein into the internal iliac vein.

Lymphatic drainage

- Upper third to the external and internal iliac nodes.
- Middle third to the internal iliac nodes.
- Lower third to the superficial inguinal nodes.

The cervix: It is pinkish in colour, opens into the vagina and continues with the uterus. It secretes mucus that changes the environment of the vagina. During childbirth it opens widely to allow the baby to move into the vaginal canal, from where it is fully delivered.

The uterus (womb):

It is a hollow muscular organ. It is pear-shaped and is connected to a fallopian tube on each side of the upper part. From the inner lining of the uterus, monthly bleeding known as menses occurs. The baby develops in the uterus and receives nutrition from the mother via the placenta attached to the uterus.

Blood supply

The *uterine artery* (from the internal iliac) runs in the base of the broad ligament and crosses above and at right angles to the ureter to reach the uterus at the level of the internal os. The artery then ascends in a tortuous manner alongside the uterus, supplying the corpus, and then anastomoses with the *ovarian artery*. The uterine artery also gives off a descending branch to the cervix and

branches to the upper vagina. The veins accompany the arteries and drain into the internal iliac veins, but they also communicate via the pelvic plexus with the veins of the vagina and bladder.

Lymph drainage

1. The fundus (together with the ovary and Fallopian tube) drains along the ovarian vessels to the aortic nodes, apart from some lymphatics which pass along the round ligament to the inguinal nodes.
2. The body drains via the broad ligament to nodes lying alongside the external iliac vessels.
3. The cervix drains in three directions—laterally, in the broad ligament, to the external iliac nodes; posterolaterally along the uterine vessels to the internal iliac nodes; and posteriorly along the recto-uterine folds to the sacral nodes. Always examine the inguinal nodes in a suspected carcinoma of the corpus uteri—they may be involved by lymphatic spread along the round ligament.

The fallopian tubes

The fallopian tubes are delicate tubular structures which carry the ovum or sperm between the ovary and uterine cavity. The tubes are divided into named regions, most medially the cornu and interstitial portion within the uterine wall, then the isthmus followed by the infundibulum, ampulla and finally fimbrial ends. They are lined by columnar epithelium and cilia, which together with the peristaltic action of the surrounding smooth muscle propel the fertilized ovum towards the uterine cavity.

Blood Supply

The blood supply of the fallopian tubes arises from both the uterine and ovarian arteries through the mesosalpinx which is covered by peritoneum.

The Ovaries

The ovaries vary in size depending on age and their function. They are approximately 2×4 cm² with the long axis running vertically and are attached to the posterior leaf of the broad ligament by the mesovarium. In addition, they are fixed in position by the ovarian ligament (to the uterus medially) and the infundibulopelvic ligament which contains the ovarian blood supply directly from the aorta. Venous drainage is to the ovarian veins which drain directly into the inferior vena cava on the right and into the renal vein on the left. The aortic nerve plexus also accompanies the ovary in its descent from around the level of the first lumbar vertebra. The lateral pelvic side wall is covered by peritoneum which is folded to form the ovarian fossa. Pathological adhesions around the ovary will often cause it to be

Blood supply, lymph drainage and nerve supply

Blood supply is from the ovarian artery that arises from the aorta at the level of the renal arteries. The ovarian vein drains, on the right side, to the inferior vena cava, on the left, to the left renal vein, exactly comparable to the venous drainage of the testis.

Lymphatics pass to the aortic nodes at the level of the renal vessels, following the general rule that lymphatic drainage accompanies the venous drainage of an organ.

Nerve supply is from the aortic plexus (T10).

All these structures pass to the ovary in the infundibulopelvic ligament

Summary / Evaluation

- Name the external and internal parts of the male reproductive organs
- Name the external and internal parts of the female reproductive organs
- Display the diagram of the female reproductive organs and ask the participants to name and describe each organ you point to each

MODULE 4

MENSTRUAL CYCLE AND ITS APPLICATION TO FAMILY PLANNING METHODS

Learning Objectives

By the end of the session participants should be able to:

1. Explain the 4 terms commonly used in describing menstrual cycle namely:
 - Menstrual cycle
 - Menstruation
 - Ovulation
 - Hormones
2. Explain the changes that occur in the ovaries, uterus and cervix during each of the 3 phases of the menstrual cycle.
3. Identify the days during the menstrual cycle when a woman is likely to become pregnant
4. Describe how pregnancy occurs
5. Describe the changes in menstrual pattern with contraceptive usage.

Estimated Time: 2 hours

Methods

1. Power point presentation
2. Brainstorming
3. Question and Answers

CONTENTS

The Menstrual Cycle

The Menstrual Cycle occurs during the reproductive period from puberty through menopause in response to rhythmic variation of hormones in the body of a woman. The superficial lining of the uterus proliferates in preparation for implantation of a fertilized egg and in the absence of pregnancy is shed with some bleeding through the vagina and this is called menses.

There are five phases of the menstrual cycle:

1. Menstrual phase

Menstruation refers to the shedding of the superficial layers of the endometrium. The first day of commencement of bleeding is considered as the first day of a menstrual cycle.

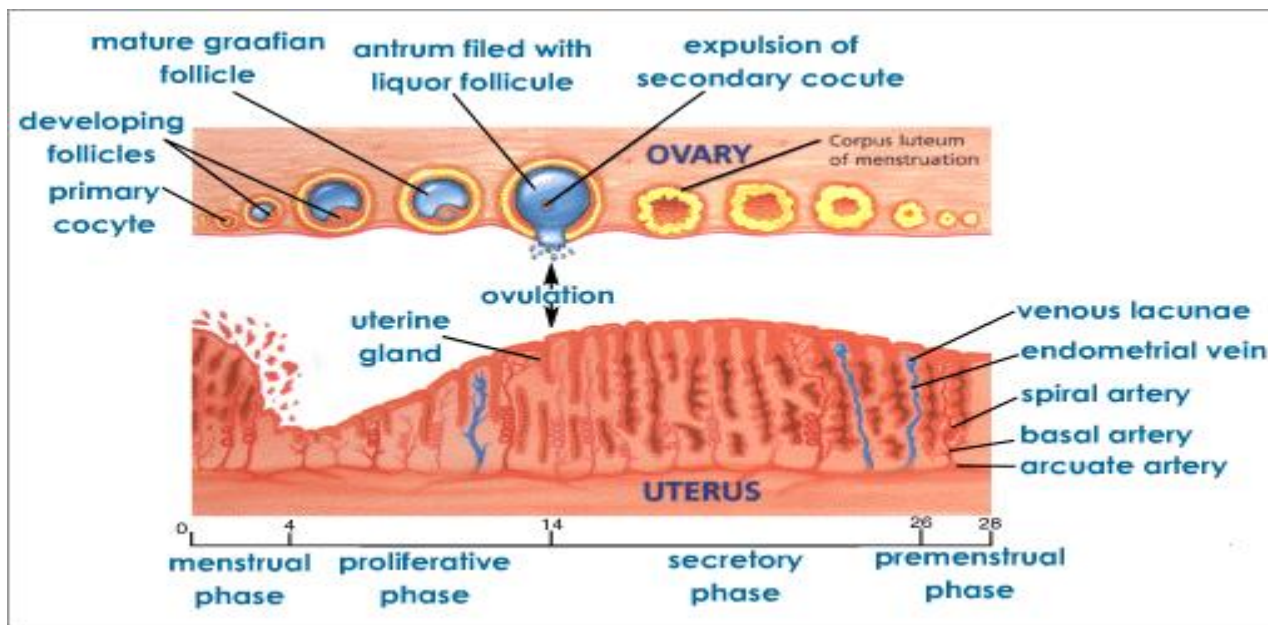


Fig 4: Showing the different phases of Menstrual Cycle in a reproductive age woman

The average duration of the menstrual flow is 3–5 days, but flows as short as 1 day and as long as 8 days can occur in normal women. The amount of blood lost may range normally from slight spotting to 80 ml. The average amount lost is 30 ml and the loss of more than 80 ml is abnormal.

2. Proliferative phase

This is the growth of the superficial or proliferation layer of the uterus. It is averagely 10 – 12 days and it enters into ovulation. The beginning of ovulation is within proliferative phase.

3. Ovulation (release of egg from the ovary)

Ovulation happens about 14 days before your **period** starts. If your average menstrual cycle is 28 days, you **ovulate** around day 14, and your most fertile days are days 12, 13 and 14. If your average menstrual cycle is 35 days, **ovulation** happens around day 21 and your most fertile days are days 19, 20 and 21.

4. Secretory phase

This is a fixed period for every woman between the ovulation and menstrual phase. It is 14 days pre shedding of superficial layers of the endometrium. This phase makes the uterine wall ready for implantation of fertilized egg if it occurs, if not the engorged uterine wall sheds and leads to menstrual phase. Glandular changes in the endometrium happens in this phase.

5. Pre-menstrual phase.

This phase is described as the last 2-4 days of the menstrual phase before the shedding of the endometrium.

In rare cases, some women suffer from Post Menstrual Syndrome (PMS) which is referred to as the presence of one or more hormone induced irregularities in the two weeks after a woman finishes her period.

The most frequent physical signs and symptoms of PMS include;

- fatigue,
- bloating (due to fluid retention),
- weight gain,
- breast tenderness,
- acne,
- Sleep, disturbances with sleeping too much or too little (insomnia), and.
- Appetite changes with overeating or food cravings.

Conditions associated with menstruation that need referral include;

- Severe Painful menstruation and PMS
- Excessive uterine bleeding showed by increasing number of sanitary pads
- Scanty and irregular menstruation
- Infertility

How pregnancy occurs

During ovulation, the mature egg leaves the ovary and travels through the fallopian tube towards the uterus. The egg stays in the fallopian tube for about 24 hours in expectation to meet any sperm deposited by a male during sexual intercourse. The sperm has up to about six days to find an egg before it is destroyed. The process of a sperm joining with an egg is called fertilization which results in pregnancy.

Contraceptive effect on menstrual patterns

Use of many of contraceptive methods bring about several changes in the menstrual cycle. The changes vary by the type of method used and duration of usage. For example, use of oral contraceptive results in fewer days of bleeding or complete amenorrhea, absence of menstruation.

The changes associated with use of IUD are increased and heavy menstrual bleeding and cramping, pulling on both sides of the abdomen. Injectable users experience extended menstrual period, light bleeding or heavy bleeding and temporary amenorrhea. Implants users experience irregular menstrual periods, they tend to lose less blood during menstruation, they also have less cramping, headaches, and breast tenderness, they could also experience light bleeding and temporary amenorrhea (Tolley and Loza, 2005).

The permanent methods (tubal ligation and vasectomy), natural methods (breastfeeding and Lactational Amenorrhea) as well as both male and female condoms have no effect on the menstrual pattern.

Evaluation

- Ask participants what they have learnt from the session.
- Ask several participants to share one thing they learned and how they think it will be useful in their practice.
- Ensure applicability and relevance, clarify as needed.

Summary and Closure

- Summarize major points of the session.
- Review session objectives checking to what extent they have been met.

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MODULE 5

TYPES OF CONTRACEPTIVES ALLOWED FOR TIER 2 PPMVS IN NIGERIA

Session 1: Short Acting Reversible Contraceptive (SARC) Methods

Learning Objectives

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

1. Describe the different types of SARC methods available in Nigeria
2. State the mode of action of each type of contraceptives
3. List at least **five** side effects of the SARC methods
4. Mention **three** advantages and disadvantages of each of the SARC methods available in Nigeria
5. Mention FP methods that second tiers can provide to clients and those which require referral
6. Demonstrate appropriate use of the Medical Eligibility Criteria (MEC)

Estimated Time: 4 hours

Overview of Session

The purpose of this module is to provide the participants (service providers) with knowledge that would deepen their understanding of the nature, types, function and scope of SARC methods.

Methods

1. Brainstorming
2. Power point presentation
3. Questions and Answers

CONTENTS

Oral Contraceptive Pills (OCs, OCPs)

Oral contraceptive pills are synthetic forms of naturally occurring female hormones – oestrogen and progestin – taken in combination or as progestin alone, by women, to prevent pregnancy. Oral contraceptives work by stopping ovulation (release of eggs from the ovaries), they also thicken the cervical mucus thereby making it difficult for sperm to pass through and alteration of the endometrium, however it does not disrupt an existing pregnancy.

Types of oral contraceptive pills

- Combined oral contraceptives (COCs) contain both oestrogen and progestin:
 - very low dose COC (those containing 20 mcg of oestrogen) e.g. Yaz
 - low dose COC (those containing 30 mcg of oestrogen) are commonly used for ongoing contraception e.g. Yasmin
 - high dose COCs (those containing 50 mcg of oestrogen) are used mostly for emergency contraception e.g. Norinyl
 - *Phasic pills* have varying/changing levels of oestrogen and progestin e.g. Trivora
- Progestin-only pills (mini pills) (POPs)

Combined Oral Contraceptive Pills (COCs)

Specific counselling issues

Advantages

- Combined pills are highly effective if used correctly
- Very safe for majority of women
- Client can discontinue independently
- Combined pills are suitable for all reproductive age and parity groups
- Use is not related to the time of sexual intercourse
- Combined pills reduce menstrual pain and mid-cycle ovulation pain, where present
- They reduce menstrual flow in women with heavy menstrual periods
- They can prevent or decrease iron deficiency anaemia
- They regularize irregular periods
- They offer some protection against cancers of the womb and ovary
- Combined pills enable postponement of period for social reasons
- They reduce the risk of ectopic pregnancy and symptomatic pelvic inflammatory disease (PID)

Disadvantages

- Combined pills must be taken daily
- They may cause minor, but usually temporary, side effects such as:
 - mild headache
 - nausea
 - spotting
 - weight gain

- breast tenderness
- mood changes
- They do not protect against STIs and HIV/AIDS
- They are not recommended for breastfeeding women
- Compliance is difficult for some women
- Serious complications are very rare, but can occur in some women with underlying health conditions

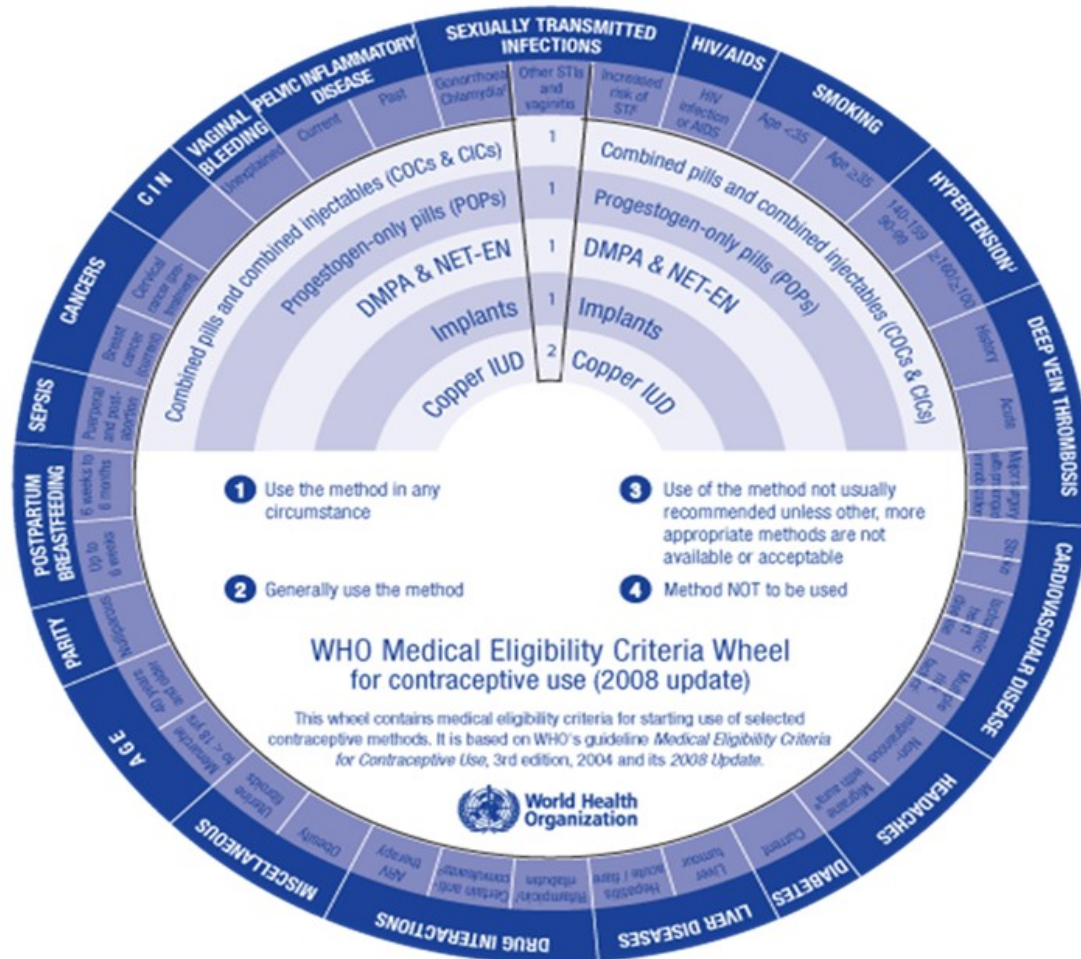
Note: The risks should be compared to the risk of pregnancy

Effectiveness

When commonly used, about 8 pregnancies occur per 100 women using combined oral contraceptives over the first year. When there are no pill-taking mistakes, less than 1 pregnancy occurs per 100 women using combined oral contraceptives over the first year (3 per 1,000 women).

The WHO Medical Eligibility Criteria (MEC) categories for Contraceptive use

Category 1	A condition for which there is no restriction for the use of the contraceptive method
Category 2	A condition where the advantages of using the method generally outweigh the theoretical or proven risks
Category 3	A condition where the theoretical or proven risks usually outweigh the advantages of using the method
Category 4	A condition which represents an unacceptable health risk if the contraceptive method is used



Women who can use combined oral contraceptive pills without restriction (WHO Category 1)

- Women who are between menarche and less than 18 years
- Nulliparous women
- Women who have puerperal sepsis and post-abortion sepsis
- Women with current and past pelvic inflammatory disease
- Women with increased risk of STIs/HIV or those with current STI, including gonorrhoea and chlamydia infection, or women with vaginitis
- HIV positive women (not on antiretroviral therapy)
- Women who have non-migrainous headache
- Women who have uterine fibroids
- Women with irregular, heavy or prolonged bleeding patterns
- Women with endometrial or ovarian cancer (awaiting treatment)
- Women with chronic hepatitis, or those who are carriers
- Women with mild (compensated) cirrhosis
- Women who take broad-spectrum antibiotics, antifungal or anti-parasitic medication

Women who can generally use combined oral contraceptive pills; some follow up may be needed (WHO Category 2)

- Women who are 40 years and older
- Women who are breastfeeding after 6 months postpartum
- Women with superficial thrombophlebitis
- Women with migraines without aura who are less than 35 years old
- Women who have cervical cancer (pre-treatment)
- Women with unexplained vaginal bleeding
- Women who are less than 35 years old and smoking
- Women who have non-vascular (uncomplicated) diabetes
- Women with asymptomatic gall-bladder disease or those treated by cholecystectomy
- Obese women (BMI greater than 30kg/m²)
- Women on antiretroviral therapy (unless their ARV regimen contains ritonavir or ritonavir-boosted protease inhibitors)
- Women with systemic lupus erythematosus who are negative for antiphospholipid antibodies
- Women who have liver tumour such as focal nodular hyperplasia

Use of combined oral contraceptive pills usually not recommended in these women; (WHO Category 3)

- Women taking certain drugs, anti-tuberculosis drugs (e.g. rifampicin/rifabutin), anticonvulsants (e.g. phenytoin, carbamazepine or lamotrigine)
- Breastfeeding women from 6 weeks to 6 months postpartum
- Non-breastfeeding women within the first 21 days postpartum
- Women who are smoking <15 cigarettes/day and are above 35 years
- Women who have blood pressure of 140–159mmHg systolic and 90–99mmHg diastolic
- Women who had breast cancer in the past and no evidence of current disease for five years
- Women with migraines without aura who are more than 35 years old
- Women current or medically treated gall-bladder disease
- Women who take ritonavir or ritonavir-boosted protease inhibitors as part of their ARV regimen
- Women with undiagnosed vaginal bleeding (until evaluated and diagnosed)

Women who should not use combined oral contraceptives pills (WHO Category 4)

- Women whose blood pressure is at or above 160mmHg systolic and at or above 100mmHg diastolic
- Women with history of or current deep vein thrombosis (DVT) or pulmonary embolism (PE), even when established on anticoagulant therapy
- Women who are smoking more than 15 cigarettes/day and are 35 years or older
- Women who are having major surgery with prolonged immobilization
- Women with stroke or ischaemic heart disease, both history and current
- Women who have migraine with aura at any age
- Women who have any liver tumour other than focal nodular hyperplasia
- Women with acute/flare hepatitis

- Breastfeeding women who are within 6 weeks postpartum
- Women with current breast cancer
- Women with systemic lupus erythematosus who have positive or unknown antiphospholipid antibodies
- Women with complicated diabetes or diabetes of more than 20 years duration

Equipment and materials

- Combined pills
- Condoms
- Clinic card
- Equipment for physical examination
- Visual aids

Procedure

When to initiate pills

Pills can be initiated anytime during the menstrual cycle, when provider is reasonably sure that a woman is not pregnant.

Client's preparation

- Greet client and offer a seat
- Make her comfortable and relaxed
- Find out what she already knows about combined pills and fill any gaps in her knowledge
- Provide adequate information on the pills including advantages, disadvantages and side effects
- Take a thorough history of the client and screen the client for eligibility using the screening checklist for initiation of COCs.
- Physical examination is necessary particularly blood pressure and weight)
- Pelvic examination is not necessary for safe initiation of COCs but should be offered in clinical settings as part of good preventive healthcare.
- Give new clients one cycle of pills and a one-month appointment. If she is a revisit client, give her three cycles of pills and an appointment to return in three months.

Instructions for using combined oral contraceptive pills

Instruct the client to:

- Take one tablet preferably around the same time every day whether she is likely to have sexual intercourse or not
 - if she starts her first pack of pills within the first five days of menstrual cycle, no back-up method needed.
 - if it is more than five days, client should use back-up method, such as condom, for seven days.
- Explain to the client that there are two types of pill packs – those containing 28 pills and those containing 21 pills.
- For 28-pills packs explain that:

- the first 21 of the 28-tablet pack are the active tablets and they have the same colour. The last 7 tablets have a different colour and are the non-active tablets (contain no hormones)
 - she should start with the 21 same colour tablets and continue with the 7 differently coloured ones
 - she should begin the next pack the day after taking the last tablet of the present pack, whether menses has occurred or not. There should be no break between packs
 - she should always start a new pack with the group of 21 same colour tablets
 - she should visit the clinic for refill whenever she is on her last pack of pills before she finished taking the last 7 same colour tablets
- For the 21-tablet pack, explain to the client that:
 - all the tablets are of the same type and colour
 - she should wait for seven days after taking the last tablet in the present pack before starting to use a new pack, whether menses has occurred or not

What can a woman do if she misses the combined oral contraceptive?

1. If she misses one or two active (hormonal) pills or if she starts a pack one or two days late:
 - she should take an active (hormonal) contraceptive as soon as possible and continue taking pills as usual (that means she may take 2 pills on the same day or at the same time)
 - she does not need any additional contraceptive
2. If she misses three or more active (hormonal) pills or if she starts a pack three or more days late:
 - she should take an active (hormonal) contraceptive as soon as possible and continue taking the pills as usual (that means she may take 2 pills on the same day or at the same time)
 - she should also use condoms or abstain from sex until she has taken active (hormonal) pills for seven days in a row
 - If she misses pills in the third week, she should finish the active (hormonal) pills in her current pack, throw away 7 inactive (brown) pills and start a new pack the next day. She should also use a backup method (condom) for the next 7 days.
 - If she missed three or more active pills at any time or started a new pack 3 or more days late **and** she had sex in the past 5 days, she may consider using a backup method (condom) for the next 7 days.

Note: If the client thinks it would be hard for her to remember to take contraceptive pills on time, or if she keeps missing pills, the provider should encourage her to consider changing to another method.

Important issues that the client should remember

- Combined oral contraceptive does not protect against STIs and HIV/AIDS
- Use condoms in addition to pills for protection against STIs and HIV/AIDS
- Keep a back-up method, like condom and vaginal spermicides
- If the client is seeing a doctor for any health problem, she should inform the health provider that she is using combined oral contraceptive

- How and where to get supplies
- The importance of keeping appointments
- Conduct regular self-breast examination
- Report to the clinic
 - if there are questions or concerns
 - on the scheduled date
 - 4–6 weeks before and after major operations
- Report immediately to the clinic if she experiences any of the following:

A -Abdominal pain (severe)
 C- Chest pain (severe)
 H - Headache (severe)
 E - Eye problems, blurring of vision
 S- Severe calf pain

Note: Anti-TB agents (Rifampicin, rifabutin), anti-convulsant (Phenytoin, Phenobarbitone, Primidone, Carbamazepine) and antiretroviral agents (ritonavir) reduce the efficacy of oral contraceptives. Rifampicin also causes possible breakthrough bleeding. Women who take these medications should not use COCs.

Follow-up

At one month after the initial pill prescription:

- Check blood pressure and weight
- Ask of any early side effects, respond to them and re-assure her
- Rehearse the method of taking pills with client by asking her to tell you how she should take the pill and what to do if she misses the pill(s)
- Give 6 months' supply if client shows the ability to use pills correctly
- Instruct the client to come for re-supply before the last pack finishes
- If you still have doubts about her ability to take pills properly, see her monthly until you are satisfied or consider counselling about another method
- Then see her every three months for re-supply and once a year for general check-up
- Tell her to return to the clinic without appointment any time she has any problems or doubts
- Encourage her to carry out self-breast examination monthly

Note: If the client cannot revisit the original clinic, she should go to the nearest family planning clinic.

