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Trip Report

0-407

Travelers: Ms. Maureen T. Brown,
INTRAH Program Officer
Ms. Betty Farrell, IHP Consultant

Country Visited: Benue State, Nigeria

Date of Trip: October 31 - November 11, 1987

Purpose: To conduct a Mid-Project Review of the Benue State CS/ORT/CHE Project.

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LIST OF ABBREVIATIONS

CHA	Community Health Aide or Community Health Assistant
CHE	Community Health Education
CS	Child Spacing
HSMB	Health Services Management Board
IEC	Information, Education and Communication
IUCD	Intra-Uterine Contraceptive Device
MOH	Ministry of Health
ORT	Oral Rehydration Therapy
PPFN	Planned Parenthood Federation of Nigeria
SET	State Evaluation Team
SOM	School of Midwifery
SON	School of Nursing
STT	Benue State Training Team
TOT	Training of Trainers

EXECUTIVE SUMMARY

INTRAH Program Officer Maureen T. Brown and IHP Consultant Betty Farrell visited Makurdi, Benue State November 1 - 11, 1987 for the purpose of conducting a mid-project review of the CS/ORT/CHE training project.

Working in collaboration with the State FP Coordinator and several members of the State Evaluation Team (SET), the following were accomplished:

- project objectives achieved to date were determined;
- interviewed members of the State Training Team (STT), State Evaluation Team (set), service provider graduates of the CS/ORT and CHE workshops and senior project managers and obtained feedback concerning the training received and problems experienced;
- observed core STT members conducting their first independent CS/ORT workshop; assessed three STT members while performing IUCD insertion; visited five MCH/CS clinics to assess their suitability and readiness for on-the-job IUCD training;
- held meetings with School of Nursing/School of Midwifery staff to determine degree that CS/ORT content/skills are being integrated into the pre-service curricula;
- discussed in detail the findings of the project review with senior MOH/HSMB officials, and made recommendations concerning project-related problems; and
- debriefed with AAO/Lagos.

Major findings of the visit indicated that the project is progressing well, on schedule and under budget (the latter because of exchange rate differences in the naira and dollar). Project objectives are, on the whole, being achieved as measured against anticipated program and operational objectives. Several project objectives only partially achieved to date include a SET not yet fully

functional and in need of direction, budget and time to conduct evaluation activities; and, STT clinical preceptors not adequately prepared to conduct on-the-job IUCD training planned for November/December 1987.

Major recommendations include the following: the project should be funded to its planned completion, facilitated by development of an on-going CS/ORT training workplan for implementation by the MOH/HSMB STT on completion of the INTRAH-MOH project in March 1988; development of post-training function descriptions for the STT and CHE service providers; provision of a budget for the SET for implementation of the evaluation workplan; and, provision of technical assistance to the STT clinical preceptors for a CS clinical up-date and assistance in preparation of a curriculum for on-the-job IUCD training.

SCHEDULE OF ACTIVITIES

October 30 Departed USA for Nigeria at 3:15 p.m.

October 31 Arrived Lagos at 8:15 p.m.

November 1 Departed Lagos at 2:15 p.m. for Makurdi.

Arrived Makurdi at 3:30 p.m.

Initial briefing meeting with Project Review Team member Ms. Betty Farrell and IHP Consultant (already in Makurdi).

November 2 Briefing and review meeting with MOH/HSMB State Evaluation Team and State FP Coordinator. Met with:

- Mrs. Susannah O. Attah, State Family Planning Coordinator;
- Ms. Justina S. Abeda, Deputy State Family Planning Coordinator;
- Mr. Felix B. Gbillah, Chief Tutor, SON, and Chairperson of the SET;
- Mrs. Susan Ibrahim, Principal Health Sister;
- Ms. Victoria Kuwua Shaku-Nor, Midwifery Tutor/Assistant Chief Public Health Nursing Tutor;
- Mrs. Rosaline U. Gbadamosi, State EPI Manager;
- Mrs. Awa Aruwa, Family Planning Clinic, General Hospital;
- Mr. Joshua L. Kon, Principal Nutrition Officer, Epidemiology Unit;
- Mrs. Stella G. Ogbaje, Senior Matron, General Hospital.

Met with Benue State Training Team Trainers at School of Nursing during preparations for CS/ORT Workshop:

- Ms. Sara Tebu, Midwifery Tutor;

- Ms. Victoria Kuwua Shaku-Nor, Midwifery Tutor and IEC Coordinator;

- Mr. Justin Loho, Principal Nursing Tutor.

November 3 State Public Holiday.

Meeting at Ministry of Health to discuss project financial and technical reports (Brown only). Met with:

- Mr. Stephen A. Orsule, Senior Accountant;

- Mrs. Susannah Attah, Family Planning Coordinator.

Visited School of Nursing to observe three members of the State Training Team prepare for the CS/ORT workshop, and met with five nurse-midwife participants.

November 4 Site visit to North Bank MCH/CS Clinic to observe CHE activities and assess readiness of clinic for on-the-job IUCD training. Met with:

- Mrs. Susan Ibrahim, Principal Health Sister and STT member;

- Mrs. Jullianna Itolo, Senior Community Health Sister and CS/ORT Service Provider;

- Mrs. Becky Heinyi, Senior Community Health Officer and CS/ORT Service Provider.

Site visit to Gboko MCH/CS Center to assess readiness of clinic for on-the-job IUCD training and to interview STT member. Met with:

- Mrs. Bridget Tilley-Gyado, Family Planning Senior Nurse Midwife and STT member;

- Mrs. Rifkntn Alkassan, Community Health Nurse Midwife and CS/ORT Service Provider;

- Mrs. Hannah Humbe, Senior Sister - Midwife and CS/ORT Service Provider;

- Mrs. Grace V. Akegh, Community Health Sister and CS/ORT Service Provider.

November 4 Observed afternoon session of CS/ORT Clinical Skills workshop.

November 5 On-site visit to the EPI Unit, MOH, to interview community health aides (graduates of CHE workshop). Met with:

- Ms. Rosaline U. Gbadamosi, State EPI Manager and SET member;
- Ms. Sarah M. Sereki, Community Health Aide and CHE Service Provider;
- Mrs. Esther O. Ibu, Community Health Aide and CHE Service Provider;
- Ms. Grace S. Nyamor, Community Health Aide and CHE Service Provider.

On-site visit to Makurdi MCH/CS Center, HSMB to observe CS activities and assess readiness of clinic for on-the-job IUCD training. Met with:

- Mrs. Esther Onaji, Community Health Sister and STT member;
- Mrs. Nancy Sugh, Senior Nursing Sister and CS/ORT Service Provider.

On-site visit to Makurdi General Hospital, MOH to interview CS/ORT trainee and assess readiness of FP clinic for on-the-job IUCD training. Met with:

- Mrs. Awa Aruwa, Senior Nursing Sister and STT member;
- Mrs. Victoria Damicor, Staff Midwife;
- Mrs. Margaret Dutsa, Community Health Sister;
- Mrs. Patience Ogenyi, CS/ORT Trainee, Basic Health Clinic, Igumale.

On-site visit to PPFN Clinic to assess FP clinic readiness for on-the-job IUCD training. Met with:

- Mrs. Lydia Orphin, Principal Health Sister and STT member;

- Mrs. E. Yasin, Senior Nurse In-Charge.

On-site visit to Nigerian Army MRS Unit to interview CS/ORT trainee. Met with Mrs. Margaret Makundo, HSMB Community Health Sister.

Site visit to Nigerian Army Engineers MRS Family Planning Clinic to interview CS/ORT trainee. Met with Mrs. Ann Adzam.

Meeting at SON to discuss and review the project training workshops, process, and identify constraints. Met with STT and SET members:

- Mrs. Aruwa, STT
- Mrs. Ibrahim, STT
- Mr. Loho, STT
- Mrs. Onaji, STT
- Mrs. Orphin, STT
- Mrs. Kuwua, STT
- Mrs. Tebu, STT
- Mrs. Ogbaje, SET
- Mr. Gbillah, SET
- Mrs. Attah, FP Coordinator

November 6

Met at the Ministry of Health with members of the SET to review the week's activities and brief on findings and recommendations. Met with:

- Mr. Gbillah
- Mrs. Aruwa
- Mrs. Ibrahim
- Mrs. Ogbaje
- Mrs. Attah

Met at Makurdi School of Nursing to discuss SON plans for integration of CS/ORT into basic nursing curriculum. Met with Mr. Andrew Odah, Principal.

Met briefly with CS/ORT workshop trainers and participants during lunch break.

INTRAH/IHP team worked on findings and conclusions of the visit.

November 7 INTRAH/IHP team worked on trip report findings and conclusions.

November 8 INTRAH/IHP team worked on trip report recommendations.

November 9 Met at the Ministry of Health with Senior MOH/HSMB Project Managers to discuss the week's activities, findings and recommendations. Met with:

- Dr. (Mrs.) Rosemary Abdullahi
- Dr. (Mrs.) Mary Ogebe
- Mrs. S. Attah
- Mrs. R. Gbadamosi
- Mr. J. Kon

Meeting at the MOH with Permanent Secretary to brief on the week's activities, findings and recommendations. Met with:

- Dr. N.I. Bur, Permanent Secretary
- Dr. (Mrs.) Abdullahi
- Mrs. S. Attah
- Mrs. R. Gbadamosi

Met with Mr. John Okpanachi, Deputy Principal, SON, to discuss SON plans for CS/ORT curriculum development.

Evening dinner meeting at home of Dr. (Mrs.) Abdullahi. Present were:

- Dr. (Mrs.) Abdullahi
- Dr. Samuel Abdullahi, Ex-Deputy Director, HSMB
- Mrs. S. Attah
- Mrs. R. Gbadamosi

November 10 Met briefly at the hotel with Mrs. Martha Delata, Principal, School of Midwifery, to discuss SOM plans for CS/ORT curriculum development.

Met briefly at HSMB with Dr. (Mrs.) Ogebe to discuss final recommendations.

Briefly interviewed two graduates of CS/ORT project workshops:

Mr. John M. Ejimatswa, (orientation participant) Community Health Officer, Rural Health Center, Abejkoto, HSMB;

Mrs. Rhoda Yaasa, (CS/ORT participant) Zakibiam, HSMB.

Departed Makurdi at 1:30 p.m.

Arrived Lagos at 3:15 p.m.

November 11 Debriefed with AAO/Lagos with Ms. Keys MacManus, AID Affairs Officer.

Departed Lagos for USA at 11:55 p.m.

I. PURPOSE OF TRIP

The major purpose of this visit was to conduct a mid-project review of the Benue State CS/ORT training project.

Major objectives were to:

1. assess the extent of progress achieved in meeting project objectives;
2. identify project-related problems and problem-solve unmet objectives;
3. assess the extent of training applied to on-the-job performance; and
4. formulate recommendations pertaining to project-related activities.

II. ACCOMPLISHMENTS

In collaboration with members of the MOH/HSMB State Evaluation Team (SET), State Training Team (STT), State FP Coordinator, and senior project managers, the following was accomplished:

A. Reviewed in detail project objectives achieved to date and confirmed current status of anticipated program and operational outcomes.

B. Met with 8 members of the State Evaluation Team and reviewed accomplishments to date; discussed SET post-training function; identified constraints; and discussed future plans for monitoring and evaluation of training activities.

C. Met with 11 members of the Benue State Training Team and obtained feedback concerning TOT training received, reviewed training activities and accomplishments achieved to date, discussed the team's post-training function; identified constraints to training and the

STT recommendations for solving constraints; and planned for futura project training activities.

D. Observed 3 members of the core STT during first independent implementation of a CS/ORT workshop for 12 nurse midwife service providers.

E. Interviewed 10 CS/ORT and 3 CHE service providers and obtained feedback regarding the training received; post-training application of CS/ORT or CHE activities; solicited recommendations for training program improvement; and observed 1 CS/ORT nurse midwife perform a physical exam.

F. Observed and assessed 2 STT preceptors during CS/ORT service delivery activities, including IUCD insertion technique.

G. Visited 5 MCH/CS clinics and assessed the suitability and readiness of each for on-the-job IUCD insertion training.

H. Met with the Principal and Deputy Principal of the School of Nursing (SON), and the Principal of the School of Midwifery (SOM), to determine the extent that principles and practice of CS/ORT have been or will be integrated into the basic nursing program curriculum.

I. Debriefed senior MOH/HSMB administrative project managers and the Permanent Secretary in regard to the project review findings and conclusions; discussed identified project-related constraints and made recommendations for correction of these; reviewed and revised the schedule for upcoming project training activities; and discussed future CS/ORT training plans of the Benue State MOH.

J. Debriefed with AAO/Lagos.

III. BACKGROUND

This mid-project review is Activity #12 of the Benue State MOH-INTRAH CS/ORT Training Project. It follows the completion of 3 TOT activities (1 TOT for senior MOH/HSMB trainers; 1 for the Benue State Training Team and 1 for the Benue State Evaluation Team); 5 MOH/HSMB/NGO orientation seminars; 2 CS/ORT service providers workshops and 2 CHE training workshops. Details of these activities are reported in INTRAH Trip Reports #0-401, #0-402, #0-403, #0-404, #0-405, #0-406, and #0-273.

IV. DESCRIPTION OF ACTIVITIES

A. AAO/Lagos

No briefing was held as Ms. Farrell was in-station in Makurdi and Ms. Brown was in transit through Lagos during a weekend.

At the debriefing, Ms. MacManus, AAO, was given a verbal summary of the findings, conclusions and recommendations of the Benue State CS/ORT project review. Ms. Farrell also briefed the AAO regarding the CS/ORT workshop conducted October 5 - 30, 1987, (contract workplan Activity #11). It was learned from Ms. MacManus that the Benue State Commissioner of Health, Dr. C.H. Bello, was currently attending an STD seminar in the United States. It was hoped that his participation would highlight the need for a STD prevalence study in Benue State, particularly in light of MOH future plans to expand on-the-job IUCD training for CS service providers.

B. Ministry of Health/Health Services Management Board

As senior Benue State project management staff were out of the state during the week planned for the review, a decision was made to meet and work with the state FP

Coordinator and members of the State Evaluation and State Training Teams. At the initial meeting between the INTRAH/IHP team and the Benue State FP Coordinator, and State Evaluation Team, the purposes of the review were clarified; project objectives were reviewed in detail and the degree of accomplishments discussed; a partial list of project-related problems was compiled and a workplan for the one-week review developed. It was agreed that the INTRAH/IHP team would visit clinics, trainers and trainees for assessment and feedback, and would be accompanied by the State FP Coordinator and/or a member of the SET. Opportunity was taken during this meeting to review the SET accomplishments to date (reported in section V, G. of this report).

Three days were devoted to visiting 5 CS/MCH clinics to assess their suitability to offer on-the-job IUCD training experience for 5 CS service provider participants (Activity #15 of the contract workplan). Details of the statistics for each clinic and contraceptive service are described in Appendix C.

Opportunity was taken during these visits to interview and observe graduates of the CS/ORT workshops (see section V, H.). Three of the STT preceptors were observed while performing IUCD insertion and one CS/ORT graduate was observed conducting a physical examination of a prospective Depo-Provera client.

Several informal sessions were held with the core STT members, and one major group meeting was held with eight members of the STT, State FP Coordinator and two members of the SET to identify individual and group accomplishments to date, and to discuss specific areas of constraints affecting the training process. Findings are elaborated in Section V of this report.

A debriefing meeting was held with the SET to describe the findings of the week's activities and to discuss recommendations related to the findings.

Two major debriefing meetings were held, one with senior MOH project managers and one with the Permanent Secretary, to describe the findings of the week's review activities, to confirm/clarify aspects of project achievement, to discuss areas of identified project constraints and to reach consensus regarding ways and means to solve project-related problems. Points covered and recommendations made in these debriefings are summarized as follows:

a) The project is progressing well, on schedule as planned and apparently under budget. Almost all project objectives have been fully or partially achieved when measured against anticipated program and operation outcome targets (see Appendix D). These include establishment of a functioning STT; 60 CS/ORT/CHE service providers have been trained; 230 MOH/HSMB/NGO personnel have been oriented to the CS/ORT Benue State CS/ORT program; a SET has been trained and has conducted one trainee follow-up study; CS and CHE protocols have been developed; CS/ORT/CHE curricula have been developed; plans are in progress to integrate CS/ORT into the pre-service curricula of the SON and SOM, and CS/ORT services are now available to at least 15 new CS service delivery points throughout the state. Interviews with STT members, SET members, participants who attended the CS/ORT, CHE and orientation workshops revealed highly positive responses to the training received, its relevance to work performed and knowledge and skills acquired.

b) Project objectives partially achieved to date include a SET not fully functional, no follow-up of CS/ORT/CHE trainees to ascertain the impact of training on CS service delivery, and STT clinical preceptors inadequately prepared to conduct on-the-job IUCD training.

c) Project-related constraints identified include some unresolved coordination and communication problems between project managers and STT members; unclear or lack of post-training function

descriptions for the STT and CHE trainees, a lack of budget for SET to conduct monitorings and evaluation follow-up, and, low numbers of IUCD acceptor clients for on-the-job IUCD training.

d) It is recommended that the project be funded to its planned completion in March 1988 facilitated by development of an on-going MOH training workplan, provision of budget for implementation of the SET workplan, development of post-training function descriptions for the STT and CHE trainees, provision of technical assistance to the clinical preceptors to help them prepare for on-the-job IUCD training, and investigation into what appears to be declining numbers of IUCD acceptor rates.

V. FINDINGS/CONCLUSIONS AND RECOMMENDATIONS

A. AAO/Lagos

1. Findings/Conclusions

The AAO/Lagos was debriefed regarding the current status of the Benue State CS/ORT project including accomplishments to date, constraints and problems experienced, recommendations made and action to be taken to implement the remaining project activities. Concern regarding the issue of IUCD training and the unknown STD prevalence rate in Benue was discussed. The revised schedule and recommendation that Ms. Farrell return to Benue in January 1988 to provide technical assistance to the clinical preceptor was approved by Ms. MacManus (see recommendation #16 of this report). Ms. MacManus was also informed of the shortage of CS commodities being experienced by Benue State.

Recommendations

The issue of IUCD insertion training and prevalence of STDs should be re-examined by INTRAH during the final project review planned for March 1988, and a recommendation made to the MOH of the need for such a study before expansion of on-the-job IUCD training in Benue State.

B. Project Design

2. Findings/Conclusions

It was learned that STT clinical preceptors would have benefitted from a CS clinical skills update prior to or immediately following the TOT. This would have helped to ensure competency levels of all preceptors, uniformity of IUCD insertion technique and standardization in the way CS procedures are taught during clinical practica.

The lack of a budget line item for monitoring and evaluation activities is perceived by the SET as a major constraint to carrying out their function as originally envisaged during the SET training workshop.

The terms "community health aides" and "community health assistants" were used interchangeably in the project contract document and resulted in confusion during the selection of participants for the CHE workshops. This resulted in one batch of each being trained in the two CHE workshops held.

The continuity and quality of the consultants who provided technical assistance for the training activities in this project were greatly appreciated and viewed most positively by MOH/HSMB officials, trainers and participants.

Recommendations

a. In future TOTs for CS/ORT clinical skills, the Lagos model should be followed.

b. A budget for evaluation activities should be built in all future projects.

c. Clarification of terms should be ensured in future project documents.

d. INTRAH should ensure continuity in technical assistance for all future projects whenever possible.

C. Project Management

3. Findings/Conclusions

Project savings accrued from exchange rate differences between the naria and dollar have been used to: conduct three additional orientation seminars, fund an additional three-day training

for CS/ORT workshops (required to cover in-depth content on STDs and other material), and follow-up by the SET of 40 orientation seminar participants. Senior project managers requested that any remaining exchange rate savings be applied to support additional CS/ORT and CHE workshops. The INTRAH/IHP team suggested that given the lack of budget for monitoring/evaluation activities by the SET, and in view of the full training schedule planned for the remaining life of the project, these funds should be used for SET activities, but the question should be discussed with the INTRAH Associate Director of Administration during his visit to Benue in early December 1987.

Coordination and communication linkages between MOH project managers appear to be improving but there remain some issues that need to discussed and resolved. A lack of collaborative planning on matters regarding training activities, unclear policies and decisions concerning selection/notification of participants and per diem payments, and the uncertain future status of the STT were reported, and perceived by STT members as being disruptive to the training process and a source of disaffection among some members of the team.

No plan has yet been developed by the MOH/HSMB for on-going CS/ORT/CHE training following completion of the INTRAH project, although a FP budget has been included in the FY 1988 MOH budget request.

It was learned that Ms. Victoria K. Shaku-Nor had recently been posted from the SON/SOM to the IEC unit of the MOH. Given her strong training skills, CS/ORT and CHE background, she could well be a leader in initiating an in-service CS/ORT/CHE training program and an important bridge in maintaining pre-service/in-service linkages. This may be an opportune time for the MOH to establish such a unit within the FP section, in order to institutionalize CS/ORT/CHE training.

<u>Recommendations</u>

a. A review of the amount of funds accrued from exchange rate differences should be determined by the INTRAH Associate Director of Administration during his visit in December 1987 and a decision made in collaboration with MOH/HSMB project managers regarding the most effective training use of project savings. It is further recommended

that first priority for these funds should be given to the SET to enable them to conduct monitoring and follow-up activities. An estimate of costs should be prepared by the SET and the evaluation workplan implemented as soon as possible.

b. MOH/HSMB project managers should initiate a meeting with all members of the STT in order to:

- clarify the role and post-INTRAH project training function of the STT;

- develop a training workplan for CS/ORT training activities after March 1988 complete with dates, participants, and trainers/ preceptors; and

- arrive at a consensus on administrative policies concerning implementation of workshop activities (including per diem payments, transport and trainer/preceptor responsibilities).

c. Senior project managers should now begin planning the formation of an in-service training unit within the FP Section of the MOH which will be in place on completion of the INTRAH project in March 1988. Plans should include budget, staff, training workplan, job descriptions, support staff, and transport.

