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DEVELOPING COMPANY-BASED FAMILY PLANNING SERVICES

A Module for Use by Trainers in Workshops for Managers



Revised August 1989

The Enterprise Program

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John Snow, Inc.
In collaboration with
Birch & Davis Associates, Inc.
Coverdale Organization, Inc.
John Short & Associates, Inc.

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THE ENTERPRISE PROGRAM

Foreward

At least one-third of all couples in the developing world are still unprotected from unplanned pregnancies. Governments and donors alone cannot support all the family planning services being demanded in these nations. It is evident therefore that the private sector, especially the for-profit private sector, must be encouraged to participate more fully in the provision of family planning work to supplement government and ongoing private voluntary/non-governmental organization (PVO/NGO) activities already underway. In many countries, the potential of the private sector in the all important family planning area remains virtually untapped.

Funded by the United States Agency for International Development, the Enterprise Program of John Snow, Inc. -- in collaboration with John Short and Associates, Birch and Davis Inc. and the Coverdale Organization, Inc. -- is a direct response to this challenge. The Enterprise Program's resources are directed toward assisting private organizations initiating or augmenting their own high quality cost-effective voluntary family planning services. Profit-making entities, and to a limited extent non-profit agencies, are supported in collaborative efforts under this new initiative. Strong emphasis is placed in every project on having the private sector take on the recurrent costs of providing family planning services.

During its first two years, The Enterprise Program has funded collaborative subprojects with profit-making and non-profit entities in 12 countries. Typical recipients have been industries, factories, mines, and plantations including affiliates of major multi-nationals. The Enterprise Program has also implemented three multi-country regional private sector workshops as well as two in-country training programs. Three training modules for private sector entities will be developed over the program's five-year life span; and two now completed, are being field tested. A major program component continues to be technical assistance to AID missions and local private sector organizations in areas such as income generation, cost recovery, and computerized management information systems development for family planning institutions. Some twenty-two countries have benefited from such technical assistance.

The module which follows represents an effort by many individuals in both its design and field testing. We hope you find it useful. Comments and suggestions on how it might be improved are welcomed.

Joel Montague
Project Director

**DEVELOPING COMPANY-BASED
FAMILY PLANNING SERVICES**

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**DEVELOPING COMPANY-BASED
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SECTION I: AN INTRODUCTION TO THE MODULE

This section provides the user with a "road map" to the module. The purposes, objectives, and audiences of the module and the way in which it is intended to be used are explained.

Purposes of the Module

The module:

- is designed to promote increased involvement of the private sector in providing family planning services as part of a company-based health benefits package.
- familiarizes private sector management and managers of factory health services with the mechanics of how to plan, set up, manage, evaluate and promote company-based family planning services.
- provides trainers, consultants, workshop planners and organizers with a set of reference and resource materials, and structured activities and guidelines for organizing and presenting workshops to factory owners, managers and health services personnel on planning, implementing, managing and evaluating company-based family planning services.

Audience for the Module

The module has been developed for use by workshop organizers, planners, trainers and consultants in planning and implementing short training workshops for a range of private sector personnel. Potential workshop participants could include personnel directors, medical and nursing directors, chairmen and directors of corporate affairs, managers, assistant managers, and managing directors of commercial firms, factories, mines, and plantations. When the word factory or company is used, the intent is to cover a range of for-profit, private enterprises.

Objectives of the Module

Workshop organizers, planners, consultants and trainers will:

- be able to use the module to design and implement short training programs for factory management and health personnel on establishing and operating company-based family planning services. Some sections of the module can be easily used in other types of training for health and family planning personnel.

After using this module, workshop participants (company management and health personnel) will:

- a. understand the role of the for-profit private sector in promoting and providing company-based family planning services;
- b. examine and share experiences and become aware of the successes and failures of others who have set up company-based services;
- c. examine benefits derived from providing company-based family planning services;
- d. review various contraceptive options which can be made available through company-based family planning services;
- e. review the role of efforts to promote acceptance of family planning services and examine various Information, Education and Communication (IE&C) approaches in the factory context;
- f. identify decision points in planning, implementing and evaluating company-based family planning services;
- g. prepare work plans for setting up family planning services in conjunction with existing factory health services or independently in their workplace.

Organization of the Module

.....The second section describes the positive role which private enterprise and the private sector can and have played in promoting and implementing company-based family planning services;

.....In the third and fourth sections, more abstract concepts such as the benefits of family planning and population dynamics are used to further develop a rationale for private enterprise involvement in the development and delivery of family planning services as part of a company-based benefits package. Benefits are discussed in terms of those which are more immediate to the employer, employee, and the nation and those which take longer to materialize.

.....The fifth section is more technical in nature and presents factory management with information on various contraceptive options and IE&C/promotion approaches which can be included in company-based services.

.....The sixth section constitutes the core material of the manual. In it are identified the decision points that a factory manager or owner must consider in planning for company-based family planning services. The discussion then turns to the steps involved in setting up, managing and evaluating family planning services.

.....In the last section of the manual, participants prepare a work plan for setting up family planning services in their workplace.

The assumptions which have guided the development of the module are:

- that the trainers using the manual are experienced trainers; information on training techniques is not provided.
- that the trainer will want to choose from the materials provided in the manual and the reference set depending on the amount of time available for the workshop and participants' needs;
- that the trainer is aware that the decision making structure varies across organizations and from country to country;
- that participants in workshops based on the module will be interested in and perhaps already considering setting up company-based family planning services; and
- that participants involved in the workshop will not know much about the mechanics of setting up family planning services in a factory or plantation.

How to Use the Module

FOR TRAINERS, CONSULTANTS AND WORKSHOP ORGANIZERS---

While the content in the module is "suggested," there is a logical progression implicit in these suggestions. Sections II, III and IV help build a rationale for promoting family planning services through the commercial sector. As such, these sections provide a valuable backdrop for Sections V and VI in which contraceptive technology, IE&C promotional activities and the tasks involved in setting up family planning services are discussed. All five of these sections culminate in an exercise in Section VII where participants complete a work plan and time line for setting up family planning services in their enterprises. As with the objectives and rationale statements, you will want to adapt the content to the social and political context in which the training is to take place.

If you are planning a three to four-day workshop for middle level management and health personnel, we would suggest that you review the whole module and consider using as much of it as you think pertinent. If your audience consists of management personnel who have not yet decided to set up family planning services, you might want to concentrate more on developing an understanding of the benefits to management from such services, then focus on the specifics of what needs to be considered in setting up services on site. If, for example, your audience is mainly clinicians, then you may want to spend more time on reviewing and updating their knowledge of contraceptive technology and less time on the earlier sections of the module. If you have participants who have already decided to set up family planning services, then you may want to move directly to later sections of the manual and focus on the "nuts and bolts" of setting up services in commercial enterprises.

If you have less time than what the manual suggests, you will want to pick and choose from the module depending on the time available. You should keep in mind that you will need to adapt some of the materials in the manual so that they reflect prevailing cultural and social practices as well as current national population policies. In particular, you will want to collect up-to-date information on specific government policies, data on recent contraceptive prevalence surveys, and recent research findings on knowledge, attitudes and practices studies and surveys.

To help you.....

.....**TRAINER'S NOTES** (on white stock) are provided in each section. These present objectives and a rationale for the section; both are suggestive only. In using the module in a workshop, objectives may differ given the cultural and political context in which training is to take place and the audience for the training.

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.....**PROCEDURES** for presenting the content are included. Again, the intent is to suggest how one could present workshop content. As training methods can be culturally specific, you should take into consideration whether a specific method is appropriate or not. The manual does include short lectures and suggests a number of participatory approaches to presenting the workshop content.

.....**MATERIALS** and **REFERENCES** are listed. The materials needed to deliver the workshop exercises and references to which you may wish to turn for further assistance, or to which you may want to direct participants are included. **Trainer's materials** are printed on white stock. **Participant materials** are printed on pink stock. As participants' need for information about and level of knowledge of contraceptive technology may differ, the bulk of this information is contained in the reference set. Summary statements, which are appropriate for use as handouts, are provided as part of the manual. All references (**on blue stock**) annotated in the manual are contained in the reference set. You should at the same time identify and review locally available resources for use in any training which you provide.

....**EVALUATION ACTIVITIES** are described at the end of each section of the module. Evaluating training activities as they take place is important. Sample evaluation exercises have been included to help you think about evaluation as an integral part of training. Special evaluation forms for trainers and for participants are included in the last section of the manual. The Enterprise Program would like to hear from users of the manual and have included an address to which the completed forms can be sent.

Section II: The Role of the For-Profit Commercial Sector in Developing and Promoting Company-Based Family Planning Services

This section describes the role of the organized sector, management, employees, and trade unions in the promotion and development of family planning services in factories and on plantations.