At six months and one-year visits:

- Obtain information on the use of the pill
- Check blood pressure and weight
- Ask about side effects and danger signals and manage appropriately
- Supply pills (six packs every six months)
- Give a return appointment for six months
- Encourage client to do a pap smear at the appropriate time

Progestin-only Oral Contraceptive Pills (POPs)

Types

- | | | |
|---------------|--------------|--------------|
| - Exluton | - Microlut | -Norgeal |
| - Femulen 0.5 | -Micro-Novum | -Norgestrone |
| - Micronor | -Neogest | -Norstrel |
| - Nor QD | -Ovrette | |

Specific counselling issues

Inform the client of the advantages and disadvantages.

Advantages

- Very safe for majority of women
- Very effective if taken correctly
- Does not disturb breast milk production
- Less likely to cause headaches or raised blood pressures
- No increased risk of cardiovascular complications
- No health risks associated with oestrogen
- Can be used for emergency contraception

Disadvantages

- The woman must take the one pill every day, preferably at the same time. POPs require stricter pill schedule than COCs
- For non-breastfeeding women, they are slightly less effective than combined pills
- Have common side effects, including frequent bleeding, irregular bleeding, prolonged bleeding, or amenorrhea, headaches, dizziness, mood changes, nausea, breast tenderness and abdominal pain
- Do not protect against STIs and HIV/AIDS

Effectiveness

Breastfeeding women as commonly used, about 1 pregnancy occurs per 100 women using POPs over the first year. With perfect use there is less than one pregnancy over one year.

Non-breastfeeding women: as commonly used, 3 to 10 pregnancies per 100 women over one year; with perfect use, less than 1 pregnancy per 100 women over one year.

Women who can use POP without restriction (WHO Category 1)

POP is suitable for women who:

- are of any age or parity, including nulliparous
- smoke at any age
- have non-migrainous headache or migraines without aura at any age
- have acute/flare hepatitis, chronic hepatitis or are carriers
- have mild (compensated) cirrhosis
- are obese
- have uterine fibroids

- are breastfeeding within six weeks to six months postpartum
- have blood pressure below 160/100 mmHg
- have puerperal and post abortion sepsis
- have cervical cancer (pre-treatment) or cervical intraepithelial neoplasia/cervical carcinoma in situ (CIN)
- have endometrial or ovarian cancer
- have current and past pelvic inflammatory disease
- have increased risk of STIs or current STI including gonorrhoea and chlamydia
- have HIV infection or AIDS, but not on antiretroviral therapy
- take broad-spectrum antibiotics, antifungal or anti-parasitic medications

Women who can generally use POP; some follow up may be needed (WHO Category 2)
 Women who have:

- blood pressure of 160/100 mmHg and above
- history of deep vein thrombosis or current thrombosis, but established on anticoagulant therapy
- major surgery with prolonged immobilization
- history or current ischemic heart disease or stroke (initiation only; women who develop heart attack or stroke while using POPs reclassified as category 3)
- multiple risk factors for cardiovascular disease
- migraine with aura
- current diabetes with or without complications
- gall-bladder disease
- benign liver tumour, such as focal nodular hyperplasia
- antiretroviral therapy (unless the regimen contains ritonavir or ritonavir-boosted protease inhibitors)
- irregular, heavy or prolonged vaginal bleeding patterns and unexplained vaginal bleeding

Use of POP usually not recommended in these women (WHO Category 3);
 Women who:

- have acute deep vein thrombosis
- have liver tumour (other than focal nodular hyperplasia)
- have severe (decompensated) liver cirrhosis
- are on Rifampicin/Rifabutin
- are taking ritonavir or ritonavir-boosted protease inhibitors as part of their ARV regimen
- are on certain anti-convulsant, e.g. Phenytoin
- are breastfeeding up to six weeks postpartum
- developed heart attack or stroke while taking POPs
- noticed their migraine with aura became worse while taking POP
- women with history of breast cancer and no evidence of current disease for 5 years

Women who should not use POP (WHO Category 4)

- Women with current breast cancer

Equipment and materials

- Progestin-only pills
- Vaginal spermicides
- Condoms
- Clinic card
- Equipment for physical examination
- Visual aids

Procedure*Client preparation*

- Greet client and offer a seat
- Make her comfortable and relaxed
- Find out what she already knows about POP and fill any gaps in her knowledge
- Provide adequate information on the pills including advantages, disadvantages and side effects
- Take a thorough history of the client
- Physical and pelvic examination is not necessary for safe initiation of POPs but should be offered in clinical settings as part of good preventive healthcare.
- Give the client one cycle of pills and a one-month appointment if she is a new acceptor. If she is a revisit client, give her three cycles of pills and an appointment to return in three months
- Ensure that the client wishes to use the minipills and has no contraindication to them.

When to initiate POP

- The woman can start any day during the menstrual cycle when it is reasonably certain that she is not pregnant. If she starts within 5 days after the start of her monthly bleeding, no need for a backup method. If she starts after day 5, she will need a backup method for the first 2 days of taking pills.
- As early as six weeks after childbirth
- If she is breastfeeding and has no monthly bleeding, she can start any time, but will have to use a backup method for the first 2 days of taking pills if it has been more than 6 months after childbirth

Specific instruction to POP users

- Supply three packets of minipills in subsequent visits
- Take one pill every day, preferably at the same time
- Missing pills may lead to pregnancy
- After one pack is finished, start the next pack on the very next day without a break
- If pill is taken five days after menstruation had started, use protection or abstain from sexual intercourse for two days
- Be aware that menstrual bleeding may become irregular, frequent or infrequent, prolonged, or stop altogether
- Report to the clinic if the following occurs:

- You think you might be pregnant (e.g. you missed taking pills)
- You are prescribed drugs for TB or seizures, or starting ARV treatment for AIDS
- You have any concerns or problems

Important things the client should remember if she misses pill(s)

- Remind the client to take one pill every day at the same time
- If she is 3 or more hours late taking a pill or misses one or more completely, instruct the client to take the forgotten pill as soon as she remembers and take the day's pill at the usual time.
- In addition, if she has monthly bleedings, she should use a barrier method for the next two days
- Instruct the client to consider changing to another method if she keeps forgetting
- If the client experiences severe vomiting or diarrhoea, instruct her to use a barrier method or avoid sex for two days after the illness is over. If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible and keep taking pills as usual

Follow-up

First follow-up visit

- Check blood pressure and weight
- Ask if there are any side effects, respond to them and re-assure her
- Rehearse the method of taking pills with client
- Give 6 months' supply if client shows the ability to use pills correctly
- Breastfeeding women: explore if she is planning to continue taking POPs after she stops breastfeeding. If not, discuss other available methods and help her make an informed choice
- Instruct the client to come for re-supply before the last packet finishes
- If she keeps missing pills or not sure in her ability to take pills correctly, help her choose another method
- See her every six months for check-up and re-supply
- Inform her that she can return to the clinic without appointment anytime she has problems or doubts
- Encourage her to carry out self -breast examination monthly

Injectable

Injectables are hormonal contraceptives that contain combined oestrogen and progestin or progestin only and are given by intramuscular injection. They provide contraceptive protection from 1 to 3 months, depending on type.

Types of injectables

Progestin-only injectable contraceptives

- Norethisteroneenanthate (Noristerat, NET-EN)
- Depot-medroxy-progesterone acetate, intramuscular (DMPA-IM, Depo-Provera)
- Depot-medroxy-progesterone acetate, subcutaneous (DMPA-SC, Sayana Press)
- Sayana Press
 - Contains 104mg DMPA
 - In microcrystalline suspension form
 - Now subcutaneous compared with intramuscular for Depo provera
 - Given every 12-13 weeks
 - Should not be used for more than 2 years

Specific counselling issues for progestin-only injectable contraceptives

Advantages

- Progestin only contraceptives are highly effective and safe
- They have minimal client dependence
- They are not related to sexual intercourse
- They are culturally acceptable
- They make sickle cell crises less frequent and less painful
- They may protect from iron-deficiency anaemia
- They may protect against symptomatic pelvic inflammatory diseases
- They protect from endometrial cancer and uterine fibroids
- They reduce symptoms of endometriosis
- They do not decrease breast milk production
- They may protect against ectopic pregnancy
- They offer privacy
- Progestin only injectable contraceptives have no drug interaction
- They have no known health risks

Disadvantages

- Progestin only injectables require regular visits to the clinic (1–3 months interval)
- They have common side effects including:
 - irregular, prolonged or heavy bleeding
 - infrequent bleeding or absence of bleeding (amenorrhea)
 - weight gain,
 - headaches, dizziness, mood change, decrease in sex drive

- Return of fertility may be delayed
- They do not protect against STIs and HIV/AIDS

Effectiveness

As commonly used, about 3 pregnancies occur per 100 women using progestin only injectables over the first year. When women have injections on time (perfect use), less than 1 pregnancy occurs per 100 women in the first year of use.

Women who can use progestin-only injectables without restriction (WHO Category 1)

Women who:

- are between 18 and 45 years old
- are smoking at any age
- are nulliparous
- have puerperal and post abortion sepsis
- have current and past pelvic inflammatory disease
- are at increased risk of STIs or have current STI, including gonorrhoea and chlamydia infection
- are HIV- infected, have AIDS or are on ART, including ritonavir (ART applies to DMPA only)
- have non-migrainous headache
- have uterine fibroids
- are breastfeeding any time after six weeks postpartum
- are obese
- have depressive disorders
- have acute/flare hepatitis, chronic hepatitis or are carriers
- take any medication, including anti-TB and anti-seizure medications (applies to DMPA only, NET-EN is category 2)
- have severe dysmenorrhoea
- have endometrial or ovarian cancer

Women who can generally use progestin only injectables; some follow up may be needed (WHO Category 2)

Women who:

- are less than 18 or older than 45 years
- use certain anti-convulsant, e.g. Phenytoin or anti-TB drugs, e.g. rifampicin/rifabutin (applies to NET-EN only, DMPA is category 1)
- are on ARV therapy, including ritonavir (applies to NET-EN only)
- have migraine with or without aura
- had major surgery with prolonged immobilization
- have history of deep vein thrombosis
- have blood pressure below 160/100 mmHg
- have irregular, heavy or prolong vaginal bleeding patterns
- have gall-bladder disease
- have benign liver tumour, such as focal nodular hyperplasia

- have rheumatic disease such as lupus erythematosus if negative for antiphospholipid antibodies
- have cervical cancer (pre-treatment) or cervical intraepithelial neoplasm (CIN)
- have diabetes without vascular complications

Use of progestin only injectables usually not recommended in these women (WHO Category 3)
Women who:

- have acute deep vein thrombosis
- have liver tumour (other than focal nodular hyperplasia)
- are breastfeeding up to six weeks postpartum
- have blood pressure 160/100mmHg and above
- have diabetes with vascular complications
- have unexplained vaginal bleeding (before evaluation)
- have multiple risk factors for cardiovascular disease
- have current or history of stroke or ischaemic heart disease
- noticed their migraines with aura getting worse while taking progestin-only injectables
- have rheumatic disease such as lupus erythematosus with positive or unknown antiphospholipid antibodies
- history of breast cancer and no evidence of current disease for 5 years

Women who should not use progestin only injectables (WHO Category 4)

- Women who have breast cancer (current)

Equipment and materials

- Depo-Provera, Noristerat, Sayana Press
- Client cards
- Equipment for medical check
- Tray or kidney dish, galipot, syringes and needles (NET-EN, DMPA-IM)
- Swabs and methylated spirit
- Safety box
- Disposable gloves
- Vaginal spermicides or condoms

Procedure

When to initiate progestin only injectables

- Anytime it is reasonably certain that a woman is not pregnant
 - If initiated within the first 7 days of menstrual cycle, no back-up method needed
 - If initiated after the first 7 days of menstrual cycle, client will have to use a back-up method (e.g. condom) for the first 7 days after injection
- Six weeks after childbirth
- Immediately after a miscarriage or abortion
- Immediately after stopping another method

Giving the injection (NET-EN/DMPA-IM)

- Check the label carefully for confirmation and expiry date
- Rock the bottle to and fro to allow the contents mix properly
- *Do not shake the bottle vigorously* because this produces foam, which makes complete withdrawal difficult thus reducing the desired dosage
- *Do not heat up the NET-EN/DMPA-IM ampoule/vial* as this will reduce the potency of the drug
- Wash hands
- Pierce top of ampoule/vial with sterile needle and fill syringe with proper dosage, withdraw contents and expel any air from syringe
- Clean the injection site with cotton wool soaked in methylated spirit or water
- Inject the drug slowly
- Apply pressure on injection site with the cotton wool to prevent bleeding
- Do not rub injection site
- Dispose needles and syringes appropriately (see Chapter 19)
- Record all information and actions on client's card

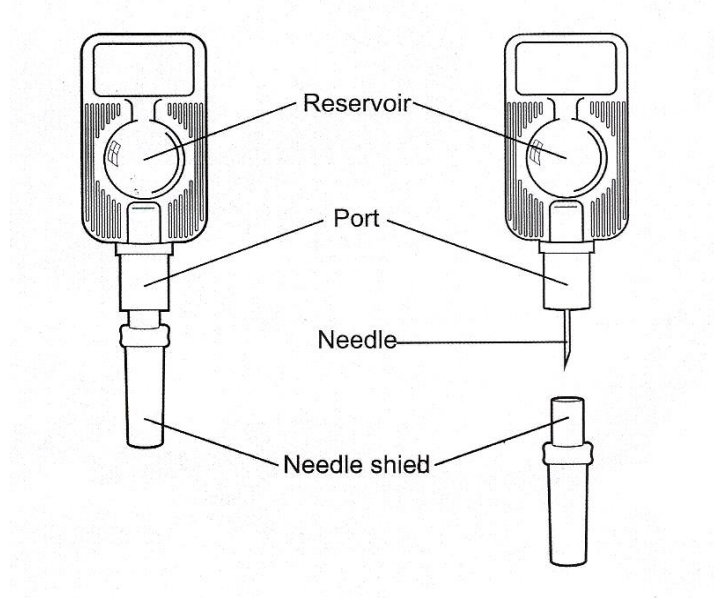
Post-injection instructions

Give client the following instructions:

- Do not to rub injection site because this can hasten absorption and reduce duration of efficacy
- Irregular, heavy or prolonged bleeding or amenorrhea (no menses) may be experienced – this is normal with injectables use and not harmful to your health
- Return to the clinic in three months (13 weeks) for repeat injection if on Depo-Provera and Sayana Press, or two months (eight weeks) if on Noristerat
- Encourage client to keep appointments, but come back even if she is late for her re-injection
- Return to the clinic if the following is experienced:
 - Suspicion about pregnancy
 - Any concerns about the method
 - Migraines with aura became worse while using progestin-only injectables
 - If there are any significant changes in her health which may or may not be related to the use of injectable contraceptives (e.g. she had heart attack or stroke, or deep venous thrombosis)
 - Heavy bleeding that concerns her
 - Jaundice
- Client should inform the physician that she is using injectable contraception whenever she consults a physician or is admitted to hospital

NOTES ON ADMINISTERING SAYANA PRESS (DMPA-SC)

- DMPA-SC (Sayana Press®) is delivered in an all- in-one injection system called Uniject that is already filled with DMPA that can be injected under the skin.
- The diagram below shows the Uniject device and its different parts



Parts of the Uniject

There are 5 main steps in administering DMPA-SC to eligible clients

- Rule out pregnancy
- Prepare the Uniject for injection
- Identify the three appropriate injection site areas
- Give DMPA-SC injection in the correct way
- Follow safe disposal methods

Rule out pregnancy

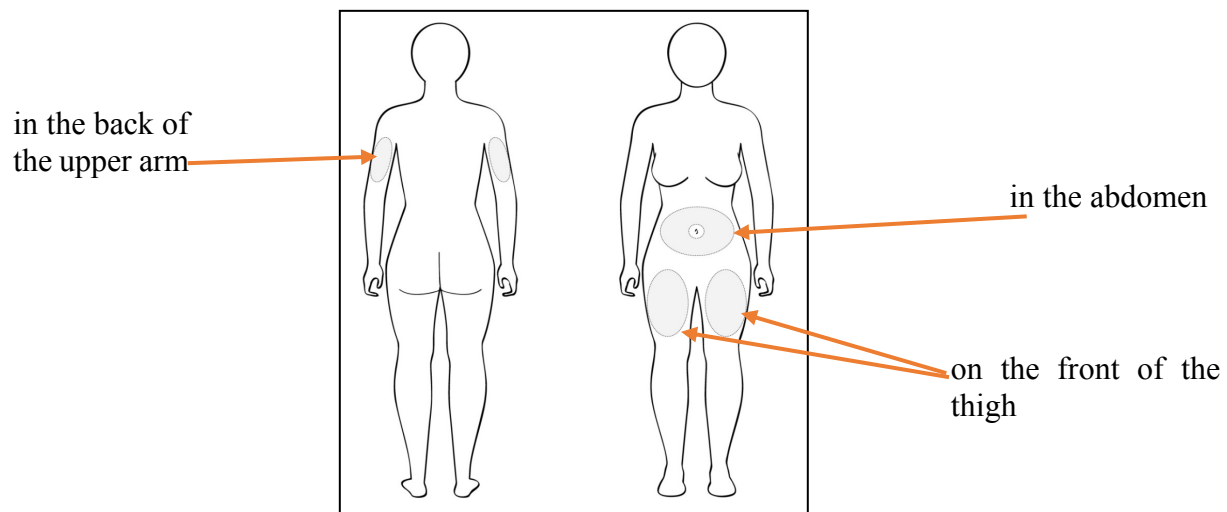
- You must confirm that your client is not pregnant before giving her the injection. You can do this using a pregnancy test kit or asking relevant questions.
- If you cannot confirm that she is not pregnant, counsel her on backup methods such as condoms and tell her when she can come back for the injection.
- If you confirm she is NOT pregnant, proceed to the next step

Prepare the Uniject for injection

- Make sure that you have all the following supplies and equipment you will need
 - Soap
 - Water
 - Cotton wool
 - DMPA-SC unit
 - Waste disposal box
- Wash your hands with soap and water after you have set out your supplies and before you give the injection. This helps prevent infection.
- Let your hands air dry

Identify the three appropriate injection site areas

- There are three appropriate injection site areas for administering DMPA-SC. Ask your client which she prefers

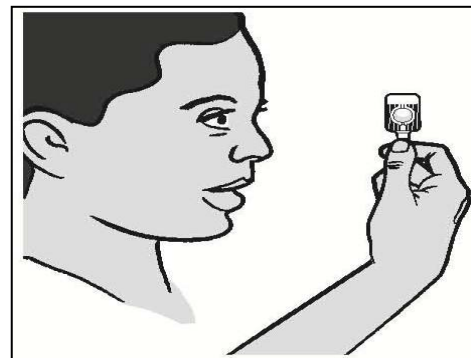
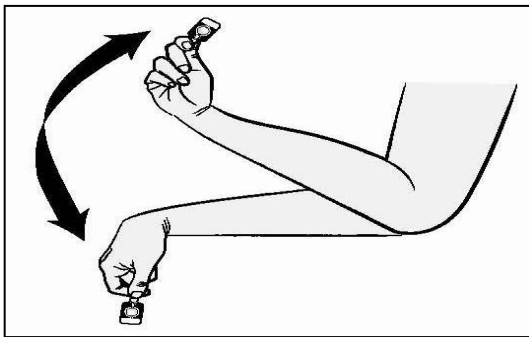


NOTE: DMPA-SC should **NOT** be injected in the buttocks, hip like with DMPA-IM

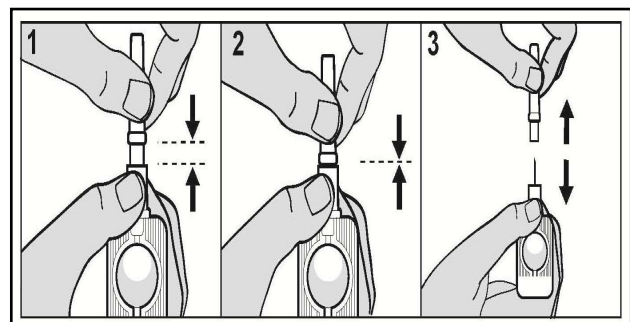
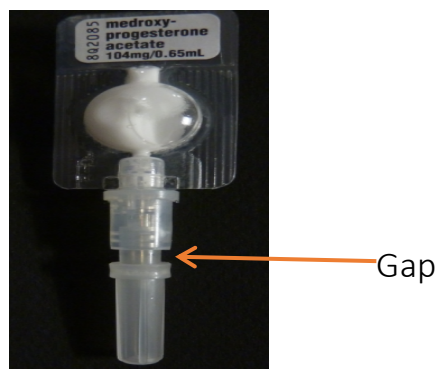
Give DMPA-SC injection in the correct way

- Check the expiration date on the pouch.
- Open the foil pouch and remove the Uniject.
- Hold the Uniject by the port.
- Shake it vigorously for 30 seconds.

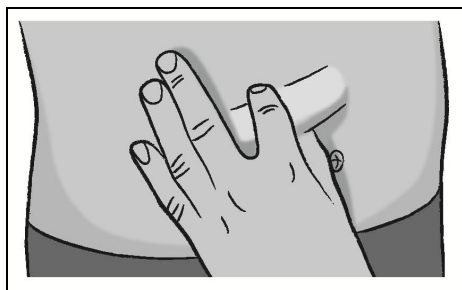
- The DMPA-SC unit must be mixed right before it is injected. If you mix it and there is a delay, you must mix it again before you give the injection
- Do not flick or bend the Uniject. This can damage the Uniject
- The Uniject has a full dose of DMPA but it only takes 3/4 of the space in the reservoir. The remaining space is filled with air. **This is normal**
- Check to make sure the solution is mixed and there is no damage or leakage
- Hold the Uniject by the port.
- Keep the Uniject pointed upward during activation to prevent spilling the drug
- Push the needle shield into the port to activate the Uniject.
- Continue to push firmly until the gap between the needle shield and port is closed.



- If the gap is only partly closed, the DMPA-SC injection will **NOT** work



- Gently pinch the skin at the injection site. The pinch is important to make sure DMPA-SC is injected into the fat, and not into the muscle



- Position the needle for injection
 - Insert straight into the skin at a downward angle
 - A slight downward angle helps prevent injection of air
 - Needle should **NEVER** be pointed upward during injection



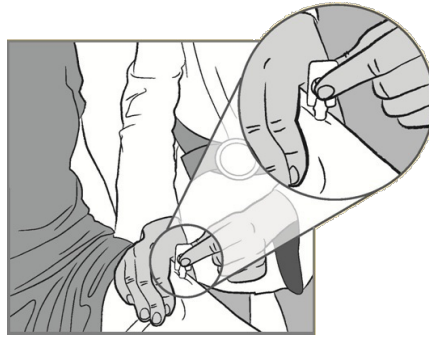
Arm

Abdomen

Thigh

- Port should touch the skin.
- Squeeze the reservoir slowly for 5 to 7 seconds
 - Still pinching the skin, move your thumb and forefinger from the port of the Uniject to the reservoir.
 - Squeeze the reservoir slowly to inject the contraceptive. This should take about 5-7 seconds.
 - There may be a little medication left in the reservoir. **This is normal.**
 - Remove the Uniject and then release the pinched skin

NOTE: Do **NOT** clean or massage the site after injecting.

**Follow safe disposal methods**

- Do **NOT** replace the needle shield onto the Uniject.
- Place in waste disposal box

Help clients plan for their next injection

- Circle the date of the client's injection in her DMPA-SC calendar
- Also write that date on the next page of her card
- Use her calendar to count 13 weeks to her next injection
- Then circle her next injection date in her DMPA-SC calendar
- Also write that date on the next page of her card

What to do during a reinjection visit**Decide if a client is eligible for DMPA-SC re-injection**

- To check if your client is on time for reinjection, find out when she received her last DMPA injection.
- Count 13 weeks from her last injection to find her reinjection date.
- If today is her reinjection date, she can get the injection.
- If she is up to 2 weeks early or up to 4 weeks later than her reinjection date, she can get the injection.
- If your client is more than 4 weeks late for reinjection, you must make sure that your client is not pregnant before giving the injection by administering a pregnancy test or using the pregnancy checklist.

- If you can confirm that your client is not pregnant and give her the injection, she must use a back-up method (e.g. male and female condoms) for 7 days. After 7 days, the client will be protected by DMPA-SC
- If you cannot confirm that your client is not pregnant, tell her that she might be pregnant and ask her to visit the nearest health facility to confirm if she is pregnant.
- Tell her that she must use condoms or not have sex until she can get another injection

Effectively counsel clients for self-injection

You need to learn how to advise clients on:

- Proper storage of DMPA-SC
- Proper disposal of DMPA-SC
- Proper DMPA-SC self-injection technique
- How to calculate their reinjection date
- When and how to seek help from a provider

You will need to give the job aid and reinjection calendar to your client. In addition, play the self-injection demonstration video to the client. The observation checklist is for your use to evaluate each client. These materials will help you train clients to self-inject DMPA-SC and to calculate and remember their reinjection date.

Proper storage of DMPA-SC

- It is important to explain proper storage of DMPA-SC to your clients.
- Emphasize that DMPA-SC should be stored in a safe place, away from extreme heat or cold.
- Discuss with your client on possible locations where they could safely store DMPA-SC at home.
- You should also explain to your clients that they and others should avoid touching the needle to prevent a needle stick injury or infection.