D. State Training Team

4. Findings/Conclusions

Feedback from 11 members of the STT interviewed was uniformly positive regarding the TOT and TA received. Comments made by trainers included the following: "I am glad to be a trainer;" "I've learned the difference between teaching and training;" and "I feel more confident working with trainees."

Of the 19 STT trained, 9 were recommended by the IHP trainers to form the core training team (CTT) (5 for CS/ORT; 4 for CHE), 5 were designated as clinical preceptors in clinics located in/near Makurdi, 4 are available only as required because of heavy work commitments or work locations outside of Makurdi, and 1 was not recommended as a trainer. It was noted that STT members who work

at NGO posts were not available to participate in recent training activities; thus, these members are being minimally utilized and skills minimally developed, and the bulk of the training conducted to date has fallen to a few CTT members.

The STT post-INTRAH project training function has not yet been defined which is a cause of concern to the members interviewed. Furthermore, the STT function as it presently exists, is likely to conflict with individual primary job responsibilities, especially in the case of the core team members, if they are expected to conduct the bulk of future CS/ORT training.

Three core STT were observed conducting their first independent CS/ORT workshop using the curriculum developed (and subsequently revised) in the TOT. They worked well as a team, appeared to have a good grasp of the content and process, and displayed strong commitment to providing quality training. It was noted that although clinical preceptors were in place to work with the participants during the clinical practicum, the three trainers (all nurses) also accompanied the trainees to the clinical sites. Some evidence of inefficient pre-workshop planning was noted (late notification of participants which resulted in three participants being excluded from the workshop, last minute duplication of training materials, CS protocol still being typed, etc.). There is obviously a need for improved coordination of workshop tasks, and more timely decision-making and action; this could be accomplished by development of a trainers workshop checklist and more frequent planning meetings between the FP coordinator and STT members.

Experience gained during implementation of the first two CS/ORT workshops indicated that the four-week training period was too short to cover all the content and practice as planned. Three additional days have been added (and funded from project exchange rate savings) to cover more adequately content on STDs, health education, communication, and other clinical skills.

A CS protocol for use by CS/ORT service providers was developed by the STT. This document, an adaptation of the Zimbabwe protocol, needs to be reviewed carefully for clarity and accuracy. A copy is attached as Appendix E.

Only two members of the STT responsible for the CHE training were interviewed, and only one of these observed briefly in an actual training activity. The INTRAH/IHP project review team was unable to make any definitive statements regarding this group's training capabilities, and the reader is referred to trip report #0-404, for findings and recommendations of the IHP/CHE trainer.

Recommendations

a. MOH/HSMB project managers should initiate contact with supervisors of NGO members of the STT and clarify the training role, responsibilities and expectations for these members in conducting CS/ORT/CHE training in Benue State. These matters should also be discussed with supervisors of MOH/HSMB STT members in order to prevent conflict with primary job responsibilities and possible career problems for individual members.

b. The FP Coordinator should meet with STT members to develop a workshop checklist complete with tasks to be performed, by whom and expected date of completion. Samples of a checklist should be sent by INTRAH to STT members for review and adaptation.

c. The CS protocol developed by the STT should be carefully reviewed by all STT members and senior project managers for accuracy, clarity, and any necessary corrections. It should then be distributed to all CS service delivery sites.

d. Follow-up of the STT CHE members should be conducted by the final project review team in March 1988 to ascertain the skills and utilization of this group of trainers.

E. STT-Clinical Preceptors

5. Findings/Conclusions

Of 9 potential STT clinical preceptors, 4 are fully recommended by the IHP clinical trainer as possessing the necessary clinical skills, knowledge and attitudes required to provide quality clinical training. Two of these four work for non-government organizations, and a third works at a clinic 1½ hours outside of Makurdi. Thus, these excellent trainers are not readily available to precept when required and have not

been involved in recent training activities. This is another instance where a training workplan would enable NGO STT members to plan for participation in training and would be an effective tool to help ensure full utilization of all STT members.

Three clinical preceptors who will be among the trainers responsible for on-the-job training were observed performing an IUCD insertion. One performed the procedure while maintaining aseptic technique throughout, one demonstrated correct insertion procedure but broke technique during gloving, and one did not demonstrate correct procedure (by not using a tenaculum during sounding/insertion). As these three preceptors were trained at different times in different places (Philippines, 1985; Zimbabwe, 1985; and Ibadan, date unknown), it is not surprising, however undesirable it may be, that procedural differences are present or that technique had slipped. However, this has serious implications for CS clinical skills training, and unless rectified, will result in poorly and improperly trained CS service providers, a lack of uniformity in IUCD insertion procedure and a lack of standardization in the way that clinical CS procedures are taught.

It was learned that no plans or preparations had been initiated by the trainer-preceptors for on-the-job IUCD training scheduled for November 30 - December 11, 1987. Four of the five preceptors plan to take leave during November or December; several preceptors indicated they felt they needed a CS/IUCD insertion technique clinical skills up-date before undertaking the training of other CS service providers. Given the above findings, it is clear that the on-the-job IUCD training will need to be postponed until technical assistance can be provided for a clinical up-date and assist in the development of a curriculum for this activity.

The above findings were discussed with senior project managers who were in agreement with the recommendations listed below.

Recommendations

a. To address the issues of standardization and uniformity of CS procedures, and uncertainty regarding the skill levels of preceptors in IUCD insertion technique and clinical

training curriculum development, it is strongly recommended that the on-the-job IUCD training should be postponed to January 1988 so that preceptors can be given a CS clinical content up-date and practicum (to include IUCD insertion) by an INTRAH clinical skills consultant. Additionally, the technical assistance consultant should assist the preceptors in the design and preparation of a clinical program for on-the-job IUCD training, including a curriculum complete with objectives, knowledge/skills to be mastered, standards to be met and competency levels to be achieved, and, methods by which the trainees will be evaluated (including a clinical performance appraisal tool).

b. Savings accrued from exchange rate differences should be utilized to fund this activity.

c. Even though not all will be involved in the initial on-the-job IUCD training, all nine potential STT preceptors, including NGO members, should be involved in the CS/IUCD clinical up-date and on-the-job IUCD curriculum development activity. Furthermore, all NGO STT members should be actively involved in the upcoming CS/ORT workshop (now planned for February 1988).

d. It is recommended that, for reasons of continuity and proven strong clinical trainer skills, IHP Consultant Betty Farrell should provide the technical assistance for this assignment.

e. In order to accommodate the preceptors CS clinical up-date and the on-the-job IUCD training, the remaining activities in the INTRAH training workplan should be rescheduled as outlined in Appendix F.

F. MCH/CS Clinics for IUCD On-the-job Training

6. Findings/Conclusions

a. Five MCH clinics frequently used for CS/ORT clinical training were assessed for readiness and suitability to offer on-the-job IUCD training experience for selected CS/ORT nurse-midwife service providers. Four of the five visited offered suitable facilities but only three of these had a sufficient case-

load of IUCD clients to permit IUCD training. Details of each clinic are reported in Appendix C. Perusal of clinic registers at Makurdi General Hospital and Makurdi MCH Center seem to indicate a declining trend in the number of new IUCD clients, but a conclusive pattern was not evident. CS service providers stated that Depo-Provera had gained popularity in recent months.

b. Given the success experienced some months ago, when the MOH/HSMB offered free CS services in the clinics for a limited time, this strategy should again be used to increase the number of CS clients during on-the-job IUCD training.

c. It was reported that Benue State was experiencing a shortage of CS commodities and had not received supplies for some two-three months. The FP Coordinator was aware of the problem and had initiated requests to Lagos for action, apparently without much success. She planned to visit Lagos to follow-up. Four of the clinics visited were using new MIS FP records (samples attached as Appendix G). These are being tested in selected MCH clinics in a pilot project introduced by Mr. Thomas Ubwane, FMOH Statistician.

Recommendations

a. Gboko MCH Center, Makurdi MCH Clinic and the FP Clinic of the Makurdi General Hospital are recommended as clinical training sites for on-the-job IUCD training.

b. The MOH/HSMB should again offer free CS services to the public during the period of on-the-job IUCD training.

G. State Evaluation Team (SET)

7. Findings/Conclusions

It appears that the SET has yet to forge themselves into a working team and lack direction, time and budget. Of the 10 SET members trained, 4 have a dual function as STT members, 4 are potentially available to conduct monitoring and follow-up of evaluation as required, and 2 are unavailable (because of study and maternity leave). Other than the INTRAH initiated follow-up of the orientation seminar participants (see trip

report #0-273), no other training/program evaluation has been conducted to date. However, the 4 STT/SET members have been active at the micro-level during individual training events, but this was more a function of their role as trainers rather than that of evaluators. Major reasons cited for the inactivity were heavy primary job responsibilities and lack of budget. It was clear that this group is willing and capable of conducting evaluation, but require direction from senior project managers and provision of funds.

Recommendations

The SET should meet with senior project managers and STT members in order to:

- review and revise, if necessary, the evaluation workplan developed during the evaluation workshop, and develop a plan of action and schedule for conducting monitoring and follow-up evaluation activities;

- follow-up CHE workshop trainees to ascertain where they have been posted, what CS/ORT/CHE activities they have conducted since the training, and what impact their activities have had in generating CS/ORT service demand;

- meet with the STT trainers during and after each training event to monitor and evaluate the effectiveness of the training; and

- investigate what appears to be declining numbers of IUCD acceptor rates in Makurdi MCH clinics, and make recommendations to MOH/HSMB health planners concerning the feasibility of large-scale on-the-job IUCD training.

H. Graduates of the CS/ORT and CHE Workshops

8. Findings/Conclusions

a. Feedback from 9 CS/ORT graduates indicated very positive feedback regarding the training received. One service provider (working in a Nigerian army clinic) stated that since the training, she had given CS seminars to military officers; had taught clinic staff how to prepare and give ORS; was providing health education talks on CS/ORT in child welfare clinics; and was providing CS supplies to people from her home.

Suggestions made by several graduates for future training included:

- personnel management training;
- HE strategies for CS/ORT training of staff;
- to train more midwives in CS/ORT.

As few CS clients were present during the time of our site visits to CS/ORT graduates, no significant on-the-job performance appraisal was possible.

b. Of the 3 newly-trained CHE community health aides available for interview in Makurdi, only one reported opportunity to practice her newly acquired CHE skills, and that was in a clinic setting. The other two stated they had been posted to the onchoceriasis unit and were not conducting any CHE activities. They also indicated they were unable to work in the community without permission from their supervisor, and had experienced difficulties in obtaining FP commodities and CHE referral slips.

c. Community health aides were trained in the first CHE workshop, at which time it was learned that the participants had difficulty with the content and lacked English language fluency. A decision was made to train community health assistants in the second workshop with the expectation that they would conduct CHE activities in the community. However, as no post-training CHE function has been developed for either of these groups, it was reported that clinic supervisors are reluctant to release them from clinic-based activities to work in the community. At present, it is unknown where or how the CHE trainees are functioning. Given that it was envisaged the CHE graduates would function at least part-time in the community in order to raise CS/ORT awareness and generate demand for CS/ORT services, it is thought important that follow-up of this group be conducted as soon as possible.

Recommendations

a. Senior project managers and CHE trainers should develop a post-training community job description for graduates of CHE workshops.

b. If community health aides are to be trained in future CHE workshops as originally envisaged, the MOH/HSMB STT needs to modify the CHE curriculum to meet the learning needs of this group. To do this, it is recommended that Mrs. Rosaline Gbadamosi work with the CHE STT members. If community health assistants are to be trained, the MOH/HSMB needs to revise their job descriptions to include community CHE activities, and the revised description should be communicated to the clinic supervisors. This issue should be resolved before initiating future CHE training workshops.

c. Senior project managers should communicate to the appropriate officers responsible for MOH/HSMB staff placements, the post-training CHE function of community health aides and assistants, to minimize inappropriate postings and under-utilization of newly-trained CHE workers.

d. The FP Coordinator should follow-up reports of lack of FP commodities and CHE referral slips and should develop a regular supply mechanism, if required.

e. The INTRAH final project review team should attempt to assess on-the-job performance of CS/ORT and CHE graduates. Arrangements for this should be made with MOH/HSMB project managers and SET well in advance of the team's in-country arrival. (See trip report #0-273, section 3).

I. Integration of CS/ORT into the Pre-service/in-service Training Curricula

9. Findings/Conclusions

a. Plans are in progress to integrate CS/ORT into the SON/SOM curricula. Principals of both institutions indicated they are awaiting the new, revised National Nursing Council curriculum, which is reported to contain an expanded CS/ORT component, before taking action. The SON plans to integrate this

curriculum into the core three-year program and add an expanded CS/ORT practice module to the community health nursing course. The Deputy Principal, SON, informed the INTRAH team that he was actively involved in a three-state CS curriculum development committee (which includes members from the National Nursing Council) that has been developing the CS curriculum for introduction into nursing and midwifery schools. This is expected to be ready by August 1988.

b. Having three members of the SON/SOM staff on the core STT, and using the SON/SOM facilities to conduct the CS/ORT/CHE training, has contributed significantly to raising awareness of SON/SOM tutors to the importance and priority of CS/ORT activities.

c. The newly-appointed principal, SON, indicated he found the TOT (for conducting the orientation seminars) he received very useful in his new job, and that he has applied his expanded CS knowledge in seminars for SON tutors. The principal also informed the INTRAH team that he had developed a proposal for submission to the MOH to establish an FP training school at the SON (Appendix H). This proposal appears to be a close duplication of what the MOH/HSMB CS/ORT training program is attempting to accomplish, with the exception that participants may be SON/SOM students who have completed training but cannot be posted to service until nursing/midwifery examination results are reported (a process which takes about six - eight weeks), and who are therefore free to pursue this particular program. Senior MOH/HSMB project managers were not aware of the proposal and expressed the opinion that it was not likely to siphon off training funds from the MOH FP budget.

Recommendations

The INTRAH final project review team should re-examine the progress made by the SON/SOM in integrating CS/ORT content and practice into their curricula. They should also follow-up what, if any, impact MOH approval and funding of the SON proposal will have on the existing CS/ORT training program.

APPENDIX A

Persons Contacted/Met

Appendix A

Persons Contacted/Met

AAO/American Embassy

Ms. Keys MACMANUS, Aid Affairs Officer

Benue State Ministry of Health

Dr. (Mrs.) Rosemary ABDULLAHI, Chief Health Officer, CS/ORT Program Director

Dr. N. I. BUR, Permanent Secretary

Mr. Felix GBILLAH, Chief Tutor/Evaluator

Mr. S. A. ORSULE, Senior Accountant

Health Services Management Board

Dr. Samuel ABDULLAHI, Ex-Deputy Director, HSMB

Mrs. Justina ABEDA, Deputy State FP Coordinator

Mrs. Grace V. AKEGH, Community Health Sister, Gboko MCH/CS Center

Mr. Rifkntn ALKASSAN, Community Health Sister, Gboko MCH/CS Center

Mrs. Awa ARUWA, Senior Nursing Officer, Makurdi General Hospital

Mrs. Susannah ATTAH, FP Coordinator

Mrs. Victoria DAMICOR, Staff Midwife, Makurdi General Hospital

Mrs. Margaret DUTSA, Community Health Sister, Makurdi General Hosptial

Mr. John M. EJIMATSWA, Community Health Officer, Rural Health Center, Abejkoto

Mrs. Rosaline GBADAMOSI, Assistant Chief Public Health Tutor, State EPI Manager

Mrs. Becky HEINYI, Senior Community Health Officer, North Bank MCH/CS Clinic

Mrs. Hannah HUMBE, Senior Sister Midwife, Gboko MCH/CS Center

Mrs. Susan IBRAHIM, Principal Health Sister

Mrs. Jullianna ITOLO, Senior Sister Midwife, North Bank MCH/CS Clinic

Mr. Joshua KON, Principal Nutrition Officer

Mrs. Stella G. OGBAJE, Senior Matron, Makurdi General Hospital

Mrs. Esther ONAJI, Community Health Sister and STT member

Mrs. Lydia ORPHIN, Principal Health Sister and STT member

Ms. Victoria K. SHAKU-NOR, Midwifery Tutor/Information, Education and Communication

Mrs. Nancy SUGH, Senior Nursing Sister, Makurdi MCH/CS Center

Mr. J. A. TANDYER, Chief Community Health Officer

Mrs. Bridget TILLEY-GYADO, Family Planning Senior Nurse Midwife and STT member

Planned Parenthood Federation of Nigeria

Mrs. E. YAASHI, Senior Nurse In Charge

Community Health Aides with EPI Office, Graduates of Community Health Education Training

Mrs. Esther O. IBU

Ms. Grace S. NYAMOR

Ms. Sarah M. SEREKI

Graduate Trainees of CS/ORT Clinical Training

Mrs. Ann ADZAM, Senior Nursing Sister, 72 Airborne

Mrs. Margaret MAKUNDO, Community Health Sister, NASME

Mrs. Rhoda YAASA, Nurse-midwife, Zakibiam

School of Nursing

Mr. Justin LOHO, Principal Nursing Tutor, CS/ORT Trainer

Mr. Andrew A. ODAH, Principal

Mr. John OKPANACHI, Deputy Principal

School of Midwifery

Mrs. Martha DELATA, Principal

Current CS/ORT Clinical Trainers

Ms. Nancy AJEIKI, Community Health Sister, Utonkon

Ms. Becky AUDU, Community Health Sister, Otukpo

Ms. Felicia GBANGBAN, Community Health Sister, Asikpo

Ms. Naomi GUBE, Nursing Sister, Vandiskya

Ms. Elizabeth OKO, Community Health sister, Makurdi

APPENDIX B

List of Participants

Appendix B

List of Participants

S/NO	NAMES	JOB TITLE	PREVIOUS FP TRAINING RECEIVED	ADDRESS	TRAINING LEVEL SKILLS
1.	Mrs. Cecilia ABBA	Principal Community Health Officer	2 Weeks Mini-lap Training 6 Weeks Clinical FP	Rural Health Centre, Utonkon	Intermediate level; good CHE trainer
2.	Mrs. Justina ABEDA	Assistant Chief Health Community Officer	6 Weeks Clinical FP 2 Weeks TOT for Serior Staff	Health Services Management Board, Makurdi	Weak training skills; designated logistic coordinator
3.	Mrs. Awa ARUWA	Senior Nursing Sister	10 Weeks Clinical FP 2 Weeks Evaluation skills (INTRAH)	Family Planning Clinic, General Hosptal, Makurdi	Weak classroom trainer; fair preceptor - CS/ORT team
4.	Mrs. Christiana GBAKKAN	Senior Nursing Sister	6 Weeks Clinical FP 1 Week Motivation (VSC)	Family Planning Unit, General Hospital K/Ala	Beginning level trainer; fair-good preceptor - CS/ORT team
5.	Mrs. Priscilla GBILLAH	Senior Matron (State Coordinator of Women's and Health Development Programs)	5 Days CS/ORT Training	General Hospital, Makurdi	Intermediate level trainer; good classroom; not available except as resource
6.	Mrs. Susan IBRAHIM	Principal Health Sister	6 Weeks Clinical FP 2 Weeks INTRAH/MOH Evaluation skills	Basic Health Clinic, North Bank, Makurdi	Beginning level trainer; prefers not to train; fair preceptor
7.	Mrs. Rebecca ICHAVER	Midwifery Tutor	6 Weeks Clinical FP	School of Midwifery, Mkar Christian Hospital, Gboko NGO	Intermediate level; good classroom; strong preceptor - CTT-CS
8.	Mr. Dzever ISHENGE	Principal Health Educator (Nurse)	No FP Training	State Epidemiological Unit, Makurdi	Good intermediate skills; has hearing defect and limited as a trainer
9.	Mr. Joshua I. KON	Principal Nutritionist (ORT Manager)	2 Weeks INTRAH/MOH Evaluation skills No FP Training	State Epidemiological Unit, P.M.B. 102009, Makurdi	Strong Intermediate skills; class-room CTT-CHE

S/NO	NAMES	JOB TITLE	PREVIOUS FP TRAINING RECEIVED	ADDRESS	TRAINING LEVEL SKILLS
10.	Mr. Justin LOHO	Principal Nursing Tutor	4 Weeks Clinical FP 4 Weeks I & EC Training	School of Nursing & Midwifery, Makurdi	Excellent intermediate skills in classroom; fair-good preceptor, CTT CS/ORT; good candidate for advanced training
11.	Mrs. Elizabeth MAMODU	Community Health Sister	6 Weeks Clinical FP 1 Week CBD Training	Family Planning Unit, General Hospital, Ankpa	CTT-CME not assessed
12.	Mrs. Rekia MUSA	Senior Nurse Midwife (Matron)	No FP Training (Proposed for Clinical Skills Training in Ibadan)	General Hospital, Ankpa	CTT-CME not assessed
13.	Mrs. Titi Ademu OMALE	Staff Midwife		General Hospital, Idah	Very weak and not recommended as trainer
14.	Mrs. Esther OWAJI	Community Health Sister	6 Weeks Clinical FP	Health Service Management Board, Makurdi	Very weak classroom trainer; good clinical hand skills trainer; weak clinical content trainer
15.	Mrs. Lydia ORPIN	Principal Health Sister	6 Weeks Clinical FP	PPFN, P.O. BOX 31, Makurdi NGO	Weak trainer due to lack of interest; fair clinical preceptor
16.	Miss Victoria K. SHAKU - NOR	Midwifery Tutor (Deputy I & EC Coordinator)	4 Weeks Clinical FP 2 Weeks INTRAH/MOH Evaluation skills	School of Nursing and Midwifery, Makurdi	Excellent classroom/field trainer; on CTT-CME; filling in on CS training; good candidate for advanced training
17.	Mrs. Sarah TEBU	Midwifery Tutor	6 Weeks Clinical FP	School of Nursing and Midwifery, Makurdi	Excellent intermediate level trainer; good clinical preceptor; CTT-CS; good candidate for advanced training
18.	Mrs. Bridget TILLEY - GYADO	Nursing Sister	2 Weeks TOT for TBA training program 6 Weeks Clinical FP	MCH Clinic, General Hospital, Gboko	Good beginning level trainer; strong preceptor; CTT-CS
19.	Mrs. Tabitha ZAWUA	Principal Midwifery Tutor	3 Weeks CS skills and Training skills (Training of Trainees)	School of Midwifery, Mkar Christian Hospital, P.M.B. 190, Gboko NGO	Excellent intermediate level trainer; good clinical preceptor; CTT-CS (Resource)

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APPENDIX C

Benue State MOH/HSMB MCH Clinics Assessed for On-the-job IUCD Training

Appendix C

Benue State MOH/HSMB MCH Clinics Assessed for On-the-job IUCD Training

1. North Bank MCH Center, Makurdi

Facility: Clean, spacious, privacy for counselling and examination, but still no running water; equipment includes table, light, complete IUCD kit and gloves, and sterilization by boiling and/or soaking (povodine).