TRAINER'S NOTES

Objectives for this Section:

After completing the activities in this section of the manual, workshop participants will:

1. have examined the experience of other private sector organizations and enterprises in promoting and developing company-based family planning services;
2. have identified common elements in private sector involvement in family planning services through an analysis of select case studies; and
3. will have developed a better understanding of the potential role which the organized private sector can play in adapting family planning services to local needs (factory-specific applications) and involving the community served in the planning and implementation of services.

Rationale:

An examination of the experiences of other private enterprises which have set up company-based family planning services is an important first step in gaining a better understanding of the general issues involved in planning, setting up and managing such programs. By identifying and discussing common elements of company-based family planning services, participants will establish a framework for use in analyzing their role in providing family planning services to employees and the basic steps to be followed in setting up programs in factories or on plantations.

PROCEDURES

- **Slide Presentation: The Private Sector Family Planning Project in Kenya.**

Time: 10 minutes (with narration by trainer)

- **Introductory Lecturette: Increased Attention on Private Sector Involvement in Promoting Company-Based Family Planning Services.**

The presentation introduces and outlines the role of the commercial sector in supporting the development and promotion of company-based family planning services.

Time: 15 minutes (by trainer)

- **Case Study Presentation: Two Factory Experiences**

Participants read and discuss case studies of two LDC efforts which involved the commercial sector in setting up, managing and evaluating company-based family planning services. Each case study is accompanied by questions which provide direction for participants' review of the case, and a structure for group discussion of the cases.

Time: 20 minutes in small groups

- **Case Study Discussion and Identification of Issues**

In each small group's discussion of their case with the larger group, the trainer draws attention to a number of common issues which any enterprise will have to consider in setting up, managing and evaluating company-based family planning services.

Time: 20 minutes

Evaluation

Participants discuss and share written statements on the role their company will play in providing company-based family planning services.

Time: 20 minutes

TO THE TRAINER:

A full set of materials for both trainer and participant use in Section II follows immediately.

**SLIDE PRESENTATION:
SUPPORTING PRIVATE SECTOR FAMILY PLANNING PROGRAMS IN KENYA**

12'

SUPPORTING PRIVATE SECTOR FAMILY PLANNING PROGRAMS IN KENYA

#1 [FPPS Logo]

The Family Planning Private Sector Programme (FPPS) in Kenya provides private sector enterprises and organizations with the resources and expertise to offer a full range of family planning and maternal and child health services. FPPS project inputs include management technical assistance, clinical, management and family planning training, clinic equipment and supplies, and community outreach activities. Recipients of the family planning services include employees, employees' dependents, and members of the surrounding community.

#2 [Map of Kenya]

Currently, more than 30 private sector enterprises and organizations throughout Kenya are involved in setting up family planning services on-site in factories, on tea estates and in industrial sites. These 30 subprojects cover service areas ranging in size from 1,400 to 500,000 people and are each projected to attract between 200 and 12,000 family planning acceptors. The 30 subprojects also represent more than 125 new family planning service delivery sites in areas where no such services previously existed.

#3 [Factory] and #4 [Agricultural Workers]

In recruiting private sector organizations to develop subprojects, the focus has been on industries in the modern sector of the economy. Participating private sector organizations include factories, plantations, church-sponsored organizations, and private medical groups. One particularly large participating employer is Brooke Bond, which employs approximately 26,000 workers in its tea, coffee, sisal, and flower estates throughout the country. Other subprojects include a number of sisal, sugar, and cashew nut plantations, a flourspar mine, and factories that produce paper, beer and cement.

#5 [Women and Children]

There is a high degree of interest by private sector organizations in Kenya in setting up family planning services on-site. With a current population growth of approximately four percent (at this rate of growth Kenya's population will double in less than 20 years), many of Kenya's business leaders recognize that it is in the country's economic interest to provide families

with the means to reduce their fertility. In addition, private sector Kenyan organizations provide benefits to their employees which become more expensive as an employee's family grows in size.

#6 [Group of Children] and #7 [Family Housing]

These benefits include maternity leave (required by law), sick leave, day care, nursery school, housing, and medical care. Managers have recognized that it is likely to be less expensive to provide their employees with the means to space their children and to possibly limit their family size than to restrict access to family planning services.

#8 [Men in Front of Company Clinic]

A prerequisite to FPPS funding is that the organization provides health services to its employees and its employees' dependents. This provides a base upon which high quality family planning services can be added. In addition, potential participating organizations must commit themselves to continuing the program at the end of the two-year funding period.

#9 [Clinic Under Construction]

Project staff work individually with each subproject to develop a complement of inputs that best meet the needs of the service area population. At Kenya Flourspar, project funds are being used to construct a new clinic where family planning and maternal and child health (MCH) services will be provided. At this site, the clinic will be open to all members of the surrounding community as health facilities are scarce and the population is widely dispersed.

#10 [Nurse, Doctor and Group of Patients]

At other sites, a greater percentage of the resources are used to train medical and nursing staff in the provision of family planning services. At this Africa Highland Tea Estate clinic in Kericho, a nurse and doctor provide family planning and maternal and child health patients with information about family planning methods.

#11 [Women and Children in Front of Clinic]

At most subproject sites, an attempt is made to completely integrate family planning with maternal and child health. This makes it easier for busy mothers to be seen for all their needs in a single visit and also to avoid unnecessary exposure of shy family planning acceptors.

#12 [Rights and Responsibility Chart]

At all sites, the emphasis is on providing high quality services that are appropriate to the needs of the individual patients.

#13 [Women and Nurse]

Family planning patients are provided with individualized counseling and follow-up procedures are in place to assure that problems are minimized. At a Kenya Cannons clinic, the nurse explains how an IUD works using a pelvic model.

#14 [Voi Sisal Chart]

At some subproject sites there is a large, "pent up" demand for family planning services. As soon as services are available, many women flock to the clinic, such as at the Voi Sisal Estate.

#15 [Nzoia Chart]

At other sites, the increase in demand is more gradual. After the initial demand for services has been met, any large increases are often the result of a successful Information, Education and Communication Programme.

#16 [Gathering of People]

At many sites, IE&C activities are based on the concept of community involvement. IE&C workers are trained to evaluate their communities' needs and to respond appropriately. At Nzoia Sugar Company, for example, IE&C committees are being used to plan folk media activities with the aid of a media consultant who helps them orient script writers to write on health, nutrition, and family planning subjects, to select and direct casts, and to plan follow-up activities and performances.

#17 [Three Boys at Microphone]

This use of folk media, including songs, dance, poetry, and drama, is being used as a method of informing large crowds, especially illiterate audiences, about the benefits of family planning. Large crowds turned up to witness these performances at Nzoia Sugar which included school choirs, traditional dancers, and company employees.

#18 [Groups of Artists]

Another interesting project involves using artwork developed by Kenyan artists to promote family planning. Local leading artists were selected and briefed about the family planning issues and messages that the programme seeks to highlight through posters, pamphlets, and the use of "T" shirts. The artists were asked to translate these messages into posters and later brought their interpretations to a follow-up workshop. All of the artwork was reviewed and the artists shared ideas on what to change, improve and emphasize.

#19 [One Artist]

Their products were pre-tested with workers at subproject sites to determine the appropriateness of the posters. The artists were then briefed on changes to be made on promising posters. The revised posters which were selected were exhibited in Nairobi and at the subproject sites. A traveling exhibition has been organized in order to help viewers talk about family planning topics, controversies and problems.

#20 [Artist's Book]

A booklet describing the process of developing the artwork was also prepared.

#21 and #22 [2 posters]

These are two of the paintings that have been made into posters and distributed to other family planning clinics throughout the country.

LECTURETTE:

**INCREASED ATTENTION ON PRIVATE SECTOR INVOLVEMENT IN
PROMOTING COMPANY-BASED FAMILY PLANNING SERVICES**

**PRIVATE SECTOR INVOLVEMENT IN
PROMOTING FAMILY PLANNING SERVICES**

Preventive and promotive health services in developing countries have generally been viewed as services that governments must provide citizens on a subsidized or free basis if morbidity and mortality rates are to be lowered. Family planning services (or more accurately, contraception services) have been considered to be part of the government's overall preventive and public health system. As a result, from their inception, the overwhelming majority of government-sponsored family planning programs in developing countries have provided free or heavily subsidized contraceptive services to couples who choose to contracept. Three assumptions formed the original basis for the free contraceptive service policy: (1) reduced fertility has benefits for the society as a whole; (2) most couples are either unaware of contraceptive technology, do not know how to use modern contraception, or do not have access to the means for limiting their families; and (3) low levels of monetization and exceedingly low per capita incomes in developing countries severely constrain couples' ability to buy contraceptives, even where private supplies are available.