Proper disposal of DMPA-SC

- Refer your client to Step 9 in the job aid or appropriate portion of SI video and explain the options for DMPA-SC disposal.
- After the injection, remind clients that they should immediately discard device in a puncture-proof container such as a wide-mouth bottle or jar with a lid for safe return to the PPMV shop or a clinic
- Clients should keep the container in a safe place, away from children, until they can give it to a health worker to be disposed of at a clinic.
- Give your clients examples of homemade puncture-proof sharps containers, such as wide-mouth bottle with lid e.g. Petroleum jelly bottle, body cream containers, etc.
- It is very important for you to explain to clients that the used DMPA-SC injection is dangerous and that safely disposing it is critical.
- Ask your client for ideas on how she plans to dispose the used DMPA-SC injections.

Proper DMPA-SC self-injection technique

- Use booklet Steps 1–9 or the SI demonstration video as a guide.
- The client should follow along as you play the SI demonstration video or in the booklet by turning the pages while you show her each step.
- Be sure to give the client time to become familiar with the booklet or the SI demonstration video as you proceed through the steps.
- Coach your client while she practices self-injection.
- Using the steps in the booklet or the SI demonstration video, emphasize:
 - Step 3: Shake the DMPA-SC solution vigorously for about 30 seconds and check for damage and leakage
 - Step 4: Activate the device by pushing the needle cap and port together to close the gap
 - Step 6: Gently pinch the skin at the injection site to form a “tent” and inject the needle
 - Step 7: Press the reservoir slowly to inject for about 5 to 7 seconds.

- Steps that have been shown in research to be most prone to error include shaking the solution, activating the device, and pressing the reservoir slowly. Be sure to emphasize these steps to the client.
- Use the observation checklist to record her performance during her practice self-injection on herself.
- Discuss what did and did not go well.
- If the client is able to successfully practice self-injection at the first visit, **inform her that her next injection must also be provider-supervised and if proficient, she will be given 2 additional doses to take home for her next two injections**
- When she gives herself the next injection in 3 months, she should choose a different injection site.
- Ask if she has questions or concerns about self-injection
- If the client fails at the self-injection practice, explain that provider administration may be the best option for the client. However, let her know that she will have another opportunity to try at her next visit.

How to calculate reinjection dates

- You need to assist your successful client to learn how to calculate her next injection date to help ensure that she is protected from pregnancy.
- Explain to your client that it is important for her to reinject with DMPA-SC at 3 months to prevent pregnancy.
- Explain that the blank calendar will help her calculate her next injection date.
- Review booklet Step 12 with the client.
- The client will need to circle her current injection date on the calendar, count 3 months, and then circle the next injection date. She should write the dates in the booklet if possible
- You may need to coach clients on how to write dates. It is best to write the month name instead of a number, such as “2 November 2015.”
- If she cannot write, she may need to rely on the circled dates.
- Help her practice by giving her some example dates to circle, write, and count 3 months ahead.

- Help your client remember her reinjection date. Identifying ways to remember is especially important for clients with limited reading skills. Discuss with your client ways she can remember her reinjection date, such as:
 - Crossing off each week on the calendar
 - Noting whether the reinjection date is the same as holidays, market days, or other events.
 - Asking a friend, partner, or family member to help her remember the date.
- Review with the client the information about the reinjection window in the job aid and video.
- The World Health Organization reinjection recommendations for all DMPA products:
 - DMPA reinjections should be administered every 3 months (13 weeks)
 - Reinjections can be given up to 2 weeks early
 - Reinjections can be given up to 4 weeks late without requiring additional contraceptive protection.
- Remind the client that while DMPA-SC can be given up to 4 weeks late if necessary, this does not mean that the regular DMPA-SC injection interval can be extended by 4 weeks. It is intended only as a backup for women who are not able to make their 3-month injection.
- Explain to your client misses her **scheduled** reinjection date but is within the “window,” she should count 3 months from her **actual** injection date when calculating her next injection.
- It is important to properly explain the reinjection to the client to empower them with full information to be in charge of their health
 - For example, a client should not have to return to the clinic if she is only a day or a week late for her injection.
 - Providers also want to avoid a situation in which the client decides not to give herself the injection at all because she missed her reinjection date, not understanding that she has up to 4 weeks after the date

- If the client is **4 weeks late** for her scheduled reinjection OR If she **does not remember** the date of her last injection,
 - She should **NOT** give herself a DMPA-SC injection.
 - She should contact a health worker.
 - She should use condoms or not have sex to avoid unintended pregnancy until she speaks with a health worker
- Explain to the client that that it may take time for women to become pregnant after discontinuing DMPA-SC
- In addition, explain to clients that DMPA-SC does not protect from HIV and other sexually transmitted infections (STIs), and that women at high risk for HIV infection should use condoms in addition to DMPA-SC

How to seek help from a provider

- Before your client leaves, discuss with her whom she should contact (e.g., a trained PPMV, health worker or clinic) if she has questions or concerns. Make sure you offer to give your phone number to the client.

Client self-injection package

- Check the expiration date before giving DMPA-SC packages to clients. You need to make sure that DMPA-SC units will not expire before the client's last scheduled self-injection
- Send clients home with the following self-injection supplies and information:
 - Two doses of DMPA-SC for future self-injections.
 - Self-injection instruction booklet
 - Self-injection demonstration video
 - Calendar marked with the client's reinjection dates

- Use the following checklist to ensure you have covered all the necessary topics with the client before finally sending the client home
 - ☒ Safe storage
 - ☒ Safe disposal
 - ☒ How to give an injection
 - ☒ How to calculate the reinjection date
 - ☒ The reinjection window
 - ☒ Common side effects
 - ☒ Injection site reactions
 - ☒ Return to fertility
 - ☒ HIV and STI prevention
 - ☒ Information and supplies to take home

Condoms

Condoms provide mechanical barriers to the passage of sperms between the genital tracts of sexual partners. Condoms help prevent both pregnancy and sexually transmitted diseases (STDs). There are two types –male and female condoms.

The male condom

The male condom is mostly a thin latex rubber sheath that is worn over the erect penis before penetration. It acts as a barrier preventing semen from entering the vagina.

Effectiveness

With common use, about 15 pregnancies per 100 women whose partners use male condoms over the first year can occur. With perfect use failure rate is 2%.

Advantages

- No medical prescription is required
- Condoms are widely available
- They have no systemic side effects
- Condoms (other than natural condoms) protect against some sexually transmitted infections in addition to pregnancy including HIV/AIDS
- They are relatively cheap
- They promote partner participation in family planning
- May promote foreplay in some couples

Disadvantages

- Condoms may decrease sexual enjoyment for some partners
- A new condom must be used with each act of intercourse
- Condoms may interrupt foreplay in some partners
- They deteriorate if not properly stored
- The condom may burst or slide off a flaccid penis during withdrawal and get retained in the vagina
- They require partner cooperation

Men who can use the male condom

In general, anyone who is not allergic to latex can use the condom, but condoms are particularly useful when:

- sexual intercourse is infrequent
- non-prescription type contraceptive is desired
- a temporary contraceptive method is required between pregnancies or before a first pregnancy
- the male wants to share in the contraceptive responsibility
- no other contraceptive methods are available or acceptable to the partners
- there are contraindications to the use of the IUD and the hormonal contraceptive in the partner on medical grounds
- multiple sexual partners are involved
- used as back-up for some other methods

- protection against STIs/HIV is required

Men who cannot use the male condom

Condoms are not useful for men who:

- have severe allergy to latex (rubber): extremely rare
- are unable to sustain erection

Equipment and materials

- Packet of condoms
- Contraceptive cream or jelly
- Wooden or plastic model of an erect penis
- Instructional pamphlet on use of condoms

Client preparation

- Demonstrate proper use of the condom (see Figure 7)
- Carefully open the packet by tearing it at the designated point to avoid damaging the condom
- Do not open with the teeth or sharp fingernails and other sharp instruments
- Pinch the nipple end as you unroll the condom over a model (wooden/plastic) penis, leaving a small space at the tip if there is no nipple (see figure 7)

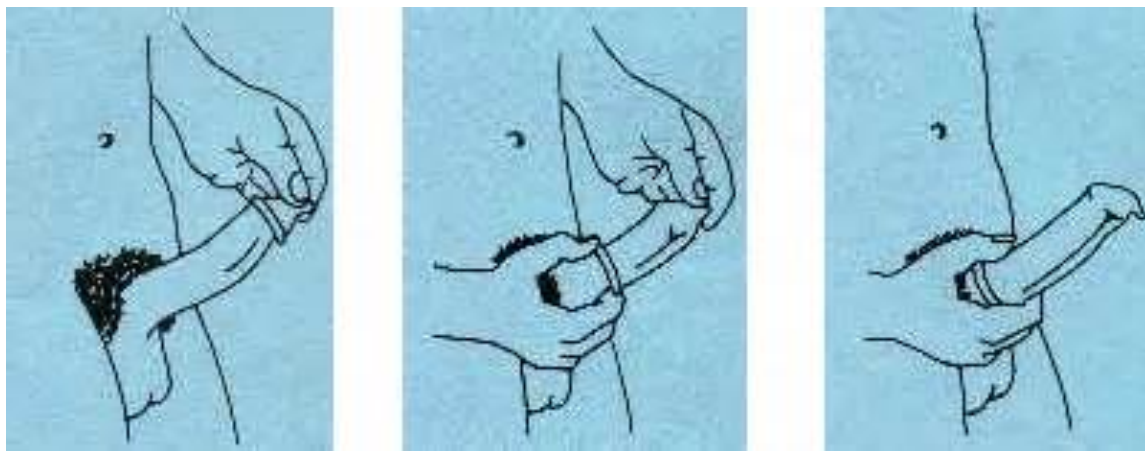


Figure 7: Procedures for correct wearing of the condom

The Female Condom

The female condom is a sheath of soft polyurethane or latex, which is inserted into the vagina before sexual intercourse (see Figure 8). It has two flexible rings – a removable ring at the closed end to aid insertion and a fixed ring at the open end, which sits on the vulva to hold the condom in place.

Effectiveness

With common use, 21 pregnancies occur per 100 women yearly and 5 pregnancies per 100 women yearly with perfect use.

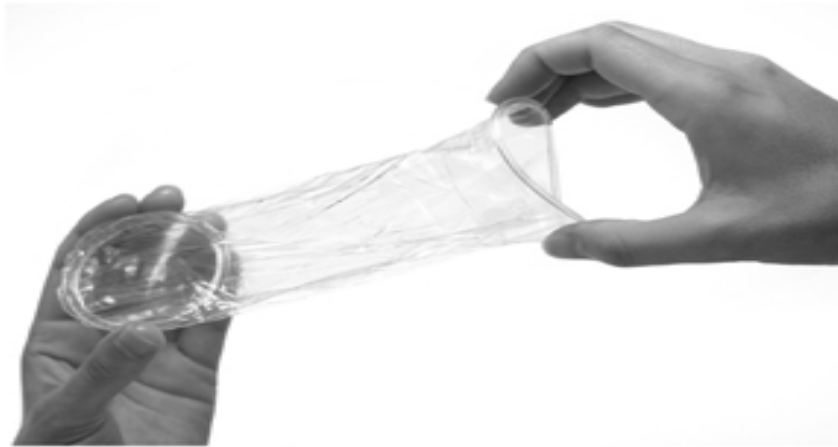


Figure 8: The female condom

Specific counselling issues

Advantages

- No medical prescription is required
- Female condom is widely available
- It has no systemic side effects
- It protects against some sexually transmitted infections including HIV/AIDS in addition to pregnancy (dual protection)
- It is free in public health facilities
- It promotes partner participation in family planning
- Usage is controlled by the woman and needs only to be used when required

Disadvantages

- Use may be associated with excessive (unpleasant) noise during intercourse
- The penis needs to be guided to avoid passing outside the outer ring
- Application involves the woman touching her genitals

Women who can use the female condom

Anyone can use the condom if the person is not allergic to polyurethane/synthetic nitrile, but condoms are particularly useful when:

- sexual intercourse is infrequent
- non-prescription contraceptive is desired
- a temporary contraceptive method is required between pregnancies or before a first pregnancy
- no other contraceptive method is available or acceptable to the partners
- there are contraindications to the use of the IUD and the hormonal contraceptive
- client has multiple sexual partners
- used as back-up for some other methods
- protection against STIs/HIV is desired

Women who cannot use the female condom

- Women who have genital prolapse
- Women who have vaginal abnormalities, e.g. septa, atresia/stenosis

Equipment and materials

- Female condom
- Pelvic model
- Instructional leaflet on female condom

Procedure

Demonstrate proper use of the female condom as follows:

- Condom can be inserted anytime within 8 hours before intercourse
- Spread the lubricant evenly by rubbing the sides of the condom packet together
- Carefully open the packet by tearing it at the designated point to avoid damaging the condom
- Stand with legs astride or squat or lie down
- Squeeze the inner ring of the condom (at the closed end) between the thumb, index finger and middle finger
- With the other hand, separate the labia
- Insert the squeezed ring into the vagina as far as possible; insert a finger into the condom and push in the rest of the condom with the index or middle finger until the inner ring reaches the end of the vagina
- Gently curve the finger towards the front of the vagina to feel the pubic bone, indicating that the condom has been inserted correctly. About 2 to 3 cm of the condom and larger outer ring remain outside the vagina
- The larger outer ring is smoothened over the vulva to ensure that the penis goes into the shield and not by its side
- The penis does not have to be withdrawn immediately after ejaculation
- To remove the condom, hold onto the outer ring and twist it so that the semen does not spill out
- Gently pull and slide the condom out of the vagina
- Do not re-use the condom

Post-prescription Instruction

Instruct the client clearly as follows:

- Do not test the condom by stretching it
- Put condom in before any sexual intercourse
- Discard each condom after use
- Use a new condom for each act of intercourse
- Throw the condom away in a pit latrine, burn or bury it
- Do not flush the condom down the toilet because it may cause blockage
- Do not leave the condom where children can find and play with it

Note:

- i. The male and female condoms should not be used together as increased friction may cause either condom to burst.
- ii. Correct and consistent use ensure optimum effectiveness

Session 2: Emergency Contraceptives Pills

Learning objectives

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

1. Define the meaning of emergency contraceptive pills
2. List the types of ECP available in Nigeria
3. Describe conditions under which ECP can be used

Estimated time: 30 minutes

Methods

1. Power point presentation
2. Discussion
3. Brainstorming

CONTENTS

Emergency Contraceptive Pills (ECP)

Emergency contraception (EC) is a safe and effective way of preventing pregnancy after having unprotected sexual intercourse or after a contraceptive accident, such as condom slippage or breakage and dislodgement of diaphragm. Emergency contraception can be achieved using special dose of hormonal oral contraceptive pills within 5 days after unprotected sexual intercourse to prevent pregnancy.

Note: Emergency contraception has no effect on already established pregnancy

Effectiveness of emergency contraceptive pills

If taken within 120 hours after unprotected intercourse, ECPs prevent 75% to 95% of expected pregnancies. The sooner ECPs are taken after unprotected sex, the more effective they are. Also, progestin-only regimen of ECPs is more effective than combined pills regimen.

Specific counselling issues

Discuss the common side effects associated with emergency contraceptive pills (ECPs) with the client:

- Nausea (it does not last for more than 24 hours)
- Vomiting occurs in 20% of women
- Irregular bleeding or spotting
- Breast tenderness
- Headache
- Dizziness
- Menstrual cycle disturbance: the next menstrual bleeding may be a few days early or late

Advantages

- ECs are safe for all women regardless of age and health status
- EC drugs exposure and side effects are of short duration
- ECs are readily available (combined oral contraceptives are more readily available for emergency contraception throughout the country)
- They are convenient and easy to use
- They significantly reduce the risk of unwanted pregnancy
- They reduce the need for abortion
- They are appropriate for women who may have unplanned intercourse
- They can provide a bridge to the practice of regular contraception

Disadvantages

- ECs offer no protection against the transmission of STIs and HIV/AIDS
- They must be used within five days of unprotected intercourse. The sooner they are taken after unprotected sex the higher the efficacy
- They are less effective than regular contraceptives

- They may produce nausea and sometimes vomiting
- They may change the time of the woman's next menstrual period

Women who can use emergency contraceptives

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

Equipment and materials

- Progestin only pills, e.g. Ovran, Ovrette or Ovidon
- Combined oral contraceptives, e.g. Duofem,
- Clinic card
- Equipment for physical examination
- Visual aids

Session 3: Long Acting Reversible Contraceptives (LARC)

Learning Objectives

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

1. List the two forms of LARCs (IUCD and implant) available in Nigeria
2. State the mode of action of implant.
3. List eligibility criteria for using implant.
4. List at least *two* side effects of implant.
5. Mention *three* advantages and disadvantages of implant.

Estimated Time: One hour

Methods

1. Power point presentation
2. Discussion
3. Brainstorming

CONTENTS

Types contraceptive implants

- Jadelle®— two silicon rods; each containing 75mg levonorgestrel (see Figure 9). It is an improved version of Norplant®. Jadelle is effective for 5 years.
- Implanon®—one rod containing a progestin called etonogestrel. Implanon is effective for 3 years
- Implanon NXT™ – one rod containing a progestin called Etonogestrel (see Figure 10). It contains in addition 15mg of barium sulphate and is effective for 3 years.
- Sinoplant or sino-implant —two thin flexible silicon rods that contain 75 mg levonorgestrel each (similar to Jadelle). Effective for 5 years.
- Uniplant®—one rod that contains 55mg of nomegestrol acetate.
- Norplant®—six soft plastic rods that each contain 36mg levonorgestrel. Effective for 5-7 years. Norplant has been discontinued due to the availability of newer and better implants, but there are still women using it who will be due for removal over the next few years.

Specific counseling issues

Provide the following information to the client:

Advantages

- No repeated visits to the clinic are required
- Contraceptive implants are effective immediately if inserted within the first 7 days of menstrual cycle (5 days for Implanon)
- They are very effective in preventing pregnancy and safe for majority of women
- They are long-acting
- They may help prevent iron deficiency anemia, symptomatic pelvic inflammatory disease, and ectopic pregnancy



Figure 9: Jadelle® implants



Figure 10: Implanon NXT™

- Do not disturb breast milk production
- Less likely to cause headaches or raised blood pressures than oestrogen-containing contraceptives
- No increased risk of cardio-vascular complications

Disadvantages

- Contraceptive implants have common side effects:
 - may cause spotting and irregular vaginal bleeding for 60–70% of users
 - amenorrhea (less common than irregular bleeding with all implants, but Implanon)
 - headaches, abdominal pain, weight gain, breast tenderness, dizziness, nausea, mood change, acne
 - some women may develop enlarged ovarian follicles
- Insertion and removal involve minor surgical procedures and therefore may be associated with bruising (discolouration of the arm), infection or bleeding
- The client cannot discontinue the method on her own
- Outline of the rods may be visible under the skin of some women, especially when the skin is stretched
- Contraceptive implants do not protect a woman from STIs and HIV/AIDS

Effectiveness

- Less than 1 pregnancy occurs per 100 women using implants over the first year (5 per 10,000 women)
- About 1 pregnancy per 100 women for over five years of Jadelle use
- Less than 1 pregnancy per 100 women (1 per 1,000 women) for over three years use of Implanon

- Over four years for Sino-implant use: 0.3 to 1.1 pregnancies per 100 women in the first year of use
- Over seven years of Norplant use: about 2 pregnancies per 100 women

Women who can use implants without restriction (WHO Category 1)

Women who:

- are of any age and parity, including nulliparous
- obese¹
- have uterine fibroids
- are breastfeeding within six weeks to six months postpartum
- have puerperal and post-abortion sepsis
- have pelvic inflammatory disease (previous and present)
- have increased risk of STIs or current STIs, including gonorrhea or chlamydia
- have HIV infection or AIDS, but are not on ARV therapy
- are smoking at any age
- have hypertension below 160/100 mmHg
- have non-migrainous headaches
- have depressive disorders
- have endometrial or ovarian cancer
- have iron-deficiency anemia or sickle cell disease
- have acute or flare hepatitis, chronic hepatitis, or carrier
- have mild (compensated cirrhosis)
- take broad-spectrum antibiotics, antifungal or antiparasitic medication

Women who can generally use implants; some follow up may be needed (WHO Category 2)

Women who have:

- drug interactions such as Rifampicin, Rifabutin, certain anti-convulsants, e.g. Phenytoin, ARVs
- cervical cancer (pre-treatment) or cervical intraepithelial neoplasia
- hypertension higher than 160/100mmHg
- history of DVT or current DVT while established on anticoagulant therapy
- major surgery with prolonged immobilization
- multiple risk factors for cardiovascular disease
- history or current ischaemic heart disease or stroke (for initiation only)
- migraine with aura at any age (for initiation only)
- diabetes with or without complications
- rheumatic disease, such as systemic lupus erythematosus if negative for antiphospholipid antibodies

¹Implants start to lose effectiveness sooner for heavier women (>70kg for Jadelle and >90kg for Implanon): these women may have to replace their implants earlier. (Three years for Jadelle and 2 years for Implanon)

- irregular or heavy vaginal bleeding patterns
- gall-bladder disease
- liver tumour, such as focal nodular hyperplasia
- are breastfeeding up to six weeks postpartum

Use of implants usually not recommended in these women (WHO Category 3);
Women who:

- have unexplained vaginal bleeding
- have deep vein thrombosis (acute)
- have liver tumour other than focal nodular hyperplasia
- have severe (decompensated) liver cirrhosis
- have rheumatic disease, such as systemic lupus erythematosus with positive or unknown antiphospholipid antibodies
- have history of breast cancer and no evidence of current disease for 5 years
- noticed their migraines with aura getting worse while using contraceptive implants
- were diagnosed with ischaemic heart disease or stroke while using implants

Women who should not use contraceptive implants (WHO Category 4)

- Women who have current breast cancer

Equipment and materials

- One set of desired implant capsules
- Trocar and cannula as supplied
- Sterilized surgical drapes
- Sterile gloves preferably devoid of talcum powder
- Antiseptic solution like *Savlon*, *Hibitaneor* *Betadine*
- Local anesthetic agent like *Xylocaine* 1%
- Syringe and needle
- Sterile gauze cotton wool
- Plaster
- Artery forceps (2)
- Scalpel and blade (size 12) (optional)
- Examination couch with arm rest
- Decontaminant e.g. *Jik*
- Plastic bowl

Procedure

Client preparation

- Screen the client for eligibility using the screening checklist for initiation of contraceptive

implants (See Appendix)

- Listen to the client's concern and respond to her questions appropriately
- Give clear information about probable changes in bleeding pattern during the menstrual cycle and other possible side effects
- Describe the insertion and removal procedures and what the client should expect during and afterwards
- Ensure client's cooperation and relaxation
- Review client assessment data to determine if the client is an appropriate candidate for implants or if she has any problems that should be monitored more frequently while the implants are in place
- Do a general examination
- Do a pelvic examination if needed or requested by client (pelvic examinations are not necessary for safe implant initiation and use, but may be indicated for other reasons and are part of the preventive medicine practices and health promotion)

Steps for inserting contraceptive implant

- Instruct the client to lie on the couch with arm stretched out comfortably
- Support arm with arm rest
- Use proper infection prevention procedure (see Module 11: Section 1)
- Wash hands with soap under running water, dry and wear surgical gloves
- Clean the area of insertion with antiseptic solution: iodine (if available) and finally with spirit
- Apply sterile drapes exposing the insertion area only (under the skin of the upper arm).
- Using the standard technique, insert the Implant under the skin.
- Cover the insertion point with sterile dressing gauze, and plaster
- Apply bandage if necessary

Note: The insertion and removal procedures are similar for all implants.

Post-insertion care and instructions

- Observe the client in the clinic for 15 minutes for signs of fainting or bleeding from insertion site
- Instruct the client to:
 - keep the insertion area dry and clean for five days
 - avoid carrying heavy load or applying unusual pressure to the site
 - inform the doctor that she is using contraceptive implant(s) if there is need for other medical treatment
- Return to the clinic if any of the following danger signs are experienced:
 - feeling unwell
 - fever
 - severe abdominal pain
 - pus at site of insertion, pain or redness
 - capsules falling out
- Return to the clinic at any time to receive advice and medical attention and, if desired, to have the rods removed
- Return for removal at the appointed time (a year earlier if she has gained a lot of weight)

- Request the client to repeat all instructions
- No scheduled follow-up required. It is usually recommended to come back for a yearly check-up for general health purposes
 - Write down clearly for the client the type of implant she has, date of insertion, month and year when implants will need to be removed/replaced (in 5 years for Jadelle; 4 years for Sinoimplant and 3 years for Implanon)

Follow-up counseling

- Check whether the client is satisfied with method
- Inquire about problems and respond to concerns about side effects
- Re-assure the client that the rods can be removed at any time if desired
- Review the warning signs that indicate the need to return to the clinic
- Remind the client of removal date

Removing contraceptive implant capsules

Equipment and materials

- Sterilized surgical drapes
- Sterile syringe (5–10mls) and needle (23G or 21G) to apply anesthesia
- Sterile gloves
- Antiseptic solution like *Savlon*, *Hibitane* or *Betadine*
- Local anesthetic agent, e.g. 1% *Xylocaine*
- Scalpel blade holder and surgical blade
- Artery forceps (mosquito) 2
- Examination couch with arm rest
- Sterile gauze and cotton swabs
- Decontaminant e.g. *Jik*
- Plastic bowl

Steps

- Position the client and prepare the area of procedure as for insertion of implant
- Raise the head of the examining table so that the client can be more comfortable
- Be sure you are comfortable. You may be more at ease sitting rather than standing
- Locate the implants by palpation, possibly marking the position
- Inject the local anesthetic slowly under the implants. It is recommended that you initially inject approximately 1cc of 1% *Xylocaine*. Have an additional 2–5cc of *Xylocaine* available, which can be used for the removal of each implant if required
- Make a 2–3mm incision with the scalpel blade also to the ends of the implants. Do not make a large incision
- Rather than making the incision at the same site as the location of the incision used to insert the implant, you may wish to make the incision as close as possible to the tip of all the implants. Some physicians use the incision to avoid a second scar
- If one implant is far from the other and cannot be reached, make a second incision
- Throughout the procedure, ask the client if she feels any pain and provide additional local anesthetic as needed

- With your finger, apply pressure to the distal end of each implant. Push the implant towards the incision with the fingers
- With a sharp blade, a gauze pad, or mosquito forceps, remove the scar tissue covering the implants (i.e. gently opening the tissue capsule around the implant (Figures 8.1–8.4)
- When the tip of the implant is visible in the incision, grasp it with the mosquito forceps
- Remove the implant from the incision with the second forceps
- The removal of the implants should be performed very gently and will take more time than the insertion

Session 4: Permanent Methods

Learning Objectives

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

1. Describe the two forms of permanent contraceptive methods.
2. State the mode of action of each method
3. List at least **five** side effects of each method
4. Mention **three** advantages and disadvantages of each of the methods

Estimated time: 60 minutes

Methods

1. Lecture
2. Presentation
3. Discussion
4. Brainstorming

CONTENTS

Permanent Contraceptive Methods

These forms of contraception are irreversible and are undertaken by a surgeon and thus beyond the scope of operation of the 2nd tier family planning providers.