FP Staff: 2 nurse-midwives with FP training:

1 with IUD insertion skills (STT-clinical preceptor trained in Zimbabwe)

1 with CS/ORT training

FP Client Load: Total number clients Jan-Oct 1987, all methods: 473

Averages 4 IUCD insertions per month

Recommendation: Not suitable for IUCD on-the-job training until IUCD client numbers increase. Otherwise, one of the best physical facilities observed in Makurdi.

Service Statistics:

	Oral Contraceptives		Depo-Provera		IUCDs
	New	Old	New	Old	
April 1986	10	5	7	5	6
May	6	5	9	1	2
June	2	7	7	2	3
July	6	5	8	1	4
August	7	8	10	5	2
September	9	8	8	7	2
October	11	3	15	7	4
November	5	5	16	14	9
December	6	3	5	10	0

	All methods	IUCDs
January 1987	-	
February	-	
March	-	4/month
April	22	(32 total
May	18	Jan-Sept '87)
June	24	
July	27	
August	25	
September	34	
October	43	

2. **Gboko MCH Center, Gboko**

Facility: Large, spacious compound just off the main highway; center offers other PHC services including EPI and delivery; large staff; lacks piped water and electricity; equipment in FP clinic includes privacy for counselling and examination, table, gloves and 2 IUCD kits.

FP Staff: 3 trained in FP skills:

1 with IUCD insertion skills (Manila) and TOT training - STT clinical preceptor

1 with CS/ORT training

1 with 5-day CS/ORT training

FP Client Load: Averages 18 IUCD insertions per monch

Recommendation: Very suitable for IUCD on-the-job training; can accept 2 trainees at a time.

Service Statistics:

	1986		1987
	All Methods		IUCD
	New	Old	
January	28	60	15
February	46	56	21
March	39	53	27
April	51	68	29
May	48	101	14
June	36	57	24
July	44	89	20
August	46	73	9
September	60	150	17
October	44	104	
November	42	79	
December	70	118	

3. **Makurdi General Hospital, FP Clinic, Makurdi**

Facility: 3 small rooms (records, interview and examination); crowded and very busy; privacy for examination but not so for counselling; equipment includes gloves, table, light and 2 complete IUCD kits.

FP Staff: 3 trained in FP clinical skills:

2 with IUCD insertion skills (1 Zimbabwe; 1 Ibaden)

1 with 5-day CS/ORT training

FP Client Load: Averages 12 IUCD insertions per month

Recommendation: Suitable for IUCD on-the-job training for 1 trainee

Service Statistics:

	Oral Contraceptives		Depo-Provera		IUCD
	New	Old	New	Old	
January 1987	44	180	12	103	16
February	18	183	11	74	11
March	36	121	20	89	13
April	27	200	16	106	13
May	13	170	9	91	5
June	21	170	14	65	8
July	13	171	14	84	8
August	38	157	0	106	11
September	47	126	23	64	N/A

4. **Makurdi MCH Center, Makurdi**

Facility: 2 reasonably sized rooms, clean but not a bright or attractive facility; privacy adequate for counselling and examination; equipment includes table, light (no bulb), piped water with sink, gloves and at least 1 complete IUCD kit observed; sterilization done by boiling and soaking in povodine solution.

FP Staff: 2 trained in FP clinical skills:

1 STT clinical preceptor (Ibaden-trained in IUCD insertion)

1 with FP and IUCD training (Ibaden)

FP Client Load: Averages 14 IUCD insertions per month (but numbers appear to be declining)

Recommendation: Suitable for IUCD on-the-job training of 1 trainee, but could accommodate 2 if the number of IUCD acceptors increases.

Service Statistics:

	Oral Contraceptives		Depo-Provera		IUCD	
	New	Old	New	Old	New	Old
August 1986	21	-	14			
September	41	16	13			
October	52	16	11		6	
November	62	21	20		16	
December	38	27	27		8	
January 1987	12	41	33	7	30	
February	7	52	12	4	30	
March	8	50	36	7	33	
April	4	39	15	5	16	11
May	13	46	14	14	14	6
June	1	29	18	4	16	8
July	21	27	46	9	14	1
August	18	27	34	15	11	30
September	1	14	33		5	26

5. **PPFN Clinic, Makurdi**

Facility: Large 4-room facility with good waiting space, privacy for counselling and examination; dark and in need of painting and cleaning; recently moved into this building; no clients present, equipment was reported to be complete but not observed; still in process of setting up.

FP Staff: 2 trained in FP clinical skills:

1 STT clinical preceptor (Zimbabwe-trained)

1 PPFN staff (training unknown)

FP Client Load: Averaging about 5 IUCD insertions per month in old clinic; unknown what numbers will be in new clinic location.

Recommendation: Not suitable for IUCD on-the-job training at this time; should be reassessed by MOH/HSMB project managers in January 1988.

Service Statistics:

	Oral Contraceptives		Depo-Provera		IUCD
	New	Old	New	Old	
January 1987	17	59	19	110	11
February	22	40	12	109	5
March	23	65	16	111	9
April	12	49	22	102	2
May	13	50	20	112	5
June	19	57	25	123	3
July	43	94	20	106	3
August	13	75	13	87	1
September	41	76	59	164	12

APPENDIX D

Benue State CS/ORT Training Project
Current Status of Project Objectives
(November 12, 1987)

Appendix D

Benue State CS/ORT Training Project
Current Status of Project Objectives
(November 12, 1987)

ANTICIPATED	ACTUAL	COMMENTS
1. 10 senior MOH/HSMB staff trained to conduct orientation seminars	8 trained	·Two did not complete the TOT; ·Three trainers conducted 2 2 seminars; four conducted 1; 1 did not conduct training.
1 orientation curriculum developed	1 developed	
2. 100 government and NGO staff oriented to the national population policy, Benue State CS/ORT Action plan, supportive of CS/ORT activities in three seminars	230 trained in five seminars	·3 additional seminars held at Otukpo, Idah and Gboko zones with funds obtained from exchange rate savings.
3. 10 MOH/HSMB staff trained as State Evaluation Team to monitor and evaluate CS/ORT program	10 member team trained	·2 members not available for evaluation activities; ·Not functioning as a team; ·Need direction, budget, time.
·monitoring and evaluation plan will be developed; ·evaluation tools developed; ·preliminary baseline data collected; ·follow-up of orientation seminar participants; ·survey of clinics to determine suitability for IUCD insertion on-the-job training.	·plan, tools developed in workshop but not adhered to; ·baseline collected during workshop; ·40 followed-up ·Not done	·No monitoring of training or follow-up of CS/ORT/CHE trainees conducted to date; ·Data not utilized to date; ·INTRAH initiated activity; no other follow-up conducted.
4. 20 MOH/HSMB/NGO staff trained as State Training Team	19 trained	·All have conducted at least 1 CS/ORT or CHE workshop; three have conducted 2 workshops; one has conducted 3 workshops.
5. 2 training curricula will be developed	1 CS/ORT and 1 CHE curriculum developed	·Both have been revised once and are in use by the STT.
6. Development of CS protocols for use by CS/ORT service providers	CS protocol developed	·Adapted Zimbabwe protocols.
7. Standards for CS practicum developed	not developed as such but a CS performance appraisal tool developed	·will be used during on-the-job IUCD training and CS clinical practicum.
8. 50 nurse-midwives trained to provide CS/ORT services	31 trained to date	·Service providers from at least fifteen different sites have been trained.
9. 32 community health aides/ assistants trained to provide CHE services in the community	29 trained to date	·18 health aides and 11 health assistants trained.
10. Linkages improved between pre-service education, in-service training and service delivery	linkages established through joint training activities of PST/IST/ service staff on STT	·Linkages not formalized but PST/IST/Service personnel work closely together in CS/ORT training and clinical activities.

ANTICIPATED	ACTUAL	COMMENTS
11. CS/ORT to be integrated into pre-service nursing/ midwifery curricula	Plan in progress	·Awaiting Nursing Council revised curriculum before integrating.
12. Establishment of in-service CS/ORT/CHE training program	No formal plan developed to date	·One CS/ORT/CHE STT member transferred from SON to MOH/IEC unit.
13. Maintenance of CS records	New MIS CS records introduced in selected MCH clinics.	·Records observed in use at 4 of 5 clinics.
14. Demand increased for CS/ORT services	Unknown	·No follow-up studies done and CHE referral slip reports unreliable or not recorded.
15. 5 nurse-midwife clinicians trained in IUCD insertion technique and management	Activity must be postponed; training program not developed; not ready for on-the-job training.	·Re-scheduled for Jan. '88 -clinical preceptors on leave in Nov/Dec '87 -preceptors require CS CS update; 3 MCH clinics only have sufficient number of IUCD clients.
16. Project/program review conducted with senior MOH/ HSMB managers, STT and SET	Conducted	·Full input from all from all participants.

APPENDIX E

CS Clinical Protocol Prepared by STT
Benue State, Nigeria

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PHYSICAL EXAMINATION

OBJECTIVES

1. To detect medical conditions that contra-indicate certain contraceptives
2. To obtain a complete data base on the client
3. To detect gynaecological conditions and sexually transmitted diseases and manage according to clinic practice (see sections on sexually Transmitted Diseases and Gynaecological Conditions).

Preparation of the Room

Collect the necessary equipment for the examination procedure and laboratory tests you plan to do (refer to section on clinic Management)

Preparation of the Client

Briefly outline to client the procedure that you will follow. She will undress, put on a gown, and then she will be examined. Ask her to empty her bladder.

Steps for the Procedure

Explain to the clinent what will happen at each stage of the examination.

General Examination

1. As the client walks into the examination room look for the following:-
   (a) Crouching or limping with pain
   (b) Obvious ill health.
2. Check blood pressure and record
3. Check the weight and record
4. Position the client in a comfortable sitting position on the couch and ask her to relax
5. Hair: check for alopaecia (Hair loss)

6. Face: (a) Check for acne, chloasma and hirsutism
   (b) Eyes - check for jaundice and anaemia
   (c) Mouth - check tongue for anaemia
   (d) Inside mouth - for enlarged or inflamed tonsils

7. Neck: (a) Inspect for scars and lumps
   (b) Palpate the front of the neck for enlarged goitre. If there is a lump ask her to swallow and observe if the lump moves up. Check the radial pulse, Determine if it is rapid (over 90 beasts per minute) or slow (below 60 beats per minute). Test for tremors by asking the client to extend her arms in front of her and spread her fingers. Place a light piece of paper to see if any shaking is present.

8. Ears: Check for allergy to metallic earrings.

9. Breasts: Inspect for size, equality, skin changes (peau d'orange) "orange - like skin" yeining and obvious masses. Ask client to raise her arms slowly onto her head and check whether the breasts rise equally and whether there is any nipple retraction. To place hands on hip and tighten chest muscles by pressing firmly inward. Supporting clients hands in yours. Ask client to lead forward, observe for any change in shape, size of breast, dimping of skin, pulling in of nipples, in any of these changes in arm position. Then ask the client to lie down in a supine position. Make the client comfortable and cover her from the waist downwards. Always watch the client's face for any indication of tenderness as you papate. Place the client's left arm over her head and:

   (a) Make imaginary divisions of the breast into quadrants.

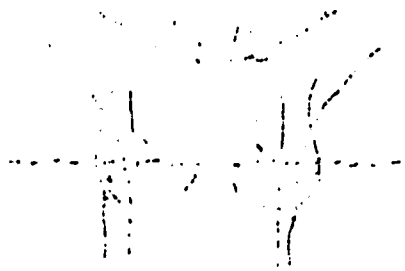

Figure 1

(b) Working in a clockwise direction use the flat areas of the fingers to palpate the breast tissue.

(c) Starting from the outer edge of the quadrant to be examined, palpate towards the nipple with the other hand supporting the breast.

Figure 2

(d) Now use the palms of the hands to feel large areas of the breast against the chest wall.

(e) If the breast is pendulous, examine the breast tissue with both hands

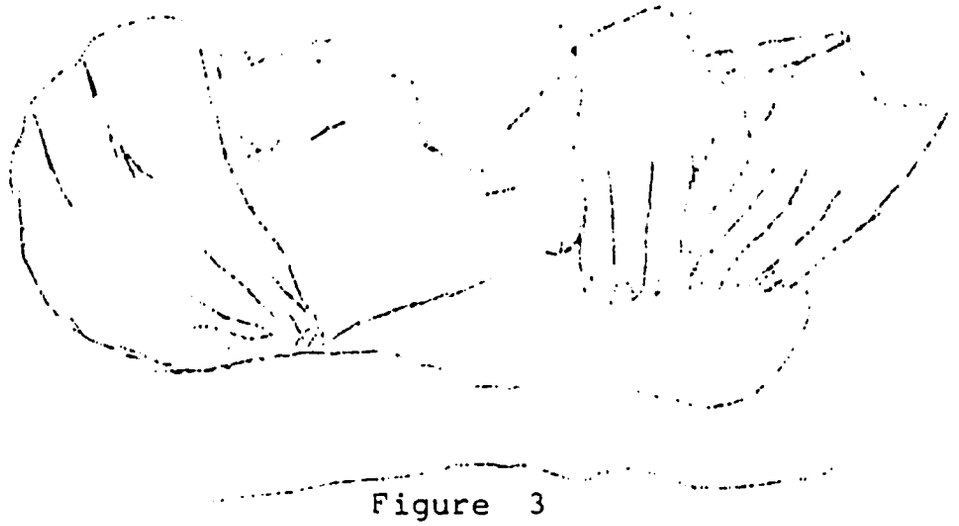

Figure 3

(f) Gently express the nipple to demonstrate the presence or absence of secretions, e.g. milk, pus or blood.

Figure 4

(g) Bring the client's left arm down to her side and feel under the pectoralis muscle in the left axilla for any lymph nodes.

Figure 5

(h) Repeat the whole procedure with the right breast.

(i) If there is a lump, ask client if she is aware of it. If so when she first felt it, if it is growing and if it is painful. Refer to hospital.

(j) Teach client how to examine her breast.

Timing for Breast Examination

As a clinic procedure:

(a) At registration of all new clients

(b) Annually

As self examination by the client:

(a) At least on a monthly basis after the menses.

10. Abdomen:

Inspect her abdomen for the following:-

(a) Operation scars

(b) Medicinal marks

(c) Obvious swelling or distension

(d) Hirsutism - hairy, male-type distribution of body hair.

Divide the abdomen into six imaginary parts. Ask the client, if she has any pain, to point to the area. Gently palpate that painful area last.

PALPATION

Light palpation

Always start in the area removed from the site of any pain and watch the client's face for any indication of tenderness.

Deep and bimanual palpation

With one hand behind the right subcostal region, place the other hand on the right lower abdomen with fingers pointed upwards. Move the hand on the abdomen towards the costal margin with each inspiration until the liver edge is felt or the costal margin is reached.

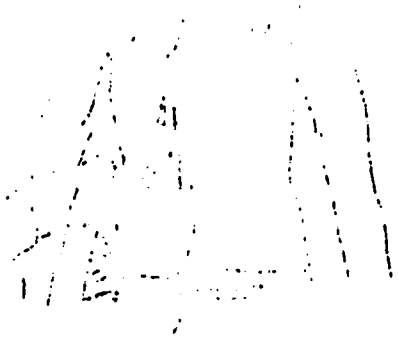

Figure 6

If the liver is enlarged (palpable), refer to hospital.

General abdominal palpation

Palpate abdomen with flat of fingers with the other hand supporting the adjacent part of the abdomen to detect any masses or tenderness . During deep palpation support the palpating hand by placing the other hand on top of the examining hand and guiding its movements. If masses and tenderness are present, refer to hospital.

11. Pubic area

Inspect the distribution of pubic hair

If hirsutism is present, see section on the relative contra-indications of COC's.

12. Inguinal glands
Palpate the inguinal region for any enlargement or tenderness of the gladd. If enlarged, look for cause, eg lesions on legs or genitals.

13. Legs
Test for oedema by applying finger pressure two inches from the ankle of the inner tibial aspect of both legs for 30 seconds. If there is pitting, oedema is present.
Inspect for varicose veins on upper and lower legs.

Pelvic examination

Physical setting

(a) Explain again to the client that you are going to examine her internal parts
(b) Position trolley and light/torch
(c) If laboratory tests are to be taken prepare all instruments:-
correctly labelled slides, Ayres spatulae, transport media, pap smear fixative, pus swab, labelled forms.
(d) Wash your hands with soap.
(e) Put on glove on the examining hand
(f) Get a receiver containing a Cuscos speculum, a sponge holding forceps, a swab, an Ayres spatula and lubricant
(g) Ask the client to bend her knees
(h) Ask the client to open her legs
(i) Place the receiver with the instruments on the couch between the client's legs.

Steps to follow in pelvic examination

(a) Inspection of external genitalla:
    (i) Take note of signs of bleeding, vaginal discharge, abrasions, rash, scars, condylomata or enlarged bartholin's glands
    (ii) Separate labia majora from labia minora
    Check the vulva for sores, warts, discharve or bleeding
    Bartholin's cysts and other swellings by palpating with thumb and fore finger at 4 O'clock and 8 O'cock position of vaginal opening.

(iii) Separate the labia minora, check for the hymen, If she is a virgin, do not proceed to do a digital or speculum examination.

(iv) Inspect the urethral opening for any discharged and signs of inflammation. Then insert finger into vagina, put pressure on the anterior vaginal wall, moving finger forward, milking the urethra, observe for discharge at urethra and skene's gland.

(b) Speculum examination

(i) Lubricate the speculum before insertion; use only water if you expect to take a smear for cytology of culture for gonorrhoea. Otherwise any lubricant will do.

(ii) Hold the speculum with the blades closed between the index and middle fingers.

(iii) With the other hand, spread the labia and ask the client to push down (to relax perineal muscles).

(iv) Insert the speculum so that the blades slip obliquely between the labia into the vaginal canal. Avoid pressing on the sensitive urethra and clitoris. Be particularlly careful not to catch the skin and hair between the blades and hinge of the speculum.

(v) As the blades are halfway into the vaginal canal, turn them in the usual horizontal plane. Gently open the blades to find the cervix, while putting a little downward pressure on the fourchette. Advance the speculum slowly and gently in the direction of the cervix.

(vi) When the blades are placed into the anterior and posterior fornix, and the cervix is well visualised, tighten the thumb screw so as to maintain the speculum in position.

(vii) Inspect the cervix and vaginal mucosa for:-

IUD strings	- Visible, length
Cervix	- smooth, lacerations, polyps, erosion, cysts, colour, endocervical discharge or bleeding
Cervical OS	- nulliparous or multiparous
Vaginal mucosa	- colour, tumours, discharge (odour, colour, consistency, presence of bubbles, curd-like quality). The vaginal mucosa will be carefully and more fully inspected during the removal of the speculum.

(c) Laboratory specimens:

(i) Do not take a Papanicolau (Pap) Smear during a normal menstruation. If there is abnormal bleeding and the client presents herself during the abnormal bleeding, it may be very helpful to obtain a smear at that time.

(ii) An accurate technique is essential. Have the correctly labelled slides, labelled forms, the spatula and the fixative ready for use.

(iii) Use a wooden spatula (Ayre spatula) and obtain cells from the squamo-columnar junction of the cervical os, using a firm scraping rotation of the spatula through a full 360° of the cervical os.

(iv) Spread (do not scrub) the material on the labelled slides; better to be too thin than too thick.

(v) Fix the material before it can dry; either use the Papä smear fixative or a can of hairspray.

Culture for gonorrhoea

(vi) Using a cotton swab, take material for the culture from the endocervical canal

(vii) Gonorrhoea cultures are sensitive and will need to be placed in a jar of carbon doixide and to be incubated fairly promptly.

(viii) The speculum may now be removed. Loosen the thumb screws, and using slight downward traction, again turn the blades obliquely and remove the speculum from the vaginal canal. As the speculum is being slowly removed from the vagina observe the vaginal mucosa once again for colour, tumours and discharge.