With economic modernization and the development of family planning information and technology, supplies have become more readily available, couples are more knowledgeable about contraception, incomes have risen overall, and the degree of monetization in most societies has increased sharply over the past 25 years. However, this rise in demand has occurred as the availability of government and donor family planning resources has remained static or fallen. Responding to this disequilibrium requires a careful assessment of family planning demand and supply, identification and analysis of service, supply, and manpower gaps and their causes and creative approaches to meeting demand in an affordable and efficient manner. One such approach is private sector investment in setting up family planning services on site in factories or on plantations.

If the private sector is to expand its activity, demand and a willingness to pay for services must exist, and/or private businesses need to be convinced of the net benefits to them of providing family planning to their employees. A major goal of this manual (workshop) is to examine a range of private sector experiences to identify planning issues and constraints to private sector involvement in shouldering a larger portion of the government's current task of providing employees with access to family planning services.

The activities of Brooke Bond, Nzoia Sugar Company and Lever Brothers installations in Kenya and the assistance provided to them by the Kenya Family Planning Private Sector Programme, highlighted in the slide presentation at the beginning of this section, are examples of successful programs run by private sector sugar companies, breweries, and tea plantations. Other opportunities abound. For example, union- and employer-based health care programs, health care components of cooperative service packages, and local physician groups are becoming more prevalent in some developing countries and can serve as ideal settings for delivering family planning services. Contraceptive services are generally not available through these groups at the present time. This is particularly true for the more effective methods: IUDs and sterilization, but applies to resupply methods as well. The solution to this relatively new problem has been to initiate family planning activities in the corporate and private sector so that newly created demands can be met.

Accessibility is of course the key element in family planning delivery. It is not at all clear that the current mix of service providers maximizes access to family planning services, or provides the most cost effective means for meeting the demand for family planning among poor or the growing number of working class couples in the developing countries. The limited experience to date demonstrated that factory-based family planning may increase both accessibility and follow-up possibilities.

Recent experience in the developing world has demonstrated that for-profit entities occasionally have lower unit costs, emphasize management and efficiency in service delivery, focus on higher income groups, and tailor their products to the most profitable segment of the market rather than the needier groups. They also appreciate the need for financial controls that reduce costs and raise profits, and probably most importantly, understand and use market forces to promote their products and generate profits. The entrepreneurial spirit embodied in successful private sector endeavors cannot be underestimated. Entrepreneurship is characterized by persistence, adaptiveness, and financial control, three of the critical elements in harnessing market principles to achieve social objectives such as family planning. On the other hand, the entrepreneurial approach may include a lack of incentive to educate and inform clients of their family planning options and the side effects of each. Moreover, private entrepreneurs are far less sensitive to the psychic costs that dissuade consumers and are less concerned with such issues because acknowledging such difficulties might very likely cut into profits.

One opportunity for closing gaps between contraceptive demand and supply rests on expanding and improving the delivery of services. The private sector's role in family planning provision in less developed countries (LDCs) is potentially very large. It requires encouragement and perhaps some new ideas and approaches.

It is quite clear from private experience to date that much has been learned about providing family planning services on-site in an efficient and effective way. The two case studies which are presented next in this manual offer positive suggestions for employers to establish and expand services, as well as involve both labor and employees/clients in the delivery of contraceptive services and family welfare education.

[NOTE TO TRAINER: You may want to add examples here of other private sector family planning activities which are country or region specific. Additionally, the article "Tapping Private Industry" cited in the references for this section describes private sector activities in several countries.]

CASE STUDIES:
TWO FACTORY EXPERIENCES

22'

CASE STUDY: INDUSTRIAS UNIDAS, S.A. (MEXICO)

Industrias Unidas, S.A. operates a major factory at Pasteje, State of Mexico, some 75 miles from Mexico City. Products manufactured by Industrias Unidas, SA (IUSA) range from zippers and ball point pens to telephones and airplane parts. IUSA employs a total of over 9,000 people in several locations, with about half of its workforce being women. The EPQ complex in Pasteje has 6,000 employees. Of these, half are female and most of them are relatively young - 18 to 25 - years and drawn from the surrounding areas. Most belong to indigenous rural groups demographically characterized by high birth rates.

Since its initiation, the EPQ Complex at Pasteje has provided health/medical and safety services to its workers. All services have been provided within norms established by the Federal Government of Mexico. Because of the distance from the factory site, accessing other health and medical services required lengthy travel or leaves.

In recent years, the management of the EPQ complex has kept detailed records for pregnancy rates. These records (from 1983 to 1986) present total work-hours lost, based on Mexican law which provides that a pregnant woman is entitled to 90 days maternity leave (45 before and 45 after delivery). As Table 1 shows, the average rate of pregnancies for these four years is 11.68% of female workforce per year.

Table 1

**COMPARATIVE FIGURES ON PREGNANCIES CARRIED TO TERM
DURING THE LAST 4 YEARS**

Year	Avg. # women of reproduc- tive age in the company	Pregnancies carried to term	% of total # of women	days of pregnancy leave	man- hours lost	Difference from year to year
1983	2,152	284	13.20%	25,560	204,480	
1984	2,005	223	11.12%	20,070	160,560	43,920(+)
1985	2,400	260	10.86%	23,400	187,200	26,640(-)
1986	2,845	331	11.57%	29,790	238,320	51,120(-)
11/86 -3/87	2,031	135	4.76%	12,150	97,120	

Source: EPQ, IUSA
1987.

Table 2 breaks figures out into man-hours lost and multiplies this figure by the overall Mexican minimum wage to reach a peso figure of 37,000,000 cost to the company for time lost. Under Mexican law, the company pays employees for maternity leave, with a resultant quantifiable figure which management viewed as minimal in relation to other costs which they have yet to quantify. These include costs of training and employee replacement, loss of productivity as a result of leave, extra accounting costs involved in monitoring temporary employees who must be discharged and rehired after 89 days of work.

Table 2

**WOMEN WHO CARRIED A PREGNANCY TO TERM
AND RECEIVED THE CORRESPONDING 90 DAYS LEAVE
AS SPECIFIED BY MEXICAN LAW**

Month	Total women in the company	Pregnancies carried to term		Monthly percent	Average % per month for this 5-month period	Total man-hours lost per month
11/86	2,794	20		0.71	0.95	14,400
12/86	2,714	29		1.06	.885	20,880
1/87	2,748	27		0.98	.916	19,440
2/87	2,827	30		1.06	.952	21,600
3/87	3,075	29		0.94	.95	20,880
		T.135	P.M.27			97,880

NOTE: Days off granted by law through the month of March = 12,140

Average man hours lost per month = 19,424

These figures represent an actual financial loss, based on the minimum wage, of M\$ 37,000,000

Management Action

IUSA management established an IE&C component in 1983 for inclusion in its 90-day training program for entering employees. While achieving a modest degree of success with the IE&C component, the company's awareness of the costs and problems associated with employee pregnancies led them to set up a more aggressive program in 1986-87.

The company management decided to establish a pilot family planning program within the general area of mother and infant health and family prosperity. This combination of factors (i.e. family prosperity and corporate progress) is at the base of the new range of services offered by IUSA. The program started with a decision to build onto existing facilities with certain remodeling. As personnel needs and demand grow, management may enlarge the facilities.

The family planning program is a well-organized program serving EPQ's worker population. The objectives of the program are three-fold:

- Establish, at the EPQ complex, a family planning program that will allow a reduction in the birth rate from 10.2% to 5% within two years.
- Reduce the loss of man hours related to maternity leave, etc., by about 50%.
- Demonstrate the benefits to families and profitability to companies of family planning projects.

The program reflects the objectives of the National Family Planning Program which states that "its success depends largely on the active participation of the various organizations and institutions of the public and private sectors, for only thus can the population be linked with the actions that derive from the Program." If this pilot program proves to be a success, it will have a self-multiplying effect in the other IUSA factories, and, given IUSA's prestigious standing, perhaps in the rest of the country.

Educational Activities

Existing IE&C activities relating to the family planning program have been incorporated into the complex's current training system. Family planning information and education are part of the health training offered to all divisions of IUSA. The following family planning activities have been developed:

- (a) A monthly course (12 per year) of 8 sessions (2 per week) offered to a mixed group of 70 to 90 people most of whom are in their twenties, at the Industrial Complex's Pretraining School. These twelve courses are designed to reach all new recruits at the workers' level. No worker starts at EPQ without first having gone through this industrial pretraining school.
- (b) Three family planning courses a year for new technical personnel. These courses are of 12 sessions each and last one month and a half. Each course is for a mixed class of 30 to 40 people who are either professionals or semi-professionals.
- (c) Two family planning courses per year for those students enrolled in the company's technical high school. These courses consist of 12 sessions each and last one month and a half. Each course is for a mixed class of 35 young men and women who are in their last year of high school and most of whom will become IUSA employees upon graduation.