Bilateral Tubal ligation

Tubal ligation is a surgical procedure usually carried out by a surgeon. The surgeon makes a small incision in the woman's abdomen and blocks off or cuts the two fallopian tubes carrying eggs (ova) from the ovaries to the uterus. With the tubes blocked, the woman's eggs cannot be fertilized by the man's sperm. Tubal ligation provides a permanent contraception for women who do not want to have any more children; it is a safe surgical procedure that is done with just a local anesthesia and light sedation. It is also called Voluntary Surgical Contraception (VSC) or female sterilization

The advantages of tubal ligation include the following:

- a. It is permanent and very effective;
- b. There is no interference with sexual intercourse and does not affect a woman's ability to have sexual intercourse;
- c. It has no effect on breast milk;
- d. There is nothing to remember, no supplies needed, and no repeated clinical visits. and
- e. It has no long- term effect side effect or health risks.

The disadvantages of tubal ligation highlighted by Hatcher et al. (2005) are as follows:

- a. Risks of anesthesia;
- b. Usually painful at first, but pains go away after a day or two;
- c. Requires physical examination and minor operation by a health care provider;
- d. Reversal surgery is difficult, and
- e. It offers no protection against STD's including HIV/AIDS.

Vasectomy (Male Sterilization)

Vasectomy is a permanent method of contraception for men who decide not to have any more children, it is a safe and simple method, which involves a quick surgical procedure, and it can be carried out in a clinic or office under a proper infection-prevention procedure. It is however not castration and does not affect the testes, neither does it affect men's sexual ability. The man can still have erection and ejaculate semen, but his semen can no longer make a woman pregnant because there is no sperm contained in it. Vasectomy is very effective and permanent; however, there is a failure rate of 0.15 pregnancies per 100 men in the first year after the procedure.

The advantages of vasectomy are as follows:

- a. It is very effective;
- b. It is permanent and requires a single procedure that leads to lifelong, safe and effective family planning method;
- c. No apparent long-time health risks;
- d. No interference with sex, it does not affect a man's ability to have sex, and

- e. There is nothing to remember except to use condoms or another effective method for at least the first 20 ejaculations or for the first three (3) months.

Conversely, the disadvantages of vasectomy include the following:

- a. It requires a minor surgery by a specially trained health care provider.

Session 5: Natural Contraceptive Methods

Learning Objectives

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

1. Describe the different forms of natural contraceptives methods available in Nigeria
2. State the mode of action of each method
3. List at least **five** side effects of each method
4. Mention **three** advantages and disadvantages of each of the methods

Estimated time: One hour

Methods

1. Lecture
2. Presentation
3. Discussion
4. Brainstorming

CONTENTS

Natural Contraceptive methods

Natural methods are dated back to the early days. The natural family planning method helps a woman to know when she could become pregnant and therefore the couple avoids pregnancy by changing their sexual pattern during the woman's fertile days. Throughout the woman's fertile period the couple may abstain from sexual intercourse or use a barrier or withdrawal method

Natural contraceptive methods otherwise called natural family planning are methods, which concentrate on the knowledge a woman has in recognizing when she is fertile during her menstrual cycle; the fertile period is when a woman can get pregnant). Natural family planning demands discipline and understanding of sexuality. It is also not meant for everyone because only women who are knowledgeable about it can use it correctly and consistently

The natural methods include Basal Body Temperature (BBT), cervical mucus method, symptothermal method, periodic Abstinence, *Coitus Interruptus*, Rhythm Method, and Standard Days Method), but for the purpose of this training manual, the beads and the lactational amenorrhea methods shall be discussed.

Cycle Beads/Standard Days Method (SDM)

SDM is a simple and effective method of family planning which is based on the timing of the "fertile window" (several days before ovulation and a few hours) when a woman can become pregnant. The developers of method (Institute for Reproductive Health at Georgetown University) made the analysis that a woman's fertile period is likely to occur between days 8 and 19 of the menstrual cycle and so unprotected sex should be avoided on those days

To help women keep track of their fertile days, the developers of the method created a string of colour-coded beads (white and brown) called Cycle Beads that represent a woman's menstrual cycle. To use Cycle Beads, a woman moves a rubber ring to the next bead each day to identify where she is in her cycle. The colour-coded beads indicate whether she is on a fertile or infertile day, when the rubber ring is on a white bead, it signifies a fertile day, and thus the couple should avoid unprotected sex, but when the rubber ring is on the brown bead, it signifies an infertile day where unprotected sex is safe.

SDM works best for women who usually (in at least 10 of every 12 cycles) have menstrual cycle between 26 and 32 days long this method is not effective for women who have shorter or longer cycles because they may ovulate outside of days 8 through 19. For women with regular cycle (between 26 and 32 days long) the SDM is an effective barrier method.

In a clinical trial in Bolivia, Peru and the Philippines, which included only women who have regular cycles, SDM resulted in 12 pregnancies per 100 women in one year of use, while among those who used the method correctly, (abstaining from sex during the fertile days), 5 of every 100 women became pregnant in one year.

The following are the advantages of the natural methods by:

- a. They are natural option with no side effects;
- b. Their use has very little or no cost implication;
- c. They do not require surgery or medical supervision;
- d. Once learnt, may require no further help from the health care provider;
- e. Periodic abstinence is acceptable to some religion that reject or discourage the use of other methods;
- f. Helps partners to understand fertility cycle;
- g. Involves men in decision making process as it relates to family planning
- h. The option is reversible if couple decided to change method

The disadvantages of the natural methods) include the following:

- a. The use of some of the methods such as BBT and Cervical mucus can take up to 2 or 3 cycles before a woman can learn how to accurately identify her fertile period;
- b. Their effectiveness depends highly on the level of commitment between the woman and her male partner;
- c. Natural method can become unreliable or hard to use if the woman has a fever, has vaginal infection, is breastfeeding, or has any other condition that changes her body temperature;
- d. Most methods require the woman or both the couple to keep careful daily records and play close attention to body changes
- e. None of these methods protect against sexually transmitted diseases (STDs) including HIV/AIDS.

Lactation Amenorrhea Method (LAM)

The lactation amenorrhea method makes use of breastfeeding as a temporary family planning method. Lactation refers to production of breast milk during breastfeeding (Amenorrhea means absence of menstrual bleeding). If the woman keeps breastfeeding often; her protection from pregnancy may last longer than six months and perhaps as long as nine months. It is highly effective when used correctly and consistently as 0.5 pregnancies occur per 100 women in the first six months after childbirth (1 in every 200); and with common use 2 pregnancies occur per 100 women in the first six months after childbirth.

LAM works by stopping ovulation because breastfeeding changes the rate of release of natural hormones; LAM provides natural protection against pregnancy and encourages starting another family planning method at the proper time. stated that a woman is naturally protected against pregnancy when:

- a. She has a baby that is less than six months
- b. Her menstrual periods have not returned
- c. Her baby receives at least 85% of her breast milk and she breastfeeds her baby often, both day and night.

The advantages of LAM include the following:

- a. It effectively prevents pregnancy for at least 6 months and may be higher if a woman keeps breastfeeding often, day and night;
- b. It encourages the best breastfeeding patterns;
- c. It can be used immediately after childbirth;

- d. There's no need to do anything at the time of sexual intercourse and no direct cost for the family or for the baby,
- e. No procedures or supplies needed to prevent pregnancy and no hormonal side effects.

Other benefits of LAM for the mother and her baby are as follows Providing the healthiest food (breast milk) for the baby

- i. Protecting the baby from life-threatening diseases such as measles and pneumonia by passing the mother's immunities to the baby
- ii. Helps in developing close relationship between the mother and the baby.

Conversely, the disadvantages of LAM are as follows:

- a. Its effectiveness after 6 months is uncertain;
- b. Frequent breastfeeding may be inconvenient for some women, especially working mothers;
- c. It offers no protection against STDs including HIV/AIDS
- d. If the mother is HIV positive, there is a small chance that the breast milk will pass HIV to the baby.

MODULE 6

COMMUNICATION AND COUNSELLING IN FAMILY PLANNING SERVICE PROVISION

Learning Objectives:

By the end of this session, participants should be able to:

- Define effective communication
- Understand the strategic steps in effective communication in FP
- Screen clients for FP needs

Time: 60 minutes

Methods

- Lecture
- Presentation
- Role play
- Brainstorming

Content

Definition of Effective Communication

It is a two-way information sharing process which involve one party sending message that is easily understood by the receiving party. It has the same meaning for both sender and receiver.

Strategic steps for effective communication in FP

<p>1.Establishing Rapport</p> <ul style="list-style-type: none"> • Ensures appropriate physical environment • Demonstrates culturally appropriate eye contact • Uses appropriate facial expressions, posture, gestures • Uses effective rate of speech, positive tone • Assures confidentiality • Ask reasons for visit • Uses open ended questions • Encourages, gives praise • Ask about feelings
<p>II. Gathering, Providing and Exchanging Information.</p> <ul style="list-style-type: none"> • Follow client's topic • Avoid talking about self except if necessary • Does not interrupt

<ul style="list-style-type: none"> • Asks one question at a time Refrains from using leading questions or other irrelevant questions • Find out about client issues • Find out about client's status of STIs – HIV/AIDS
III Planning Decision-Making, Problem Solving <ul style="list-style-type: none"> • Let client do most of the talking • Reflect content • Reflect feelings • Feel free when discussing sex related issues • Help client identify decision areas or problems • Help client explore the full range of options. Provide correct information on LARC methods, STIs- HIV/AIDS and dual protection. • Assist client to explore consequences of each option, starting from the clients preference • Ask client to make the decision and let the client know that the decision is hers • Reflect client's decision for confirmation • Provide what the client wants except there is medical reason not to • Explain any IEC material given to the client
IV. Next Steps <ul style="list-style-type: none"> • Offer support/referral resources- plan the next visit if needed • Summarize • Confirms decisions or choices made by the client • Client to return any time if there is any reason to. • Encourage client to bring others

Screen Clients for FP Needs

FP counseling should begin with screening clients for family planning needs. This means asking a series of brief questions to guide FP counseling. It involves asking four questions from all the clients. These questions are:

1. When was your last menstrual period?
2. Do you want to become pregnant in the next year?
3. Are you currently using a contraceptive method?
4. How many children do you have?

These questions help providers determine if the client has Unmet FP Need, No FP Need, or Met FP Need.

Instructions for Screening

Begin by asking Question 1: “When was your last menstrual period?”

If pregnancy is ruled out proceed to Question 2.

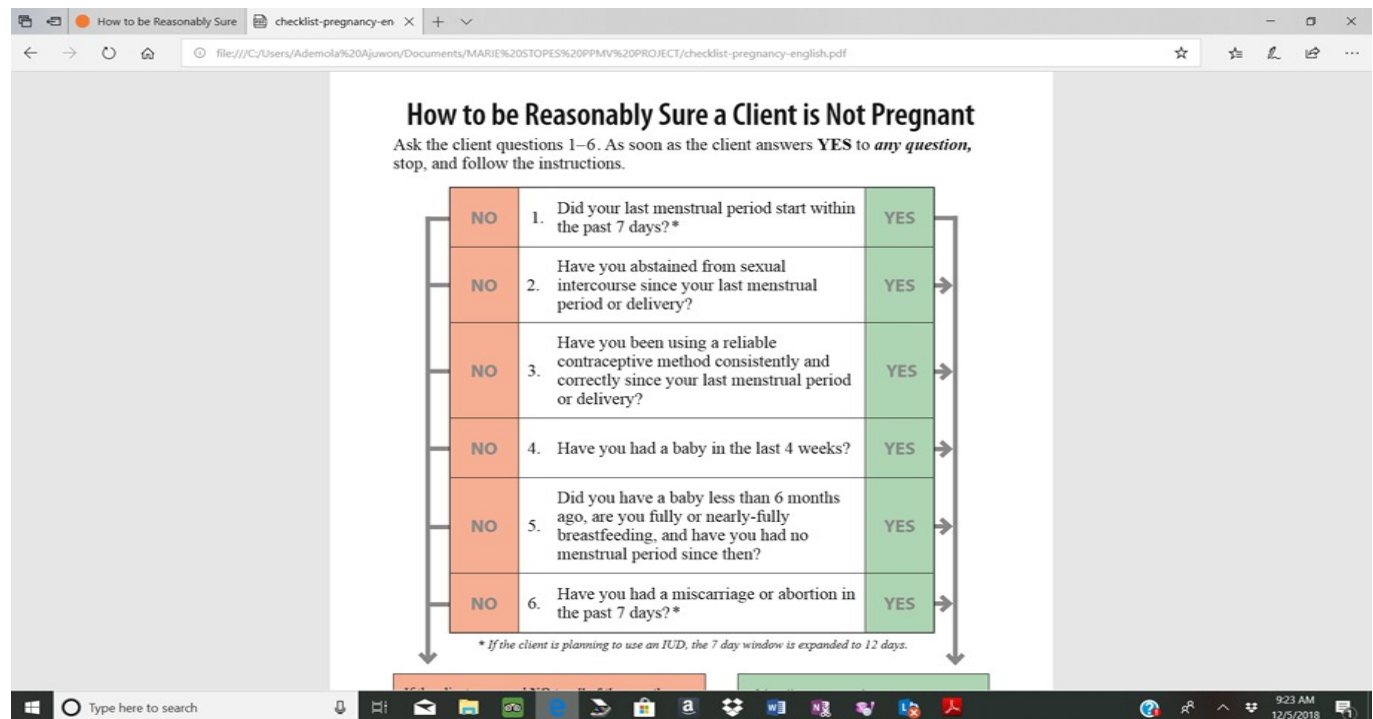


Fig 5: Pregnancy Screening Steps

Continue with Question 2 for clients who are not pregnant (or who do not have a pregnant partner):

“Do you (or your partner) want to become pregnant in the next year?”

- If the client answers “yes”, she/he has FP need
- Then, She/he is counselled on a short acting family planning methods (oral pills and barrier)
- If the client answers “no”, proceed to Question 3.

Continue with Question 3 for clients who do not want to become pregnant in the next year:

“Are you currently using a contraceptive method?”

- If the client answers “yes”, she/he has a met FP need.
- If the client answers “no”, ask a follow-up question: “Can you tell me why you are not using a method? If the reason is “sterility or infertility”, she/he has no FP need. If the reason is “not sexually active”, she/he has no FP need. If the reason is anything other, she/he has unmet FP need.

SESSION TWO: COUNSELLING IN FAMILY PLANNING SERVICE PROVISION

Learning Objectives:

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

- Define Counselling
- State the objectives of counselling in Family Planning
- Discuss the qualities of a good counselor
- Explain the terms “Informed Choice and Informed Consent”
- Discuss the concerns and perceptions of potential users of family planning methods

Time: 80 minutes

Methods

- Lecture
- Presentation
- Role play
- Brainstorming

CONTENT

Definition of Counselling

Counselling refers to the provision of the client with information and support to allow her to make a decision regarding her immediate reproductive health needs. For example, by describing to the woman (and sometimes her partner) the contraceptive options available to her, the benefits and risks of the methods, and what side effects to expect.

Family Planning counselling helps a client decide if he or she wants to use contraception, choose a method that is personally and medically appropriate, and understand how to correctly use the method of her or his choice. During FP counseling, clients are given the opportunity to:

- Explore their contraceptive options;
- Obtain accurate and unbiased information about the methods;
- Clarify their feelings and values about using contraception;
- Identify their reproductive goals, concerns about safety, effectiveness and reversibility,
- Come to his or her individual decision.

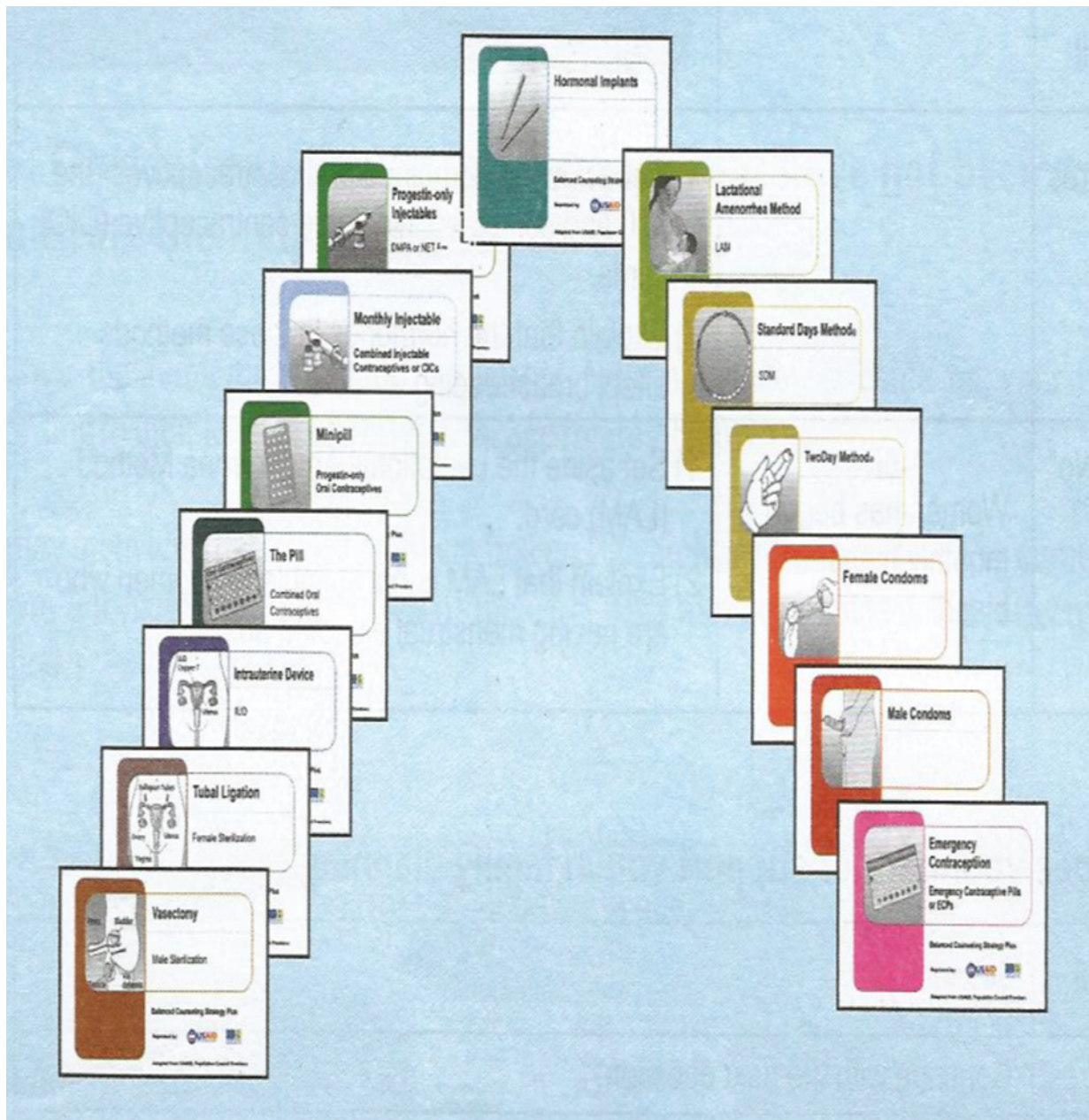


Fig 6: The Counselling Cards

Good FP counselling occurs when mutual trust is established between client and provider. The service provider respects the client, identifies and addresses the client's concerns regarding the use of contraception. Both the client and the service provider give and receive relevant, accurate and complete information that enables the client to decide about FP.

Objectives of Counselling in Family Planning

- To provide complete, accurate information in terms the client can understand;
- To identify and discuss any concerns or fears a client may have;
- To help the client choose the best family planning method for her choice

- To inform the client adequately about effectiveness, side effects, benefits, and risks on available methods.

Qualities of a good Counsellor

A good Counsellor has the following attributes:

A sensitivity (i.e. ability to understand other people's feelings) that earns the trust of the client;

- A good understanding of family planning methods.
 - An understanding of the cultural and psychological factors that affect a woman's or a couple's decision to use family planning methods
 - A non-judgmental approach, treating the client with respect and kindness
 - A way of encouraging clients to ask questions
 - An ability to listen
 - The ability to recognize when he or she cannot sufficiently help a client and to refer the client to other professionals
 - An appreciation of non-verbal communication (body language).

Skills of an Effective FP Counsellor

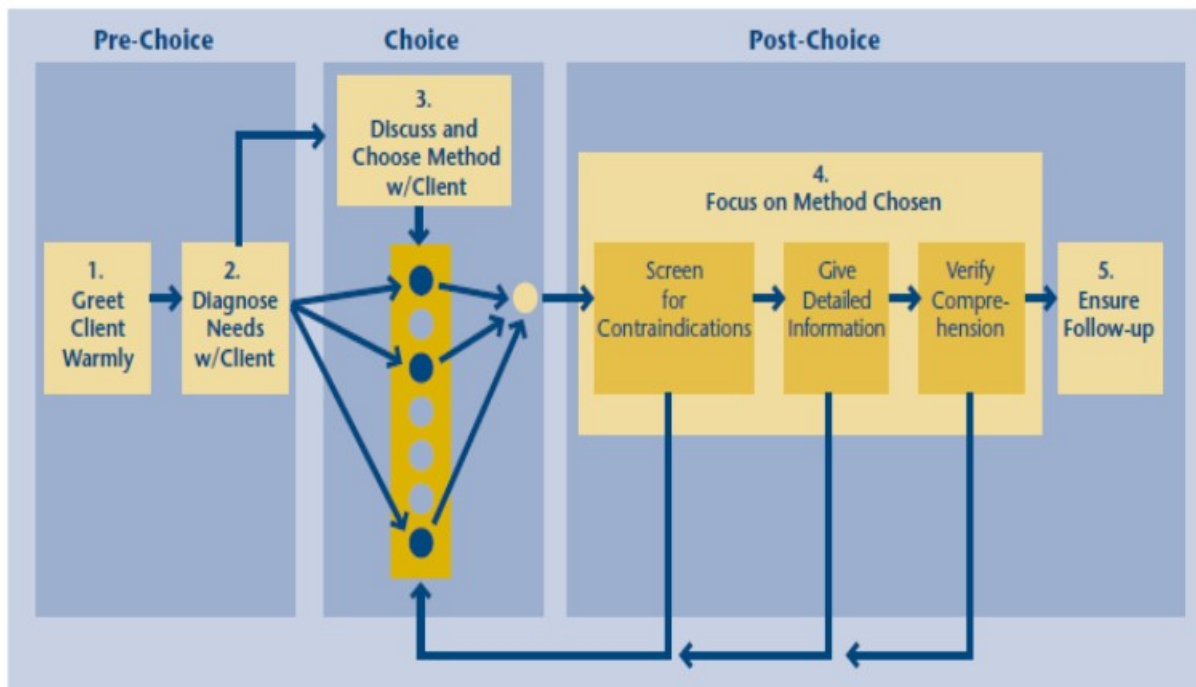
An effective Counsellor

- Possesses strong technical knowledge of contraceptive methods
- Listens attentively
- Poses questions clearly, using both open-and close-ended questions appropriately
- Recognizes and correctly interprets nonverbal communication and body language.
- Interprets, paraphrases, and summarizes client comments and concerns
- Offers praises and encouragement
- Explains information in language the client understands in culturally appropriate ways
- Tailor counselling session to needs of client
- Demonstrates commitment to the principles of client rights
- Address clients in a respectful, non- judgmental and objective manner.

Informed Choice

“Informed” means that:

- Clients have the clear, accurate, and specific information they need to make their own reproductive choices including a choice among family planning methods.
 - Good quality family planning programme emphasizing the need for FP providers to explain each family planning method as needed, without information overload and can help clients use each method effectively and safely.
 - It is important that all FP methods are available to see or feel it to enable her make an informed choice



Source: León et al. 2003b.

Fig 7: Balanced Counselling Model with specific tasks for Family Planning providers

“Choice” means that:

- Clients having a range of family planning methods to choose from. Good quality family planning services offer different methods to suit people’s needs, not just 1 or 2 methods. If PPMVs cannot provide a method or service, they refer clients somewhere else for that method.

Informed Choice means that the client has the right to choose any contraceptive method that she/he wishes based on a clear understanding of the characteristics of all the available methods, including the option not to adopt any method. For this, the client needs to know:

- Types of methods available,
 - Characteristics of each method
 - Effectiveness of each method
 - Possible side effects and
 - The risks of not using any method
- Clients make their own decisions. Family planning providers help clients think through their decisions, but they do not put pressure on clients to make a certain choice or to use a certain method.

Informed Consent implies that a client has been counselled thoroughly regarding all the components described in the section on informed choice, and that based on this information, she/he has freely and voluntarily decided which method she/he wants to use. This is particularly important when a client chooses Voluntary Surgical Contraception (VSC) or any method that may have serious complications for a particular client (e.g. a woman over 35 years who smokes and wants to use combined oral contraceptive pills) which may result in serious cardiovascular complications.