(d) Bimanual examination

NB. The term "vaginal fingers/hand" refers to the fingers/hand used to examine inside the vagina regardless of whether right or left. The same applies to the term "abdominal finger/hand"

1. Separate the labia with the two fingers of one hand
2. With the palm up, using the two fingers in the vagina, follow the anterior vaginal wall deep into the anterior fornix, of the vagina and locate the cervix

Figure 7

3. Feel the cervix with the vaginal hand, noting the position, consistency and whether it is open or closed. Feel the shape of the external os, recognize any old lacerations and the presence of any cysts or polyps you saw on speculum examination.

4. Place the abdominal hand gently on the lower abdomen above the symphysis and exert steady downward pressure; the purpose of the abdominal hand is to steady the pelvic organs so they can be felt with the vaginal hand. With the fingers anterior to the cervix, gently lift the vaginal hand to the abdominal hand to discover if the position of the uterus is anterior to the cervix.

Figure 8

5. If the uterus is not palpated anteriorly, then place the vaginal fingers posterior to the cervix and gently lift the cervix (and uterus) towards the abdominal hand. The movement may identify position of the uterus as anterior or mid-position.

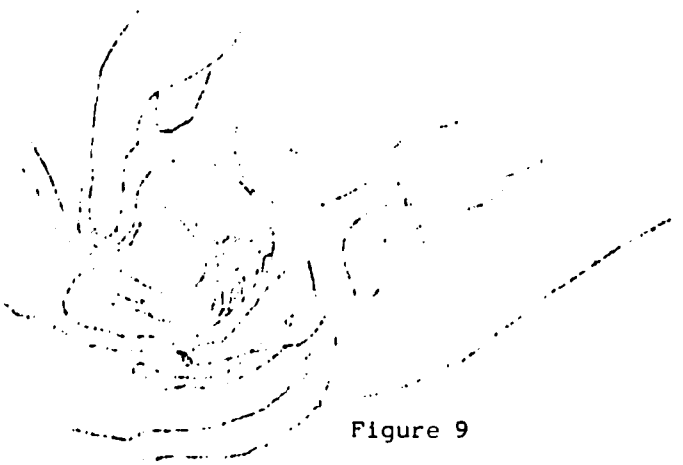

Figure 9

6. If the uterus is not felt between the two hands, it may be in a posterior position and may be in the Pouch of Douglas. Turn vagina hand palm down and maintaining abdominal pressure with the abdominal hand, explore the area.

7. As soon as the position of the uterus is identified, divide the two vaginal fingers into a V and with these fingers on either side of the cervix, try to outline the uterus by "walking up" the body of the uterus with the abdominal hand. Note the size, shape, consistency and mobilityof the uterus or deviation to the right or left.

8. Palpate the adnexae. To do this, move both vaginal fingers into the lateral fornix and the abdominal hand to the same side of the uterus. While the abdominal hand presses the adnexae towards the vaginal hand, try to palpate the ovary and tube on the side of the uterus as they slip between the examining fingers. Repeat the procedure on the other side of the uterus.

9. Examination of area of discomfort must be done last to avoid the client becoming too tense and intolerant of continued examination. Refer to the doctor for any enlargement or any other mass in the pelvis. With the fingers in one lateral fornix, push the cervix to the opposite side. If this produces pain, it indicates inflammation in the adnexae. Carefully manipulate the cervix in all directions to locate any abnormality.

10. Separate the labia with the two fingers of one hand.

11. Insert the two fingers of the examining hand well inside of the vagina and use downward pressure to expose the anterior vaginal wall.

12. Ask the client to cough; observe directly, approximately at the level of the vagina, look for urinary incontinence and bulging of the vaginal wall that might suggest a cyctocele or urethrocele.

13. Using upward pressure, with the two examining fingers, expose the posterior vaginal wall and ask the client to cough and observe for bulge of the vaginal wall which might suggest a rectocele.

14. Ask the client to squeeze your vagina fingers to check tone of pelvic musculature.

Recording

(a) Record all findings of the physical examination on the Card. Use a red pen for all abnormal findings.

(b) Record the appropriate contraceptive method and any medication for treatment in the Treatment Column of the Record Card.

(c) Give the client a return date.

ORAL CONTRACEPTIVES

Objectives

1. To summaries the indications and contra-indications for hormonal contraceptives
2. To list the available preparations with their physiological characteristics
3. To provide direction in the routine use of oral contraceptives together with guidelines for the management of common problems.

Combined Oral Contraceptives

Made of Synthetic Oestrogens and Progestogens.

1. Indications

   To prevent pregnancy, either temporarily or permanently

   (a) For women who want the highest level of protection

   (b) for selected women for whom pregnancy involves a high risk to maternal health or socio-economic stress.

2. Absolute Contra-Indications

   You must not initiate combined oral contraceptives for clients with:-

   (a) Thrombophebitis or thromboembolism or history of either

   (b) History of cerebro vascular accident (stroke)

   (c) Known or suspected breast cancer or genital cancer

   (d) History of coronary artery disease

   (e) Pregnancy or possibility of pregnancy

   (f) Impaired liver function or history of hepatic adenoma; hepatitis less than one year ago

   (g) Undiagnosed abnormal uterine bleeding

3. Strong Relative Contra-indications

You are strongly advised not to intiate combined oral contraceptives for clients with:-

(a) Hypertension with diastolic pressure of 90mm hg on three or more separate visits; or above 90 mmHg on a single visit

(b) Uncontrolled diabets mellitus

(c) Severe headaches particularly migraine

(d) Fibroids

(e) Age 35 years or above and a history of smoking more than 10 cigarettes a day or have a family history of diabetes mellitus or hypertension

(f) Blood dyscarsias that carry an increased risk of thrombosis, eg polycythaemia, leukaemia and sickle cell anaemia.

(g) History of jaundice during pregancy

(h) Extreme depression

(i) Previous gall bladder disease and surgery

(j) Conditions which are aggravated by fluid retention eg cardiac disease with a tendency to congestive cardiac failure and renal disease

(k) Epilepsy (whether under treatment or not)

(l) History of late menarche after seventeen years of age or irregular infrequent menses (far in between)

(m) Active pulmonary tuberculosis on anti-tuberculosis treatment

(n) Varicose veins

(o) Severe fibrocystic breast disease

(p) Cigarette smoking - over 10 cigarettes a day

(q) Thyrotoxicosis

(r) Girls under 16 who have never been pregnant

(s) Immobilization of the lower leg

(t) Elective surgery planned in four weeks of major surgery requiring immobilization

(u) Age over 40 years.

(However, if other factors rule out the use of alternative methods, then this method would be acceptable if you carefully monitor the client for signs of trouble).

4 Other Relative Contra-indications

You may be able to initiate the method for clients with the following if you know they may have problems with it and are willing to assume responsibility for seeking help the mement early danger signals appear.

(a) Menarche within the last two years

(b) Obvious obesity

(c) Controlled diabetes mellitus or strong family history of

(d) Termination of a pregnancy within 14 days

(e) Weight gain of more than seven kilograms, on the pill, in three to six months

(f) Acne

(g) Chloasma

(h) Alopaecia

(i) Asthma

(j) Conditions likely to make clients unreliable to follow pill instructions: (mental retardation, major psychiatric problems, alcoholism, history of repeatedly taking pills incorrectly).

5. Conditions which warrant immediate stopping of COC
   (a) Pregnancy through client or method failure
   (b) Severe headaches especially when associated with visual disturbances - seeing spots or loss of vision
   (c) Numbness or paresis (weakness) or extremities
   (d) Unexplained chest pain or shortness of breath
   (e) Severe leg pains
   (f) Development of any of the absolute contra-indications
   (g) Increase in the severity of any of the relative contra-indications.

6. Content of combined oral contraceptives

   The combined oral contraceptives contain synthetic oestrogen and progestogen (progestin)

   (a) Types of synthetic oestrogen being used in combined oral contraceptives in this country

   Ethinyl Estradiol

   (b0 Types of synthetic progestogens being used in combined oral contraceptives in this country.

   Norgestrel.

7. Selection of pills

   We should not give more hormones than is absolutely necessary. It is currently recommended that we use preparations containing an oestrogen dosage of 35mcg and below and the lowest effective dose of progestogen. Some 50 mcg pills are still being used.

   The preparations available more or less fit this criteria. One should start with preparations which contain 30-35mcg of oestrogen.

8. Selection of Clients

Based of history, physical examination and assessment of the client, the cs/fp clinical course graduate must be sure that:

(a) No absolute contra-indications exist.

(b) For cases with strong relative contra-indications, strongly advise client not to use combined oral contraceptives but to use an alternate method.

(c) For those with other relative contra-indications, you may advise the client to use combined oral contraceptives and seek advice if problems arise.

(d) The client is well motivated to follow directions and will:-

(i) take one pill every day; this is a new habit for many people

(ii) Not become disturbed by slight changes in breasts or menstruation

(iii) Keep clinic appointment for supplies and routine examination

(iv) Report at the clinic or doctor promptly for any unusual problem.

9. Instructions for Clients for Administration of Combined Oral Contraceptives

ROUTINE CLIENTS NOT POST NATAL OR BREAST FEEDING

(a) Client starts the first pill of the first packet on first day of her menses which is the first day of her cycle. If she starts on Day 2 to Day 5 of her cycle, she needs to use a non-hormonal method (eg condom) as well, for the first two weeks of her packet of pills.

(b) If she is more than five days from onset of last menses, she should await her next period. She should use a non-hormonal method until then.

(c) She takes one pill about the same time every day, even if her partner/husband is away

(d) She should not worry if she has irregular spotting of blood, nausea or vomiting for the first few months. This usually settles down.

(e) She should expect her periods, which could be lighter, when she is taking the last line of pills wigh a different colour (placebos)

(f) She should always start a new packet of pills the day after she has finished the packet she is on, even if she has not bled, has finished bleeding or is still bleeding. She should report back to the clinic if she does not bleed.

(g) If she forgets to take a pill, she should take it as soon as she remembers, and also take her regular pill at the regular time.

(h) If she forgets to take more than one pill, she should continue to take her pills (even if she has a little spotting) but use a non-hormonal metnod until her next period.

(i) If she is worred at all, she should report back to her clinic

(j) If she attends a clinic for treatment or sees a Doctor, she should report that she is on the pill.

(k) When reporting back to clinic for SC she should be advised to bring her pills with her.

POST NATAL CLIENTS

(a) NOT BREAST FEEDING

(i) If she has just delivered, she may start her pills two weeks from the day of delivery

(ii) If she is back for her 6 weeks post natal examination, she starts her pills on that day.

(iii) If she is more than 6 weeks post natal she should wait until her next period and start her pills on the first day of her period and meanwhile she should use a non-hormonal method (eg Condom).

(b) BREAST FEEDING

1. If lactation is well established she could start on a low dose oestrogen oral contraceptive pill (30-35mcg EE) at 6 weeks post natal, since estrogen may diminish the milk supply, mothers begining COC's should be enccuraged to breast feed more frequently during the first week.

2. If lactating mother is more than 6 weeks and has had no intercourse since delivery, she may beging COC that day.

3. If lactating mother is more than 6 weeks and has resumed intercourse, Rule out pregancy by pelvic examination and pregnancy test, when possible, before initiating COC's; alternately, clinent may be offered non-hormonal barrier method till menses is resumed or pregnancy can be ruled out.

ADVERSE ORAL CONTRACEPTIVE DRUG INTERACTIONS

Interacting Drugs	Adverse Effects
Contraceptives, Oral, with:	
Ampicillin	Decreased contraceptive effect
Barbiturates	Decreased contraceptive effect
Phenytoin	Decreased contraceptive effect
Rifampin	Decreased contraceptive effect
Tetracyclines	Decreased contraceptive effect.

If you get sick and have severe diarrhea or vomiting for several days, use your backup method of birth control until your next period. Start using a backpu method your first day of diarrohea or vomiting.

Management of Problems on Combined Oral Contraceptives:-

Problem	Areas to be investigated	Possible solutions
Nausea and Vomitting	1. Find out from client (a(Are the pills being taken on an empty stomach? does her diet include fatty and gaseous food? 2. Exclude other causes, eg. (a) Jaundice (b) Pregnancy	1. (a) if yes, advise client to take pills with an evening meal (b) Discuss changing of these foods to less fatty and gaseous foods. If no cause is found, change to a pill with low oestrongen POO, IUD or Diaphragm, Review frequently. If persistent refer.

Weight gain	1. Find out from client if this is due to (a) Poor eating habits (b) Increased appetite since the pill was started (c) A cyclic fluid retention Exclude other conditions, eg depression, myxoedema	1. (a) Advise on diet (b) Give her a pill with less progestogen or change to non hormonal methods (c) Give a pill with less oestrogen 2. If no cause is found, change to pill with low oestrogen and progestogen, POP or non-hormonal method. If weight gain continues, stop hormnal method. Review fequently. If persistent, refer
Bleeding between periods	Exclude causes of withdrawal bleeding. 1. Find out from the client if: (a) She has been taking her pills correctly or not (b) She has had diarrhoea or vomiting (c) She has been taking drugs which are known to interact with oestrogen in the pill.	1. (a) re-instruct client on the necessity of taking them properly. , Continue taking her pills. (b) Instruct client to continue taking her pills and see her doctor/clinic (c) Re-instruct to use a non hormonal method during treatment and for two weeks after.
	2. Exclude Gynaecological conditions, eg: Complications of pregancy, fibroids, PID, malignancy of the genital tract	2. Treat and/or refer

Bleeding between periods	3. Exclude break through bleeding (Common within the first three months of starting the pill and very rare after three months)	3. If 1 and 2 are negative, STOP present packet of pills for four days, restart on a new packet on the 5th day. Use a non-hormonal method during the first two weeks. If it persists or recurs, change to a pill which is high in oestrogen and progestogen or to a non-hormonal method.
Amenorrhoea	(a) Pregnancy (b) Effects of pill	(a) If pregnancy test is positive, stop pill and refer to ante-natal clinic (b) If pregnancy test is negative: (i) One period missed, re-assure client and instruct her to continue taking her pill. (ii) If 2 periods have been missed, change to non-hormonal method. monitor monthly X2 and exclude pregnancy. Allay fears concerning absence of menses. (iii) After 3 months still amenorrhoeic and not pregnant, refer to the doctor.
Acne	(a) Find out about her diet: If it contains a lot of fats, carbohydrates, fizzy drinks and sweets. (b) Find out about her skin toilet	(a) Advise on diet: cut down on these foods (b) Advise on cleaning face with an astringent, eg lemon. If persistent and client is worried, change to a non-hormonal method
Chloasma	(a) Exclude other causes eg. skin lightening creams containing mercury, pregnancy, sunburn (b) If no.	(a) If the cause is due to the pill, change to a non-hormonal method. (b) If due to other causes advise according to clinic practice

Headaches	Find out from client (a) Did they occur prior to the pill, eg due to social, financial and physical problems? (b) Do they occur on hormonal pills or on placebos?	(a) Try to assist client to correct any causes of problems (b) Check blood pressure first to exclude hypertension. If on placebos, change to POP or a non-hormonal method. If on hormonal pills change to a low dose oestrogen preparation or to a non-hormonal method.
Hypertension	(a) Find out from client: Is this the first episode? (b) If diastolic pressure is 90mm Hg or more for 3 visits or 110mm Hg for 1 visit (c) High blood pressure persists or is accompanied by oedema and/or headache	(a) Repeat blood pressure reading (b) Change to POP or a non-hormonal method and review blood pressure within a month (c) Change to POP or a non-hormonal method and refer
Loss of Libido	(a) Exclude other causes (i) marital problems (ii) dysparunia (iii) dry vagina (b) If cause is hormonal	(a) (i) Refer (ii) Determine cause, try to correct the cause or refer to doctor/clinic (iii) Lubricant (b) Change to a non-hormonal method
Depression	(a) Exclude other causes, eg. marital or social problems (b) If cause is hormonal	(a) Refer to social welfare (b) Change to a non-hormonal method

Breast Changes	(a)	If tender, exclude breast infection	(a)	Advise her to put on a firm, well fitting bra all the time
	(b)	If they increase in size and the client is worried	(b)	Change to a low oestrogen pill, POP or a non-hormonal method
Monilia Infection	(a)	Exclude other causes eg. diabetes mellitus immuno suppressed clients	(a)	Refer on one of the barrier or chemical methods
	(b)	If the cause is hormonal	(b)	Change to low oestrogen pill POP or non-hormonal methods.

PROGESTOGEN ONLY PILL

1. Indications

   (a) For women with relative contra-indications to combined oral contraceptives

   (b) For women with fibro-cystic breast disease who want oral contraceptives

   (c) For women with sickle cell anaemia who want oral contraceptives

   (d) For women with elevated blood pressure no other method is acceptable.

2. Absolute Contra-Indications

   The same absolute contra-indications apply for Pregestogen Only Pill as for the combined oral contraceptives.

3. Strong Relative Contra-Indications

   There are none but POP may be used in women with conditions in this category under COCs.

4. Other Relative Contra-indications

   (a) Previous history of ectopic pregnancy
   However POP may be used in women listed under this category on the topic 'COCs'.

5. Conditions whith Warrant Immediate Stopping of the Pregestogen Only Pill
   (Same as for Combined Oral Contraceptives)

6. Content of Progestogen Only Pill

   The types of synthetic progestogen being used in POP in this country are:-
   Levonorgestrel and
   Norethisterone.

7. . ection of Clients

Based on history, physical examination and assessment of the client, the Clinical Course graduate must be sure that:

(a) No absolute contra-indications exist

(b) For those with relative contra-indications, you may advise the client to use the POP and seek advice if problems arise.

(c) The client is well motivated to follow directions and will

(i) Take one Pill every day; this is a new habit for many people

(ii) Not become disturbed by slight changes in menstruation

(iii) Keep clinic appointments for supplies and routine examinations

(iv) Report at the clinic or doctor promptly for any unusual problem.

8. Instructions for Clients for Administration of Progestogen Only Pill

(a) The client can start her pill on day 1 of the menstrual cycle or immediately post-partum or post-abortal.

(b) When starting the first packet, she must use a non-hormonal method, eg condom for twoo weeks

(c) She must take the pill at the same time every day

(d) As soon as she finishes one packet, she must start a new packet the next day. There is no break.

(e) Her periods might be irregular or even missed, she must not worry as this is normal. She must continue to take her pills.

(f) The first three or four periods may come sooner and may be heavier.

(g) If she forgets to take one or more pills, she should continue with her packet of pills but use a non-hormonal method for two weeks

(h) If she is worried at all, she should report back to her clinic

(i) Although POP does not affect lactation, she should take plenty of fluids

(j) If she goes into hospital or sees her doctor for any reason she should tell him/her that she is on POP.

MANAGEMENT OF PROBLEMS ON PROGESTOGEN ONLY PILL

Problem	Areas to be investigated	Possible solutions
Spotting	(a) Exclude other causes of spotting, eg. PID, Fibroids, Abortion	(a) Treat according to clinic practice
	(b) If spotting is hormonal find out from client how many days she has been spotting	(b) (i) Less than 10 days Re-assure (ii) More than 10 days give POP 1 pill BD for 7 days
Bleeding	(a) Exclude other causes of bleeding eg PID, Fibroids, Abortion	(a) Treat according to clinic practice
	(b) If cause is hormonal, find out how many days she has been bleeding	(b) Less than 7 days and not heavy - re-assure More than 7 days. give POP 1 pill BD for 14 days (c) If persistent refer
Amenorrhoea	(a) Exclude other causes of amenorrhoea eg. pregnancy	(a) If pregnancy test is positive, stop the pill and refer to ante-natal clinic
	(b) If cause is hormonal	(b) Re-assure of change method

BARRIER AND CHEMICAL METHODS

Objectives

1. To summarize indications and contra-indications of the barrier and chemical methods available.
2. To list the available barrier and chemical contraceptive preparations being used
3. To provide instructions on the use of the barrier and chemical methods.

Barrier Methods

A. Diaphragm (Cap and Cream)

A shallow dome-shaped rubber cap with a firm but flexible rim inserted into the vagina prior to coitus, to cover cervix.

1. Indications
   (a) When oral contraceptives and IUD are contra-indicated
   (b) When the client prefers it as a method
   (c) As a method effective immediately, eg convenient for couples who do not stay together.

2. Absolute contra-indications

   You must not initiate for clients with:
   (a) Fixed retroverted uterus
   (b) Prolapsed uterus
   (c) Extremely relaxed vaginal muscles
   (d) Severe cystocele or rectocele
   (e) Poor retro-public ridge

3. Strong relative contra-indications
   You are strongly advised not to initiate for clients with:
   (a) Active PID
   (b) Negative attitude
   (c) Allergy to rubber
   (d) Partner against the method

4. Conditions which warrnat re-fitting
   (a) Weight gain or loss of 7 kg or more
   (b) After termination of each pregnancy
   (c) After any pelvic floor operation

5. Conditions which warrant replacement of the Diaphragm
   (a) After a year's use
   (b) When the diaphragm is defective

6. Instructions for the client for the use of a Diaphragm
   (a) The diaphragm must be inserted into the vagina before sexual intercourse
   (b) She must smear a little of the contraceptive jelly well round the rim. Squeeze two 2.5 cm strips in length or 1 teespoon on one side of the cap and spread the jelly with fingers. Repeat on the other side.
   (c) She must fold diaphragm in half using the index finger as a guide.

Figure 11

Diaphragm held in the hand ready for insertion into the vagina.