These family planning educational activities are supported and complemented by the educational and informational efforts of a social worker who provides liaison between educational offerings and the services. The social worker's role in providing private counselling is central to the continuation and evaluation of the project.

Provision of Services

The program provides a full range of family planning services offered in accordance with the National Family Planning Program's population policy. The methods offered include IUD insertion, contraceptive distribution, and counselling for natural family planning. Clients interested in minilaps or vasectomies are referred to the Social Security Hospital in Toluca, or to the MEXFAM Clinic in the same city.

The program has strengthened the company's health facility with a physician, a nurse assistant and a social worker. These personnel are wholly devoted to the pilot program and their presence contributes to the development of education, services and continuous evaluation.

Organization of Services

The project is headed by a medical doctor who is responsible for all health-related activities at EPQ. A Project Operations Director, an obstetrician-gynecologist with experience in family planning programs and knowledge of the social-cultural context of the majority of the industrial complex's population, is responsible for all family planning activities. A nurse assistant is responsible for clinical activities.

The Operations Director is assisted in the implementation of social and educational activities by a Social Worker, who is responsible for family planning promotion and personalized counselling. Her liaison between the education activities and the clinical services is very important given the factory population's rural-indigenous context. An important part of the social worker's job is that of evaluation. She assists the Operations Director with sampling, surveys, statistics, etc..

Evaluation Activities

Since IUSA's program is a health and family planning program that affects the individual, the family and the community, and given that it is a pilot project that links these services to cost savings for the company, the on-going evaluation of the program will be complemented by an examination of the profitability to the firm of an efficient family planning program.

IUSA requested outside assistance with the design of an on-going, continuous evaluation process to collect necessary data to comply with the requirements of a model that could be replicated in installations.

Discussion Questions

1. Why did Industrias Unidas, S.A. decide to expand its family planning services beyond IE&C efforts?
2. Does your firm keep data on employee pregnancy costs? Have you been able to quantify the costs of maternity leave? Employee replacement and training? General loss of productivity?
3. What value do you think IUSA management derived from dialogue with employees prior to setting up a pilot family planning program?
4. IUSA decided to place heavy emphasis on education. Where would you place the emphasis in your enterprise? IE&C? Providing contraceptive services? Other?

CASE STUDY: INDUSTRIAS UNIDAS, S.A. (MEXICO)

Industrias Unidas, S.A. operates a major factory at Pasteje, State of Mexico, some 75 miles from Mexico City. Products manufactured by Industrias Unidas, SA (IUSA) range from zippers and ball point pens to telephones and airplane parts. IUSA employs a total of over 9,000 people in several locations, with about half of its workforce being women. The EPQ complex in Pasteje has 6,000 employees. Of these, half are female and most of them are relatively young - 18 to 25 - years and drawn from the surrounding areas. Most belong to indigenous rural groups demographically characterized by high birth rates.

Since its initiation, the EPQ Complex at Pasteje has provided health/medical and safety services to its workers. All services have been provided within norms established by the Federal Government of Mexico. Because of the distance from the factory site, accessing other health and medical services required lengthy travel or leaves.

In recent years, the management of the EPQ complex has kept detailed records for pregnancy rates. These records (from 1983 to 1986) present total work-hours lost, based on Mexican law which provides that a pregnant woman is entitled to 90 days maternity leave (45 before and 45 after delivery). As Table 1 shows, the average rate of pregnancies for these four years is 11.68% of female workforce per year.

Table 1
COMPARATIVE FIGURES ON PREGNANCIES CARRIED TO TERM
DURING THE LAST 4 YEARS

Year	Avg. # women of reproduc- tive age in the company	Pregnancies carried to term	% of total # of women	days of pregnancy leave	man- hours lost	Difference from year to year
1983	2,152	284	13.20%	25,560	204,480	
1984	2,005	223	11.12%	20,070	160,560	43,920(+)
1985	2,400	260	10.86%	23,400	187,200	26,640(-)
1986	2,845	331	11.57%	29,790	238,320	51,120(-)
11/86 -3/87	2,031	135	4.76%	12,150	97,120	

Source: EPO, IUSA
1987.

Table 2 breaks figures out into man-hours lost and multiplies this figure by the overall Mexican minimum wage to reach a peso figure of 37,000,000 cost to the company for time lost. Under Mexican law, the company pays employees for maternity leave, with a resultant quantifiable figure which management viewed as minimal in relation to other costs which they have yet to quantify. These include costs of training and employee replacement, loss of productivity as a result of leave, extra accounting costs involved in monitoring temporary employees who must be discharged and rehired after 89 days of work.

Table 2

**WOMEN WHO CARRIED A PREGNANCY TO TERM
AND RECEIVED THE CORRESPONDING 90 DAYS LEAVE
AS SPECIFIED BY MEXICAN LAW**

Month	Total women in the company	Pregnancies carried to term		Monthly percent	Average % per month for this 5-month period	Total man-hours lost per month
11/86	2,794	20		0.71	0.95	14,400
12/86	2,714	29		1.06	.885	20,880
1/87	2,748	27		0.98	.916	19,440
2/87	2,827	30		1.06	.952	21,600
3/87	3,075	29		0.94	.95	20,880
		T.135	P.M.27			97,880

NOTE: Days off granted by law through the month of March = 12,140

Average man hours lost per month = 19,424

These figures represent an actual financial loss, based on the minimum wage, of M\$ 37,000,000

Management Action

IUSA management established an IE&C component in 1983 for inclusion in its 90-day training program for entering employees. While achieving a modest degree of success with the IE&C component, the company's awareness of the costs and problems associated with employee pregnancies led them to set up a more aggressive program in 1986-87.

The company management decided to establish a pilot family planning program within the general area of mother and infant health and family prosperity. This combination of factors (i.e. family prosperity and corporate progress) is at the base of the new range of services offered by IUSA. The program started with a decision to build onto existing facilities with certain remodeling. As personnel needs and demand grow, management may enlarge the facilities.

The family planning program is a well-organized program serving EPQ's worker population. The objectives of the program are three-fold:

- Establish, at the EPQ complex, a family planning program that will allow a reduction in the birth rate from 10.2% to 5% within two years.
- Reduce the loss of man hours related to maternity leave, etc., by about 50%.
- Demonstrate the benefits to families and profitability to companies of family planning projects.

The program reflects the objectives of the National Family Planning Program which states that "its success depends largely on the active participation of the various organizations and institutions of the public and private sectors, for only thus can the population be linked with the actions that derive from the Program." If this pilot program proves to be a success, it will have a self-multiplying effect in the other IUSA factories, and, given IUSA's prestigious standing, perhaps in the rest of the country.

Educational Activities

Existing IE&C activities relating to the family planning program have been incorporated into the complex's current training system. Family planning information and education are part of the health training offered to all divisions of IUSA. The following family planning activities have been developed:

- (a) A monthly course (12 per year) of 8 sessions (2 per week) offered to a mixed group of 70 to 90 people most of whom are in their twenties, at the Industrial Complex's Pretraining School. These twelve courses are designed to reach all new recruits at the workers' level. No worker starts at EPQ without first having gone through this industrial pretraining school.
- (b) Three family planning courses a year for new technical personnel. These courses are of 12 sessions each and last one month and a half. Each course is for a mixed class of 30 to 40 people who are either professionals or semi-professionals.
- (c) Two family planning courses per year for those students enrolled in the company's technical high school. These courses consist of 12 sessions each and last one month and a half. Each course is for a mixed class of 35 young men and women who are in their last year of high school and most of whom will become IUSA employees upon graduation.

These family planning educational activities are supported and complemented by the educational and informational efforts of a social worker who provides liaison between educational offerings and the services. The social worker's role in providing private counselling is central to the continuation and evaluation of the project.

Provision of Services

The program provides a full range of family planning services offered in accordance with the National Family Planning Program's population policy. The methods offered include IUD insertion, contraceptive distribution, and counselling for natural family planning. Clients interested in minilaps or vasectomies are referred to the Social Security Hospital in Toluca, or to the MEXFAM Clinic in the same city.

The program has strengthened the company's health facility with a physician, a nurse assistant and a social worker. These personnel are wholly devoted to the pilot program and their presence contributes to the development of education, services and continuous evaluation.

Organization of Services

The project is headed by a medical doctor who is responsible for all health-related activities at EPQ. A Project Operations Director, an obstetrician-gynecologist with experience in family planning programs and knowledge of the social-cultural context of the majority of the industrial complex's population, is responsible for all family planning activities. A nurse assistant is responsible for clinical activities.

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3. What value do you think IUSA management derived from dialogue with employees prior to setting up a pilot family planning program?
4. IUSA decided to place heavy emphasis on education. Where would you place the emphasis in your enterprise? IE&C? Providing contraceptive services? Other?