Table 2: Advantages and Disadvantages of Family Planning Method

S/N	Family Planning Methods	Advantages	Disadvantages
1.	Natural	<ul style="list-style-type: none"> • Safe • Return to fertility is high • No side effects 	<ul style="list-style-type: none"> • Failure rate is high • High sense of consciousness. • Sensitivity and specificity are low. • Interference/interruption with sex
22.	Hormonal	<ul style="list-style-type: none"> o Prevention of ectopic pregnancy. o Protection against pelvic infection. o Lighter less painful periods o Relief of symptom of premenstrual syndrome o Reduced pelvic pain caused by endometrial Shedding. 	<ul style="list-style-type: none"> o Headaches o Weight gain o Amenorrhea/irregular vaginal bleeding or spotting o Nausea o Anxiety o Breast tenderness o acne o Unwanted hair growth o Dizziness

		<ul style="list-style-type: none"> o Reduced risk of ectopic cancers-ovarian and endometrial. 	<ul style="list-style-type: none"> o Delay in return fertility o Vaginitis/vaginal irritation (in vaginal ring)
3.	Barrier	<ul style="list-style-type: none"> • Protection against STI and HIV/AIDS • Non-Prescriptive • Immediately effective • Used only when needed • Do not affect body systems • Used as back up for other methods 	<ul style="list-style-type: none"> • High user failure rates • Resentment of self-insertion /covering of objects in the vagina /penile????
4.	<p>Intrauterine contraceptive device</p> <p>Caution on IUDs</p> <ul style="list-style-type: none"> • Postpartum between 48 hours and 4 weeks • Persistent Vaginal bleeding • Ovarian cancer 	<ul style="list-style-type: none"> • Effectiveness percentage is 99% • Fertility returns almost immediately after removal. • It has long term protection. • Does not interfere with coitus • It is cost effective. 	<ul style="list-style-type: none"> • Increase menstrual loss • Mild/moderate abdominal discomfort • Risk of pelvic infection • Expulsion of the device • The strings may be felt by some men during intercourse • Uterine perforation

	<ul style="list-style-type: none"> • Very high individual likelihood of exposure to gonorrhea or Chlamydia STIs • AIDS (unless clinically well on anti – retroviral therapy) • Nulliparous women • Distortions of the uterine cavity by uterine fibroids or anatomical abnormalities 	<ul style="list-style-type: none"> • Does not affect breastfeeding. • Reduces menstrual-flow and cramps. • May improve anaemia 	<ul style="list-style-type: none"> • Risk of ectopic pregnancy • Miscarriages/premature delivery if there is pregnancy with IUD
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SESSION THREE: MYTHS AND MISCONCEPTIONS IN FAMILY PLANNING IN NIGERIA

Learning Objectives:

By the end of this session, participants should be able to:

- Explain Myths and Misconceptions
- List and Discuss the types of Myths and Misconceptions in FP in Nigeria

Time: 60 minutes

Methods

- Lecture

- Presentation
- Brainstorming

Materials Required

- Laptop
- Projector
- Flip Charts and stand
- Markers
- Training manual

Content

Myths is defined as a traditional story, especially one which explains the early history or a cultural belief or practice of a group of people, or explains a natural event.

Misconception is defined as an idea that is wrong because it has been based on a failure to understand a situation

Table 5: Myths and Misconceptions on family planning:

S/N	Family Planning methods	Myths and Misconceptions
1.	Natural	<ul style="list-style-type: none"> • It is a form of wickedness (Coitus Interruptus methods) • Sex absenteeism will lead to abdominal pains, prostate diseases. • Sex absenteeism will lead to complications for women during pregnancy • Sex absenteeism causes women to be ugly and have small breasts

2.	Hormonal	<ul style="list-style-type: none"> • The capsule can travel in the body (Implants) • Belief that Implants insertion/removal is a major surgical procedure • Returning to the clinic (distance and time) for insertion and removal at proper time(Implants) • With foreign object in the arm, soul cannot leave body after death • Religious/traditional/cultural reasons • Waste of time and money for follow-up visits • bleeding occurs non stop • For Implants, sites can become unattractive • women are being used as guinea pigs • Chance of losing fertility, sex drive is high • Fear that the Implants capsules will cause weakness and/or ill health to self and/or husband • • Amenorrhoea causes a permanent build-up of blood in uterus that must be “drained” periodically, otherwise illness will result.
3.	Barrier	<ul style="list-style-type: none"> • Family/friends may find out and the users will be stigmatized • • No way to hide use of female condoms from husband • Sex not pleasurable

4.	Uterine Devices	<ul style="list-style-type: none">• The device can travel in the body• Insertion/removal is a major surgical procedure•• With foreign object in the womb , soul cannot leave body after death•• waste of time and money for follow-up visits• No way to hide use of method from husband• women are being used as guinea pigs• Chance of losing fertility, sex drive is high• The device will cause weakness and/or ill health to self and/or husband•• It makes a woman to be lean/or a woman stomach to be big
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MODULE 7

CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM

SESSION ONE: INTRODUCTION TO CONTRACEPTIVE LOGISTICS MANAGEMENT SYSTEM (CLMS)

Objectives: By the end of the session, participants should be able to:

- Explain the CLMS
- Describe the levels of contraceptive logistic system available in Nigeria
- Discuss the contraceptive Logistics system
- Explain the flow of contraceptives in the Private health sector supplies
- Explain and practice the use of the NHMIS tools in FP CLMS

Time: 120 minutes

Methodology

- Lectures
- Discussion
- Brainstorming
- Group work

Materials

- Flip chart and markers
- Multimedia projector
- NHMIS Tools - Individual client record form: Daily activity register, monthly summary for health facilities, Requisition, issue and report form

Contents

Key Logistics Terms

Service delivery point (SDP). Any facility where clients receive supplies eg PPMV facilities.

Pipeline. The entire chain of physical storage facilities and transportation links through which supplies move from the manufacturer to the user, including port facilities, central warehouse, regional warehouses, state warehouses, all SDPs, and transport vehicles

Lead time. Time between when products are ordered and when they are received and available for use.

Requisition system. *In a requisition (pull) system, the personnel who receive the supplies calculate the quantities of commodities required.*

Allocation system. *In an allocation (push) system, the personnel who issue the supplies calculate the quantities of commodities required.*

Issues data. *Information about the quantity of commodities moved from one storage facility to another (either between levels or within a facility).*

Contraceptive Logistics Management System (CLMS)

Overview: Logistics management is the governance of supply chain functions. Logistics management activities typically include product selection, forecasting/quantification, procurement/supply planning, port clearing, warehousing/ distribution including: inventory management/ transportation and customer services.

Contraceptive Logistics Management System in Nigeria

Overview

The CLMS focuses on forecasting and procuring the right contraceptive quantities, storing and distributing them through all levels of the health system to be accessed by clients. The required information for management and decision-making is collected through the logistics management information system. The contraceptive inventory management system supports the ordering and re-supply to ensure uninterrupted availability of commodities at the service delivery point. Supervision and monitoring helps to promote continuous performance improvement throughout all the functions as represented by the logistics cycle (Figure 18.below).

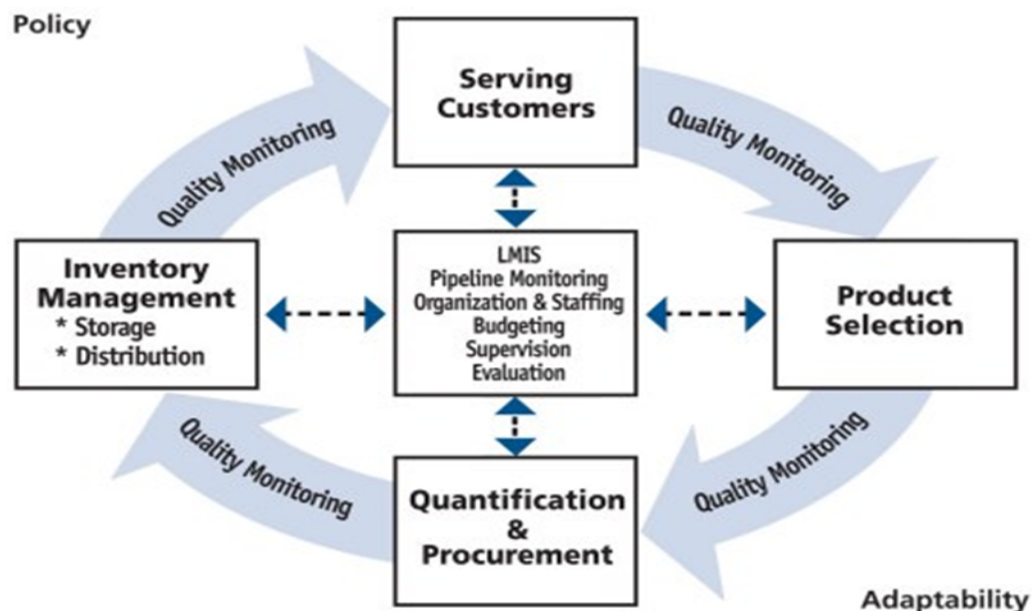
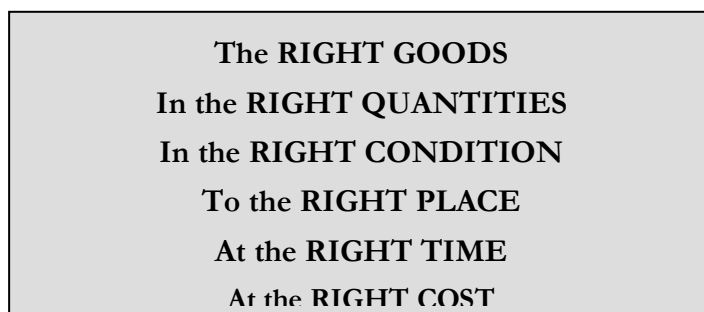


Figure 18: Logistic Cycle

Purpose of the Contraceptive Logistic Management System

The purpose of the contraceptive logistic management system is to ensure that all Nigerians are able to receive the contraceptives they need through their service delivery points. This requires that the system guarantee the supply of:



The specific objectives of the system include:

- Enhanced distribution of a complete range of family planning products through the different levels of the supply system (Public sector, social marketing sector or commercial outlets)
- Sustained availability of contraceptives with adequate stock levels to meet clients demand
- Expanded access to a complete range of contraceptive methods with greater choice for clients.
- Increased capacity at all levels of the system to manage contraceptive supply.
- Adequate flow of essential information on the movement and utilisation of contraceptives.
- Improved contraceptive quality throughout the supply chain, through adherence to established guidelines.

- Reduced waste and increased efficiency throughout the supply chain
- Enhance visibility of routine data throughout the system, for program monitoring and performance improvement
- Employ effective monitoring and supervision techniques at all levels to improve quality and staff motivation

CLMS: Commodity and Data Flow

Source: National Guidelines to Family Planning Commodities in Nigeria 2017

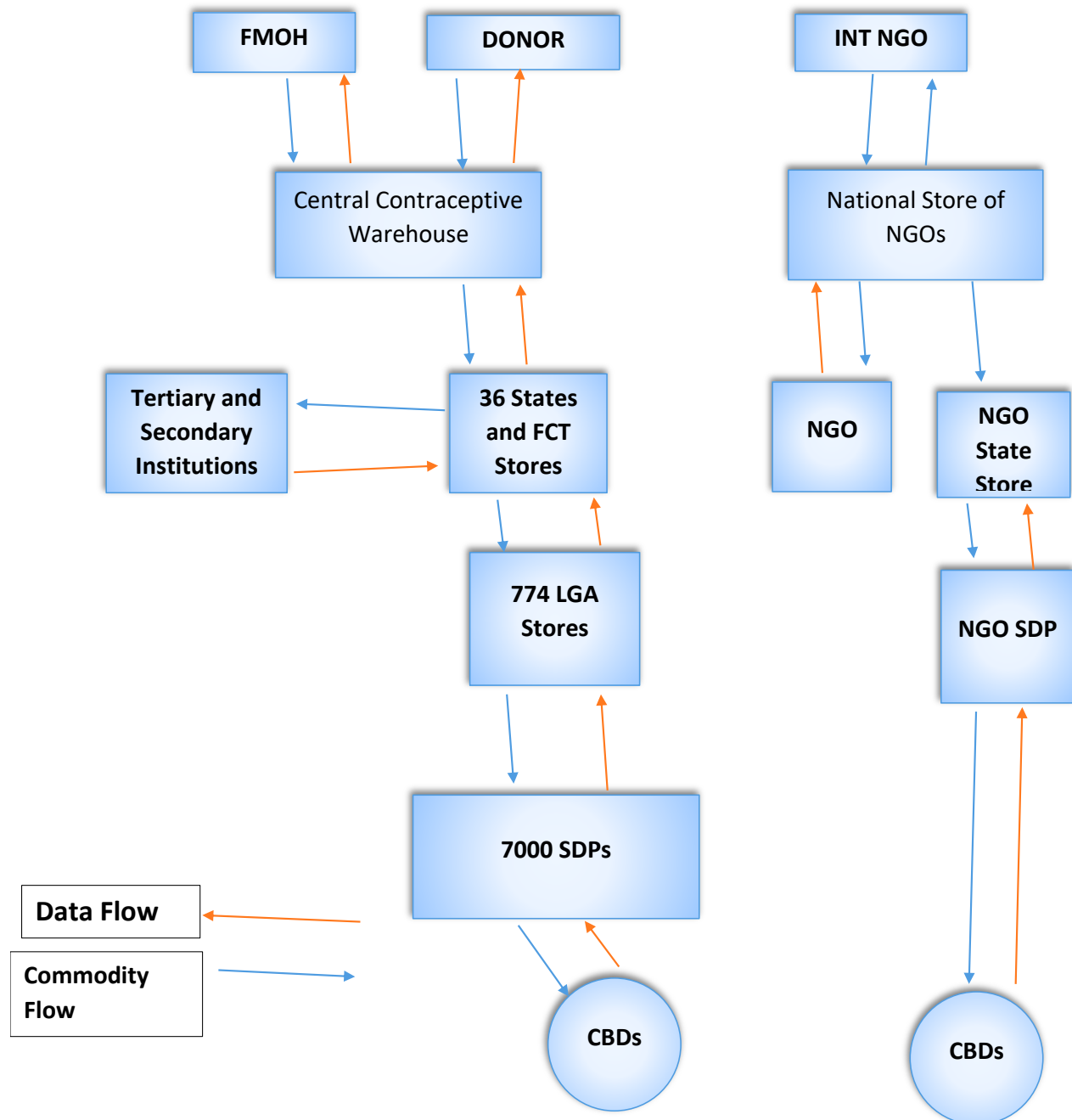


Fig 19 : Showing Contraceptives Data Flow

Type of Logistics System:

- Four level pull system

Supply Frequency:

- State store – 4 months
- LGA store – 3 months
- SDP – 2 months
- CBD – 1 month

The system serves the public health sector including contraceptive stores at State and LGA levels, SDPs at teaching, general and specialist (secondary/tertiary) hospitals, and primary health care facilities and CBD agents (Figure). Not-for-profit NGOs, such as PPFN, ARFH and other approved Organization also receive contraceptives through the system. To be eligible, NGOs must be registered as a not-for-profit and possess authorization to operate in the health system. They also must submit the required LMIS forms. NGOs may access supplies at the level that is most appropriate (e.g. national NGOs can order at the central level, state NGOs at state stores). Additionally, NGOs will be directed by the FMOH to the store where to collect their supplies (Figabove)

***Private pharmacy and for profit outlets (PPMV) are not eligible to receive their supplies through this system. Instead they can use the social marketing or other private sector or NGOs sources for contraceptives distribution.**

Note: In states where the National Guideline for the private health facilities access government commodities, PPMVs could be integrated into the supply chain system

Contraceptives Distribution System

- Contraceptives are delivered to State stores according to a distribution calendar
- LGA/MCH Coordinators pick up commodities at quarterly intervals
- SDP/Service Providers pick up commodities at bi-monthly intervals
- Pick up can be at commodity coordination meetings
- At the commodity Coordination meeting , participants present their data (Registers, Daily Consumption Records/ tally cards, Requisition, Issue and Report Form (RIRF))
- Review and validate the data and calculations, then resupply commodities accordingly.
- Provide feedback to participants on their logistics performance.

The commodity coordination meeting is an opportunity to engage service providers and MCH Coordinators in discussions about program developments and share best practices related to Contraceptives commodities and service provision

Completion of the Logistic Management Information System Tools

It is important that the data generated at the lower level be transmitted to the higher level using the logistic management information system tools.

Table 7 : Summary of LMIS tools in CLMS

LMIS Tools	Purpose
Requisition, Issue and Report Form (RIRF)	To record information about movement of stock from one facility to another To provide information on quantity issued at all levels of the system To provide consumption data from SDP
Daily Consumption Record	To summarize consumption data, track stock levels, and facilitate the calculation of re-order quantities
Supervision Checklist	To monitor logistics activities and supervise personnel on carrying out their logistics responsibilities
Monitoring & Supervision Checklist/Feedback Form	To document and communicate major findings and recommend performance improvement actions to CLMS facility staff
CBD Form	To collect information on quantity issued to CBDs
Delivery Note	To track delivery of contraceptives and ensure that all items issued from CCW are what are actually received by the state store

Table 8: CLMS Responsibilities undertaken at the CBD and LGA level

CBD and LGA Responsibilities		
Who	Actions	When
CBD Agent	1. Distributes contraceptives to clients in the community	During the Month
	2. Picks up contraceptive supplies from supervisor (e.g. Service provider) at the time of their monthly meeting (and when needed)	Monthly or when needed
	3. Receives <i>CBD Record</i> at each pick up of contraceptives.	
	4. Stores/cares for contraceptive supplies in accordance with guidelines.	
Service Provider at	1. Distributes contraceptives to clients who come to the Health Centre and completes the <i>Daily Consumption Record</i> .	During the Month
	2. Maintains stock under appropriate storage conditions.	

the health facility	3. Meets with the CBD Agent once per month 4. Issues a <i>CBD Record</i> at each issue of contraceptives to a CBD Agent. 5. Supervises the CBD Agent and provides guidance and on-the-job training.	Monthly
	6. Using the information on the <i>Daily Consumption Record</i> , completes his or her portion of the <i>Requisition Issue and Report Form (RIRF)</i> 7. Present the <i>Requisition Issue and Report Form</i> at the LGA store. 8. Picks up contraceptive supplies from the LGA store and fills the <i>RIRF</i> accordingly.	Bi-Monthly
LGA store keeper (RH/FP coordinator)	1. Receives <i>Requisition Issue and Report Forms</i> from each health facility. 2. Ensures that <i>RIRF</i> for supplies from the health facilities are filled and issued when the facilities come to collect them. 3. Maintain <i>Stock Cards</i> as at when supplies are received and issued	During the month
	4. Completes the <i>Requisition Issue and Report Form</i> . 5. Submits order for contraceptives for the LGA using the <i>RIRF</i> 6. Picks up stock from the State Store	Quarterly
	7. Prepares and undertakes supervision visits of all SDPs 8. Fills <i>Monitoring and Supervision Checklist/Feedback Report</i> and provides a copy to the SDP 9. Verify progress on recommendations of earlier supervision visits and prepare comments and recommendations at the end of the visit.	Bi-annually

Simulation Exercise for Completion of Daily Activity Register

1. May 2, Aisha, a 29 year old woman has been on combined oral contraceptive pill (combination 3) for over a year. She came she received 3 cycles of the product
2. May 2: Mr Udom, a policeman visited the clinic, his wife does not want to come to the clinic, he was given 8 pieces of condom and encouraged to bring his wife

MODULE 8

PHARMACOVIGILANCE (REPORTING OF ADVERSE DRUG REACTIONS)

Learning Objectives

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

1. Define the term pharmacovigilance and adverse drug reactions.
2. List the aims and goals of pharmacovigilance
3. List the roles and responsibilities of patent and proprietary medicine vendors in pharmacovigilance
4. Demonstrate how to use reporting tools to report adverse drug reactions
5. List complications of use of contraceptives and proper channel of referrals

Estimated time: 1 hours; 30 minutes

Overview of the session

This module is designed to explain the concept of pharmacovigilance and illustrate how to properly report adverse drug reactions.

Methodology

- Lecture
- Discussion
- Demonstration
- Role play

CONTENTS

The repeated occurrence of unexpected, serious adverse drug reactions (ADRs) over the years has attracted public and healthcare practitioners' attention. Spontaneous reporting of suspected adverse drug reactions has long been the cornerstone of pharmacovigilance for the identification of early signals of problems of drug safety related to the use of medicines worldwide. In view of the foregoing, all health professionals, including patent and proprietary medicine vendors are to make significant contribution to the success of pharmacovigilance through spontaneous reporting of adverse drug reactions.

Define the terms “Pharmacovigilance and Adverse Drug Reaction”

Pharmacovigilance: science and activities relating to the detection, assessment, understanding and prevention of adverse effects of drugs or any other possible drug related problems

Adverse drug reaction (ADR): response to a medicine which is harmful and unintended and occurs at normal doses used in man for prevention, diagnosis or treatment of disease or the change of normal body function. In Nigeria several medicinal products including drugs, herbal preparation, are monitored for ADR in Nigeria (see Figure 15).

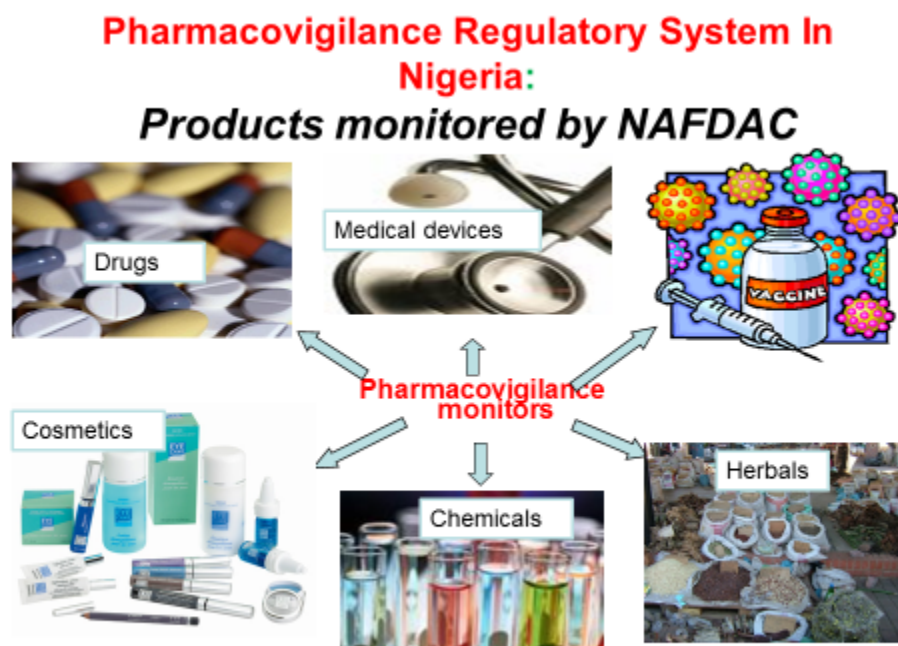


Figure 15: Products monitored by NAFDAC

Types of ADR reporting system

Voluntary

It is voluntary for health providers & traditional herbal medicine practitioners. Although it is voluntary, *it is a professional duty*.

Mandatory

It shall be mandatory for all Marketing Authorization Holders (MAHs). These include Manufactures and their local agents in Nigeria including public health programs.

Events leading to Pharmacovigilance

1. DEG poisoning from 1937-2008, about 600 deaths in 11 countries
2. Heparin — 131 heparin-related deaths reported to FDA 1st Jan 2007 and 13th April 2008
3. Thalidomide: 1956 – 1962 about 10,000 children were born with severe malformations, including phocomelia (see Figure 16).



Figure 16: Phacomelic baby

Examples of medicines that have been withdrawn due to ADR Analgin, Gentamycin 280 mg, Butazolidine

Aims and goals of Pharmacovigilance

The aims and goals of pharmacovigilance are:

- To document all forms of adverse reactions to drugs and other medicines related products
- To ensure the use of drugs that are effective, **safe** and of good quality
- To ensure the **proper use** of such drugs

The roles and responsibilities of PPMV in pharmacovigilance

The major responsibilities of patent and proprietary medicine vendors in pharmacovigilance are to document and report all forms of adverse drug reactions (see Figure 17). Other professionals that should also document and report adverse drug reactions are:

- Doctors,
- Dentists,

- Pharmacists,
- Nurses
- Community health workers
- Traditional medicine practitioners and other community health professionals

What is to be reported?

All response to medicines used in humans which are harmful and unintended

- No improvement after treatment
- Medication error
 - Overdose
 - Misuse and/or abuse of a medicine
- Counterfeit or substandard medicine
- Case reports of acute and chronic poisoning
- Assessment of drug-related mortality
- Adverse interactions of medicines with chemicals, other medicines and food

Report all suspected adverse drug reactions & other related problems on:

- Orthodox medicines
- Biologicals including vaccines
- Chemicals
- Consumable Medical products
- Cosmetics
- Traditional and herbal remedies, etc.

Where do I report?

- Through NAFDAC offices in the 36 states & FCT
- The National Pharmacovigilance Centre (NPC) – NAFDAC
Plot 2032 Olusegun Obasanjo Way Wuse Zone 7, Abuja
- Reports can also be scanned & emailed to npcadr@nafdac.gov.ng

What will happen to my ADR reports?

- Your reported case will be entered into the national adverse drug reaction database and analyzed by expert reviewers.
- The result of the assessment will be communicated as feedback through pharmacovigilance/food & drug information quarterly newsletters
- Details of the reports are also sent to the WHO Collaborating Centre for International Drug Monitoring (UMC) for international

Benefits of ADR reports to the PPMV and their clients:

- Improvement on the quality of care offered to patients.
- Reduction in drug related problems
- Improved patient confidence in professional practice.
- Improved knowledge.
- Access to feedback information on drug related problem.
- Satisfaction for the fulfillment of a moral and professional obligation (see Figure 18).