   (d) She must part the labia with the other hand
   (e) She must push the diaphragm well into the back of the vagina
   (f) She must now check the position of the diaphragm with her finger. The diaphragm should cover the cervix (which feels like the tip of the nose) which is the entrance to her wom. SHE MUST FEEL THE CERVIC THROUGH THE DIAPHRAGM

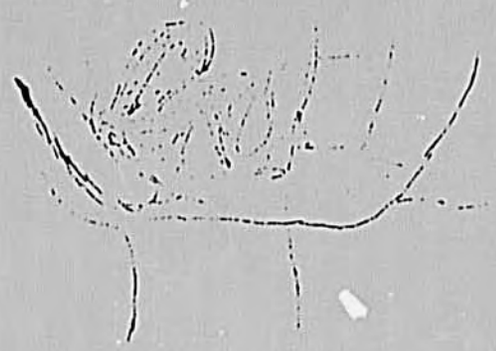

Figure 12

Diaphragm in place in the vagina, with the woman's finger feeling the cervix through the rubber dome

(g) If intercourse take place two hours or longer after the insertion of the diaphragm, using the plunger provided, more cream should be inserted into the vagina. (without removing the diaphragm) squeeze tube to fill applicator

Figure 13

(h) The diaphragm should not be removed until at least 8 hours after the last intercourse.

(i) The diaphragm should not be worn for more than 20 hours without removal for cleaning. She should not worry if her period starts while the diaphragm is in place

(j) The diaphragm should be removed by hooking the rim one finger and pulling downwards

Figure 14

7. Care of the Diaphragm (CAF)

   (a) After use the cap should be washed with water and mild soap and rinsed thoroughly and dried.

   (b) It should be inspected regularly for defects by holding it to the light

   (c) It should not be stretched with sharp finger nails

   (d) It should be kept in its container, keeping the rim circular

   (e) The following must never be brought in contact with the diaphragm: carbolic soap, disinfectant, grease and detergents, petroleum jelly "vaseline".

   Note: In clinic, fitting diaphragms may be washed with soap and water, then soaking in 70% spirits (alcohol) for 20 minutes, Dry and Store.

8. After initial fitting

   The client should be given a diaphragm to go and try fitting herself at home for one week. At return visit, client is to come with Diaphragm in place, assess for correct placement. The trial should include keeping it in for at least eight hours even if she does not have intercourse.

9. Follow up visits

   (a) Review after trial period

   (b) The client returns for spermicidal jellies as needed

   (c) Annually, for physical examination, routine Pap smear, re-check of diaphragm and re-prescription for a new one

10. Subsequent visit

   Record in the record card: re-supply of jelly or cream, re-instruction if given and any procedure done, eg. Pap smear

B. Condom (Sheath, Durex)

Cylindrical thin rubber sheat fitted onto an erect penis before coitus.

1. Indications
   (a) When the male partner wants to be responsible for child spacing/family planning
   (b) As a back-up method, eg when commencing oral contraceptives and at midcycle with an IUD
   (c) To prevent STD
2. Contra-indications
   (a) Allergy to rubber
   (b) Men who cannot maintain an erection with a condom on
3. Instructions
   (a) Sheaths are packed pre-rolled. Some have teat ends, others are round ended. With the latter, a 2 cm free space must be left when placing it on the penis to prevent the sheath from breaking and for collection of semen

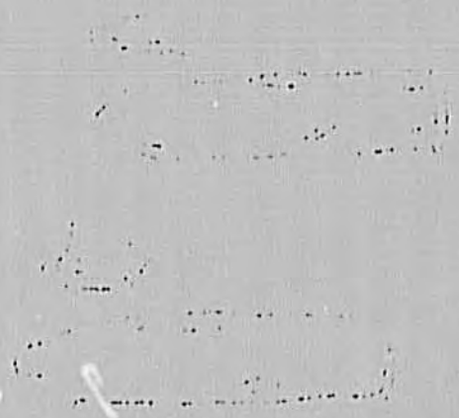

Figure 15
Condoms, plain and teat-ended, rolled and unrolled

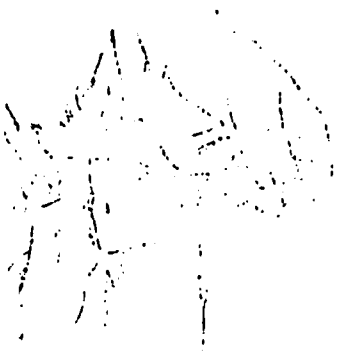

Figure 15b

When putting on a condom without a rounded end, pinch the tip to leave 2 cm free space for semen.

(b) The condom must be fitted on the erect penis before any contact with the woman's genitalia

(c) The penis must be removed immediately after intercourse. The sheath must be held during removal to avoid spilling or the sheath slipping off

(d) Sheaths are meant to be used only once and then flushed down the toilet or burn

(e) Use of the condom also prevents the spread of Sexually Transmitted Diseases

4. Problems

(a) Reduction of glans penis sensitivity

(b) Some men are unable to enjoy intercourse or are unable to maintain an erection while wearing condoms

(c) Allergy to latex rubber

(d) Some couples object to interruption of fore-play to put on a condom

Possible solutions to above problems

(a) Change to another contraceptive method

(b) Make putting on of the condom part of the fore-play or change to another method.

CHEMICAL METHODS

These consist of spermicidal agents

1. Indications
   (a) As a back-up method, eg broken down condom, unexpected running short of contraceptives, expelled IUD, planning pregnancy after stoppoing oral contraceptives.
   (b) As a contraceptive alone or in combination with condoms of diaphragm
   (c) Increasing effectiveness of IUD, condoms and natural methods of family planning at mid-cycle.
2. Contra-Indications
   (a) Allergy to foams, jelly and tablets
   (b) Unwillingness to use foam at time of intercouse
3. Methods available
   (a) Foam
   (b) Jelly
   (b) Foaming tablet
   (d) Pessary
4. Instructions for the use of Foam
   (a) The can should be shaken vigorously 20 times before using so that the foam will be well mixed.

After shaking the bottle of foam insert applicator into bottle. Tilt the applicator to one side, and the foam will fill applicator automatically.

Figure 16
Using foam

(b) The applicator filled with foam is inserted deep into the vagina.

(see Visual Aids for the correct and incorrect internal placement of foam applicator).

Figure 17 1.
Correct placement of foam deep in the vagina

Figure 17 2.
Incorrect placement of foam.

(c) The applicator should be washed with soap in lukewarm water

(d) A spare container of foam must be kept on hand. With most brands, there is no way to tell when the foam is about to run out.

(e) The effectiveness of foam in preventing pregnancy can be increased if it is used with another method of child spacing and family planning such as condoms.

5. Instructions for Foaming Tablets

(a) Client inserts one tablet deep into the vagina 5 minutes before intercourse,

(b) She inserts shallowly first with two fingers and withdraws the middle finger

(c) She should push in deeper with the index finger until it reaches the cervix

(d) The tablet dissolves in the vaginal fluid and spontaneously foams and is effective for 20 minutes

(e) For repeated intercourse, the client should insert another tablet.

6. Instructions for Pessaries

(a) Client inserts one pessary deep into the vagina 5 minutes before intercourse

(b) The effectiveness of the pessary lasts 20 minutes

(c) Another pessary must be inserted before repeated intercourse

(d) The pessary requires about 5 minutes to melt at body temperature.

INTRA-UTERINE CONTRACEPTIVE DEVICE (IUCD)

Objectives

1. To provide guidelines for the selection of clients for whom the IUCD will be the most suitable and least complicated contraceptive technique
2. To assure the prompt recognition and appropriate management of any problems that may develop
3. To give IUCD instructions.

1. Definition
   Device inserted into the uterine cavity to prevent pregnancy
2. Indications
   (a) Those clients contra-indicated to hormonal contraceptive methods
   (b) Clients living far away from family planning service facilities
   (c) Clients over 40 years who are not suitable for hormonal contraceptive
   (d) Clients who have a mongamous lifestyle
   (e) Clients who prefer IUCD as a contraceptive method.
3. Absolute Contra-indications
   You must not initiate IUCD in clients with:-
   (a) Active PID
      (i) acute
      (ii) sub-acute or chronic
   (d) Pregnancy - known or suspected
   (c) Uterine abnormality
4. Strong relative contra-indications
   You are strongly advised not to initiate in clients with:
   (a) PID - recent or recurrent
   (d) Abnormal uterine bleeding
   (c) History of ectopic pregnancy

(d) Genital malignancy

(e) Impaired response to infection, eg in conditions like diabetes melitus, renal diseases

(f) Bleeding disorders

(g) Valvular heart disease

(H) Cervicities

(i) Cervical erosion

(j) Ovarian/tubal masses

5. Other relative contra-indications Uterus less than 6.5 cm or more than 10.0 cm

You may be able to initiate in clients with:

(a) Cervical stenosis

(b) Endometriosis

.. 7. INSTRUCTIONS FOR IUCD INSERTION

With all IUCDs, manufacturers' instructions for insertion should be followed exactly. IUCDs and instruments inserted into the endocervical canal and uteru's should be sterile. The following steps are recommended in the 1978 US food and Drug Administration's Second Report, on Intrauterine Devices (511)

1. Administer analgesics and sedatives if needed. Use atropine if there is reason to expert syncope (temporary loss of consciousness). For parous women IUCD insertion usually involves brief discomfort rather than pain, but there is great individual variation.

2. Insert a speculum into the vagina and inspect the cervix and vaginal walls.

3. If possible, take a papanicolaou cervical smear and a culture for gonorrhea.

4. Perform a bimanual examination to determine the size, shape, position, and mobility of the uterus and to rule out malignancy or inflammation of adjoining organs.

5. Reinsert the speculum and swab the endocervix and vaginal walls with an antiseptic solution.

6. Use intracervical anesthesia or a paracervical block at this time if necessary. This may be helpful for nulliparous women, women with cervical stenosis, or women who may experience syncope.

7. Place a tenaculum on the cervix and apply gentle traction to straighten and stabilize the uterus. This will minimize bleeding and risk of perforation.

8. Insert a uterine sound to determine the direction and size of the endocervical canal and internal os and the position and depth of the uterus. Sounding should be done gently to avoid perforation. If any obstruction is encountered, the IUCD should not be inserted If the uterus is smaller than 6.5cm in depth, consider using a smaller than standard IUCD if available.

9. Insert the IUCD, following the manufacturer's instruction, up to the uterine fundus, with only the strings remaining in the endocervical canal. An IUCD should not remain in the inserter tube longer than three minutes or the IUCD will not resume its shape.

7. B HOW TO INSERT

A. Pre-insertion:

1. It is essential that sterile technique be utilized throughout the insertion procedure.
2. Perform a thorough pelvic examination to determine freedom from overt disease and to determine position and shape of the uterus. Rule out pregnancy and other contraindications.
3. Gonorrhea cultures should be taken
4. The endocervix should be cleansed with an antiseptic solution.
5. With a speculum in place, gently insert a sterile sound to determine the depth and direction of the uterine canal. Be sure to determine the position of the uterus before insertion. The use of a tenaculum to straighten the uterine canal prior to sounding and insertion is recommended.

6. The copper 'T' should preferably be inserted during or shortly after menstruation to insure a non-pregnant state. (This approach may not be practical in certain clinical situations).

Step 1

To minimize chance of introducing contamination, do not remove the 'T' from the inserter tube prior to placement in the uterus. Do not bend the arms of the 'T' earlier than 5 minutes before it is to be introduced into the uterus.

In the absence of sterile glows, this can be accomplished without destroying sterility by folding the arms in the partally opened package. Place the partally opened pack ge on a flat surface and pull the solid rod partially from the package so it will not interfere with asserbly. Place thumb and index finger on top of package on ends of the horizontal arms. Push insertion tube against arms of 'T' as indicated by arrow in figure (1) to start arms folding. Complete the bending by bringing thum and index finger goether e while using the other hand to maneuver the insertion tube to pick up arms of the 'T' (Fig. 2). Insert no further than necessary to insure retention of the arms. Introduce the solid rod into the insertion tube from the bottom alongside the threads until it touches the bottom of the 'T'

Step 2

Adjust the movable flange so that it indicates the depth to which the copper 'T' should be inserted and the direction in which the arms of the 'T' will open. At the point make certain that the horizontal arms of 'T' and the long axis of the flange lie in the same horizontal plane. Introduce the loaded inserter through the cervical canal and upwards until the 'T' lies in contact with the fundus. The movable flange should be at the cervix.

Step 3

To release the copper 'T' withdraw the insertion tube not more than ½ inch while the solid rod is not permitted to move. This releases the arms of the 'T'

Step 3 A

After the arms are released the inserter tube should be moved upward until the resistance of the fundus is reached. This assure placement of the 'T' at the highest possible position within the endometrial cavity.

Step 4

Withdraw the solid rod while holding the insertion tube stationary.

Step 5

Withdraw the insertion tube from the cervical os until strings are visible. Be sure sufficient length of string is visible to facilitate checking for the presence of the copper ""

8. Post Insertion Prophylaxis

Administer to Client after IUCD insertion

(a) Tetracycline 500 mg p.o Q6H x 5 days followed by

(b) Flagly 500 mg TiD p.o. x 5 days

Note:

Instruct client

- During tetracycline therapy, take it one hour before eacting or two hours after eating. Avoid the use of Antacids, Iron or mineral preparations and milk/dairy products when taking tetracycline as they interfer with absorbtion.
- During Flagyl therapy avoid alcoholic drinks (Beer local or bottled, spirits, wine) and for 48 hours after taking the last tablet to avoid sickness due to drug alcoholo interaction.

Types of IUCD

(a) Lippes Loop (sizes C. and D)

(b) Copper 'T' copper 'T' 200, 380

Figure 18.1.
Lippes Loop

Figure 18.2.
Copper T

7. Instructions for Insertion of IUCD

8. Post Insertion Prophylaxis

9. Timing of insertion
   (a) With menses
   (b) Any time when client is on POP, Depoprovera and CCC
   (c) at 6 weeks post-natal or non septic post-abortion and non-coital
   (d) after 12 weeks post caesarean section and non-coital

10. Instructions to women after the insertion of an IUCD
   (a) There is a very small pregnancy risk with the device. If she is worried about this she should use a non-hormonal contraceptive method (eg condom) mid-cycle for extra protection

   (b) She should try to abstain from intercourse or use condom for the first three days to reduce the chances of infection.

   (c) The device is sometimes expelled during the first 6 weeks or during a period. Therefore, she should check that she is properly protected by feeling for the threads (after washing her hands) twice a week for the first 6 weeks, then after every period and inspecting her sanitary pads and tampons before disposal.

   (d) Cramping pains may occur for the first 24 to 48 hours after insertion of the device. If she experiences this she should take something for it (eg panadol or Aspirin). If it does not settle or becomes severe she should report back to the clinic. (Pain does not usually occur after this time. She should contact the clinic if she does have pain).

   (e) Her periods will probably be heavier for the first three months. She may have spotting or a brownish or clear discharge during the first month. She should report back to the clinic if her periods are more than twice as heavy as normal or the discharge becomes excessive or does not clear up.

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(f) If she:-

(i) Misses the threads

(ii) Feels the hard part of the device

(iii) Expels the device

(iv) Missess a period

She should use a non-hormonal method and immediately report back to the clinic.

(g) Her next check-up is at six weeks after initial insertion, the following check-up is in 3 months; 6 months then yearly.

(h) When she wants to plan the next pregnancy, she should come to the clinic during her period for removal of the device.

11. Routine Checks

(a) First check at six weeks after insertion "perform pelvic examination

(b) 3 months after six weeks visits pelvice examination

(c) 6 months after six weeks visits pelvic examination

(d) Yearly "perform complete physical examination.

12. Procedure for removal

(a) Indications and timing

(i) Client's request:
It is preferable to remove with menses, but it can be done at any time

(ii) Excessive bleeding
Remove as soon as the diagnosis is made.
May be due to malposition of IUCD, too large a device partial expulsion, pelvic infection, threatened abortion.

(iii) Pain:
May be due to cramping or dysmenorrhoea in the absence of infection

(iv) Infection:
If severe hospitalisation, for parenteral antibiotic therapy and removal, may be necessary.
If mild, outpatient antibiotic therapy and removal if infection persists, may be sufficient.

(a) Steps for a safe removal
History in sufficient detail to confirm the indication and to orientate the client towards future contraceptive practice.

(b) Pelvic examination - Speculum and Bimanual

(i) To confirm indication

(ii) To rule out active infection take specimen, when possible, abscesses or pelvic mass

(iii) To determine the size, shape, position and consistency of the uterus

(c) Removal Procedure

1. Reinsert speculum
2. Swab the cervix with an antiseptic
3. Apply the tenaculum/volsellum at the 10.00 O'clock to 2.00 O'clock positions and apply steady traction to align the endocervical cana uterine cavity and vaginal cavity (optional)
4. If the string is visible
   Grasp it close to the cervix with the sponge holding forceps while maintaining traction with the tenaculum. Pull slowly and firmly on the string to remove the device.

13. Management
Clients seen at six weeks post-natal or post-abortal (non-septic). If client presents herself at six weeks post-natal or post-abortal for insertion of an IUCD and no doctor or designated person is available she should be

(i) Checked for pregnancy

(ii) If negative, given two packets of POP Or COC and asked to return 4 - 6 weeks later for insertion. On return, she should be checked and if nothing abnormal is detected and IUCP is inserted by the 'IUCD' course graduate.

This applies to breast feeding or nonbreast feeding women

(i) Checked for pregency

(ii) If negative, given two packets of POP or COC and told to return in 4-6 weeks for insertion.

Management of Side Effects and Complications of an IUCD

Problem	Areas to be Investigated	Possible solutions
Spotting	(a) Exclude other causes of spotting, eg PID fibrodi uterus: abortion cancer of cervix	(a) Manage according to clinic practice
	(b) If cause is displacement or partial expulsion of IUCD	(b) Remove and refer/ re-insert
	(c) If no obvious cause found	(c) Within three months of insertion: re-assure. After three months of insertion: Refer.
Bleeding	(a) Exclude other causes of bleeding eg PID fibroid uterus, abortion, cancer of cervix	(a) Manage according to clinic practice
	(b) If cause is displacement or partial expulsion	(b) Remove and refer/re-insert
Lower Abdominal Pain (LAP)	(a) Within 48 hours	(a) Give analgesia
	(b) If pain persists	(b) Remove IUCD and re-insert or change method
	(c) Exclude other causes of LAP's eg ectopic pregnancy dysmenorrhoea, PID	(c) Manage according to clinic practice
	(d) If cause is displacement or partial expulsion	(d) Give analgesia. Remove and refer for re-insertion or change of method

Missing Threads	(a) Find out from client (i) LMP (ii) When she last felt the threads (iii) Whether she used any extra non hormonal method (eg condom) from the time she missed the threads	(a) Speculum and vaginal examination. Threads may be in posterior fornix
	(b) If no threads are seen on vaginal examination	(b) Give a non-hormonal method (eg condom) and then review with menses or in four weeks if she does not get her menses
	(c) If she comes back with menses (i) If threads are present (ii) If threads are still missing	(c) Speculum examination threads may come down with menses (i) If threads are present, re-assure client. (ii) If threads are still missing, refer to physician for X-ray. IUCD may be in situ: Refer for removal at hospital (iii) IUCD may be translocated, refer to physician (iv) IUCD may have been expelled unnoticed Refer for re-insertion Change to another method

	(d) If she comes back in four weeks without menses exclude pregnancy by a pelvic examination and pregnancy test	(d) Speculum examination to see if threads have come down. If pregnant, refer to ante-natal clinic with letter stating that she is pregnant with IUCD in situ
Vaginal discharge	(a) Find out from client (i) Colour (ii) Amount (iii) smell	(a) Speculum examination to confirm type and cause of discharge.
	(b) Exclude other causes of vaginal discharge	(b) Treat according to type and cause of discharge
	(c) If no cause found	
	(i) Within the first three months of insertion	(i) Re-assure client this is expected
	(ii) After three months of insertion and client is worried	(ii) Remove device and change method
	(iii) After three months of insertion and client is not worried	(iii) Re-assure
Amenorrhoea with IUCD in situ	(a) Find out from client (i) LMP	(a) Speculum examination to check for threads and colour of cervix. Pelvic examination to exclude prenancy. Do a pregnancy test.
	(ii) When she last felt threads	(b) If pregnant and threads seen re-assure and refer to a doctor with a letter stating that she is pregnant with an IUCD
		(c) If pregnant and threads are not seen (Device may have fallen out) re-assure and refer to ante natal clinic stating that she is pregnant and IUCD may still be in

NATURAL METHODS

Objectives

1. To provide information on matural methods to those persons who do not wish to use drugs or devices for child spacing/ family planning

2. To provide information on the fetile and infertile phases of the menstrual cycle

3. To guide clients in the timing of intercourse in order to avoid pregnancy.

Instructions to be given to Clients

Withdrawal

1. Before intercourse, fluid at top of penis should be wiped off completely (sperms may be found in this fluid)

2. When the man feels he is about to ejaculate he should remove his penis from inside the vagina. (Be sure ejaculation takes place away from entrance to the vagina).

Abstinence

Man and woman have made a conscious decision not to engage in sexual intercourse due to:-

(a) Age, illness or injury
(b) Sexual dysfunction
(c) Requirement of fertility awareness methods
(d) Requirement of religion, culture (eg post-natal)

Fertility Awareness

A. Calendar (Rhythm)

1. On a calendar, record the length of each menstrual cycle for the last eight cycles (explain that a cycle begins on Day 1 of menstrual period and ends on the Day before your next period begins)

2. The earliest fertile day when you are likely to be fertile is calculated by subtracting 20 from the shortest cycle of the 8 cycles recorded.

3. The last fertilie day when you are likely to be fertile is calculated by subtracting 10 from the longes cycle of the 8 cycles recorded.

4. Next, find out the dates for the client's fertile days for the coming cycle.
   (a) Take note of the first day of her current menstrual cycle
   (b) Count forward the number of days in the first fertile day (she has recorded her shortest cycle in the last eight cycles)

B. Basal Body Temperature (BBT)

(BBT normally rises soon after ovulation and remains high until next menstrual period begins).