CASE STUDY: BURSA MERINOS TEXTILE FACTORY (TURKEY)

Bursa Merinos Textile Factory (BMTF) is one of the oldest wool textile manufacturing enterprises in Turkey. It is located in the city of Bursa, an important industrial center, which has a population of one million. BMTF employs approximately 3200 workers; 800 of these workers are female. The factory is divided into five production units: weaving, spinning, combing, tweezing, and garment making. Women are employed in all units except the garment unit. The factory operates on a 24-hour basis with three shifts: 8:00 - 16:00, 16:00 - 24:00, 24:00- 8:00. Employees work eight hours per day, six days per week. Workers are divided into shift groups with the shifts rotating every week.

In 1981, BMTF was asked to participate in a family planning research program sponsored by the Hacettepe University Department of Public Health. BMTF was selected based largely upon the willingness of the factory management to cooperate by providing factory space for a family planning clinic and by permitting workers to attend meetings for family planning education.

The purpose of the program was to increase the number of users of modern contraceptives, particularly the IUD (a government priority). The researchers wanted to determine if union shop stewardesses who were trained in family planning were as successful as professionally trained health educators at motivating employees to use more effective methods of contraceptions. Using shop stewardesses as motivators would make it more feasible for private enterprises to provide and promote family planning services; trained health educators are scarce and expensive in Turkey.

At the beginning of the program, a baseline survey was conducted to determine the use of contraceptives among the women working in the factory. The results of the survey indicated that contraceptive practice is quite high among female workers but that less effective methods (such as coitus interruptus and spermicides) were used by most women. Contraceptive failure rates (as evidenced by the large number of abortions) were high among this group.

Prior to the onset of the research program, family planning services were provided at three Ministry of Health and Social Assistance family planning clinics in the city of Bursa. Services are provided at no charge to all women at these clinics. In addition, oral contraceptives (no prescription required) and condoms were sold at chemists' shops in the city. Private

practice gynecologists also provide family planning services to their patients. As part of the study, a family planning clinic was established at BMTF, in an area adjacent to the factory's infirmary and nursery. The clinic site was chosen because workers were accustomed to coming to that area of the factory for health care and child care. IUDs, oral contraceptives, and condoms were provided at the clinic.

The new family planning services were targeted at the 410 married female employees (ages 15-49) who worked in the combing and spinning units of the factory. The 410 women were divided into three groups, depending on the shift that they worked. A professional health educator was hired to motivate members of one of the groups of women to use modern methods of contraception. The health educator held several small group education sessions with these women. Members of a second group of women were motivated by shop stewardesses. Eight shop stewardesses were selected by the union to receive training to become family planning motivators. The stewardesses were foremen and supervisors in the factory and were chosen for their leadership skills. The union shop stewardesses were trained by the same health educator who held the educational sessions for the first group of workers. Four training sessions of two hours each were held. A third group of women received no formal motivation to use a modern method of contraception, although they were informed about the new family planning clinic and were allowed to use its services.

Lectures, group discussions, and a slide show on family planning were the main training methods. In addition to the training, the shop stewardesses were given written educational materials to use when talking to workers. Most of the motivational activities carried out by the shop stewardesses were one-on-one education sessions/discussions during working hours, primarily during rest periods and social gatherings.

A second survey was conducted 10 months after the implementation of the motivational activities. The survey results indicated that the overall use of contraceptives increased, particularly the use of more effective methods. The percentage of the contraceptors increased from 80 percent to 87 percent; more importantly, the percentage using the more effective methods increased from 23 percent to 49 percent. These increases can be attributed both to the convenience of having family planning services available in the factory and to the increase in education and motivation. The shop stewardesses were found to be as effective as the health educators in motivating women to use more effective methods of contraception.

An important outcome of this project was its impact on factory managers and the leaders of the Confederation of Labour Unions. Based on the results of this study, union leaders convinced the Social Security Administration to start providing family planning services in its hospitals. Several factory owners were also convinced to establish in-house family planning clinics. The Confederation also established a unit in their headquarters to organize family planning activities. In the three years following the BMTF experiment, 25 family planning units were established in 14 cities. Thirteen of these clinics provide IUDs, pills and condoms, four provide pills and condoms, and eight provide only condoms. Union stewards and stewardesses were used as family planning motivators at many of the sites.

Source: World Health Organization. Special Programme of Research, Development and Research Training in Human Reproduction. Ankara, Turkey: Hacettepe University, 1986.

Discussion Questions:

1. What motivated the BMTF to set up company-based family planning services? What motivated the union to expand on the idea?
2. How were BMTF's needs met through the services? The employees' needs? The union's needs? The government's needs?
3. What form did the family planning services take? (Integrated? Types of methods? etc.)
4. What outside assistance (if any) would be needed to implement this model in a different setting?
5. How were workers and management motivated to participate?
6. Who would be a good "motivator" in your particular setting?
7. Should BMTF have continued providing services after the study was completed? How would/could/should the program change?

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5. How were workers and management motivated to participate?
6. Who would be a good "motivator" in your particular setting?
7. Should BMTF have continued providing services after the study was completed? How would/could/should the program change?

**CASE STUDY DISCUSSION:
DISCUSSION QUESTIONS**

CASE STUDY DISCUSSION

In facilitating the reporting back of the smaller groups on their respective cases, the following questions may help you probe for more complete responses to the questions which are included with each case. These questions include:

- a. What motivated the enterprise to set up company-based family planning services?
- b. How were the enterprise's needs met through the services? employees' needs? government's needs? How did the enterprise calculate need for contraceptive services?
- c. What was the basic process which the enterprise used in setting up family planning services?
- d. What form did the family planning services take? integrated services? free-standing? one method only? a variety of methods?
- e. Where did the enterprise go for assistance with equipment? supply of contraceptives? staff training? technical assistance?
- f. How were workers and management motivated to participate?
- g. What kind of promotional activities were necessary? How else did the management show their support for the new services?
- h. Do you think that the enterprise's investment was a good one? If yes, why? If no, why?

DESIRED OUTCOMES

An outcome of the case study discussion should be the identification of a number of issues which private sector management will need to consider when designing company-based family planning services. This list includes:

- employer motivation, benefits and incentives (questions a & b);
- process (questions b & c);
- relationship between company-based services and government services (question b);
- calculating unmet need for services (questions b,c, & d);
- mix of services/integration with existing health services (question d);
- calculating resource needs (questions b,c,d & e);
- sources of support---financial, logistical and technical (question e);
- IE&C needs and employee motivation (questions b,f & g); and
- rate of return on investment (question h).

EVALUATION

EVALUATION EXERCISE: SECTION II

Each participant is asked to write down on a piece of paper the role his or her enterprise can play in providing family planning services. The participants are asked to keep the statement simple and short. When this task is completed, the trainer calls on three people, in turn, to read what they have written. The trainer writes the three statements on newsprint where all can see them. Participants are then asked to look for common elements in each of the statements. As they do this, the trainer highlights the common elements with a marker.

Then, the group is asked if they have anything more to add and others are encouraged to read their statements to the group. Participants are asked to keep the statement so that they can review it at the end of the training to see if they have more to add.

The trainer can judge the appropriateness of material in this section by observing the general level of participation. Measures might include:

- if all of the participants can prepare a statement;
- if the statements draw on information presented in the section; or
- if the participants show enthusiasm in their presentation of statements.

Time: 20 minutes

EVALUATION EXERCISE: SECTION II

In a simple and brief statement, please write down the role you feel your enterprise can play in the promotion of family planning and the provision of on-site family planning services.

REFERENCES

How to use the Reference Materials for this Section:

A number of documents are listed here that may be helpful to trainers as they prepare for workshops and to participants as additional reference material on the topics presented in this section of the manual. While all the articles are useful, the following provide a significant background in the role of the for-profit commercial sector in developing and promoting company-based family planning services.

JSI. Family Planning Private Sector Programme, Annual Report 1985. Nairobi: Family Planning Private Sector Programme, JSI, 1985.

This document describes a project in Kenya that assists a number of private businesses and non-governmental institutions to add family planning services to their existing health services. Of special interest to this Section are the short case studies of 26 subprojects that provide examples of successful private sector family planning efforts. These examples are useful to a trainer to help "bring alive" the content of this Section in a training session. They can also be read by a workshop participant to stimulate ideas of how family planning might fit into his or her enterprise.

Krystall, Eric. "Private Sector Family Planning," Populi, Vol. 12, No. 3, 1985, pp. 34-39.

This article explains the rationale for involving the private sector in family planning programs and looks again at the Kenya project as a model for developing these programs. This piece provides a trainer or trainee with a brief and logical argument for the involvement of the private sector in planning, implementing and evaluating family planning services.

Population Crisis Committee. Toward Small Families: The Crucial Role of the Private Sector. Draper Fund Report, Number 25. Washington, DC: Population Crisis Committee, December, 1986.