Basic Principles of Efficient Reporting

- Prompt reporting
- Correct reporting
- Complete reporting
- Write clearly

Complications

- The complications or adverse effects people experience with contraceptive pills are headaches, migraine, irregular periods, nausea, bleeding between periods, or spotting, breast tenderness, weight gain, mood swings, dizziness, fatigue and lower abdominal pain or cramps.
- The use of injectable contraceptives such as Depo-Provera is also associated with irregular menstrual bleeding, termination of periods, bone density Loss, weight gain, delayed return of fertility and local injection reactions

Referral pathway

- Cases of complications to contraceptives should be referred to the nearest primary health care center or nearest general hospital for appropriate care of the patients. However, all cases of adverse reactions to contraceptives must be properly documented using the Adverse Drug Reaction form (see Figure 17).

Demonstrate how to use form for reporting adverse drug reactions

NATIONAL PHARMACOVIGILANCE CENTRE (NPC) NIGERIA

National Agency for Food and Drug Administration & Control (NAFDAC), Headquarters Office
Plot 2032 Olusegun Obasanjo Way Wuse Zone 7 Abuja
Tel: 98086899571 or Fax: 99-5241108

FORM FOR REPORTING OF SUSPECTED ADVERSE DRUG REACTIONS
IN STRICT CONFIDENCE

1. * PATIENT'S DETAILS					
Full Name or Initials: _____			Patient Record No: _____		
AGE/DATE OF BIRTH: _____			SEX: M <input type="checkbox"/> F <input type="checkbox"/> WEIGHT (kg): _____		
HOSPITAL/Treatment Centre: _____					
2. * ADVERSE DRUG REACTION (ADR)					
A. DESCRIPTION			C. OUTCOME OF REACTION TICK AS APPROPRIATE		
DATE Reaction Started: _____ DATE Reaction Stopped: _____			<input type="checkbox"/> Recovered fully <input type="checkbox"/> Recovered with disability (Specify) _____		
			<input type="checkbox"/> Congenital Abnormality (Specify) _____ <input type="checkbox"/> Life Threatening (Specify) _____		
			<input type="checkbox"/> Death <input type="checkbox"/> Others (specify) _____		
B. Was Patient Admitted Due to ADR			Yes <input type="checkbox"/> No <input type="checkbox"/>		
If Already Hospitalized, Was it Prolonged Due to ADR			Yes <input type="checkbox"/> No <input type="checkbox"/>		
Duration of Admission (days): _____ Treatment of Reaction: _____					
3. * SUSPECTED DRUG (Including Biologicals Traditional/Herbal Medicines & Cosmetics)					
A. DRUG DETAILS (State name and other details if available / Attach product label / Sample (if available))					
Brand Name: _____		Generic Name: _____		Batch No: _____	
NAFDAC No: _____		Expiry Date: _____			
Name & Address of Manufacturer: _____					
B. Indications for Use	Dosage	Route of Administration	Date Started	Date Stopped	
4. * CONCOMITANT MEDICINES (All medicines taken within the last 3months including herbal and self medication)					
Brand or Generic Name	Dosage	Route	Date Started	Date Stopped	Reason for Use
5. * SOURCE OF REPORT:					
Name of Reporter: _____					
Address: _____					
Profession: _____					
Signature: _____ Tel No/E-mail: _____					

***: MANDATORY FIELDS**

Figure 17: Adverse Drug Reaction (ADR) form

Practical Session: Filling the AD Reporting Form*An identifiable patient-*

Name/Initials

Sex

DOB/Age

NATIONAL PHARMACOVIGILANCE CENTRE (NPC) NIGERIA	
National Agency for Food and Drug Administration & Control (NAFDAC), Headquarters Office Plot 2032 Olusegun Obasanjo Way Wuse Zone 7 Abuja	 FORM FOR REPORTING OF SUSPECTED ADVERSE DRUG REACTIONS IN STRICT CONFIDENCE
Tel: 08086899571 or Fax: 09-5241108	
1. * PATIENT'S DETAILS	
Full Name or Initials: _____ Patient Record No: _____ AGE/DATE OF BIRTH: _____ SEX: M <input type="checkbox"/> F <input type="checkbox"/> WEIGHT (kg): _____ HOSPITAL/Treatment Centre: _____	

Description/Dates of the suspected reaction-

Brief description of the reaction

Date ADR started and stopped

Outcome of reaction

2. * ADVERSE DRUG REACTION (ADR)	
A. <u>DESCRIPTION</u> <div style="display: flex; justify-content: space-between;"> <div style="width: 45%;">DATE Reaction Started</div> <div style="width: 45%;">DATE Reaction Stopped</div> </div>	C. <u>OUTCOME OF REACTION</u> TICK AS APPROPRIATE <input type="checkbox"/> Recovered fully <input type="checkbox"/> Recovered with disability (Specify) _____ <input type="checkbox"/> Congenital Abnormality (Specify) _____ <input type="checkbox"/> Life Threatening (Specify) _____ <input type="checkbox"/> Death <input type="checkbox"/> Others (specify) _____
B. Was Patient Admitted Due to ADR Yes <input type="checkbox"/> No <input type="checkbox"/>	
If Already Hospitalized, Was it Prolonged Due to ADR Yes <input type="checkbox"/> No <input type="checkbox"/>	
Duration of Admission (days) _____	
Treatment of Reaction: _____	

Name of suspected product-

Name of drug

Date started and stopped

Indication for use

3. * SUSPECTED DRUG (Including Biologicals Traditional/Herbal Medicines & Cosmetics)						
A. DRUG DETAILS (State name and other details if available / Attach product label / Sample (if available))						
Brand Name: _____		Generic Name: _____		Batch No: _____		
NAFDAC No: _____		Expiry Date: _____				
Name & Address of Manufacturer: _____						
B. Indications for Use	Dosage	Route of Administration		Date Started	Date Stopped	
4. * CONCOMITANT MEDICINES (All medicines taken within the last 3months including herbal and self medication)						
Brand or Generic Name	Dosage	Route	Date Started	Date Stopped	Reason for Use	

An identifiable source of Information/Reporter-

Name of reporter

Email and telephone number

5. * SOURCE OF REPORT:	
Name of Reporter: _____	
Address: _____	
Profession: _____	
Signature: _____	Tel No/E-mail: _____
*: MANDATORY FIELDS	

Where to send completed forms

- Completed forms should be sent to the following
- LGA Disease Surveillance and Notification (DSN) officers
- LGA malaria focal person
- State managers
- Through NAFDAC offices in the 36 states & FCT
- The National Pharmacovigilance Centre (NPC) – NAFDAC
Plot 2032 Olusegun Obasanjo Way Wuse Zone 7, Abuja
- Reports can also be scanned & emailed to npcadr@nafdac.gov.ng

PHARMACOVIGILANCE

Remember! Your five minutes spent filling an ADR report form can save many lives!

Filling an ADVERSE DRUG REACTION (ADR) Report form

- ✓ Guarantees Patient Safety
- ✓ Improves quality of Care Offered to Patients
- ✓ Enhances Patient Confidence in Practitioners
- ✓ Contributes to Global Knowledge on Drug Safety issues

Prepaid ADR forms can be obtained from and submitted / mailed to:
The National Pharmacovigilance Center NPC
National Agency for Food and Drug Administration and Control (NAFDAC)
Plot 2032, Olusegun Obasanjo Way, Wuse Zone 7, Abuja, FHB 5032, Wuse - Abuja
or NAFDAC offices Nationwide

Forms can also be downloaded from <http://www.nafdacnigeria.org/pharmacovigilance.htm>

Phone: +234 - (0) 9 - 524 1108 Fax: +234 - (0) 9 - 524 1108 E-mail: nafdac_npc@yahoo.com

... safeguarding the health of the nation

Figure 18: Advert of pharmacovigilance

Case Study

A 40-year-old woman sought the opinion of an experienced doctor on appropriate contraceptive for her. The doctor placed the woman on progestogen-only contraceptive. She had received one course of nitrofurantoin 5 months earlier before commencing the progestogen-only contraceptive. After 2 months of initiating progestogen-only contraceptive, she developed severe liver injury with alanine transaminase (ALT) and aspartate aminotransferase (AST) levels of 179 and 198 U/L, respectively. Progestogen only contraceptive was discontinued, and she commenced an oestrogen-based contraceptive. Her transaminase levels then normalised and, after 12 months, she had recovered completely.

Question

Use the information from the above case study to fill the pharmacovigilance form

MODULE 9

THE ROLE OF PPMVs IN REDUCING MATERNAL DEATHS IN NIGERIA

SESSION ONE: POST ABORTION CARE

Learning Objectives

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

1. Define abortion and types of abortion
2. Define abortion and types of abortion
3. List the components of post abortion care
4. Determine use of contraceptives in post abortion care
5. List conditions requiring referral

Estimated Time: 40 minutes

Overview of the module

Abortion is a major problem in Nigeria. Through this module, participants are expected to have improved knowledge on their role in providing post abortion care and referral.

Methodology

- Lecture
- Discussions
- Brainstorming
- Evaluation

CONTENTS

Abortion

This is the loss of pregnancy before it reaches viability (28 weeks). This can be spontaneous or induced.

Spontaneous Abortion: It is the termination of pregnancy that occurs naturally.

Induced Abortion: This refers to a situation in which there has been deliberate interference with pregnancy either by the woman herself or someone else with the aim of terminating it.

Types of spontaneous abortion include:

- Threatened
- Inevitable
- Incomplete
- Complete
- Missed

All the above types could be complicated with infection leading to septic abortion, which could result to maternal death if not managed appropriately.

Septic Abortion: When an abortion of any type mentioned above is complicated by infection. This could result to maternal death if not managed appropriately.

Therapeutic Abortion: Termination of pregnancy is illegal in Nigeria except to save the life of the mother (Therapeutic abortion). Such therapeutic procedure should ONLY be done by a trained medical doctor!

Essential features for recognition and diagnosis of threatened abortion are:

- Light vaginal bleeding
- Usually painless
- Uterine size appropriate for gestational age
- Cervical is closed
- Foetus usually viable on ultrasound scan

Unsafe Abortion and Post-abortion care. As mentioned above under abortions, any of the spontaneous abortion types or induced abortion could get complicated by infection and result to severe maternal morbidity and mortality. Unsafe abortion is usually the result of unskilled management of abortion in an environment lacking necessary standards for infection prevention practices.

To prevent this condition, the PPMVs should recognize the types of abortions discussed above and be able to refer for Manual Vacuum Aspiration for incomplete abortion as appropriate.

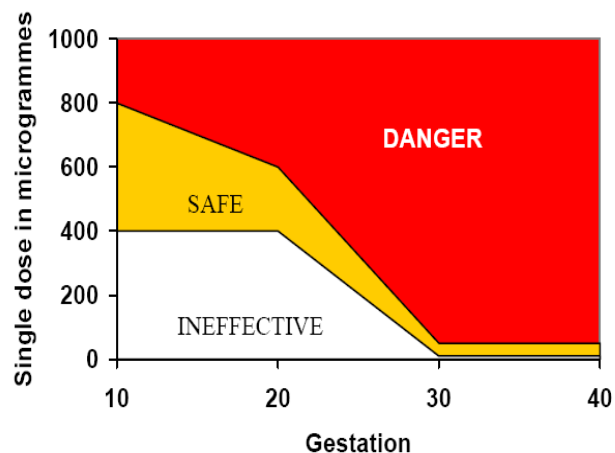
Misoprostol in post-abortion care

Misoprostol is a synthetic PGE1 analogue approved for management of obstetric haemorrhage in Nigeria

Safety of misoprostol

Safety of misoprostol should be taken seriously because of the associated danger of a possible uterine rupture and the safe dose across the gestational age is shown below:

Safe single doses of vaginal misoprostol for producing uterine contractions at various gestations. For the first trimester 800mcg 24 hourly can be safely used. In the second trimester 200mcg 12 hourly is a common dose, whilst beyond 24 weeks 25mcg 6 hourly is usually used. If a higher dose than this is used, then uterine hyper stimulation with uterine rupture or foetal distress might be the result (Reproductive Health Technologies Project, 2004).



Route of administration

Misoprostol can be given orally, under the tongue (sublingually), vaginally or rectally. The dosages quoted in these guidelines are each given with a specific route for that dose. As the bioavailability varies with each route, the correct dose must be used for the route chosen – do not change routes (e.g. sublingual to oral) without checking the dose.

The route of administration will be decided in accordance with the preference of the patient and the clinical situation. Vaginal bleeding or loss of amniotic fluid may have a negative effect on absorption through the vagina. Oral or sublingual route is preferable in these cases provided the patient has no nausea or vomiting. Also, most women prefer the oral route to vaginal application.

Example of dosage regimen for management of abortion (Please note that MVA is preferred for first trimester abortion when the skill is available)

Table 2
Showing misoprostol dosages and routes of administration in abortions

Indication	Dosage
Missed Abortion (4 – 13 weeks)	600 – 800ug sublingual or oral or per vaginam
Incomplete abortion (4 – 13 weeks)	600 – 800ug sublingual or oral
Missed abortion (14 – 24 weeks)	200ug 12hourly or 400ug 24hourly

Side effects

- Fever
- Headache
- Vomiting
- Diarrhoea
- Hyperthermia
- Shivering
- Chest pain – rare

Note: Use of Misoprostol is contra-indicated for asthmatic patients.

SESSION TWO: ROLE OF PPMV IN WARD HEALTH DEVELOPMENT COMMITTEE

Learning Objectives

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

1. Define the term Ward Development Committee
2. List the objective and Functions of Ward Development Committee
3. Describe the roles of PPMVs in WDC

Estimated Time: 30 minutes

Overview of the session

This session is aimed at improving PPMV knowledge and their role in development of ward committee and prevention of maternal deaths and surveillance response as part of task shifting policy of the FMOH.

Methodology

- Lecture
- Brainstorming
- Power points presentation

CONTENTS

Definition of WDC

Ward Development Committees is a committee established around all Health Facilities for the purpose of engendering community participation and ownership, which is an important component of the health system/scheme. The community is probably the most important link in health care delivery. It forms the support structure for the implementation of primary health care services. To this end, the 1988 National Health Policy included the creation of primary health care management and technical committees at local government levels, and ward development committees and community/village development committees at the ward and community levels.

Functions of the WDC

The committees also have the responsibility/function of monitoring the presence of the midwives in the communities, providing them with accommodation, security and an enabling environment to provide health services for their communities.

Functions of PPMVs in WDC

PPMV present in the community are members of the WDC. They are to support and strengthen the functions of WDC in that community.

SESSION THREE: ROLE OF PPMVS IN COMMUNITY MATERNAL AND PERINATAL DEATHS SURVEILLANCE AND RESPONSE (MPDSR) IN NIGERIA

Learning Objectives

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

1. Define the terms Community Maternal and Perinatal Deaths Surveillance and Response (MPDSR)
2. List the goal and objectives of MPDSR
3. Describe the structure of MPDSR
4. List the role of PPMVs in Implementation of Community MPDSR.

Estimated Time: 30 minutes

Methodology

- Discussions
- Brainstorming
- Power points presentation
- Evaluation

CONTENTS

Definition of Community Maternal and Perinatal Deaths Surveillance and Response

This is a form of community continuous surveillance that links the health information system and quality improvement processes from local to national levels, which includes the routine identification, notification, quantification and determination of causes and avoid ability of all *maternal and perinatal deaths*, as well as the use of this information to respond with actions that will prevent future deaths (see Figure 13).

When maternal or perinatal deaths occur outside health facilities where trained health care workers exist to provide accurate information and means of deciphering the determinants of the deaths, a change in strategy becomes necessary so as not to compromise the outcome of the MPDSR. Its implementation is centered on the use of Verbal Autopsy (VA) to source information from relevant persons with a view to reconstructing the events leading to the death of the deceased and enabling a compilation of the determinants.

Maternal Deaths

This is “the death of a woman while pregnant or within 42 days of termination of pregnancy, irrespective of the duration and site of the pregnancy, from any cause related to or aggravated by the pregnancy or its management but not from accidental or incidental causes”.

A **perinatal death** is a fetal **death** (stillbirth) or an early **neonatal death**

Goal of MPDSR

The goal of this initiative is to eliminate preventable maternal and perinatal deaths.

Specific Objectives

The primary goal of MPDSR is to eliminate preventable maternal and perinatal mortality by obtaining and using information on each maternal and perinatal death to guide public health actions and monitor their impacts.

MPDSR expands on ongoing efforts to provide information that can be used to develop programmes and interventions for reducing maternal and perinatal morbidity and mortality and improving access to and quality of care that women and babies receive during pregnancy, delivery, and the puerperium.

MPDSR aims to provide information and data that will lead to specific recommendations and actions and improve the evaluation of their effectiveness.

Structure of MPDSR

The medical audits structure involves:

- National MPDSR Steering Committee
- State MPDSR Steering Committee
- Facility based clinical reviews
 - Public & Private Health Facility MPDSR Steering Committee
- Community based verbal autopsy.
 - Community MPDSR Steering Committee

Primary Informer role of PPMVs in Community MPDSR

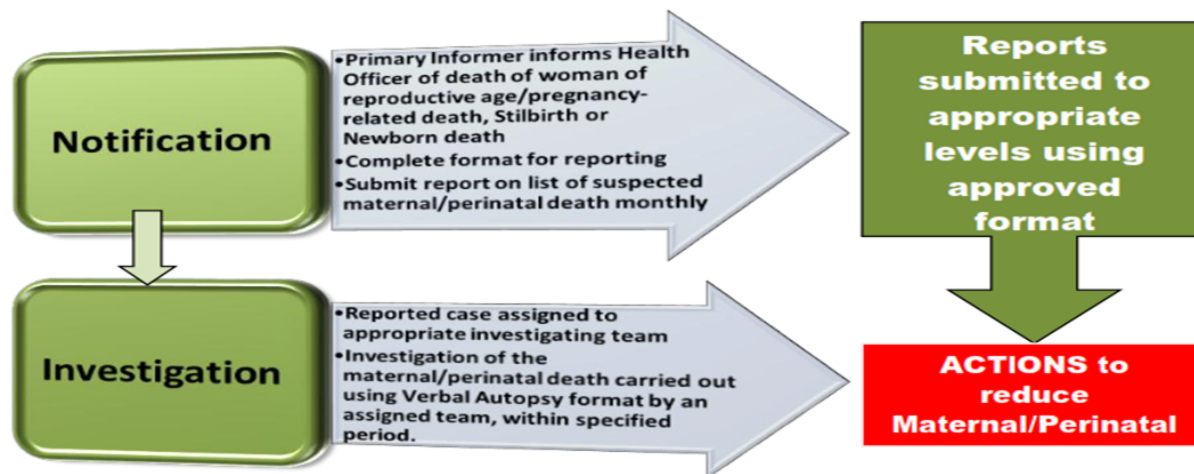


Figure 13: Community Maternal and Perinatal Deaths Surveillance and Response

References

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MODULE 10

ETHICAL, LAW ISSUES AND RESPONSIBILITIES OF TIER 2 PROPRIETARY PATENT MEDICINE VENDORS (PPMVS) IN TASK SHIFTING AND SHARING POLICY IN NIGERIA

SESSION ONE: LAWS AND REGULATION ON OPENING, MANAGEMENT AND MAINTENANCE OF DRUG SHOPS

Learning Objectives

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

1. List the different tiers of PPMVs
2. Differentiate a retail pharmacy from a patent and proprietary medicine vendor
3. Itemize the different regulatory agencies for drug shops
4. Discuss the laws and regulations guiding registration and licensing of drug shops

Estimated time: 60 minutes

Overview of session

In Nigeria, drug shops are the first and dominant point of care in many communities, particularly in rural areas where formal health systems often not within reach. Through this session participants are expected to have improved knowledge of the extant regulations on establishing and maintaining a PM shop in Nigeria.

Methodology

- Lecture
- Brainstorming
- Discussions

Materials required

- Flip charts
- Markers
- Handouts
- LCD Projector and Projector screen
- Laptop

CONTENTS

The Pharmacist Council of Nigeria (PCN), the government agency responsible for regulating the practice of PPMVs in the country, has created a three-tier system for PPMVs and a Standard Operating Procedure (SOP) for each tier. The three tiers are:

1. Vendors and intending vendors who only possess the ability to read and write having attained the minimum educational qualification of the senior secondary school Certificate.
2. Professionals in the patent medicines business or are intending to be in the business and have one form of health training background or the other such as CHEWs, CHOs, Registered Nurses/Midwives, etc.
3. Pharmacy technicians who yearly apply to retain their names with PCN but are PPMVs or intending to be.

The laws and regulations guiding the opening, management and maintenance of drug shops in Nigeria are:

- Pharmacists Council of Nigeria Decree 91 of 1992
- Pharmaceutical Premises Regulations 2005
- National Drug Policy of 2003
- NAFDAC Good Distribution Practices Guidelines for Pharmaceutical Products of 2016
- Essential Medicines List 2010
- The Counterfeit and Fake Drugs and Unwholesome Processed Foods(Miscellaneous provisions) Cap C 34 LFN 2004

Opening of Drug Shops

The Pharmacists Council of Nigeria (PCN) is the agency responsible for licensing and regulating both PPMVs and retail pharmacies. The Federal Ministry of Health (FMOH) is responsible for outlining both retail pharmacies and PPMVs' scope of practice. The National Agency for Food and Drug Administration and Control (NAFDAC) monitors the compliance and quality of drugs sold at both PPMVs and retail pharmacies. In retail pharmacies, individuals must be registered pharmacists. Their partnership must be with other pharmacists. The owner can register as pharmacist superintendent in only one pharmacy. On the other hand, PPMVs do not require formal training in medicine or pharmacy.

Registration of PPMVs

PPMV's are also required to register with the State Ministry of Health (SMoH), which in turn participates in monitoring. The PPMVs more often register with their professional association, the National Association of Patent and Proprietary Medicine Dealers (NAPPMED). The association conducts several support and oversight activities including monitoring visits, facilitating education and training sessions to disseminate information on proper PPMV practice. The PPMVs licensure does not require formal training in medicine or pharmacy. By convention, however, PPMVs are expected to have completed secondary school and undergone an apprenticeship with a more senior PPMV before opening their own shop with prescribed regulations.

Registration of pharmaceutical premises/retail pharmacies

- a. Registration of pharmaceutical premises regulations, 2005, provides for registration of new pharmaceutical premises and renewal of old premises.
- b. It provides that where the premises sought to be registered is a retail pharmacy; the company shall be wholly owned by a registered pharmacist or in partnership with another registered pharmacist.
- c. For a pharmaceutical premise involved in wholesale, distribution and importation of drugs, poisons and devices, there shall be at least one registered pharmacist on the board of directors of the company. The business shall be carried out under the direct personal control and management of a Superintendent Pharmacist.

Inspection, location and structure of pharmaceutical premises/retail pharmacies

The inspection, location and structure of pharmaceutical premises regulations, 2005 establishes a pharmaceutical inspectorate division which consist of registered pharmacists designated as pharmaceutical inspectors, appointed by the council to enter pharmaceutical premises and inspect to ensure due compliance with the provisions of the regulation.

- a. The inspection regulation provides for the location of pharmaceutical premises. It shall not be in motor parks, environment close to a location where commercial activities and enterprise are standing and growing such as marketplaces including kiosks and roadside retail.
- b. It provides that any pharmaceutical premises surrounded or covered completely by a growing market or standing close to it shall be moved to another suitable location two years after formal notification to do so by the council.
- c. Pharmaceutical premises within a shopping Centre shall not be more than three and they shall be well spaced out.
- d. Pharmaceutical premises shall be sited not less than two hundred meters from each other.

Pharmaceutical practice in Nigeria is also regulated by NAFDAC. The agency has a complementary role to play in the registration of pharmaceutical premises. It does the following;

- a) The agency oversees evaluation and registration of pharmaceutical products
- b) Post market surveillance and risk analysis of products
- c) Control of product import and export
- d) Regulation of product promotion and public education.

Documents needed for registration of pharmaceutical premises/retail pharmacies

For the registration of a new pharmaceutical retail, the following documents shall be submitted to the Registrar, of the Council, through the Director of Pharmaceutical Services of the State where the premises are to be operated;

1. An application letter (in the company's letter headed paper) to register premises
2. A duly completed Form B (PCN's application form for the registration of premises)
3. A photocopy of the annual license to practice or an application for the retention of name on the pharmaceutical register (Form J)
4. The prescribed inspection and registration fees, in bank draft, payable to the council
5. A photocopy of the letter of resignation from a previous employment (if applicable)
6. The letter of acceptance of resignation (if applicable)
7. The letter of appointment in the new premises (where applicable)

8. The legal agreement between the superintendent pharmacist and his employer (where applicable)
9. The company's certificate of incorporation (Evidence of registration of business name is acceptable in respect of a pharmacist-owned retail premises)
10. Certified copy of the company's articles and memorandum of association
11. Certified copy of particulars of the company's directors as issued by the Corporate Affairs Commission (CAC)
12. A photocopy of the NYSC discharge or exemption certificate (where applicable)
13. A letter of undertaking by the superintendent pharmacist to the effect that he has only one pharmaceutical job
14. A letter of undertaking by the managing director of the company to the effect that all pharmaceutical businesses would be under the direct, personal, control and management of the superintendent pharmacist
15. A pharmacist's inter-state movement form (where applicable), duly completed
16. Evidence of a pharmacist on the board of directors
17. The current annual license of the pharmacist director.

On the receipt of the above-named documents, inspection of the pharmaceutical premises shall be carried out to ensure compliance with the requirements for the registration of such premises.