1. Use a BBT thermometer if possible rather than a clinical thermometer.

2. Take the temperature each and every morning before you get out of bed, before smoking a cigarette or any kind of activity.

   Take a reading for 5 full minutes either orally or rectally. Pick one site and take consistently every day.

3. Record your temperature every day on a special BBT chart. Connect the dots for each day so a line goes from Day 1 ro Day 2 to Day 3, etc (See sample chart.)

4. BBT will probably rise 0.2-0.4 degrees as soon as ovulation occurs and should stay elevated above pre-ovulation temperature. For many women BBT drops about 24 hours before it begins to rise after ovulation.

   A drop in BBT probably means ovulation will occur within the next 24 hours.

5. You must remember that the BBT rises after ovulation so that you may not know ovulation has occurred and intercourse at this time would not be during a non-fertile period. Therefore, use abstinence or a back up method all through the first part of your cycle.

6. The fertile days can be assumed to be over only when the BBT has risen and remained elevated for three full days. Use abstinence or a back-up method

7. Many events may affect the BBT and offset the temperature. Therefore you must abstain or use a back-up method if in doubt. Factors affecting BBT may include:

   (i) Colds or upper respiratory tract infection
   (ii) Irregular sleeping hours
   (iii) Bad dreams
   (iv) Other infections
   (v) Temporary changes (diet changes, visiting, travelling)

C. Cervical Mucus Method (CMM) or Billings Ovulation Method

This is a method that requires the involvement of the partner and woman in order to be successful.

1. Each evening after urinating, the woman observes the color and consistency of mucus when she wipes herself
   (i) Compare the degree of wetness each day
   (ii) Notice whether mucus can be collected on the finger
   (iii) Check for stickiness and stretch.
   (iv) Record finding on a special chart each day.

2. Have client check and record mucus changes for several cycles to understand her personal mucus signs clearly.

3. As soon as the client notices any wetness or mucus of any kind she should assume she is fertile and will remain fertile until the fourth day after her peak day.

CERVICAL MUCUS CHART

Phase of Menstrual cycle		Approximate Number of days in idealized 28-day cycle	Characteristics of Mucus	Woman's Sensations	Rules for intercourse
Phase 1	Menstruation	3-5	Mucus, indicating the onset of the fertile period, may or may not be present but is obscured by menstrual flow	Wet and lubricate	Abstain, since type of mucus, if any cannot be ascetained
hase 2	Post menstrual	2-4	No mucus (dry days)	Dry	Coitus is permitted but not on consecutive days since seminal fluid following inter-course may obscure the mucus
			or	or	
			Mucus present in small amounts	Sticky and or moist	Abstain
hase 3	Early pre-ovulatory days	2	Cloudy, yellow or white, and of sticky consistency	Sticky and/ or moist	Abstain
Phase 4	Immediately before, at and after ovulation	3-5	Clear, slippery, wet, and stretchy, with the consistency of raw egg white. (last day of this phase is known as the "peak symption)	Lubricative and/or wet	Abstain

Phase 5	Immediate postovulatory days	0-3	Small amounts of cloudy, sticky mucus or No mucus	Sticky and/ or moist or Dry	Coitus is permitted beginning on the fourth day after the last day of wet, stretchy mucus coitus permitted
Phase 6	Postovulatory infertile days	7-12	Usually no mucus, dry	Dry	
Phase 7	Late postovulatory days	0-3	Clear and watery	Stocky and/or moist and/or wet	Coitus permitted

4. Advise her to abstain during the first part of her cycle until 4 days after her peak mucus days. (advance notice of ovulation cannot be determined by the CMM to prevent pregnancy.)

5. Different events can affect the CMM and offset the mucus. Advise her to abstain if in doubt. Factors affecting CMM may include:-
   (a) Vaginal infections
   (b) Use of vagina spermicides
   (c) Certain drugs (eg antibiotics)
   (d) Sexual intercourse.

D. Sympto-Thermal Method (STM)

Combining various methods probably increases the effectives of the fertility awareness/Natural Family Planning methods since fertilile days will be pinpointed more accurately. However some natural famly planning teachers feel interpreting daily temperature readings makes the S.TM too complicated for some women.

1. Advise client to record menstrual dates (use procedure on calendar method). BBT (use procedure on Basal Body Temperature) and CMM (use procedure on Cervical Mucus Method) or BBT and CMM only or dates and BBT only.

2. If the pattern is not clear to the client advise her not to guess but to assume she is fertile and to abstain or use another method.

3. Some clients may be willing to include the first four days of the cycle (during menstruation) as possible days for intercourse. If menstrual blood in the vagina is unpleasant this can be reduced by using a diaphragm during intercourse. Diaphragm will temporarily hold back menstrual blood but does not serve as a contraceptive. Therefore it may be acceptable to couples wishing to use only Natural Family Planning methods.

STERILISATION

Objectives

1. Summarize the indications for sterilisation
2. To provide information on the selection and counselling of clients for sterilisation and refer interested clients
3. To list the instructions to sterilised clients
4. To adequately state the policy on sterilisation in this country
5. To list the different methods of male and female sterilisation.

1. Definition

   A voluntary surgical operation performed on a man or woman to permanently stop him/her from having more children.

2. Indications

   (a) As a preferred method in a couple who have decided that their family is complete

   (b) Clients with medical conditions which would endanger mother's life if she got pregnant, eg severe rheumatic heart disease, severe phypertension

   (c) Obstetric conditions which would endanger a mother's life if she continued getting pregnant, eg severe pregnancy induced hypertension, repeated caesarean sections

   (d) Clients with hereditary/genetic diseases, eg haemophilia

   (e) Severe mentally and physically handicapped client.

3. Relative contra-indications

   You may refer to doctor/hospital

   (a) Clients under the age of 35 years

   (b) Clients with 2 or less children

4. Selection of Clients

(a) Decision must be made deliberately, not at a time of stress, eg in labour, with social or marital problems

(b) Preferably client should be over 35 years of age with no less than 2 living children

5. Counselling

(a) Explain fully the procedure to be performed the need for signed consent form to both partners and the cost involved, if any

(b) Stress the irreversibility of the operation

(c) Clients should consider the following possibilities

(i) Divorce or death of partner which may lead re-marrying

(ii) Present children may die, eg in a road traffic accident, war, etc

(d) Encourage clients to ask questions and dispel myths about sexual ability after sterilisation

(e) Client may be offered the use of injectable hormones (if not contraindicated) if more time is needed to decide on accepting Sterilization.

6. Government Policy on Sterilisation

(a) There is no special law on sterilisation

(b) The law requires a consent form to be signed before the operation

(c) Institutions require the client's signature and the partner's signature where applicable.

7. Sterilisation in the Male (Vasectomy)

(a) Procedure

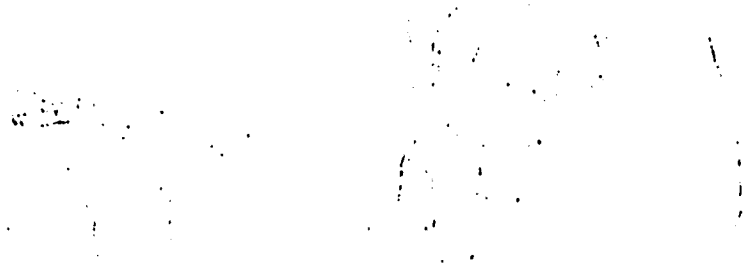

Figure 20

(a) Procedure
Bilateral vas deterens occlusion and resection via one or two incisions in the scrotum

Firure 21

Male genital tract, showing vasectomy operation - small portion of the vas deterens cut (on both sides) as it passes through the scrotum.

(a) Instructions after Vasectomy

(i) He should rest from work for about 2 days after the operation

(ii) He should use ice packs for at least 4 hours and use a scrotal support to prevent swelling and discomfort

(iii) He should avoid strenous exercise for a week

(iv) He may resume sexual intercouse but his parter should use other methods of contraception until after negative sperm counts "after vasectomy it takes approximately 10-15 ejaculations to clear sperm from reproductive treat.

(v) Sperm count can begin after 15 ejaculations for negative count or 1 week past procedure.

Procedure

Bilateral fallopian tube occlusion and resection via a mini-laparotomy or laparoscopy.

Figure 22

Instructions after Tubal Ligation

(i) She should rest for 2 days after the operation

(ii) She should avoid intercourse until she feels comfortable to begin again

(iii) She should report to her doctor if she has persistent pain which is not relieved by analgesia or if she bleeds from the incision or has fever.

Follow-up: 1 week after surgery to remove sutures, where applicable.

May return to clinic if problem arises and be referred to appropriate service.

DEPO-PROVERA (MEDROXY-PROGESTERONE ACETATE (MPA)

jectives

To summarize the indications and contra-indications for Depo-Provera

To outline criteria used in the selection of clients for this particular injectable contraceptive.

To provide guidelines for the management of common problems associated with Depo-Provera use.

Indications

(a) Multiparous women between the age of 35 years and above

(b) Mentally retarded women who are 18 years of age or above and in consultation with their guardians

(c) Breastfeeding women

(d) Client awaiting BTL

Contra-indications

You are strongly advised not to initiate for clients with

(a) Known or suspected malignancy of the breast or genital organs

(b) Abnormal uterine bleeding

(c) Impaired liver function or history of hepatic adenoma; hepatitis less than one year ago

(d) Severe headaches particularly migraine

(e) Pregnancy or possibility of pregnancy

(f) No previous history of pregnancy

(g) Desire for subsequent pregnancies

(h) Severe menorrhagia

(i) Severe obesity

(j) Severe depression

(k) Uncontrolled diabetes mellitus

(l) Severe hypertension or BP greater than $\frac{140}{90}$

Conditions for discontinuing Depo-Provera

(a) Pregnancy
(b) Excessive weight gain (nore than 7 kgs in three-six months)
(c) Severe acne or chloasma
(d) Chest paint associated with breathlessness
(e) Suspected or existing malignancy
(f) Severe depression
(g) Excessive vaginal bleeding not controlled by treatment
(h) Jaundice
(i) Sudden onset of severe headache and visual disturbance
(j) Memopause
(k) Severe hypertension or BP greater than $\frac{140}{90}$

Instructions to women on Depo-Provera

(a) "Depo-provera can be started, during menses"
(b) Women will lactational amonarrhea, may start Depo-provera, after pregnancy has been excluded by pelvic examination and/or pregnancy test.
(c) "Depo-provera can be started 4 weeks post partum/post abortion
(d) To reduce defaulting the client must receive an injection every 12 weeks
(e) She may expect irregular menses or amenorrhoea following the first two or three injections
(f) If she defaults for up to seven days, she must report back to the clinic for her next injection. She need not use extra non-hormonal method (eg condom)
(g) She should report back to the clinic if she experience danger signs
(h) Although Depo-Provera does not affect the amount of breastmilk, she should take plenty of oral fluids when breast feeding
(i) When she sees a doctor or is admitted into hospital, she should tell them that she is on Depo-Provera
(j) She may gain weight, therefore should watch her diet
(k) If she has bleeding of more than twice her usual flow of duration or amount, she must return to the clinic
(l) She must use a non-hormonal method (eg condor) for one month only after the first injection if it is given after the 5th day of her cycle. If Depo-provera is given between Day 1 to Day 5 of her cycle, a back-up method is not required

She must report to the clinic when she wants to plan for a pregnancy, if possible.

Management of Depo-Provera Problems

Problem	Areas to be investigated	Possible solutions
Bleeding	(a) After 6 weeks of 1st injection	
	(i) Exclude gynaecological conditions, eg fibroids abortion, PID	(i) Manage according to clinic practice
	(ii) If cause is hormonal	(ii) Give repeat Depo-provera 150mm IM, use this as the new schedule.
Spotting	(a) Exclude gynaecological conditions, eg fibroids abortion and PID pregnancy	(a) Manage according to clinic practice. If assessment is negative and due to hormone
	(b) If cause is hormonal and client is worried	(b) Give primolut N 5mg p.o tid x 21 days primolute is Norethisterone
Weight gain	(a) Find out from client if this due to	(a) (i) Advise on diet
	(i) Poor eating habits	(ii) Change to low progestogen COC, POP. IUCD or diaphragm
	(ii) Increased appetite since the injection was started	
	(b) Exclude other conditions eg hypothyroidism depression	(b) Manage according to clinic practice
	(c) If cause is hormonal	(c) Change to a low oestrogen COC, POP, or IUCD Review client frequently.
Dizziness	(a) Exclude other causes, eg anaemia, hypertension	(a) Manage according to clinic practice
	(b) If the cause is hormonal	(b) Rule out other possible causes Reassure client regarding this side effect; if severe, discountinue Depo-provera.

Depression	(a) Exclude other causes, eg marital or social problems	(a) Refer to social Welfare
	(b) If the cause is hormonal	(b) Change to a non-hormonal method
Loss of Libido	(a) Exclude other causes, eg dry vagina, dysparunia and marital problems	(a) See section of gynaecological conditions
	(b) If the cause is hormonal	(b) Do not repeat Depo-provera.
		(c) Change to a non-hormonal method.
Chloasma	(a) Exclude other causes, eg use of skin lightening creams containing mercury, pregnancy and sunburn	(a) See section on management of problems on COC
	(b) If cause is hormonal	(b) (i) Change to non-hormonal method
		(ii) Advise use of a sun barrier cream and sunhat
Headaches	(a) Find out from the client whether headaches occurred prior to the injection (possibly due to social, fiancial and physical problems)	(a) If so, refer to Social Welfare
	(b) If cause is hormonal	(b) Do not repeat the injection, give POP, IUCD and diaphragm
Acne	(a) Find out about her died: if it contains a lot of fats, carbohydrates, fizzy drinks and sweets	(a0 Advise on diet
	(b) Find out about her skin toilet	(b) Advise on cleasing her face with astringent, eg lemon
	(c) If the cause is hormonal	(c) Change to a non hormonal method eg IUCD, diaphragm

Amenorrhoea	(a) Exclude pregnancy	(a) (i) If pregnancy test is negative, re-assure and repeat next injection when due (ii) If pregnancy test is positive refer to ante-natal clinic
	(b) If cause is hormonal	(b) (i) Re-assure that it is often a normal side effect of the injection (ii) If client is worried, change method, four weeks before due date.
Bloated Abdomen	(a) Exclude constipation	(a) Advise on diet, plenty of roughage cut down on starch foods, Give milk of magnesium. 1 tablespoons tds for one week
	(b) Exclude pregnancy	(b) If negative, reassure and give the next injection
Default	(a) Find out for how long she has defaulted	(a) (i) Give Depo-provera 150mg. No back up
	(i) If less than seven days	
	(ii) If less than 6 weeks	Give Depo
	(iii) If more than 6 weeks	Rule out pregnancy Then give Depo. Use a back-up method in first four weeks. Counsel on importance of keeping 12 appointments.

CLINIC MANAGEMENT

Objectives

1. To liaise with other health workers, organise and manage a clinic efficiently
2. To ensure continued supplies of drugs and contraceptives
3. To collect, safely keep and account for any revenue collected
4. To provide services in accordance with the ZNFPC policy.

1. Equipment for a standar CS/FP Clinic (One Set)

	Equipment	Quantity
(a)	Steriliser or large pot and a gass stove	1
(b)	Cuscos vaginal speculum	3
(c)	Sponge holding forceps	3
(d)	8 inch kidney dishes	3
(e)	Gallipot	3
(f)	Cheatle forceps	2
(g)	Container for syringes	1
(h)	Bucket with lid for dirty gloves	1
(i)	Medicine measure	1
(j)	Jug for cheatle forceps	1
(k)	Sanica or a bucket with a lid	1
(l)	Waste paper bucket	1
(m)	Boilable nail brush	2
(n)	Container to hold nail brushes	1
(o)	Dish mop for washing instruments	2
(p)	Jug for dish mops	1
(q)	Stethoscope	1
(r)	Sphygomomanometer	1
(s)	Bathroom scale	1
(t)	Hunting torch or angle poised lamp	1
(u)	foetoscope	1
(v)	Clinical thermometer	2

If you are working at a place where you provide more services in the same room, you may require more of some of the above listed equipment.

2. Furniture
   (a) Examin table/couch
   (b) Table/trolley for instruments
   (c) Table for steriliser
   (d) Desk and 2 chairs
   (e) Stool/chairs for examiner so as to easily visualise the cervix during a speculum examination
   (f) Small table for hand washing (if sink and water from a running tap not available)
   (g) Lockable cabinet for drugs and contraceptives
   (h) Book shelves for records and files
   (i) Chairs or benches for clients
   (j) Desk and chair for secretary (if necessary)

3. Other Materials
   (a) Cotton wool
   (b) Sanitary pads
   (c) Soap and towels for hands
   (d) Antiseptic lotion, eg betadine
   (e) Gloves (disposable or rubber)
   (f) Insect killer

4. Equipment for Pap Smear
   (a) Ayres spatulae
   (b) Glass slides
   (c) Slide carrier
   (d) Pap smear fixative or a can of hairspray
   (e) Diamond pen
   (f) Cytology forms

5. Equipment for IUCD Insertion
   If IUCD's are inserted in your clinic, the following equipment will be needed:-

(a)	Curved marked uterine sounds	2
(b)	Single toothed Vollellum/tenculu forces	2
(c)	Large kidney dishes	2
(d)	Blunt nose pairs of scissors	2
(e)	Container for sterilising (loose lipped lids (if need be)	1

5G - Iodine 1:2,500 for 5-10 minutes

Note Sound and tenaculum should be sterilized, wrapper can be a sterilefied for IUCD.

6. Other Equipment
   (a) 2 dirty linen carriers
   (b) 1 double bowl stand
   (c) 4 drums for autoclaving equipment

7. Stationery
   Carbon papers, laboratory forms, duplicate or triplicate requisition book, record books for daily work, code-method numbers, pens, pencils, rubber, consent forms, memos and letter heads, bulldog clips, monthly return forms, paper punch, stapler, files for staff circulars and letters, referral slips, cash box-tin. Record cards (large and small, literature on cs/fp.

8. Linen
   Depends on how often the laundry is done.

Draw sheets	18
Large dressing towels	23
Small dressing towels	36
Clients' gowns (different sizes)	12
Pillow cases	12
Huckaback towels (for IUCD insertion)	6

9. Care of Equipment and Rooms
   Ensure that your aide is taught how to do the following
   (a) Cleaning walls and floors
   (b) Cleaning and caring of instruments
   (c) Cleaning and packing gloves and linen

10. Equipment for C&T

Cup and spoon (3ml)	1
Mixing bowl	1
Beer Bottle	1
Mineral bottle	1
Salt	
Sugar	
Water (Drinkable)	

SUBFERTILITY

Objective

1. To counsel and refer subfertile couples following the criteria for investigation
2. To take a history and examine subfertile women and record findings on the Record Card

Counselling

1. This can be done with an individual, a couple or a couple with their relatives, eg group counselling.
2. Explain in simple language the basic reproductive hpysiology necessary to conceive.

   (See end of section for glossary of simplified terms):-

   (a) Fertile sperms to be deposited into the vagina at the right time of the month

   (b) Right time ovulation - when the ovum leaves the ovary to enter the fallopian tubes

   (c) Fallopian tubes have to be open

   (d) Conditions of secretions from the cervix need to be right at the time of ovulation

   (e) Uterin lining should be in the right condition for the fertilised ovum to implant.
3. Explain the procedures of examination, treatment and the costs
4. Explain why tests are arranged in relation to the woman's menstrual cycle. Step by step treatment is essential, tedious and time consuming.

Criteria for Investigation

1. The woman must be between 20-35 years of age and the man under 55 years of age.
2. The couple must be married or have a stable relationship
3. The couple must have been cohabiting for two years, having regular sexual intercourse and not using any contraceptive method, without achieving pregnancy. (An exception to this rule many be made for women between the ages of 35 and 40 years, when investigation may be recommended after one year of trying for a pregnancy).

4. The couple must have had no more than one living child together. (Exceptions to this rule may sometimes be made in cases where there are no children in a new marriage.)

5. The couple must have been referred to the subfertility clinic by a doctor or a cs/fp trained person, where possible.

6. Both partners should be seen together. If the husband absolutely refuses, then the woman will be seen, but it is strongly recommended that both partners be referred.

History

1. A. Social History

Write down the date, name of the clinic and registration number. Ask client the following questions:

(a) Full name
(b) Full residential address
(c) Occupation
(d) Where she heard of subfertility services from
(e) Date of birth
(f) Marital status
(g) If married, date of marriage
(h) Whether it is her first marriage or not
(i) Number of children and abortions if any
(j) whether she would like to be followed up at her home if necessary
(k) Husband's occupation
(l) whether it is her husband's first marriage
(m) If not, has he any children with his previous partner
(n) If yes, what is the age of his youngest child with the former wife
(o) On average, how many times she has intercourse per week
(p) whether she has been treated for lower abdominal pain before

B. Medical hx - Systemic diseases
Surgery
Trauma
Drugs

C. Obstetric/Gynaecology hx - previous contraception
- Complication
- STD
- Pelvic conditions
- Pelvic Surgery

D. Social hx - Alcohol
- Smoking, marijuana, tobacco
- Hot baths

2. Physical Examination

Perform a physical examination and pelvic examination (refer to. sections on physical and pelvic exminations).

On physical examination, particularly look for:-

(a) Hair distribution and breast development which would be suggestive of development deficiencies such as ovarian dysfunction, hyporthyroidism and hypogonadism

(b) Laparascoypy scar which would indicate that she has been investigated for subfertility before

3. Management

(a) If no abnormalities were detected on examination and the client fits into the investigation criteria - refer to referral centres/hospital

(b) For those with two or more living children:

(i) Teach the fertile period (see fertility calendar in section natural family planning methods)

(ii) Re-assure on return visits

(c) Every client should have a Pap smear taken and husband sent for semen analysis investigations before referring to the doctor, wherever possible.