This issue of the Draper Fund Report focuses on the indispensable role of the private sector in helping governments deal with national population programs. The issue contains articles on the role of private industry and nongovernmental organization activities in designing and implementing innovative family planning programs.

Population Information Program. "Operations Research: Lessons for Policy and Programs." Population Reports. Number 31, Series J, May-June, 1986. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This 35 page publication describes a scientific approach for improving family planning service delivery by measuring and observing the behavior of the program clients. Operations research and the major results of this research worldwide are described and the trainer or trainee are provided with a comprehensive background on a wide range of family planning research topics.

Population Information Program. "Sources of Family Planning Assistance," Population Reports, Number 26, Series J, 1983. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This 20 page document identifies sources of financial aid, technical assistance and training for supporting family planning programs. Types of assistance given, amounts of money provided and examples of projects supported are discussed for governmental, multilateral and non-governmental agencies. Addresses are included.

Weerakon, Bradman. "Tapping Private Industry." in Towards Smaller Families: The Crucial Role of the Private Sector, Draper Fund Report #25. Washington, D.C.: Population Crisis Committee, December, 1986.

This article highlights the activities of several industries in both developed and developing countries in providing family planning services on-site and includes a short case based on the pioneering efforts of Godrej Enterprises in India.

World Bank. Population Change and Economic Development. (Chapter 5: Family Planning as a Service; Chapter 6: The Policy Agenda) Washington, D.C.: World Bank, 1985.

Chapter 5 of this book first explores the need and the personal desires for family planning services with specific references to a number of countries and then looks at why these needs and wants remain unmet. Examples of how the constraints on service delivery have been overcome are also provided. A number of charts and special sections provide specific information on these subjects.

Chapter 6 of this book describes the elements of a national family planning policy and explains the importance of each. Specific reference is made to a number of countries and regions of the world. This chapter provides trainers and participants with a basic understanding of the policy issues surrounding population policies, family planning programs and the positions that have been taken on the major issues.

Other References

Dedel, S.B. "Labor Management Coordinating Committees in Action" in Family Planning in the Asian Region: Part III. Bangkok: ILO, pp. 127-139.

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Section III: Benefits of Family Planning to the Employer, Employee and the Nation

This section discusses the immediate and long-term benefits derived from family planning services by the employer, employee and the nation.

TRAINER'S NOTES**Objectives for this Section:**

By completing the activities in this section, workshop participants will:

1. identify and discuss the following benefits of family planning and relate them to both the factory and country context:
 - o economic benefits to the employer and the enterprise;
 - o benefits to organized labor;
 - o health benefits to the individual (employee and family); and
 - o societal benefits for the community and the nation.
2. identify, classify and prioritize the range of benefits of family planning according to those which are immediate in nature and those which take a longer time to realize;
3. incorporate a statement of benefits of family planning to the employer into a written program rationale for the family planning services which they plan to set up.

Rationale:

By developing an understanding of the kinds of benefits of family planning and relating them to their immediate economic context, participants will be better prepared to plan and implement company-based family planning services.

PROCEDURES**o Introductory Lecturette: The Benefits of Family Planning**

Participants are introduced to the benefits of family planning to the employer and the individual.

Time: 30 minutes

o Calculating the Value of Factory-Based Family Planning Services

Participants examine a check list of pregnancy-related costs and review a short form for calculating the value of factory-based family planning services.

Time: 45 minutes

o Group Discussion: Linking Individual Benefits to Those of the Employer and of Society

Through a group discussion, workshop participants identify direct linkages between benefits of family planning to an employer and those which accrue to the individual and to the larger society. At another level, the intent is to have participants move beyond those linkages to the identification of additional benefits for the employer, the employee and society.

Time: 20 minutes

o Preparing Individual Statements of Benefits Anticipated from Offering Family Planning Services in Private Enterprises

Participants prepare written statements of anticipated benefits for employers and employees from setting up family planning services in their workplaces.

Time: 20 minutes

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o Evaluation

Participants use small task groups to review the statements of anticipated benefits prepared in the previous exercise.

Time: 30 minutes

TO THE TRAINER:

A full set of materials for both trainer and participants in Section III follows immediately.

LECTURE NOTES:
BENEFITS OF FAMILY PLANNING

**BENEFITS OF FAMILY PLANNING TO THE EMPLOYER, LABOR,
THE EMPLOYEE AND THE NATION**

Family planning serves a number of purposes at the same time. Enterprises in many countries have found that providing family planning services at the workplace has paid off in less absenteeism, lower labor turnover and improved employee morale. In turn, many labor unions have lobbied for family planning as a vital benefit for their members' welfare. As for workers, recent experiences have shown that when family planning services are readily accessible and when women and men see that family planning is used by their peers, they are more apt to become users of contraceptives.

Moderating population growth through family planning which aims at birth spacing and limiting family size has direct benefits for the employer, labor, the employee and the nation. Benefits do not necessarily accrue to each group on an equal basis, nor does each group view the benefits derived from family planning by the other groups as benefits to itself. In this section of the manual, the goal is to discuss the range of benefits derived from setting up family planning services on site.

According to the International Labour Organization (ILO), employers and employer's organizations have a collective responsibility for maintaining the social environment which provides them with the opportunity to conduct their economic activities in their own and in the country's interest. They have an obligation to improve working conditions and undertake all welfare measures necessary to promote the well-being of workers. This includes family welfare measures and family planning programs.

In Japan, some factories started providing family planning services as early as the 1950s. By 1960, 115 companies were involved in improving living conditions for workers through the New Life Movement. India's largest industrial complex, Tata Iron and Steel Company, started integrating family planning services into its existing maternal and child health program at about the same time. By 1986, about 250,000 people at the complex and in surrounding villages were covered by the services with 65% of company couples using modern contraceptives. The birthrate in the area has fallen to about 28 per 1,000 compared with a national average of 33 per 1,000. (Draper Fund Report, 1986, p. 9).

These examples and others underscore a number of major benefits derived from family planning which, for management, include:

- o direct cost savings in time and training;
- o greater efficiency achieved by keeping the same person on the job; and
- o happier employees because management has offered service, thus creating loyalty to employer.

These points, and others, were discussed in Section II in the slide presentation on the Family Planning Private Sector Programme in Kenya, as well as in the Kenyan and Turkish case studies. Two worksheets included in this section of the module will help identify other benefits to the employer, and a better understanding of how to calculate them.

As the Turkish case study in Section II highlighted, the benefits for labor include:

- o improved quality of life for union members;
- o more funds for union participation;
- o increase in benefits for union members;
- o stronger relationship with members if they are happy and healthy, resulting in stronger unions;
- o increased status for unions if the unions are the origin of family planning initiatives.

For the employee, the health benefits of family planning include:

- o survival and health of mothers;
- o survival and health of children; and
- o benefits to men as wage earners.

According to the 1986 Draper Fund Report (p.10), factory-based family planning programs have often cut pregnancy rates in half. Most women employees have indicated an interest in accessing family planning services as unplanned pregnancies can jeopardize job security.

Materials produced by IMPACT, a project of the Population Reference Bureau, highlight the fact that family planning saves lives. Family planning is viewed as one effective and inexpensive way to reduce maternity-related deaths of both mothers and infants.

Maternal mortality is usually expressed in terms of the number of deaths to women due to pregnancy and child-birth related causes per 100,000 births in one year. The Population Reference Bureau (1986) estimates that about a half million women in developing countries die each year from complications of pregnancy and childbirth within specified time (usually 42 days) after the termination of the pregnancy. The figures in Overhead A illustrate current maternal mortality rates by geographic region.

Later in this module (Section V), the point is made that some contraceptive methods involve some increased health risks. These risks are very slight when compared with the risks of dying from pregnancy or childbirth related causes. Overhead B provides a comparison of estimated death rates for younger and older women from pregnancy or childbirth versus side effects of various contraceptive methods.