Management of drug shops

I. Procurement of drugs

- a) Drugs shall be procured from reputable registered wholesale outlet or retail pharmacies
- b) Sale of drugs shall be as approved by the Federal Ministry of Health to consumers

II. Storage

- a) The store shall be of enough capacity to allow for the orderly storage of various categories of materials and products.
- b) There should be clearly demarcated areas for storing damaged and expired products.
- c) Any stock of expired or deteriorated drugs shall be officially destroyed within six months.
- d) The store shall be kept clean and dry always at acceptable temperature limits, using air-conditioners of appropriate capacities with temperature and humidity log recording equipment.
- e) The store shall be furnished with adequate number of shelves and pallets which must be in good state of cleanliness and repair.
- f) Products shall be stored off the floor on shelves/pallets and suitably spaced to permit cleaning and inspection.
- g) Appropriate storage facilities should include enough and functional refrigerators for storage of thermo labile and evidence of uninterrupted supply of electricity.
- h) Regular checks on the quality of stored drugs shall be undertaken to ensure that they do not deteriorate under storage conditions
- i) Shall comply with all other NAFDAC and PCN conditions

Documentation

The owner of drug shops shall establish and maintain inventories and records of all transactions regarding the receipt and sale of drugs and other health commodities to consumers.

The inspection and disposal of expired stock in addition to damaged stock as well as the recording of stock movements shall be done.

Maintenance of drug shops

Staff should be appropriately qualified, trained, disciplined and rewarded. The sales of medications shall take place in premises licensed for the purpose, which shall be subject to regular inspection. The continuing registration of a licensed premise shall depend on a satisfactory report by inspectors of the Pharmacists' Council of Nigeria (PCN) and the payment of prescribed fees. Similarly, in view of the need for every Nigerian to have access to appropriate drugs, it shall be permissible for certain OTC drugs to be sold in patent medicine shop operated by PPMVs, particularly in areas where there are no licensed pharmacists in practice. The premises for the sale of such drugs shall be approved and licensed and shall be subject to periodic inspection by pharmaceutical inspectors of the PCN. Stock should be verified regularly, and periodic audits should be conducted.

References

1. Federal Ministry of Health. National policy for controlled medicines and its implementation strategies 2017. Nigeria.
2. Federal Ministry of Health. National drug distribution guidelines. 2nd edition 2012. Nigeria
3. Society for family health. The Landscape of patent and proprietary medicine vendors in 16 states of Nigeria. 2015.
4. Riley P, Callahan S, and Dalious M. July 2017. *Regulation of Drug Shops and Pharmacies Relevant to Family Planning: A Scan of 32 Developing Countries*.
5. Federal ministry of health. National drug policy 2003. First revision 2005.
6. Durowade KA, Bolarinwa OA, Fenenga CJ, Akande TM. 2018. Operations and Roles of Patent and Proprietary Medicine Vendors in Selected Rural Communities in Edu Local Government Area, Kwara State, North-Central Nigeria. *Journal of Community Medicine and Primary Health Care*. 30 (2) 75-89.
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SESSION TWO: ETHICAL ISSUES IN PROVISION OF FAMILY PLANNING SERVICES

Learning Objectives

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

1. Define ethics
2. List three importance of ethics in provision of family planning services
3. State ethical requirements in providing FP services
4. List rights of customers to FP/reproductive health services

Estimated time: 1 hour

Overview of session

The module aims at informing participants of the importance of ethics in providing FP services to clients and the challenges involved in doing so in a PPMV shop setting.

Methodology

- Brainstorming
- Discussion
- Lectures

Materials required

- Flip charts
- Markers
- Handouts
- LCD Projector and Projector screen
- Laptop

CONTENTS

Definition of Ethics

These are acceptable codes of conduct of a professional; what is expected from a PPMV in providing FP/RH services to clients in a PPMV shop. Ethics also refer to the way the PPMV is expected to interact with the client during and after FP/RH service provision. Ethics of care refer to rules of conduct in relationship between a PPMV and & his or her clients who desire FP/RH services.

The range of FP/RH services that clients may request from PPMV include:

1. Counselling
2. Purchase of FP commodity
3. Injection
4. Refill of pills
5. Referral

In providing these services, PPMV must be guided by the following requirements

The ethical obligations of PPMV to their clients

- Treat clients with respect & dignity
- Obtain informed consent from client before undertaking a procedure
- Handle information about the client with confidentiality
- Set off-limits & boundaries in relationship with clients

Rights of clients

All clients who visit a PPMV shop to access any of the services listed above have rights which must be acknowledged and respected. These rights include the following:

1. Access to Information
Clients need accurate, up-to-date information on FP/RH to enable them to make informed decisions. PPMV have a duty to provide such information in a simple, easy to understand format and in the language that the client understands.
2. Informed Consent
Informed consent is a decision made by a client to access FP/RH services after he/she has been provided with (a) adequate information (b) the information is understood (c) he/she makes the decision without being forced, misled or coerced.
3. Confidentiality
The use of FP/RH services is a sensitive issue and PPMV must keep as secret all information that clients disclose during the process of counseling and even after the services have been provided
4. Privacy
All clients are entitled to privacy while they are being attended to in a PPMV shop.
5. Informed choice
All clients are entitled to choose the type of FP/RH services that they desire. The PPMV is however expected to provide appropriate information in enabling clients make such choice
6. Safe services
All clients are entitled to receive safe services from PPMV.

7. Dignity and respect

PPMV are expected to treat all clients who seek FP/RH services in their shops with dignity and respect.

Challenges for ethical requirements in a PPMV shop

By nature, a PPMV shop is a public space. Yet, use of FP/RH service is a sensitive and personal issue. Therefore, special efforts must be made to ensure that clients who require FP/RH services receive personalized and private service during their visit to the PPMV shop.

SESSION THREE: ROLE OF PPMV's IN TASK SHIFTING AND FAMILY PLANNING SERVICE PROVISION IN NIGERIA

Learning Objectives

At the end of this session participants should be able to:

1. Explain the concept of task shifting
2. List the rationale for task shifting policy
3. Describe the objectives of task shifting
4. List the tasks shifted
5. List the effects of task shifting

Estimated Time: 60 minutes

Overview of module

The goal of the module is to improve participants' knowledge of task shifting and the role that PPMV play in the process as this relates to provision of FP services in PM shops.

Methodology

- Discussions
- Brainstorming
- Power points presentation
- Group work Exercise
- Evaluation

Materials required

- Multimedia projector
- Laptop computer
- Flip Chat
- Makers
- Power point presentation

CONTENTS

Definition of Task Shifting

WHO describes task shifting as a process involving the rational redistribution of task among health work force teams. It is the process of enabling additional cadres of health workers to provide specific health intervention. Task Shifting is also defined in the guidelines as the rational redistribution of clinical and other task among health care workers according to their skills rather than their roles. Task shifting presents a viable solution for improving health care coverage; making more efficient use of human resources such as the PPMVs; strengthening the capacity of all health cadres in Nigeria.

Relevance of task shifting in Nigeria

One of the major constraints to meeting the Unmet Family Planning needs of women in their reproductive age is the shortage of health care providers and this is compounded by either lack of access to health facilities or availability of health services. Task shifting is not a replacement for or a design to slow down the development of a professional training. It is merely an emergency measure necessary to immediately ameliorate the current awful suffering of our people (Gyoh, 2011).

Task Shifting will not only increase utilization but also improve the modern contraceptive prevalence rate which has remained low at 12% (NDHS 2018). It is pertinent to note that Family Planning is an inexpensive and cost-effective intervention but health work force shortages and restrictive policies on the role of mid and lower level cadres limit access to effective delivery of contraceptive methods in many settings.

The main objective of task shifting

The objective of task shifting, or sharing is simply to get the right workers with the right skills in the right places doing the right things.

Rationale for Task Shifting in Nigeria

In Nigeria, the ratio of health care workers HCW (doctors, Pharmacist, nurses, midwives CHOs and CHEWs) to population density is 20 to 10,000 While this is a little below the WHO recommendations of 23 per 10,000,² this is due to the high number of community health practitioners. In addition, the health workers in Nigeria are poorly distributed and in favor of urban, southern, tertiary health care facilities, and curative care. For some cadres of health workers, more than 50% work in the Southwestern part of the country with the majority living in the commercial city of Lagos. Table 1 below shows the HCW to population density in the country.

Table 3: Status of Skilled Birth Attendants in Nigeria compared to WHO Recommendations

Cadre	Number	WHO recommended HCW/population density per 10,000	Actual HCW/population density in Nigeria (per 10,000 population)
Doctors	58,325	5.5	4 per 10,000 ³ Ranging from 0.11 in Adamawa State to 4.48 per 10,000 in Kwara State
Nurses and midwives	137,198	17	16 ⁶ per 10,000 Range not available
Community health practitioners	117,568	NA	20 ⁴ per 10,000 Range not available

Nigeria has approximately 20 CHEWs per a population of 10,000, representing a largely untapped resource for maternal and child health care. It is also noteworthy that the states with the lowest density of SBAs have the highest MMRs in the country, thereby necessitating the need to empower CHEWs to provide much-needed maternity services that many of them are already providing, albeit with poor quality.

A baseline survey conducted by the National Primary Health Care Development Agency (NPHCDA) in 2009 for the Midwives Service Scheme (MSS) showed that there were 36,737 CHWs working in the PHCs and only 5,604 SBAs (doctors, nurses and midwives). Figure 12 shows the distribution of human resources at the PHCs, where 28% were health assistants, 27% are CHEWs, 11% are Junior CHEWs, and 4% are CHOs. Of note, less than 8% were nurses or nurse/midwives, or midwives. The survey also revealed that 90% of deliveries at the PHCs were conducted by CHEWs. An assessment of the knowledge and skills of the CHEWs showed that even though 70.3% of them had some basic theoretical knowledge of midwifery, only 31% could correctly assess fetal well-being while only 56% knew about the routine tests to be done during ANC, indicating serious gaps in their level of skills.

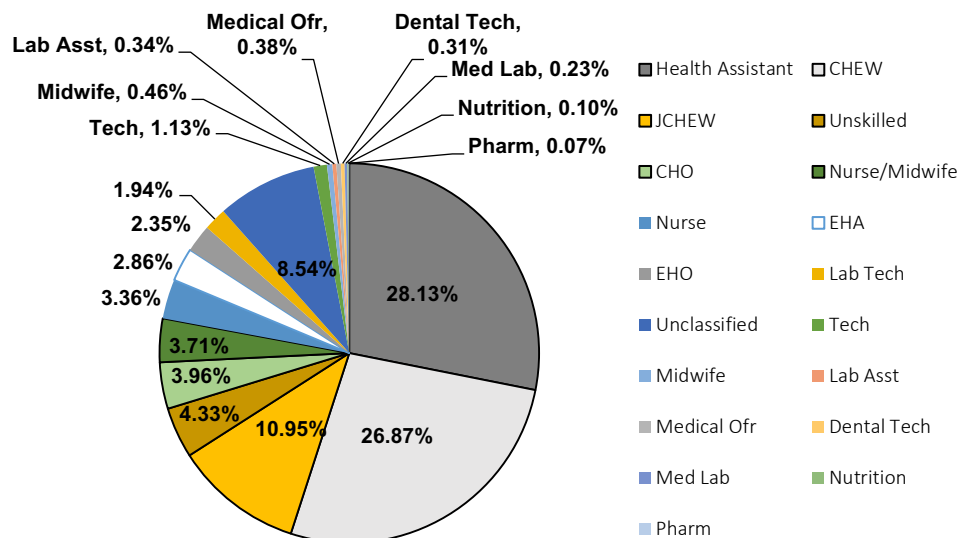


Figure 12: Distribution of Health Care Workers in Primary Health Care Centers

Note: Nurses-midwives are HCWs with double qualifications as a registered nurse and a registered midwife.

Source: NPHCDA

The rationales for Task Shifting are as a result of:

- Limited access to services by either overall shortage of health workers qualified to provide specific methods or their uneven distribution across a country or region;
- Difficulties in ensuring staff retention of higher cadres in certain setting such as rural areas;
- Lower salary levels of mid or lower cadre health workers which can usefully reduce the budgetary cost of providing Family Planning services without compromising quality of services and client safety;
- Availability of free time for higher cadre health workers which would enable them to better focus on the provision of services requiring a higher level of technical proficiency.
- Optimize the health workers roles to improve access to key maternal, new-born, and child health interventions;
- It is a strategy for improving access to contraceptives methods thus contributing to the achievement of health-related SDGs in Nigeria.

Factors that facilitate the successful implementation of Task Shifting in PPMVs

- Provision of capacity building to PPMVs
- Supply of drugs and other family planning commodities as required
- Regular supportive supervision with use of check list
- Establishment of referrals for other methods and management of complications
- Effective follow up mechanism for clients
- Ensuring that monitoring and evaluation systems are functional and effective

List of tasks shifted

The recommendation 23 of Task Shifting policy implementation is that Nigeria will consider the different types of task shifting practices and will adopt, adapt, or extend, those models that are best

suited to its community level situation (taking into account of availability of local resources, disease burden, and community referral to strengthen community-clinic linkages) that would improve the health system. PPMVs operate at the community level.

The tasks shifted at the community level are as listed in Table 4.

Table 4: Details of Tasks shifted at the community level

Community level services	VHW/Corps/PPMV's	CHEWs	Nurse	Midwives/NM	MO
Perform malaria test using rapid diagnostic test kits	√	√	√	√	√
Provide treatment of malaria using ACTs	√	√	√	√	√
Provide treatment of diarrhea using ORS and zinc	√	√	√	√	√
Provide treatment of acute respiratory infections using antibiotics	√	√	√	√	√
Dispense misoprostol in the community	√	√	√	√	√
Prevents umbilical cord infection using Chlorhexidin gel	√	√	√	√	√
Provide Oral contraceptives to clients	√	√	√	√	√
Provide Injectable contraceptives to clients	√	√	√	√	√
Provide implants family planning contraceptives	√	√	√	√	√
Provide IUCD to client			√	√	√

References

Federal Ministry of Health, 2006

WHO: Global Atlas of the Health Workforce, August 2010.

WHO, World Health Statistics, 2012.

MODULE 11

RECORD KEEPING, REPORTING SYSTEM, MONITORING AND EVALUATION IN FAMILY PLANNING

Session 1: Record keeping in Family Planning services in Nigeria

Learning Objectives

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

1. Define Record, Record Keeping and Documentation
2. State the importance of record keeping
3. Explain the disadvantages of NOT keeping record
4. Explain the content of the various national record keeping forms in Family Planning

Estimated time: 60 minutes

Overview of the module

This module is meant to transfer knowledge and skills that participants need to keep appropriate records of the FP services they provide for their clients. This is important to ensure that services rendered at PM shops are included in the national data of use of contraceptives in the country.

Methodology

- Lectures
- Discussion
- Brainstorming
- Group work

Materials

- Flip chart
- Markers
- Multimedia projector
- Laptop computer
- National Record Keeping Forms

CONTENTS

Definition of Record, Record Keeping and Documentation

Record: This is any information and document kept in a systematic, scientific and easy way to help retrieval of data when required.

Record Keeping: It is a systematic way of storing a required data, information and other relevant document and easily retrieved when it is needed.

Documentation: This can be defined as a system through which information is written down and kept for record purpose.

Components of Record Keeping

Client Medical Record Consists of :
<ul style="list-style-type: none"> • Client registration number • Date of visit • Name of patient • Address • Age • Sex • Occupation • Religion • Next of kin • Diagnosis • Mode of diagnosis • Recommendations made by the doctor in the course of management

Documentation

Client card (Form A) (see Appendix three) is a family planning form which is used for medical record documentation that is required to record pertinent facts, findings, and about an individual health history including the past and present illnesses, examinations, tests, treatments, and outcome. The medical record chronologically documents the care of the patient and it is an important element contributing to high quality care. The medical record should be complete and legible.

The need for documentation

1. It improves the ability of the physician and other health care professionals to evaluate and plan the patient immediate treatment, and to monitor his or her health care over time
2. It facilitates communication and continuity of care among the physicians and other health care professionals involved in the patient's care.
3. It ensures appropriate utilization review and quality of care evaluations.
4. It improves process data collection that may be used for research and education

Importance of record keeping

The information contained in the medical record is useful in the following areas:

- Patient care
- Health research
- Planning and administrative purposes
- Medico-legal purpose
- Evaluation of patient care
- Teaching of medical and paramedical students
- Communication between doctors, nurses and other health workers

Disadvantages of NOT keeping record

By not keeping record the provider would not:

- Know the total number of clients served
- Be able to determine the rate of acceptors for each method//procedure
- Be able to compare number of clients across Family Planning facilities in the community
- Be able to plan for future improvement and evaluate up to date progress
- Be able to supply evidence of past work
- Be able to conduct good research
- Give good impression of Family Planning Services
- Be able to make planning and evaluation easy
- Be able to obtain other adequate information in case a problem of a legal nature arises

The content of various national record keeping forms in Family Planning

HMIS Tools are used for keeping track of various services provided by the programme and activities performed.

The forms are as follows:

Client Record form//Instruction (Form A): This form is used to record client's history

Tally Sheets//Daily activity summary Forms (Form B1.1, Form B1.2): This is used to record services provided to clients at the community and facility level. Information in this sheet is summed up at the end of every day and this summation should be transferred to the monthly summary sheet (See appendix Three).

Monthly Summary Form (Form C1.1 and Form C1.2): This form is to be used for compilation of data in the Tally /Daily Activity Summary Form I.e. Form B1.1 and Form B1.2. It should be completed monthly by the responsible health worker in the facility.

Facility Based Referral Form (Form D): It is used by clinical services providers or outreach workers who provide clinical services - to clients to a referral center where further services can be obtained.

Quarterly Summary Form (Form E): This is used for compilation of the data in the Monthly Summary Form (C1.1 and C1.2). It should be completed monthly or at the end of the quarter by the responsible health worker in the facility

Annual Summary Forms (Form F): This is used for compilation of data in the quarterly summary form. It should be a summary of all quarterly reports for the year in question.

Outreach Activity Form (Form G): This is used for obtaining a record of reproductive health outreach activities undertaken by individual health workers (peer educator, community health extension workers etc.) during the month in question.

Monthly Outreach Summary Form (Form H.1): This is used for summarizing all reproductive health outreach activities undertaken by individual's health workers (peer educator, community health extension workers etc.) during the month in question. This form is filled by the supervising officer, and submitted to the project coordinator, who would use the information generated for programme planning and report writing.

Quarterly/Annual Outreach Summary (Form H.2): This form summarizes all outreach reproductive health activities carried out by health workers during the quarter of the year under reference.

Outreach Referral Forms (Form J): To be used by clinical service providers of outreach workers to refer a client to a referral Centre, where further services can be obtained.

Appointment Card (Form K): This card is used by the service providers to enter appointments for the client.

A copy of each of the forms discussed above is appended to this module will be available for practice during the module.

Session 2: Reporting System in Family Planning in Nigeria

Learning Objectives

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

1. Describe Reporting System, Community Health Management Information System
2. Describe the importance of HMIS
3. Explain the use of DHIS 2 platform (e-NHMIS) in reporting.

Estimated time: Time: 45 minutes

Methodology

- Lectures
- Discussion
- Brainstorming
- Group work

Materials

- Flip chart
- Markers
- Multimedia projector
- Laptop computer
- National Record Keeping Forms

CONTENTS

Reporting System, Community Health Management Information System

The Community HIMS is an established nationwide health management system that collects, collate and analyze MNCH and other health care services delivery data at the community level of care in the 36 states and FCT. This data should be integrated to LGA or State Health management information system. (The SHMIS software presently has provision for maternal and perinatal death information. Data generated from the maternal and perinatal death surveillance and response (MPDSR) should be processed along with the other MNCH data to the existing NHMIS /DHIS (DHIS, 2013).

The importance of HMIS

The effective management of any programme depends on availability of information for optimal decision making. In this regard the setting up of HMIS will provide the programme management with necessary information for decision. The quality of management decision making will be determined by the quality of HMIS; it is essential for effective programme management.

- It provides feedback on the performance of the critical function of the programme. Such feedback allows managers to take corrective actions when problem arise.
- It provides stakeholders with regular assessment of programme performance
- It is useful for measuring programme output i.e. numbers of contraceptives used, new acceptors, needs.
- It is used in the assessment of programme impact
- It provides answers to specific management and research questions.
- It is an important monitoring tool
- It is critical for resource allocation and evaluation

The use of DHIS 2 platform (e-NHMIS) in reporting.

The e NHMIS is the use of Demographic Health Information System (DHIS) platform version 1.3 software to collect, enter, analyze and transfer of data from the communities and health facilities to data base DHIS platform at national level. DHIS tool is an open source software developed through a global collaboration involving Nigeria and other countries such as Norway, India, Columbia, Vietnam, South Africa and Ethiopia.

Reference

DHIS: Communiqué on 56th National Conference of Health Meeting, August 2013.

Session 3: Monitoring and Evaluation of Family Planning in Nigeria

Learning Objectives

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

1. List the monitored FP National indicators
2. List available surveys for evaluation of FP commodities and services in Nigeria

Estimated Time: 35 minutes

Methodology

- Lectures
- Discussion
- Brainstorming
- Group work

Materials

- Flip chart
- Markers
- Multimedia projector
- Laptop computer
- National Record Keeping Forms

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Management Information System (MIS) is an organized way of recording, collating, and interpreting information for planning and decision-making. It is important in the Integration Initiative because client records, registers, and other Monitoring and Evaluation (M&E) systems (supervisory protocols, monitoring forms, service provider job descriptions and checklists to reflect FP services and roles) will need to be modified to account for the addition of family planning services including referrals. The systems to evaluate whether clients access services to which they are referred need to be established as well as any obstacles to access. Monitoring and output evaluations of integrated approaches should be conducted continuously, and report findings made available to providers and managers (PPMVs) on a regular basis to motivate them and improve performance.

PPMVs and supervisors will need to be equipped to monitor the quality of integrated services. Monitoring activities would include assessing adherence to service protocols, checking for contraceptive stock outs, and reviewing service statistics, such as the number of FP clients referred to FP services at nearest PHC. All these changes in MIS, M&E and facilitative supervision will require the training and re-training of PPMVs.

Family Planning national indicators

- a) Contraceptives Prevalence Rate (CPR):
- b) Unmet need for Family Planning:
- c) Fertility Rate:
- d) Unsafe abortion:
- e) Maternal Mortality Ratio:
- f) Modern Contraceptive Method:

Information/Report Flow and Feedback Mechanisms

Data flow from the SDP to the state level. This is then transmitted to the National for collation and analysis.. However, information flow according to the M&E Plan (2005-2009) shows that the direction of flow is both ways. While data moves upward for national collation and reporting, feedback mechanism move downward to the SDP; where the data are generated for strategic information and knowledge management for decision making. The illustration in Figure 14 is a graphic description of the information/reporting flow and the feedback mechanism.

Data flow and feedback mechanism

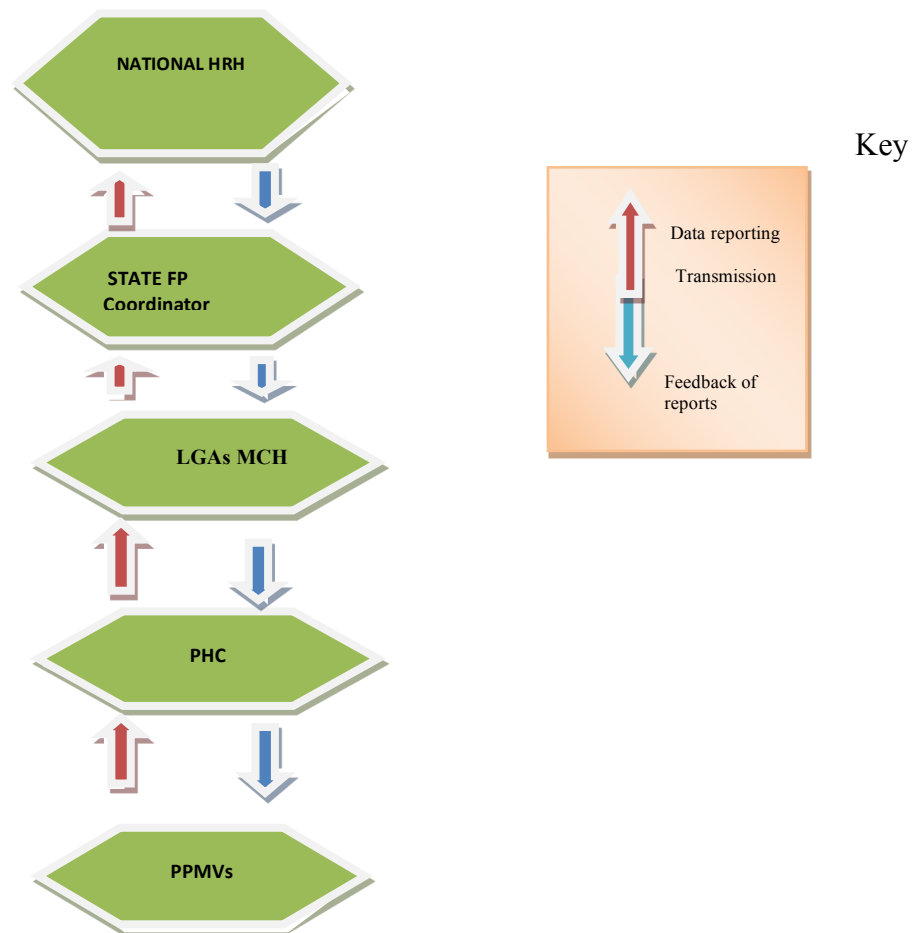


Figure 14: Information products, timeline, and target audience

The data produced from the routine daily data records forms monthly summary information for PPMVs. This information is collated on monthly basis and transmitted to catchment PHCs and to LGAs every **5th day of the new month** preceding the reporting period; that is, the reporting month. The state in turn collates and analyses the data from the different LGAs/PHC/PPMV's and transmit to State FP Coordinator every **7th day of the new month**. This is then transmitted to the Director // Head Reproductive Health Division FMOH on the **10th day of the new month**, after the state collation and analysis have been done. The data information described above is the data flow and timeline of FP activities on monthly basis.