4. Recording

Record all the findings on physical and pelvic examination and the management on the Record Card

5. Refer to Gynaccologist.

RECORDS

Objectives

1. To obtain, record and keep child spacing and family planning data
2. To submit monthly returns to area collating officer

Record the following information

1. Daily
   (a) Name of client
   (b) Registration number
   (c) Address
   (d) whether the acceptor is new or old
   (e) Other clients
   (f) Type of contraceptive supplied
   (g) Contraceptive and treatment given
   (h) Monies received from clients
   (i) Total number of clients seen (old and new)
   (j) Total amount of monies received
   (k) Total number of different contraceptives and treatment given

2. Weekly
   Submit money to the bookkeeper stating the amount of contraceptives and drugs used and the balance.

3. Monthly
   (a) Submit on stock schedule No. 1 Form, the amount of money being spnt, the amount of contraceptives and drugs used and the balance in stock
   (b) Send the money to the bookkeeper
   (c) Order contraceptives and drugs from the Provincial Manager
   (d) Submit a written report of the activities of the clinic to the provincial Manager
   (e) Submit filled in H.O. 15(a) form to the Nursing Officer.

NON-ZNFPC STAFF

NB All non-zimbabwe National Family Planning Council (ZNFPC) staff should submit a filled in H.O. 15(a) form to the ZNFPC Provincial Office

Disease/Cause	Symptoms	diagnosis	Treatment	Potential Complication	Behavioral Messages
Acquire Immune Deficiency Syndrome (AIDS) Human T-Cell Lymphotrophic Virus type 111 (TLV-111) Transmission by 1. Sexual contact, genital or genital-anal receptive intercourse. 2. Perinatal-in utero, at birth, during lactation. 3. Contaminated needles, blood, blood products.	Night sweats, fever diarrhea, anorexia (loss of appetite) extreme fatigue, unexplained weight loss, lymph node enlargement Opportunistic diseases Kaposi' sarcoma (purplish skin lesions), pneumocystis pneumonia	History of being risk group Symptomso of opportunistic disease blood screening	No cure Supportive therapy directed at opportunistic infection refer to Doctor	Fatal to 50% within 2 years of diagnosis Close to 100% mortality in 3 years	Heterosexual and Homosexual decrease numbers of casual contacts IV drug users, avoid contaminated needle. Use condoms avoid anal intercourse
Chancroid Hemophilins Ducreyi	Females, usually asymtomatic Males, single or multiple, superficial painful ulcer surrounded by reddnened hale, ragged border; inquina bubo 25-60% may rupture. Ulcer usually on glans corona, shaft of penis	Ulcer painful, bleeds easily R/O syphilis, herpes Microscopic (organisms seen in a chain or along mucous strand)	Erythromycin 500mg po qid Trimethoprim 80m/Sulfa methoxazole 500mg.2 tabs po dail x 5 days. F/U after at least 7 days and until ulcers or lymph nodes have healed. Refer to Doctor	Secondary infection of Fistula Difficult healing ulcers	Examine sexual parter. Cleanse area daily Use condoms

Chlamydl Cercicitis chlamydia Tra Chomatis Cervicitis can be used by gonorrhea also.	Mucopurulent discharge from cervix; maybe perceived by client as a vaginal discharge	Yellow mucopurulent Secretion at Cervix Chlamydia culture from cervix	Tetracycline 500mg p.o qid x 7-10 days or Doxycycline 100mg p.o BID x7-10 days	Intertility, pelvic abses Neonatal infection. Pregnant female-high risk of spontanocus Abetion BB, postpartum fever.	Complete antibiotic course. Examine & treat partner return if symptoms recur. Use condoms.
Granuloma Inquinate (Donovanosis) Calympatobacterium gramulomatis	Single or multiple suboutaneous nodules	Microsopic exam of smear from ulcer Donovan Body.	Tetracycline 500mg po.qid x 21 days or til lessions healed Trimethoprin (80mg) sulfa methoxazale (400mg) 2 tabs BID x 14 day p.o. Refer to Doctor	Secondary infection of lesions. Keloid formations Enlarge labia, penis, scrtoum. Necrosis of genitalia Toxic-fever malaise, anemia, gacheria, death.	Complete antibotic course. Tetracycline instructions. Return for F/U after therapy begin; Examine partners. Return weekly till lesion is healed.
Herpes Genitalis H.Simplex virus type 1 & 2	Single or multiple vesicles on genitalia Vesicles spontaneously rupture forming shallow ulcers. very painful. Lesions resolve spontaneously. Initial infection lasts about 12 days Recurrent infection last about 4-5 days milder. Interval between epsodes is called latency. Virus may be shed intermitently during latency.	Lesion-vesicular pattern of recurrence. Multinucleated giant cells on pap smear Positive herpes culture	No Cure Antiviral drug (Acyclovir) helps to reduce symtoms Acyclovir 200mg p.o. 5 times daily Acyclovir ointment 5% to area every 3 hours 6 x daily for 7 days R/Doctor	Men & women: Neuralgia, meningitis, urethral strictures Newborns: eye infection, skin infection, mucous membrance infection, disseminating membrance, contral nervous system involvement high mortality rate	Keep area clean and dry. Abstain from intercourse when symptomatic Risk of transmission during latency. Condoms may offer some protection Annual papsmear Inform obstetricians

Condylomata Accuminata (Genital Warts) Human papilloma virus	Single or multiple, soft caulfilower looking, painless, growth around anus, vulvo gaginal area, penis, urethra or perinium	Based on clinical presentation R/O condylomata lata with test for syphilis May biopsy	Refer to Doctor Apply podophllin 10%-25% in tincture of benzoin to wart Wash of after 1-4 hours. If warts persist after 4 weekly applications alternate therapy include cryptherapy electro-surgery by referal	Warts enlarge and produce tissue destruction May obstruct birth canal during pregnancy	Return weekly for treatments. Examine partner for warts. Abstain from sex use condoms
Gonorrhea Neisseria gonorrhea	May be asymptomatic: Male symtoms dysuria, frequency of urination, purulent urethral discharge	Male-microscopic gram negative intracellular diplococci from discharge by grain stain. Female-same from endo-cervical mat rial.	Usually present with coexisting chlamydia therefore single dose penicillin 4.8m.u mg 2 sites and probenecide 1 gm. p.o. plus Tetracycline + 500mg po gid x 7 days or Ampiciline 3.5 gm p.o at one time Tetracycline 500mg p.o qid x 7 days or Cephuroxine 1.5gm Im cefatoxine 1gm Im	Female. -PID -infertility. sterility -pelvic abscess. Male. - Epididymitis -sterility, urethral strictures - Infertility Newborens-opthalmia neonato, scalp abscess, pneumonia, rhinitis anorectal infection. Disseminated Gonococo infection if untreated	Complete a antibiotic course. Tetracycline instruction Return for test of curse 4-7 days after treatment end. Examine and treat partners. Use condoms Avoid sex until acured.

1/2

Lymphogranuloma (LGV) A type of chlamydia treacnomatis	2mm-3mm painless vesicle or non hard ulcer Enlarged lymph nodes follow 1 week to 1 month after lesion. Stiffness & aching in groin. Smelling of inguinal region Lymph nodes may subside or form abscess that rupture 7 form fistules	Complement fixation test having titre 1:16 or higher	Tetracycline 500mg po qid x 14 days or Sulfametho xaxole 1gm p.o. BID x 14 days Aspirate fluctuant lymph noes; do not incise & drain Refer to Doctor	Dissemination with Kidney, liver involvement phlebities Large poly-like swellings of vulva, anal margin rectal mucosa Rectovaginal fistulas Perianal abscesses Rectal strictures	Complete antibiotic Tetracycline instructions Tetracycline instructions Return for F/U 3-5 days after treatment begins. Examine/treat partners
Pelvic inflamatory disease (PID) N Gonorrhea C Trachomatis N Rominis	Pain/tenderness of lower abdomen, cervix, high WBC adenexa Fever, chils, high WBC court. High sed. rate History of multiple partners Use of IUCD-first 5 to 10 days of menstrual cycle See female SX for gonorrhea	Clinical presentation R/O apperdicitis Ectopic 1) pregnancy Direct visualization of pelvis (la paratemy laporoscopy) done by Doctor Culture of tubal Exudate. Combined treatment: in hospital, Iv antibiotics Outpatient same as for GC Refer to Doctor if acut or chronic.	Hospitalization if uncertain dx Surgical emergency pelvic abscess Severe illnes pregnant unable to follow or tolerate outpatient regimen failure to respond to outpatient treatment Unable to arrange F/U 48-72 hrs. after treatment Pre-pubertal children are involve	Life threatening ectopic pregnancy pelvic abscess infertility, recurrent or chronic PID, chronic adhessions, premature hysterec tomy, depression	Out patient: return - days after treatment begins to assess impreveent Return 407 days after treatment ends. Examin and treat partners. Avoid sex til cured. Remove IOCD after 48 hrs treatment. Use condoms tetracycline instructions. Complete antibiotic course

Syphilis Treponema Fallidum	Primary: Painless chance indurated, located site of exposure. Secondary: variable skin rash, mucous patches, condylomata lata, lymph adenopath Latent: No clinical signs	Primary: lesions : serologic test for syphilis (STS) STS titres with 4 fold increase, exposure within 90 days. Secondary: skin rash strongly reactive STS Latent: No clinical signs with positive STS Dark field micoro scopy of material from chance	Primary/ Secondary (1 year Benzathin Pencillin G 2.4 mu in. Primary/Sec. (1 year or undetermined length. Benzathine pencillin G 72.2 m.u. total; 2.4 m.u dm weekly x 3 consecutive weeks if allergic: Tetracycline 500mg p.o. qid 15-30 days or pr c. pencillin 600mg Im x 10 days or Erythromycin 500mg qid x 15-30 days.	Late syphilis, congenital syphils late syphilis neurosphyilis, cardiovasc involvement lesions called gummas	Return for F/U 3,6, 12 and 24 months after treatment, If blood test available. Complete antibotic course. Examine and treat partners Avoid sex till cure. Use condoms.
Vulvovaginitis 1. Trichomonas vaginalis Trichomnas (protozoa)	Excessive vag. d/c pruvitis erythema, edema. Frothy, bubbly, thin greenish white	Motiletrichomenads on microscopic saline wet mount of vag. d/c petechia on x and vag. well	Flagyl 2gm state p.o female & partner(s) Flagyl 250mg p.o. TID x 7 days	Recurrent infection salpingitis	Complete antibi otic. No alcobol up to 2 days after last dose of Flayl. Return if not cured. Use condoms.
2. Garderella Vaginalis Several species of bacteria	Excessive vag. d/c pruitis erythema maldoorus d/c yellow-gray green; thick or watery	"Clue cells" on wet mount with saline - vaginal d/c + KON 10% gives of "fishy" odor	Flagyl 500mg p.o. BID x 7 days or Ampicillin 500mg p.o qid x 7 days (less effective)	Recurrent infections salpingitis	Complete antibiotic No alcohol up to 3 days after last dose of Flagyl Return if not cure. Use condoms

3.	Candida Candida albicans not usually sexually transmitted Candida species is resident in vagina	White curdy vag. d/c excessive pruritis excoriation of labia Severe erythema, edema of ext. genitalia and/or inner things	wet mouth with KOH 10% microscopic yeast, budding cells	Nystatin vag. suppository divided p.v. BID x 7-14 days or Miconazole nitrate 2% creme applicatorful it Hs. x 7 days	Recurrent infection	complete medica oven during menses. Use mini pad to protect clothing Use cotton undewear, wash under wear in hot water

APPENDIX F

Revised Training Workplan Schedule

Appendix F

Revised Training Workplan Schedule

Contract Workplan #n/a:	Preceptors Clinical Update and Curricula Development for On-the-job IUCD Training, January 4 - 15, 1988.
Contract Workplan #15:	On-the-job IUCD Training, January 18 - 29, 1988.
Contract Workplan #14:	CS/ORT Management Workshop, February 1 - 26, 1988.
Contract Workplan #6:	Management Workshop, February 29 - March 11, 1988.
Contract Workplan #16:	Project Review, March 14 - 18, 1988.

APPENDIX G

Family Planning Activity Records and Family Planning Client Records Benue State

Form 1

Date:__/__/__ Client Reg. Number

FAMILY PLANNING CLIENT RECORD

DO NOT FILL THIS FORM FOR THOSE REQUESTING NON-PRESCRIPTIVE SUPPLIES

Clinic Name_____

Family Name_____

Given Names_____

Address(or directions to reach home) _____

_____

Age:_____(Estimate if not known) **Birthdate** _____

Education: _____ None _____ Some Secondary

_____ Some primary _____ Secondary com-

_____ Primary completed pleted or more

Religion: _ _ Moslem _____ Christian _____ Other

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

Do you want to have more children?

_____ Yes, wants child now

_____ Yes, but wants child later (spacing)

_____ No, wants no more children

_____ Not certain or counseling only

Contraception used prior to this visit?

_____No _____Yes (Specify most recent method used)

Method:_____

Reproductive History:

_____ No. of children still living

_____ No. of children born alive

_____ No. of miscarriages/stillbirths/abortions

Month/year last pregnancy ended: _____/_____

Result of last pregnancy: _____ Normal _____ Complicated

Specify complication:_____

Menses Frequency: _____

Duration: _____

_____ Regular _____ Irregular

Date of Last Menstrual Period: _____

Are you currently breastfeeding? _____ Yes _____ No

Family Name_____ Client Reg. Number:

CLIENT FOLLOW-UP (Continued)

DATE	METHOD CHANGE (Y/N)	METHOD SUPPLIED	BRAND/ SIZE/ QTY.	B/P	WGT	PELVIC INFEC.	OBSERVATIONS, LABORATORY RESULTS, TREATMENT	DATE NEXT APPT.

MEDICAL HISTORY

Note here any serious illness or condition:

_____ Yes _____ No Diabetic
_____ Yes _____ No Jaundiced
_____ Yes _____ No Frequent urinary tract infection or dysuria
_____ Yes _____ No Frequent or severe headaches
_____ Yes _____ No Sickle Cell Anemia
_____ yes _____ No Other Serious Illness or Condition
If yes, specifiy in box above

Smoker: _____ Yes _____ No

INITIAL MEDICAL EXAMINATION (Only for those selecting IUD, hormonal, diaphragm, or sterilization methods)

Blood pressure: _____/_____ Weight: _____
Breasts: _____ Normal _____ Lumps
Liver enlarged: _____ Yes _____ No
Vaginal discharge: _____ Yes _____ No
If yes: Color _____ Odor _____
Cervix: Erosion _____ Yes _____ No
Discharge _____ Yes _____ No
Tears _____ Yes _____ No
Uterus Position: _____ Anteverted _____ Retroverted
Size: _____ Normal _____ Enlarged _____ Other
Laboratory results (as appropriate): _____

Other observations: _____

Contraceptive selected this visit: _____
Brand/Size/Model _____ Quantity _____
Date of next appointment _____
Name of Examiner/Supervisor _____

PREGNANCIES WHICH OCCUR AFTER INITIAL CLINIC VISIT

Date P.Ended Pregnancy Outcome:
_____/_____/_____ Live Birth _____ Miscarriage _____
Stillbirth _____ Live birth died later _____
Complication _____
_____/_____/_____ Live Birth _____ Miscarriage _____
Stillbirth _____ Live birth died later _____
Complication _____

CLIENT FOLLOW-UP

DATE	METHOD CHANGE (Y/N)	METHOD SUPPLIED	BRAND/ SIZE/ QTY.	B/P	WGT	PELVIC INFEC-TION	OBSERVATIONS, LABORATORY RESULTS, TREATMENT	DATE NEXT APPT.

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MEDICAL HISTORY

Note here any serious illness or condition:

_____ Yes _____ No Diabetic
_____ Yes _____ No Jaundiced
_____ Yes _____ No Frequent urinary tract infection or dysuria
_____ Yes _____ No Frequent or severe headaches
_____ Yes _____ No Sickle Cell Anemia
_____ yes _____ No Other Serious Illness or Condition
If yes, specifiy in box above

Smoker: _____ Yes _____ No

INITIAL MEDICAL EXAMINATION (Only for those selecting IUD, hormonal, diaphragm, or sterilization methods)

Blood pressure: _____/_____ Weight: _____
Breasts: _____ Normal _____ Lumps
Liver enlarged: _____ Yes _____ No
Vaginal discharge: _____ Yes _____ No
If yes: Color _____ Odor _____
Cervix: Erosion _____ Yes _____ No
Discharge _____ Yes _____ No
Tears _____ Yes _____ No
Uterus Position: _____ Anteverted _____ Retroverted
Size: _____ Normal _____ Enlarged _____ Other
Laboratory results (as appropriate): _____

Other observations: _____

Contraceptive selected this visit: _____
Brand/Size/Model _____ Quantity _____
Date of next appointment _____
Name of Examiner/Supervisor _____

PREGNANCIES WHICH OCCUR AFTER INITIAL CLINIC VISIT

Date P.Ended Pregnancy Outcome:
_____/_____/_____ Live Birth _____ Miscarriage _____
Stillbirth _____ Live birth died later _____
Complication _____
_____/_____/_____ Live Birth _____ Miscarriage _____
Stillbirth _____ Live birth died later _____
Complication _____

CLIENT FOLLOW-UP

DATE	METHOD CHANGE (Y/N)	METHOD SUPPLIED	BRAND/ SIZE/ QTY.	B/P	WGT	PELVIC INFEC-TION	OBSERVATIONS, LABORATORY RESULTS, TREATMENT	DATE NEXT APPT.

Form 1

Date:__/__/__ Client Reg. Number

FAMILY PLANNING CLIENT RECORD

DO NOT FILL THIS FORM FOR THOSE REQUESTING NON-PRESCRIPTIVE SUPPLIES

Clinic Name_____

Family Name_____

Given Names_____

Address(or directions to reach home) _____

_____

Age:_____(Estimate if not known) Birthdate _____

Education: _____ None _____ Some Secondary

_____ Some primary _____ Secondary completed or more

_____ Primary completed

Religion: _____ Moslem _____ Christian _____ Other

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

Do you want to have more children?

_____ Yes, wants child now

_____ Yes, but wants child later (spacing)

_____ No, wants no more children

_____ Not certain or counseling only

Contraception used prior to this visit?

_____No _____Yes (Specify most recent method used)

Method:_____

Reproductive History:

_____ No. of children still living

_____ No. of children born alive

_____ No. of miscarriages/stillbirths/abortions

Month/year last pregnancy ended: _____/_____

Result of last pregnancy: _____ Normal _____ Complicated

Specify complication:_____

Menses Frequency: _____

Duration: _____

_____ Regular _____ Irregular

Date of Last Menstrual Period: _____

Are you currently breastfeeding? _____ Yes _____ No

Family Name_____ Client Reg. Number:

CLIENT FOLLOW-UP (Continued)

DATE	METHOD CHANGE (Y/N)	METHOD SUPPLIED	BRAND/ SIZE/ QTY.	B/P	WGT	PELVIC INFEC.	OBSERVATIONS, LABORATORY RESULTS, TREATMENT	DATE NEXT APPT.

Form 2 DAILY ACTIVITY REGISTER Page No. _____

Clients Served and Commodities Dispensed

CLINIC NAME _____ MONTH/YEAR _____/____

LGA _____ STATE _____

ENTER ALL QUANTITIES DISPENSED. CIRCLE IF SECONDARY METHOD.

Date (day/month)	Client Regis. No.	Code Source of Ref. if New	Method Dispensed this Visit																
			ORALS				INJEC		IMPLT		IUDs		VAGIN		OTHER				
			FEMENAL	LO-FEMINAL	OTHER ORAL	DEPO-PROV.	NORISTERAT	NORPLANT	OTHER IMPL.	COPPER T	OTHER IUD	FOAMING TAB	CRM/JEL/FM.	CONDOMS	TUBAL STER	OTHER SPEC.	REFERRALS
Page Totals:																	
A:NEW ACCEPTORS																	
B:REVISITS																	
C:QUANTITIES DISPENSED																	

D: SOURCE OF NEW ACCEPTOR REFERRAL
Codes and totals

Program clinic personnel	CP	
Program outreach personnel	OP	
Radio	RD	
Television	TV	
Print media	PM	
Friend, relative	FR	
Other Clinic	OC	
Community Health Worker	CH	
Other	OT	
No response	NR	

E:OTHER METHOD ACCEPTORS

Diaphragm	DP	
Rhythm, Natural	RN	
Vasectomy	VA	
Other	OT	

F:REFERRALS TO CLINICS

Inj. Referral	IJ	
Imp. Referral	IP	
IUD Referral	IU	
Steril. Referral	SR	
Medical Referral	MR	

TRANSFER TOTALS IN SECTIONS A-F TO FORM 2A

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INSTRUCTIONS FOR THE DAILY ACTIVITY REGISTER FORM 2

Use this form to register all family planning visits as they occur. This information will help you track the amounts and types of contraceptives you have distributed and the types of family planning activities you have carried out. At the beginning of a new day leave a blank line.

Date: Record the day/month only, e.g. 7th May 1987 as 7/5.

Client Registration Number: Copy the number in Form 1. For users of non-prescriptive methods, enter a dash "--" in this column. For clients' revisits, record the old registration number on the appointment card or use the cross-reference card to locate Form 1.

If New, Code Referral Source: Leave this column blank if old client. If new use the codes in Section D to match the appropriate source of referral as indicated in Form 1.