Overhead A

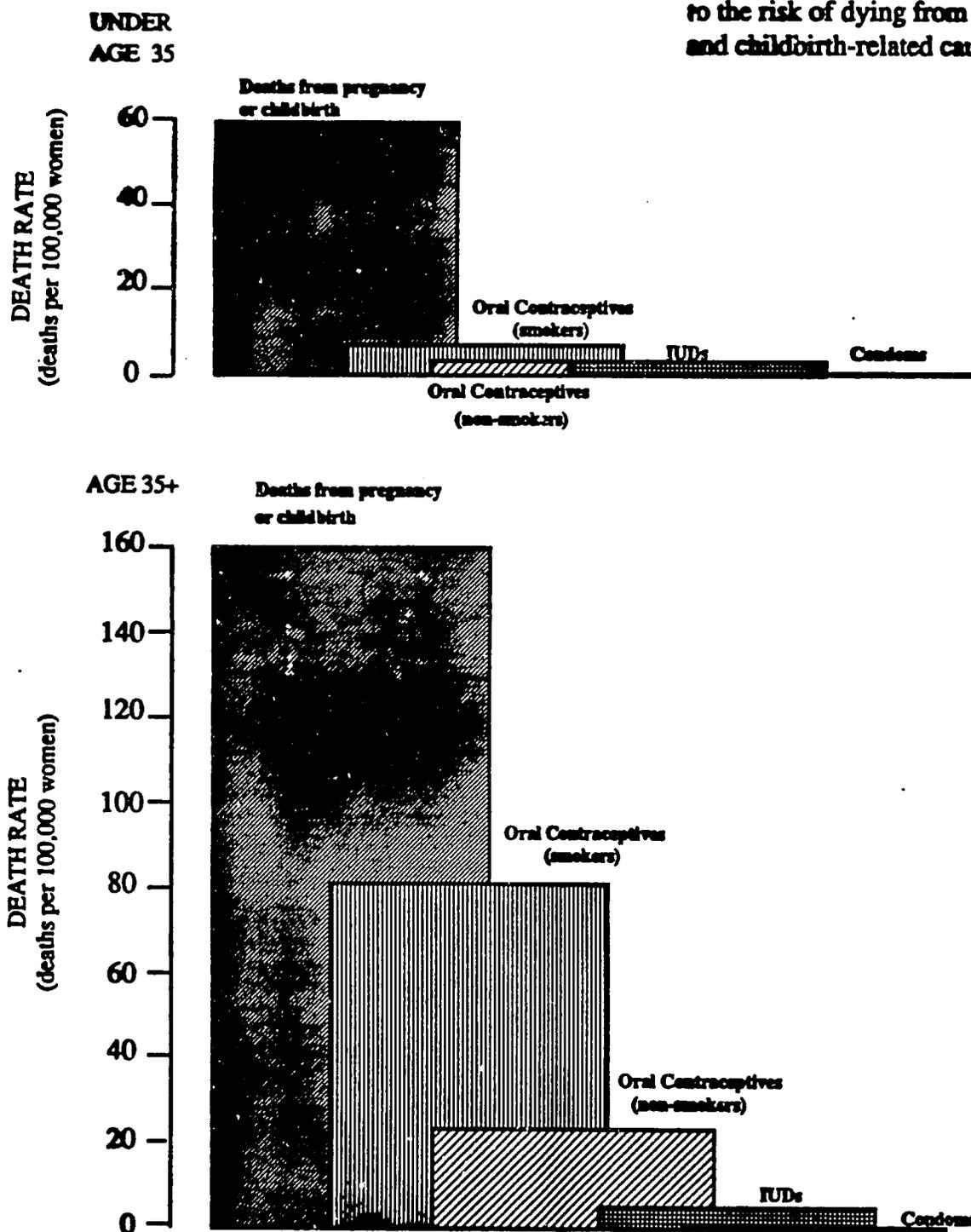
MATERNAL MORTALITY
DEATHS PER 100,000 BIRTHS

	Estimated Average	Range
AFRICA	258	78 to 1100
ASIA	310	5 to 700
EUROPE	21	4 to 28
LATIN AMERICA	112	8 to 418
NORTH AMERICA	10	6 to 10

**Source: Family Planning Saves Lives
IMPACT Project, 1986, p. 12**

Overhead B

"While some contraceptive methods involve slightly increased health risks these risks are very small compared to the risk of dying from pregnancy- and childbirth-related causes."



A comparison of estimated death rates for younger and older women from pregnancy or childbirth versus side effects of various contraceptive methods.

The IMPACT materials (1986, p. 16) cite one study based on World Fertility Survey data which estimated that maternal deaths could be reduced by almost one-third per year on average. This, the report states, could be accomplished by avoiding births to women who wanted no more children but who were not currently using any family planning method.

Low risk childbearing is another benefit to women from family planning. Family planning can help women in high risk groups such as:

- women under 18 who are not yet biologically or socially ready to safely become pregnant and give birth;
- women over 35 who are biologically not as well suited for pregnancy and child birth as are women in their 20s;
- mothers who may not have sufficiently recuperated from one pregnancy and delivery before they become pregnant again.

Overhead C outlines five major points related to women's access to and use of family planning services and contraceptive methods.

61-

Overhead C

Family Planning in Developing Countries

As modern methods of contraception have become available in many parts of the Third World, millions of women have begun to use them to plan their families. Yet there is still a great unmet need for family planning services:

Many women still have pregnancies so close together.

Many women who want no more children are not using an effective method of contraception.

Large proportions of women in some countries do not know of any place to get family planning services or supplies.

Even though some modern methods of contraception have rare but serious side effects, they pose less threat to the health of most women than do pregnancy and childbirth. This is true in developed countries, where maternal mortality rates are low. The saving of lives due to use of effective contraceptives is probably much greater in developing countries where maternal mortality rates are so much higher.

SOURCE:

Meine, D. Family Planning: Its Impact on the Health of Women and Children. New York: The Center for Population and Family Health, Columbia University, 1982, p. 39.

Family planning also helps infants and young children who might be at high risk because:

- birth defects are more frequent in children born to women under 18 and over 35;
- young mothers often lack the economic means and practical knowledge to care well for children;
- infants born at the beginning of short intervals between births may suffer because their period of breast feeding is cut short and they are weaned abruptly;
- the health of infants and young children often suffers from their mothers' ill health.

Overhead D summarizes major points related to child health and family planning.

At a more macro-level, there are a number of benefits to society at large. Societal benefits of family planning for the community and the nation include:

- o health benefits to men, women and children result in a more productive work force;
- o increased productivity resulting in increased profits;
- o reduced number of unplanned pregnancies;
- o reduced number of adolescent pregnancies;
- o provides basis for understanding how, when and where population will grow, thus facilitating more realistic development planning.

Overhead D

Child Health and Family Planning

A child's chances of being born healthy, of surviving the first few years of life and of growing well are reduced if:

Children in the family are born very close together in time.

There are already three or more children in the family.

The mother is younger than 20 or older than 35 when the child is born.

Family planning improves children's health by helping women to space their births, have smaller families, and avoid pregnancies at unfavorable ages. In countries where large proportions of women have already adopted family planning, the resulting changes in childbearing patterns have contributed substantially to recent declines in infant mortality.

Source:

Maize, D. Family Planning: Its Impact on the Health of Women and Children. New York: The Center for Population and Family Health, Columbia University, 1982, p. 9.

**CALCULATING THE VALUE
OF
COMPANY-BASED FAMILY PLANNING PROGRAMS**

**CALCULATING THE VALUE OF
FACTORY-BASED FAMILY PLANNING PROGRAMS**

In this part of Section III, attention turns to methods for calculating the value of factory-based family planning programs. Two worksheets are provided:

- o a checklist of pregnancy-related costs;
and
- o a short form for calculating the value of
factory-based family planning programs.

Both worksheets were developed by the Enterprise Program for estimating the economic returns in the factory-based programs it assists.

(Trainer should use accompanying Short Form for Calculating the Value of Factory-Based Family Planning Programs and Checklist of Pregnancy-Related Costs. A copy is provided for both trainer and participants.)

WORKSHEET I

CHECKLIST OF PREGNANCY-RELATED COSTS

Three kinds of costs are associated with pregnancies of both female employees and spouses of employees:

- o maternity leave costs
- o maternal/child health costs
- o pronatalist premiums costs

A fourth category of costs associated only with female employees is turnover costs. Each is explained more fully below.

MATERNITY COSTS

female employees
x average no. of paid pregnancy leaves/per woman/per year

average no. of births in MWR per year
x prenatal, pregnancy and delivery costs per MWR per year

costs per pregnancy leave are:

- average weekly wage x no. of weeks paid leave x % paid by employer
- training costs related to temporary replacements, reintegration, or overtime
- reduced efficiency of replacements (difficult to value/annoyance cost)
- accounting costs of legal benefits compliance (annoyance cost)

MATERNAL/CHILD HEALTH COST

female employees or spouses
x average no. of paid pregnancies/per woman/per year
x costs per pregnancy

costs per pregnancy are:

- prenatal costs (absenteeism + health services)
- delivery costs (health/medical services)
- postnatal costs (absenteeism + health services)

PRONATALIST PREMIUMS COST

- # female employees or spouses
- X average number of live births per year
- X value of the child welfare bonus per child

TURNOVER COSTS

- # female employees
- X percentage laid off due to pregnancy/per year
- X cost of recruiting, orienting and training a replacement
- X severance pay requirements (formula may vary by country)

Source: Enterprise Program,
1986.