Utilization of Data Generated from various Tools

Data from the summary forms are analyzed as desired whether monthly, quarterly or annually. This interpretation informs service providers (PPMVs) and project managers on areas of need and issues that need attention. For instance, observation in drop of number of young people utilizing a service. Interpreting this involves examining reasons responsible for the drop in the utilization of these services. Another example where analyzed data indicates that male adolescents are utilizing a service more than female adolescents or vice versa, such data will involve examining the reasons for this gender gap and re-strategizing to bridge the gap at the community level.

Evaluation of Family Planning commodities and services in Nigeria

Evaluation of Family Planning in Nigeria is done through surveys which are supported by Federal Government of Nigeria and development partners. The routine evaluation is done through DHIS 2

The surveys used to evaluate Family Planning in Nigeria are:

1. NDHS
2. GPRHCS
3. MICS
4. SMART

MODULE 12

INFECTION CONTROL, HOUSE KEEPING AND QUALITY ASSUARANCE IN FAMILY PLANNING

Session 1: Infection Control

Learning Objectives

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

1. Explain why infection control is important in family planning services
2. Define Asepsis, Antisepsis, Cleaning, Disinfection, Decontamination, High Level Disinfectant and Sterilization
3. List infection control methods
4. Demonstrate proper use of alcohol hand rub, gloving and hand-washing techniques

Estimated Time: 45 minutes

Overview of session

The goal of this session is to improve knowledge and skills of participants on infection control procedures they need to apply to provide safe and high-quality FP services to their clients. A strict compliance to universal precautions is the best way that providers can avoid workplace exposure to fluid-borne infections including HIV.

Methodology

- Lecture
- Discussion
- Demonstration
- Role play

Materials required

- Flip charts
- Markers
- Handouts
- LCD Projector and Projector screen
- Laptop computer
- Soap
- Hand wash basin
- Hand towel
- Water
- Alcohol hand rub
- Gloves

CONTENTS

Definition of terms

Microorganisms are the causative agents of infection. They include bacteria, viruses, fungi and parasites. For infection prevention purposes, bacteria can be further divided into three categories: vegetative (staphylococcus), mycobacteria (tuberculosis) and endospores (tetanus). Spores are the most difficult to kill.

Asepsis and Aseptic Technique are general terms used 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 to a safe level, or eliminate, the number of microorganisms on both animate (living) surfaces such as skin and tissue, and inanimate objects such as surgical instruments and other items.

Antisepsis is the prevention of infection by killing or inhibiting the growth of microorganisms on skin and other body tissues using a chemical agent (antiseptic).

Decontamination is the process that makes objects safer to be handled by staff before cleaning (It reduces the number of, but does not eliminate, microorganisms on instruments and other items). Objects to be decontaminated include large surfaces (e.g. capsules or operating tables) and surgical instruments, gloves and other items contaminated with blood or body fluids.

Cleaning is the process that physically removes all visible blood, body fluids or any other foreign material such as dust or dirt from skin or inanimate objects.

Disinfection is the process that eliminates most, but not all, disease-causing microorganisms from inanimate objects.

High-Level Disinfection (HLD) by boiling, steaming or the use of chemicals eliminates all microorganisms except some bacterial endospores from inanimate objects.

Sterilization is the process that eliminates all microorganisms (bacteria, viruses, fungi and parasites) including bacteria endospores from inanimate objects.

Infection control methods:

2. Hand washing
3. Gloving
4. Proper use of alcohol hand rub
5. The processing of reusable instruments
 - a) Decontamination and cleaning procedures
 - b) High-level disinfection
 - c) Sterilization
6. Waste disposal
7. Housekeeping
8. **Use new auto-disable syringes and needles for injectables**

9. Wipe surfaces with chlorine solution

Hand washing

Hand washing may be the single most important infection-prevention procedure. Wash hands before and after examining or treating each client.

Types of hand washing:

- Plain soap with running water
- Antiseptic with running water
- Alcohol scrubs

Hand washing steps (see Figure 20):

- Wet the hands with running water
- Rub both hands together with soap and lather, making sure to rub all parts of your hands
- Vigorously weave fingers and thumbs together and slide them back and forth for 10–15 seconds or for longer if hands are visibly soiled
- Remember to wash around the nails
- Rinse hands under a stream of clean, running water until all soap is gone
- Dry hands with a clean towel that no one else uses or allow hands to air-dry the hand

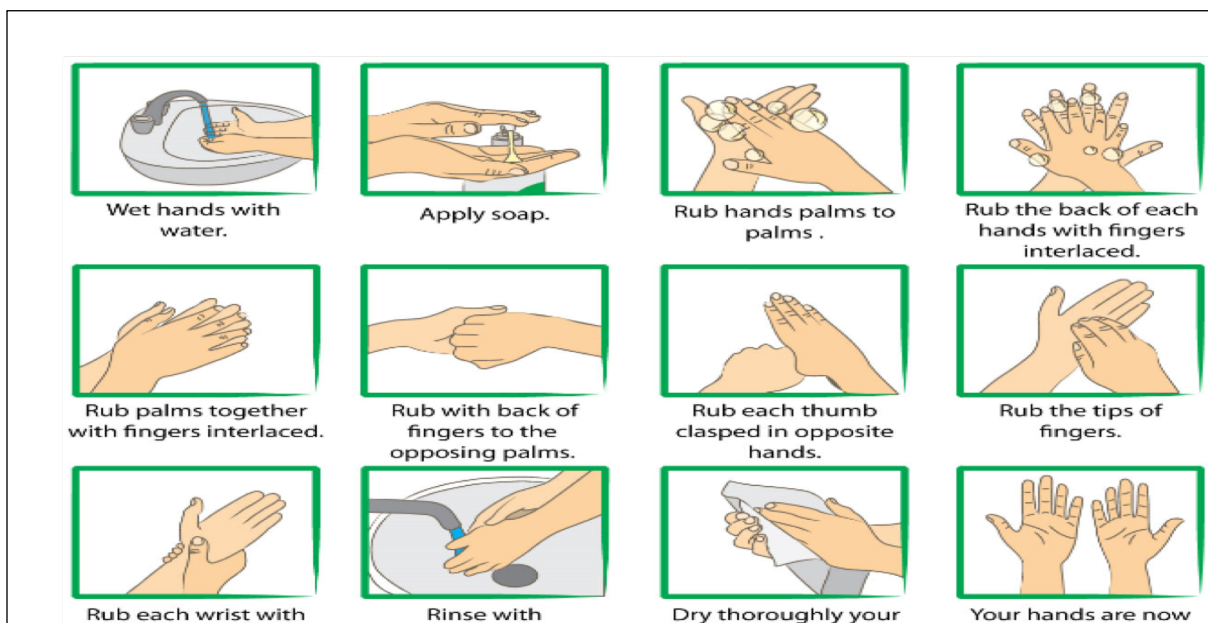


Figure 20: Hand washing practice Organization

Gloving

- Wear gloves for any procedure that risks touching blood, other body fluids, mucous membranes, broken skin, soiled items, dirty surfaces, or waste. Wear surgical gloves for surgical procedures such as insertion of implants. Wear single-use examination gloves for

procedures that touch intact mucous membranes or generally to avoid exposure to body fluids. Gloves are not necessary for giving injections.

- Change gloves between procedures on the same client and between clients.
- Do not touch clean equipment or surfaces with dirty gloves or bare hands.
- Wash hands before putting on gloves. Do not wash gloved hands instead of changing gloves. Gloves are not a substitute for hand washing.
- Wear clean utility gloves when cleaning soiled instruments and equipment, handling waste, and cleaning blood or body fluid spills.

1. Processing of reusable instruments:

Decontamination: This kills infectious organisms such as HIV and hepatitis B, thus, making instruments safer for people who uses them. Soak in 0.5% chlorine solution for 10 minutes. Rinse with clean water and clean immediately.

Cleaning: Ensures the removal of body fluids, tissue, and dirt. Wash or scrub with a brush and 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 such as goggles, mask, apron, and enclosed shoes.

High-level disinfection: This kills all infectious organisms except some bacterial endospores (a dormant, resistant form of bacteria) by boiling, by steaming, or with chemicals. This disinfect instruments that touch intact mucous membranes or broken skin, such as vaginal specula, uterine sounds, and gloves for pelvic examinations.

Sterilization: This kills all infectious organisms, including bacterial endospores, with a high-pressure steam autoclave, a dry-heat oven, chemicals, or radiation. It kills germs on scalpels and needles that touch tissue beneath the skin.

2. Waste disposal

Improper disposal of contaminated sharp objects can cause infections in facility and the community. Use personal protective equipment (such as goggles, mask, apron, and closed protective shoes) when handling wastes.

- Needles and syringes meant for single use must not be reused.
- Do not take apart the needle and syringe.
- Used needles should not be broken, bent, or recapped.
- Put used needles and syringes immediately into a puncture-proof container for disposal. (If needles and syringes will not be incinerated, they should be decontaminated by flushing with 0.5% chlorine solution before they are put into the puncture-proof container.)
- The puncture-proof sharps container should be sealed and either burned, incinerated, or deeply buried when three-fourths full.
- Dressings and other soiled solid waste should be collected in plastic bags and, within 2 days, burned and buried in a deep pit.
- Liquid wastes should be poured down a utility sink drain or a flushable toilet or poured into a deep pit and buried.
- Clean waste containers with detergent and rinse with water.
- Remove utility gloves and clean them whenever they are dirty and at least once every day.

- Wash hands before and after disposing of soiled equipment and waste

3. Housekeeping:

Housekeeping is the general cleaning and maintenance of cleanliness in the facility and its environs. In addition to cleanliness, the purpose of housekeeping is to reduce the number of microorganisms in the facility (thus reducing risks of infections among clients and staff members) and provide an appealing work and service-delivery space.

General Housekeeping Guidelines

- Cleaning schedules should be created and posted where all staff responsible for housekeeping can see them, and closely followed.
- Always wear gloves (preferably heavy utility gloves) and shoes when cleaning client-care areas.
- Cleaning should be done in a way that minimizes the scattering of dust and dirt that may contain microorganisms.
- Use a damp or wet mop or cloth to clean walls, floors, and surfaces; avoid dry-dusting or sweeping, which increases the spread of dust and microorganisms.
- Scrubbing is the most effective way to remove dirt and microorganisms. Scrubbing should be a part of every cleaning procedure.
- Wash surfaces, such as walls, from top to bottom so that debris falls to the floor, where it can be cleaned up last. Similarly, clean highest fixtures first and work down – for example, clean ceiling lamps first, then shelves, then tables and then the floor.
- Change cleaning solutions when they appear dirty. The disinfectant's ability to kill potentially infectious microorganisms is reduced when the solution contains a lot of soil.
- Wash linens (such as bedding, caps, gowns, and surgical drapes) by hand or machine and line-dry or machine-dry. When handling soiled linens, wear gloves. Hold soiled linens away from your body, and do not shake them.

4. Use new auto-disable syringes and needles for injectables

- Auto-disable syringes and needles are safer and more reliable than standard single-use disposable syringes and needles, and any disposable syringes and needles are safer than sterilizing reusable syringes and needles. Sterilizing and reusing syringes and needles should be avoided.
- Cleaning the client's skin before the injection is not needed unless the skin is dirty. If it is, wash with soap and water and dry with a clean towel. Wiping with an antiseptic has no added benefit.

5. Wipe surfaces with chlorine solution

- Wipe examination tables, bench tops, and other surfaces that meet unbroken skin with 0.5% chlorine solution after each client.

Session 2: Quality Assurance of Family Planning Services

Learning Objectives

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

1. Define the meaning of quality assurance
2. List three importance of quality assurance in family planning
3. Describe the quality assurance functions
4. Outline the quality assurance dimensions and protocols

Estimated Time: 60 minutes

Overview of session

When the quality of FP services is maintained, it will lead to sustainable service. Good quality of care leads to client satisfaction, increase in knowledge about FP services among the client and effective, long and regular use of family planning devices. Also, it ensures safety, decrease in morbidity and mortality and increase in service coverage. PPMVs must plan quality assurance into their FP service provision in order to achieve these benefits.

Methodology

- Lectures
- Brainstorming
- Discussion

Materials required

- Flip charts
- Markers
- Handouts
- LCD Projector and Projector screen
- Laptop

CONTENTS

Family planning (FP) can be defined as the voluntary decision made by the responsible individuals and couples in order to determine the desired family size and timing/spacing of births. FP is mainly about planning a family through determining the total number of desired family members and timing and spacing of the children. Because of the importance of FP, good quality of family planning services cannot be over-emphasized. Family planning services like uptake of contraceptives (barrier methods, emergency and oral pills, and injectables) can be achieved at drug shops manned by PPMVs. As a result of this, there is a need to maintain standard quality checks and specific quality assurance methods. Maintaining quality in FP services means ensuring or keeping to standards in service provision that will result in 'meeting with the need of the clients/couples.

Elements of quality care in FP services

There are six elements of quality of care in FP services, which are:

- Choice of method
- Interpersonal communication (verbal & non-verbal)
- Technical competence
- Information
- Follow-up
- Appropriate constellation of services

Functions of Quality Assurance

Quality Assurance (QA) has three major functions: defining quality, measuring quality and improving quality. For quality assurance to be effective all these functions need to be undertaken in a balanced and steady way.

Quality Assurance Triangle



Each core function represents a constellation of activities. The triangle shape indicates that rather than a unique sequence of steps that initiate QA activities, all core functions need to take place in a balanced manner for a QA strategy to be effective. The greatest impact on quality of care results only when all three functions are implemented in a coordinated fashion.

Defining Quality means developing expectations or standards of quality. Standards can be developed for inputs, processes, or outcomes (expected outputs, results or impact on health status); they can be clinical or administrative. Standards state the expected level of performance for an individual, a facility, or an entire health care system. A good standard is reliable, realistic, valid, clear, and measurable. Standards of quality can be developed for each of the nine dimensions of quality shown below, which cover widely recognized attributes of quality of care.

Dimensions of Quality Assurance

There are eight dimensions of quality assurance. These include:

- Technical competence
- Access to services
- Effectiveness
- Interpersonal relations
- Efficiency
- Continuity of services
- Safety
- Amenities
- Choice of service

Improving Quality uses quality improvement methods (problem solving, process re/design or re-engineering) to close the gap between the current and the expected level of quality (defined by the standards). This core function applies quality management tools and principles to:

- identify/determine what one wants to improve
- analyze the system of care/problem
- develop a hypothesis on which changes (solutions) might improve quality
- test/implement the changes to see if they really yield improvement; and
- based on the results of testing, decide whether to abandon, modify, or implement the solutions

Measuring Quality consists of quantifying the current level of performance or compliance with expected standards. This process requires identifying indicators of performance, collecting data, and analysing information. Measuring quality is linked with defining quality because the indicators for measuring quality are related to the specific definition or standard of quality under study. Different methods/sources of data for assessing quality in FP services can be:

Commodity record data
 Client exit survey
 Client follow-up survey
 Program reports
 Population based data
 Client flow analysis
 Provider self-assessment
 Client-provider assessment

Quality Assurance Protocol

The quality assurance protocol includes:

- Need for continuous training of providers
- Supportive supervision
- Client exit interviews
- Annual internal and bi-annual external audit of FP service provision

Quality assurance protocol is based on global standards for improving service provision

And these standards include

- technical competence
- client safety
- informed choice
- privacy and confidentiality
- continuity of care

Advantages of Quality Assurance in FP Services

Advantages of quality assurance in FP services are:

- Increases client satisfaction
- Increase in service coverage
- Longer use of FP devices and rise in Contraceptive Prevalence Rate (CPR)
- Decrease in number of unintended pregnancies
- Rise in number of more clients
- Monitors the present situation

MODULE 13

REFERRAL, LINKAGES BETWEEN PATENT MEDICINE SHOPS AND FAMILY PLANNING FACILITIES.

Learning Objective

By The end of the session, participants should be able to:

1. Explain the concept of linkages
2. Describe the process of referral
3. Discuss the process of linkages between PPMVs and FP facilities within Nigeria health system
4. List the advantages of linkages between the PPMV shop and FP service facilities .

Time: 120 minutes

Methodology

- Brainstorming
- Lecture
- Questions and Answers Session

Materials

- Flip chart stand/paper
- Markers (Various Colours)
- Laptop computer
- Projector and projector screen
- Referral forms

Contents

Referrals and Linkages

Referral is the process by which clients' need for particular health services are assessed and prioritized, and clients are provided with assistance to access the service. It is premised on the availability of functional referral systems, facilities and community level support services for the FP client, the provider and the facility. Referral should also include proactive actions necessary to facilitate initial contact with support service providers. Clients who are receiving care and treatment in primary health centres should be able to access secondary and tertiary level facilities for more advanced services, as the situation requires. Clients in health facilities should be linked to access non-medical support services that exist outside the facilities such as legal aid, Income Generating Activities etc.

A good linkage and network system among the service delivery points is necessary for quality family planning service delivery and sustainability.

If family planning services are not available on site, it is imperative for the provider to identify where the client can obtain such services. Each facility should endeavour to provide appropriate referrals and find out if clients access services which they are referred for.

Clients who are receiving FP services in primary health centres should be able to access secondary and tertiary level facilities for more advanced services, as the situation requires.

Rationale for linkages

In Nigeria, limited access to family planning/sexual reproductive health and HIV services is one of the contributory factors for the unacceptably high disease burden and maternal and child mortalities. To enable health workers/PPMVs offer quality FP services, an effective referral system, adequate infrastructure and other relevant resources should be in place. Furthermore, there is need for strong linkages between the various levels of the health care system to achieve quality FP/reproductive, maternal, new-born and child health, and nutrition services.

Advantages to the Clients

- Referral increases the client's chances of receiving better care.
- Sometimes it decreases the overall cost of medical services.
- It increases client satisfaction
- Decreases the burden of diseases
- Decreases morbidity and mortality rates

Advantages to the Health System

- It allows cross-fertilization of ideas between health care providers.
- It instils confidence in the health care system i.e. both providers and clients are assured of access to quality services.
- It allows for good record keeping and access to data.
- It allows for the tracking of disease conditions e.g. disease outbreaks or epidemics.
- It facilitates better planning with health data and resource allocation

Advantages to Providers

- There is better interaction and transfer of knowledge among providers.
- Providers are better satisfied and motivated
- It allows the clients to have confidence in the providers.

Constraints of Referral

- The client and the community may think that the referring provider is incompetent
- The clients sometimes do not go to the referral site.
- It may create the impression to the client that the case is very serious.

Process of Referral

The process of referral involves a step-by-step information on how a provider sends a client to the next level of care for further management. The essence of the process is to enable the provider to know when to refer, where to refer, how to refer and to be able to give accurate information to the clients and their relations.

When to Refer

Health care providers must identify their limits during the management of any given case in accordance with the provision of the Standard of Practice. Subsequently, every provider must refer a client at the right time and to the appropriate level of care.

Where to Refer

Levels of referral are in consonance with the tiers of care within the National Health Care System. This is from community level through to tertiary institutions and Specialist Hospitals. Given circumstances in your community, accredited private hospital networks may also serve as referral or receiving point.

Accessibility/Location

Providers need to be aware of their environment and this should include infrastructure, services and expertise available, and accessibility of the service delivery point to the clients. In this regard, it is recommended that each Local Government Area (LGA) should display a map of all facilities within the LGA and that of neighbouring LGAs.

How to Refer

Any client for referral must have the appropriate form filled by the provider describing his/her bio-data, situation at contact with service delivery point, services already rendered and reasons for referral. In addition, the provider must give other salient information which could include where the clients is going, what to expect, likely cost of services to be rendered and the need for the client to return with the appropriate portion (duly completed) in the two-way referral form.

What to expect

Providers should provide information on what the client should expect at the point of referral. This may include types and number of examinations/investigations to be carried out, that there may be need for admission or surgery, or the need for blood donation/transfusion and the likely cost of drugs that may be prescribed. These will help the clients prepare for their obligations at the referral centre. If the client's condition is so bad that he/she cannot comprehend, as much information as possible should be given to the relation(s). In emergencies, it may be necessary for the provider to make provision for someone to accompany the client.

PATENT MEDICINE VENDORS REFERRAL ALGORITHM FOR FAMILY PLANNING SERVICES

Indications for referral

- a. Demand for prescription contraceptives
- b. Irregular/Absence menses
- c. Vaginal bleeding
- d. On prescription contraceptives with related and incidental complaints
- e. Post abortion care

TIER 1 PMV SHOP

TIER 2 PMV SHOP

TIER 3 PMV SHOP

PRIMARY & PRIVATE HEALTH FACILITIES WITH FP SERVICES

SECONDARY/TERTIARY HEALTH FACILITIES WHERE FAMILY PLANNING SERVICES AND HIV SERVICES ARE AVAILABLE

PRIVATE HEALTH FACILITY WITH FAMILY PLANNING SERVICES

Fig 22: Showing the referral pathways for PPMVs**Summary**

If family planning services are not available on site, it is imperative for the provider to identify where the client can obtain such services. There is need to establish collaborative relationships and networks. Each facility should endeavor to provide appropriate referrals and find out if clients access services at the referral site.

Appendix One

Participants Feedback on Training Program

1. Describe **the most important thing** you learnt from this workshop

2. List **one thing** you liked about the workshop

3. What do you think can be done to improve a similar workshop in the future?

4. As a result of participation in the workshop, which one of the following statements best apply to you (**choose only one option**)

- a. I have limited understanding of my role as a tier 2 PPMV in the provision of family planning services
- b. I have some understanding of my role as tier 2 PPMV in the provision of family planning services
- c. I have a full understanding of my role as tier 2 PPMV in the provision of family planning services
- d. Not sure

5. Please assess the following components of the workshop

	Your assessment (Please tick as appropriate)			
Components of workshop	Poor	Good	Very Good	Excellent
Venue				
Group work				
Tea break				
Topics/contents				
The lectures				
Facilitators				

Duration of workshop				
Interactions among participants				
Clinical component				

6. What is general comments on the workshop_____

Appendix Two

The Individual Records System
Family Planning Client Record, Page 1

Form 1

Date __DD__ / MM__ / __YY__

Client Reg. Number

Facility Name _____

Surname Name _____

First Name _____ Middle Name _____

Telephone No: _____

Address (or key landmark) _____

Age: _____ (Estimate if not known)

Date of birth: _____

Educational Level (highest completed level): _____

Religion (Tick as appropriate): Islam _____ Christianity _____ Other (specify)

How did you learn of this family planning service? (Source of referral)

_____ Clinic Personnel _____ Outreach Personnel _____ Radio _____ TV

_____ Print Media _____ Friend/Relative _____ Other Clinic

_____ Community Health Worker _____ Other (specify)

Reproductive History:

_____ No. of pregnancies carried to 28 weeks gestation (parity)

-----No. of children born alive

_____ No. of children still living,

_____ No of miscarriages/stillbirths/abortions

Month/Year last pregnancy ended: _____ / _____

Result of last pregnancy(Tick as appropriate):- Normal _____

Assisted _____

Menstrual Cycle: _____

Duration: _____

_____ Regular _____ Irregular

Last Menstrual Period (LMP): _____ / _____ / _____

Are you currently breastfeeding? _____ Yes _____ No

Client Reg. Number

Family Name

Do you want to have more children?

_____ No

_____ Yes, but later (spacing)

_____ Not sure

_____ Yes, now

Contraceptive use prior to this visit?

_____ No _____ Yes (Specify most recent method used)

Method: _____

Source: Public _____ Private _____ Other (specify) _____

CONSUMPTION RECORD																		MON
			LGA															
				Quantity sold on every working														
Product Name	Unit	Begin Bal	Qty Rec'd	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15
		A	B															
				Q1+Q2+Q3+Q4+.....														
Condom Female	Piece																	
Condom Male	Piece																	
Neo-Provera 150mg syringe	Vial																	
ana Press 104mg inj.																		
iton/Microlut/Ovrette	Cycle																	
D	Piece																	
rogynon	Cycle																	
isterat 200mg + syringe	Ampoule																	
lanon NXT	Piece																	
elle Implant	Piece																	
le Beads	Piece																	
sumables Kit	Piece																	

REQUISITION, ISSUE AND REPORT FORM – SERVICE DELIVERY POINTS

Reporting Period		Starting Month				Ending Month				Year					
SDP Name						LGA				State					
Columns		A	B	C	D	E	F	G	H	I	J	K	L	M	N
N°	Product Description	Stock balance at the beginning of the 2 months	Quantities received during the last 2 months	Cons over the past 2 Months	Losses	Stock on Hand	Physical Count	AMC	Max Qty	Order Quantity	Unit	Unit Price	Value item ordered	To Be completed by the supplier.	
						A+B-(C+D)		C + 2	G x 4	H - F			I x K	Qty Supplied	Value Supplied
1	Condom Female										Piece	00			
2	Condom Male										Piece	00			
3	Depo-Provera 150 mg inj+ syringe										Vial	00			
4	Sayana Press 104mg SC inj.														
5	Exluton/Microlut/Ovrette										Cycle	00			
6	IUCD										Piece	00			
7	Microgynon										Cycle	00			
8	Noristerat 200 mg inj + syringe										Amp.	00			
9	Implanon NXT										Piece	00			
10	Jadelle Implant										Piece	00			
11	Cycle Beads										Piece	00			
12	Consumables Kit										Piece	00			
										TOTAL				TOTAL	
REQUISITION							ISSUE								
Prepared by				Date				Prepared by				Date			
								Supplied by				Date			
Authorized by				Date				Received by				Date			
Comments:															

* When you start a new form, stock balance at the beginning of the 2 months (A) must always be equal to Physical Count (F) from the preceding reporting period's RIRF

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