New Acceptors: Those who visit <u>this</u> clinic for the first time and receive a method are new acceptors. In the column of the method the new acceptor selects, draw a stroke (a diagonal line) from the lower left corner to the upper-right corner.

Method Dispensed at This Visit: Record the amount of each method dispensed to the client. If a continuing user revisits only for consultation or examination and you dispense no method, record an "X" in the column pertaining to the method for which you give consultation or examination. For example, if a Copper T user comes to discuss a problem, record an "X" under Copper T.

a. **Orals:** Record the number of cycles.
b. **Injection:** Record a "1" for each dose.
c. **Implants:** Record a "1" for each implant, "R" for removal.
d. **IUDs:** Record a "1" for each insertion or an "R" for each removal.
e. **Foaming tablets:** Record the number of tablets.
f. **Cream/Jelly/Foam:** Record the number of tubes followed in bracket by a C (for cream), J (for jelly), or F (for foam).
g. **Condoms:** Record the number of pieces.
h. **Sterilization:** Record "1" if a sterilization is actually performed on this visit, "X" if only consultation.
i. **Other:** If a client selects a method different from the methods above, specify the method using codes in Section E.

If you dispense more than one method to the same client, record the amount of <u>each</u> method dispensed. Assign primary status to the method appearing first (having the smallest number) on the following list and circle the amounts distributed for other methods:

1. Sterilization	4. IUDs	7. Foaming Tablets	10. Foam
2. Implants	5. Orals	8. Cream	11. Other
3. Injections	6. Condoms	9. Jelly	

Referrals to Clinics: Use codes from Section E in the Referral column. Code a referred client as a new acceptor only if she or he receives a method and is new to this clinic.

A: Page Totals of New acceptors (human beings): Total the number of codes for source of referral in the "If New" column and record the total in the first column of the "New Acceptors" row. Then total and record the number of <u>new</u> cases for each method not circled.

B: Page Totals of Revisits (human beings): Count the number of clients who do <u>not</u> have codes for source of referral marked in the "If New" column and enter the total in the first column of the "Revisits" Row. Then total and record the number of <u>revisit</u> cases for each method not circled.

C: Page Totals of Quantities Dispensed: For each method record the total number of units dispensed for both new acceptors and revisits. Include the amounts of both primary and secondary methods, both uncircled and circled amounts.

D: Source of Referral: Sum the number of new acceptors for each source and enter the sum in the box to the right of the code.

E: Other Method Acceptors: From the column "OTHER SPECIFY," sum the number of acceptors of other methods by type of method and record the sums in the box to the right of the code, e.g. a "D" in the column "OTHER SPECIFY" means 1 Diaphragm acceptor.

F: Referrals to Clinics: Sum the number of referrals to clinics by type of referral as recorded in the column "REFERRALS." Record the sum in the box to the right of the appropriate code, e.g. 2 sterilization referrals should be recorded as 2 to the right of the code "SR."

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Form 2A

FAMILY PLANNING ACTIVITY WORKSHEET

Clients Served and Commodities Dispensed

Worksheet No. [ ]

CLINIC NAME _____ MONTH/YEAR _____/___

LGA _____ STATE _____

		Method Dispensed														
		ORALS			INJEC		IMPLT		IUDs		VAGIN		OTHER		
A: NEW ACCEPTORS	Total	FEMENAL	LO-FEMINAL	OTHER ORAL	DEPO-PROVERA	NORISTERAT	NORPLANT	OTHER IMPL.	COPPER T	OTHER IUD	FOAMING TAB.	CRM/JEL/FM.	CONDOMS	TUBAL STER.	OTHER SPEC.
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Total															

B: REVISITS	Total														
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Total															

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Form2a (contd.) FAMILY PLANNING ACTIVITY WORKSHEET

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C: QUANTITIES DISPENSED

	Method Dispensed														
	ORALS					INJEC		IMPLT		IUDs		VAGIN		OTHER	
	FEMENAL	LO-FEMINAL	OTHER ORAL	DEPO-PROVER	NORISTERAT	NORPLANT	OTHER IMPL	COPPER T	OTHER IUD	FOAMING TAB	CRM/JEL/FM	CONDOMS	TUBAL STER	OTHER SPEC	
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Page No.															
Total															

	D:SOURCE OF NEW ACCEPTOR REFERRALS										E:OTHER METH				F: REFERRALS				
	Clinic Per CP	Outreach P. OP	Radio RD	T.V. TV	Prt.Media PM	Friend/Rel. FR	Other Clini OC	Com.Hth.Wkr CH	Other OT	No Resp. NR	Diaphragm DP	Rhythm/Nat. RN	Vasectomy VA	Other Meth. OT	Inj. Ref. IJ	Imp. Ref. IP	IUD Ref. IU	Ster. Ref. SR	Med. Ref. MR
Page No.																			
Page No.																			
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Page No.																			
Page No.																			
Page No.																			
Page No.																			
Page No.																			
Page No.																			
Total																			

FORM 3 MONTHLY/WEEKLY SUMMARY REPORT OF FAMILY PLANNING ACTIVITIES

DATE OF REPORT _____ 19___ CLINIC _____ ☐☐☐☐

LGA _____ ☐☐☐ STATE _____ ☐☐

REPORTING PERIOD: FROM ____/_____ (day) (month) TO ____/_____ (day) (month) 19____

	NO. OF VISITS	ORALS			INJECTION		IMPLANT		IUDS		VAGINALS		OTHER		
		FEM-ENAL	LO-FEM-ENAL	OTH-ER	DEPO-PRO-VERA	NOR-IST-ERAT	NOR-PLNT	OTH-ER	COP-PER T	OTH-ER	FOAM TAB.	CRM/ JEL/ FOAM	CON-DOMS	TUB. STER	OTH ER
A: NEW ACCEPTORS															
B: REVISITS															
TOTAL VISITS = A + B															
COMMODITIES BEGINNING BALANCE															
AMOUNT RECEIVED															
C: QUANTITY DISPENSED															
ENDING BALANCE															

D: SOURCE OF REFERRAL FOR NEW ACCEPTORS

Total	CP Clinic Personnel	OP Outreach Personnel	RD Radio	TV Tele-vision	PM Print Media	FR Friend/ Relative	OC Other Clinic	CH Community H. Worker	OT Other	NR No Response

E: OTHER METHOD ACCEPTORS

DP Diaphragm	RN Rhythm/ Natural	VA Vasectomy	OT Other Method

F: REFERRALS TO CLINICS

IJ Injection Referral	IP Implant Referral	IU IUD Referral	SR Steril. Referral	MR Medical Referral

Prepared by (name): _____ (signature): _____ Date: _____

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INSTRUCTIONS FOR FORM 3
WEEKLY/MONTHLY REPORT SUMMARY
OF FAMILY PLANNING ACTIVITIES

INTRODUCTION

Use this form to summarize family planning activities for each reporting period, whether the reporting routine be weekly or monthly. The form shows the status of contraceptive supplies and provides a basis for ordering new supplies. Keep one copy at the clinic and forward a second copy to the next higher administrative level.

Date of Report: Record the date when the report was prepared.
Reporting Period: Record the beginning and ending dates of the reporting period.
A: New Acceptors: Copy the total number of New Acceptors from the the total row of Section A in Form 2A. If more than one Form 2A Worksheet is used, total them to give the total for the period.
B: Revisits: Copy the total number of Revisits from the total row of Section B in the Family Planning Activity Report Summary Form (Form 2A).
Total Visits: Sum the visits of A: New Acceptors and B: Revisits in each column and record as Total Visits. Total Visits = A + B.

Commodities:
Beginning Balance: Initially obtain the beginning balance from a physical inventory of stock on hand. Subsequently obtain the beginning balance from the ending balance of the previous Summary of Family Planning Activities (Form 3). However, this balance should always be validated by a physical inventory. Resolve any discrepancies and enter the actual amounts of stock. These amounts should therefore correspond to the information on the inventory control cards (ICC) or inventory notebook for each method and brand. For each method, the number of units on hand should be entered in this row, i.e., cycles of pills, units ("pieces") of condoms, number of foaming tablets, etc. In the case of injectables, the number of doses, not vials, should be recorded.
Amount Received: Ensure that all new supplies are properly entered in the Inventory Control Cards or inventory notebook. If multiple shipments arrived during the reporting period, sum all the amounts received during the reporting period and enter the totals in this row.
C: Quantities Dispensed: Transfer the totals from Section C in Form 2A to this row.
Ending Balance: Obtain the ending balance for each method by adding the beginning balance and amount received and then subtracting the amount dispensed from the total. The ending balance should be validated through a physical inventory, and any discrepancies noted and accounted for. The Ending Balance should be equal to the the Beginning Balance + the Amount Received - the Quantity Dispensed.
D: Source of Referral for New Acceptors: Transfer information from Section D in Form 2A
E: Other Method Acceptors: Transfer information from Section E in Form 2A.
F: Referrals to Clinics: Transfer information from Section F in Form 2A.

Form 4

STATE/NATIONAL CONTRACEPTIVE REQUEST/RECEIPT FORM

Complete in four copies

STATE_____ Date of Report _____

Reporting period: From _____/19___ To _____/19___
(Day/Month) (Day/Month)

TYPE	METHOD	BEGINNING BALANCE (A)	RECEIVED DURING PERIOD (B)	ISSUED DURING PERIOD (C)	ENDING BALANCE (A)+(B)-(C)	REQUESTD	ISSUED
ORALS	FEMENAL						
	LO-FEM.						
	OTHER						
INJEC	Depo-Provera						
	Noris-terat						
IMPL	Norplant						
	Other Implant						
IUDS	Copper T						
	Other IUDs						
VAGINAL	Foaming Tablet						
	Cream						
	Jelly						
	Foam						
OTHER	Condoms						
	Other Specify						

_____ _____ __/__/19__
Name: State FP Coordinator (Status) Sig.: State FP Coord. Date

_____ _____ __/__/19__
Name: Natl.FP Coordinator (Status) Sig.: Natl.FP Coord. Date

_____ _____ __/__/19__
Name: Natl. FP Store Officer Sig.: Natl. FP Store Offcr Date

RECEIVED BY:

_____ _____ __/__/19__
Name: State Storekeeper Sig.: State FP Storekeeper Date

Form 4A STATE CONTRACEPTIVE REQUEST/RECEIPT FORM

Complete in three copies

CLINIC NAME_____ Date of Request _____

L.G.A._____

TYPE	METHOD	BALANCE AS AT TIME OF REQUEST	REQUESTED	ISSUED
ORALS	FEMENAL			
	LO-FEM.			
	OTHER			
INJEC	Depo-Provera			
	Noris-terat			
IMPL	Norplant			
	Other Implant			
IUDS	Copper T			
	Other IUDs			
VAGINAL	Foaming Tablet			
	Cream			
	Jelly			
	Foam			
OTHER	Condoms			
	Other Specify			

_____ _____ __/__/19__

Name: FP Clinic O/C (Status) Sig.: FP Clinic O/C Date

APPROVAL:

_____ _____ __/__/19__

Name:State/Zone FP Coordinator (Status) Sig.:State/Zone FP Coordinator(Status) Date

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APPENDIX H

Proposal for Establishment of Family Planning
Training School in Benue State
Ministry of Health

Prepared by
Mr. Andrew Odah
Principal, SON
Benue

PROPOSAL FOR ESTABLISHMENT OF FAMILY PLANNING TRAINING SCHOOL IN BENUE STAT, MINISTRY OF HEALTH.

1. Project Title·

Benue State: Expansion of Family Planning Services by Establishing a Family Planning School.

Location:- School of Nursing, Makurdi

2. Garantee and Qualification and Capabilities:

Ministry of Health/Family Planning Advisory Committee Benue State.

Project Sponsors: Permanent Secretary
Ministry of Health,
Chief Medical Officer.

Project Coordinator: The Coordinator of Family Planning Training School.

3. See Bn Action Plan

4. Dates of Project Period: The Project will commence on March, 1st to February, 31st, 1988. (One year duration)

Project Justification:

The Ministry of Health, Benue State, Nigeria have drawn up a proposal on establishment of a Family Planning School. It is proper at this juncture to amplify the fact that Benue State is one of the poorest State in Nigeria. Over 80% of the population live in the rural areas and are not exposed to Family Planning hence most married couples are subject to series of health hazards. Evidence in the State's poverty and ignorance abound in the recent outbreak of yellow fever, meningitis, measles etc. which claimed hundreds of lives. Ignorance and poverty have resulted to high rates of unwanted pregnancies, abortion, sexually transmitted diseases (STD) etc. The presence of these hazards have necessiated this our proposal. Our proposal seeks to train 100 nurse/midwives for the existing Family Planning Clinics with shortage of trained personnel and for the new ones in the pipe line.
Our proposed and willing agency to implement the programme is the Benue State Ministry of Health. Evidences of the Ministry of Health's willingness is shown by the following facts.

- Establishment of I.E.C. Unit in the Ministry's headquarter.
- Allocating a classroom accommodation in the School of Nursing premises.
- Appointing a Midwifery/ FP trained Tutor to coordinate the programme in the Family Planning traing School.

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- Including FP in 1988 budget of the Ministry of Health.

Statement of Problems the Project will address:

By establishing an FP. School, and training 100 nurse/midwives yearly, the entire health establishments in the State will be fully equiped by the year 2000.

The following subjects will be taught

- Human biology
- Sexiology
- Contraceptive technology
- Information, Education and communication in Family Planning.
- Sexually transmitted disease
- Population education.

Objectives of the proposal.

1. To make family planning available and accessible to the people of Benue State by the year 2000.
2. The broad objective of the proposal is to minimise the high rate of abortion, early and unwanted pregnancies, high incidence of sexually transmitted disease (STD) and our married couples to plan their lives especially child bearing and rearing.

   This is to be achieved by training 100 nurse/midwives annually in family planning and posting them to the existing health establishments and the new one in the pipe line.
3. To establish 62 family planning service delivery clinics in Health Management Board and Local Government institutions.
4. To ub-grade the knowledge of the skills of project staff by the end of the project.

..../3

CHRONO - GRAM

Activities	Months 1	2	3	4	5	6	7	8	9	10	11	12	Responsibility
1. Training													
1. Development of the training curriculum.	X												Project Coordinator
2. Development of lesson plan	X	X	X		X			X	X				Project director/ coordinator/assistant coordinator.
3. Development of criteria for selection	X												Project Coordinator
4. Identifying guest lecturers	X												"
5. Notifying guest lecturers	X												Project Director/ Coordinator
6. Select trainees													"
7. Make accommodation and transport arrangements for trainees.													
8. Coordinate 8 weeks FP training	X	X	X	X	X	X	X	X	X	X	X		
9. End of session report											X	X	
10. Evaluation of programme								X	X	X			

BUDGET: Local Costs	INPUT BY GRANTEE	INPUT BY
Salaries and Wages		
Full time Salaries for 100 trainees	725,400	
1 Co-ordinator (full time)	7,25[illegible]	
1 Assistant Co-ordinator (full time	6,084	
1 Secretary (full time)	4,824	
1 Cleaner (full time)	1,530	
	₦745,092	
Benefits:		
Annual Leave allowance for: (100 trainees)	9,600	
1 Co-ordinator	96	
1 Assistant co-ordinator	96	
1 Secretary	96	
1 Cleaner	96	
	₦9,984	
Housing allowance for: (100 trainees)	5,500	
1 Co-ordinator	55	
1 Assistant co-ordinator	44	
1 Secretary	44	
1 Cleaner	10	
	₦5, 653	
Fees/Honoraria:		
25 guest lecturers @ ₦20 per lecturer for 5 5 Sessions	1,000	2,500.00
	₦ 1,000	
General Administrator:		
Cost for 10 day refresher Course Administration		2,000.00
Stationeries, printing, typing sheets, duplicating, postages and writing materials @ ₦1,000 per Session x 5 Sessions		5,000.00

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Travel and Associated Expenses

per diem for 100 trainees @ ₦400 per trainee	40,000.00
Transportation within training area, from and to place of work is ₦100 per trainee for 100 trainees	10,000.00
per diem and Transportation for 30 Community Health Workers for 10 days refresher Course @ ₦200 per participant	6,000.00
Post training follow up by 5 Assistant Directors of Nursing each to cover 250 kilometre @ 50k per km.	625.00
Supervisory visit by project director/co-ordinator/Asst. co-ordinator to Clinical sites from FP School 1000 Km. per Session @ 50 kobo for 5 Sessions.	2,500.00
	59,125.00

Equipment and Supplies

Duplicating Machine	u.s. Cost
Xerox Machine	u.s. Cost
Slide projector (240 volts)	u.s. Cost
33mm Film projector (240 volts)	u.s. Cost
Video Recorder + Viewer	u.s. Cost
30 Chairs with small attached writing table @ ₦120 each	3,600.00
2 Giant filing cabinets @ ₦400 each	800.00
	4,400.00
GRAND TOTAL	73,025.00

U.S. Cost

100 Family Planning Methods and Practice: AFRICA

100 Health Provider's Guide to Contraception

100 Family Planning (by Margret Myles)

100 Pathpapers publications

4 Pelvic Models

1 pelvic examination film

1 Breast examination film

1 Education film of Family Planning

Counselling Skills.

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APPENDIX I

Clinical Skills Performance Evaluation Tool for Benue State Child Spacing/Oral Rehydration Therapy IUCD Insertion Training

BENUE STATE CHILD SPACING/ORAL REHYDRATION THERAPY
IUCD INSERTION TRAINING

CLINICAL SKILLS PERFORMANCE EVALUATION TOOL

This evaluation form is designed to identify levels of insertion skills level of practice and indicate growth and development in the areas of: IUCD Client Screening (HX & P.E)

-IUCD insertion

-IUCD Removal

These are the CS skills to be mastered.

NAME:

DATE:

CLINICAL PRACTICUM SITES: _____

_____

_____

CLINICAL PRECEPTOR: _____

_____

_____

IUCD INSERTION/REMOVAL PROCEDURE EVALUATION FORM

A. Client Screening	FIRST EVALUATION				FINAL EVALUATION			
	Done correctly	Needs Improvement	Not Observed	Comments	Done correctly	Needs Improvement	Not Observed	Comments
1. Obtains appropriate History from client interested in using IUCD to:								
a. Rule out contraindications								
b. Identify Risk factors for PID								
c. Evaluate clients desire for long or short term Contraception								
2. Explains, using samples, the IUCD's available, including the wearing time								
3. Counsels what to expect when using IUCD (Side effects and management)								
4. Perform a complete physical Exam on a new Acceptor or Annual visit								
5. Performs Pelvic Exam to screen for infection, Pregnancy or or abnormal Anatomy								
a) Inspects Ext. Genitalia								
b) Palpates Ext. Genitalia								
c) Performs Speculum -Sends cervical discharge to lab for gram stain, where possible. -Pap smear in presence of suspicious CX, where possible								
d) Performs Bimanual								
e) Evaluates Pelvic muscle tone								
f) Orders pregnancy Test, where possible								
6. Treats or Refers Abnormal Pelvic findings according to MS CS protocols.								

IUCD INSERTION/REMOVAL PROCEDURE EVALUATION FORM

	FIRST EVALUATION				FINAL EVALUATION			
	Done correctly	Needs Improvement	Not Observed	Comments	Done correctly	Needs Improvement	Not Observed	Comments
A. Client Screening								
7. Provides Barrier CS method til client returns with menses for insertion or after completion of treatment								
B. IUCD insertion procedure								
8. Explains IUCD insertion procedure to client in simple reassuring language								
9. Position client in lithotomy position								
10. Prepare Sterile field with tenaculum, sound gloves, Ring forceps and IUCD								
11. Perform careful bimanual to diagnose position of uterus.								
12. Insert Speculum, Visualize cervix, wash CX 3 times with antiseptic solution								
13. Prepare Client for a pinching sensation, grasp CX with tenaculum at 10 O'clock and 2 O'clock position. Close tenaculum slowly one notch at a time.								
14. Prepare client for cramping sensation gently puts traction (Pulls) on tenaculum and slowly and gently passes the sound to the fundus of uterus.								
15. Loads the IUCD under sterile conditions								
16. Measures uterine depth from sound to set Phlange on CuT-TF devices								
17. Pulling gently on Tenaculum, pass introducer through cervix to fundus of uterus, retracts outer barrel over plunger and deposits device in the fundus.								

OR

.../3

IUCD INSERTION/REMOVAL PROCEDURE EVALUATION FORM

B. Insertion Procedure A. Client Screening	FIRST EVALUATION Done correctly	Needs Improvement	Not Observed	Comments	FINAL EVALUATION Done correctly	Needs Improvement	Not Observed	Comments
17B. Pulling gently on Tenaculum, passes introducer til phlange meets CX, Slowly and gently pushes the inner plunger through the outer barrel.								
18. Clips IUCD strings 3 - 5 cm from CX os.								
19. Gives client string cliping to feel or has client feel string vaginally before [illegible]nic.								
20. Massage tenaculum and observes for bleeding from sites. Applies pressure, if necessary, to site [illegible] bleeding.								
21. Removes speculum, assists client to sitting position, Assesses client's need for analgesia								
22. Gives client instructions for IUCD use and self care.								
23. Counsels clients on IUCD Danger signs, to report to service immediately for care.								
C. REMOVAL PROCEDURE								
24. Identifies indications for IUCD removal.								
25. Performs bimanual to identify pregnancy or infection								
26. Inserts speculum and visualizes CX								
27. Gently and steadily pulls IUCD strings with ring forceps and removes device.								
28. Applies tenaculum to stabilize CX and straighten Ante or Retroversion, to facilitate difficult removal.								
29. Refers to Physician case in which IUCD can not be removed.								

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