WORKSHEET II

CALCULATING THE VALUE OF
FACTORY-BASED FAMILY PLANNING PROGRAMS
SHORT FORM

-
- NC = The number of dependent children receiving medical/social services
- MWR = Married women employees or dependents of reproductive age
- N = NC + MWR = Total women and children receiving medical/social services
- B = Average number of births per MWR per year
- D = Pregnancy, prenatal and delivery costs per delivery
- L = Average maternity leave paid per female employee taking leave per year
- M = B(D + L) = Average maternity costs per woman per year
- C = Child welfare payments per child
- H = Maternal and child health costs
- MCH = (MWR x M) + (NC x C) + (N x H) = Total maternal/child health costs
- P = Expected prevalence rate of NEW users
- BA = MWR x B x P = estimated number of births averted
- DW = Number of female employees departing due to pregnancy
- T = Turnover cost (severance, recruiting and retraining)
- CP = (M x B) + (DW x T) = Estimated total cost of pregnancies
- CYP = Couple year of protection
- C = Cost of contraceptive methods per CYP
- CC = MWR x P x MC = Estimated total cost of contraceptive commodities
- E = Cost of clinical equipment (prorated for one year)
- F = Cost of clinical facilities (building space for one year)
- V = Cost of vehicles/mobile units (prorated for one year)
- S = Personnel costs for one year
- IEC = Cost of informational and motivational materials and services
- TC = CC + E + F + V + S + IEC = Total cost of operating a family planning program
- CS = BA [(MCH + CP)/N] - TC = Estimated total cost savings of family planning program

WORKSHEET II

CALCULATING THE VALUE OF
 FACTORY-BASED FAMILY PLANNING PROGRAMS
 SHORT FORM

NC = 6000
 MWR = 1000
 N = NC + MWR = 7000
 B = 0.60
 D = \$100
 L = (three months pay) = \$300
 M = B(D + L)
 = 0.60(100 + 300) = \$240
 C = \$20 per child per month = \$240 per child per year
 H = \$150 per mother and child per year
 MCH = (MWR x M) + (NC x C) + (N x H) =
 = (1000 x \$240) + (6000 x \$240) + (7000 x \$150)
 = \$240,000 + \$1,440,000 + \$1,050,000 = \$2,730,000
 P = (as a percentage of MWR) = 30%
 BA = MWR x B x P
 = (1000 x 0.60 x 0.30)
 = 180
 DW = 150
 T = \$300
 CP = (M x B) + (DW x T)
 = (\$240 x 0.60) + (150 x \$300)
 = \$144 + \$45,000 = \$45,144

CYP = Couple year of protection

MC =

<u>Method</u>	<u>Average Need per Couple per Year</u>	<u>Yearly Cost* per Couple</u>
Pills	13 cycles	13 x 0.19 = \$ 2.47
Condoms	120 condoms	120 x 0.04 = \$ 4.80
IUD	0.4 units of an IUD	0.4 x 1.00 = \$ 0.40
Injectables	four injections	4 x \$1.00 = \$ 4.00
Diaphragm	one	1 x \$3.50 = \$ 3.50
Foam	five cans	5 x \$1.00 = \$ 5.00
Jelly	three tubes	3 x \$2.00 = \$ 6.00
Foaming Tabs	120 tabs per year	120 x 0.10 = \$12.00
** Minilaparotomy	1 procedure	1 x \$45.00 = \$45.00
** Vasectomy	1 procedure	1 x \$20.00 = \$20.00

*Commodity costs are based upon bulk purchases by USAID and your costs will vary depending on source.

**These methods are performed once in a lifetime. Therefore costs can be calculated from time of procedure until end of reproductive age. For example: Reproductive age from women is 15-44. If a minilap was performed when she was 30 years of age - then she would have CYP for 14 years. Therefore \$45 divided by 14 years = \$3.21 cost per year.

WORKSHEET II
 CALCULATING THE VALUE OF
 FACTORY-BASED FAMILY PLANNING PROGRAMS
 SHORT FORM

<u>Expected</u> <u># of users</u> <u>(MWR x P) = (1000 x 0.3) = 300</u>		<u>Estimated</u> <u>Total Yearly Cost</u> <u>For Contraceptives</u>
Pills	145	145 x 13 x 0.19 = \$358.15
Condoms	85	85 x 120 x 0.04 = \$408.00
IUD	52	52 x 0.4 x 1.00 = \$ 20.80
Injectables	5	5 x 4 x 1.00 = \$ 20.00
Diaphragm	5	5 x 1 x 3.50 = \$ 17.50
Foam	2	2 x 5 x 1.00 = \$ 10.00
Jelly	4	4 x 3 x 2.00 = \$ 24.00
Foaming Tabs	<u>2</u>	2 x 120 x 0.10 = <u>\$ 24.00</u>
Total Users	300	Total \$882.45

CC = MWR x P x C =
 E = (donated)
 F = 100 sq. ft. at \$2 per sq. ft. = \$200 x 12 = \$2,400
 V = (donated)
 S = \$20,000
 IEC = (donated)

TC = CC + E + F + V + S + IEC = Total cost of operating a
 family planning program
 = (\$882.45 + 0 + \$2,400 + 0 + \$20,000 + 0) = \$23,282.45

CS = BA [(MCH + CP)/N] - TC
 = 180 [(\$12,730,000 + \$45,144)/7,000] - \$23,282.45
 = \$48,078.40

Cost savings ratio = benefits/costs
 = \$71,360.84/\$23,282.45
 = \$3.07 saved for every dollar invested

Source: Enterprise Program,
 1988.

WORKSHEET I

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Source: Enterprise Program,
1986.

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CALCULATING THE VALUE OF
FACTORY-BASED FAMILY PLANNING PROGRAMS
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Cost savings ratio = benefits/costs

= \$71,360.84/\$23,282.45

= \$3.07 saved for every dollar invested

Source: Enterprise Program,
 1988.

**GROUP DISCUSSION ACTIVITY:
BENEFITS TO THE EMPLOYER**

11

GROUP DISCUSSION: BENEFITS OF FAMILY PLANNING FOR THE EMPLOYER

The short case study which follows describes one West African enterprise's initiative to examine ways of dealing with labor losses due to maternity costs. The case study provides an interesting follow-up to the discussion in the previous exercise. Read the case and then consider the four questions which follow it.

Taking the Initiative to Reduce Labor Losses

A West African company was interested in finding out how family planning services could make its work force more productive. Since the factory had no objective data relating to differentials in the productivity of women and men, they decided to consider industrial productivity in terms of actual productive man hours on the job. Lost time to sickness immediately before, during and after maternity leave by women was regarded as total loss time to industrial productivity. As family planning services were reported to improve the health of the female worker, the factory was interested in knowing the extent to which setting up and promoting its own family planning services might reduce time lost from industrial production by women in paid employment.

The management of the factory first examined national laws in detail to determine the maternity rights of its women employees. Then, it calculated the amount of allowable maternity leave (six weeks before and six weeks after delivery) and added in potential sick time during pregnancy and immediately after delivery (for a total of one month). Total time lost for each pregnancy was estimated at four months or 33 1/3 percent, with 66 2/3 efficiency in attendance at work. In its analysis, management saw that if a man and a woman are placed on the same job and evaluated with the same criteria and equally remunerated, the need to hire relief personnel for a long period of absence for the women makes the man more productive in terms of time on the job and consequently cheaper to employ than the woman.

Because of a preponderance of female workers in the factory (109 women to 35 men), the factory decided to assist female employees in taking advantage of family planning services. Upon receiving approval for the operation of its clinic, the plant nurse and two women employees were sent for a family planning course.

Management met with workers' representatives and agreed that the main objective of the clinic was to improve the health of mothers and babies and that interested women should get a consent form from their husbands.

Since starting the clinic, management has collected data on time lost by women over the past three years on account of maternity and sickness immediately before and after maternity and during pregnancy. It will compare this data with similar records for the next three years so that an evaluation of the impact of the services on time on the job can be made.

DISCUSSION QUESTIONS:

1. Was the company's motivation in this instance a legitimate one? Why?
2. Who were the major players in the process described in the case? What role did each play?
3. How do the company's findings compare with any informal assessment which you may have done in your enterprise?
4. Can you suggest ways in which the company might assess the returns on its investment in a shorter period of time?

[NOTE TO TRAINER: Trainer should use caution in presenting anti-female findings which might lead to decision-making which discriminates against women (e.g. hire only men or pay women less. Many women are hired in the first place because they are a cheaper form of labor.)]

TAKING THE INITIATIVE TO REDUCE LABOR LOSSES

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INDIVIDUAL ACTIVITY:

**PREPARING INDIVIDUAL STATEMENTS OF
ANTICIPATED BENEFITS OF FAMILY PLANNING**

- 82

**PREPARING INDIVIDUAL STATEMENTS OF ANTICIPATED
BENEFITS FROM INVESTMENTS IN FAMILY PLANNING**

This section of the module has discussed the benefits of family planning from three perspectives:

- o benefits to the employer;
- o benefits to organized labor; and
- o benefits to the individual.

To bring this discussion to a close, please give some thought to the investment you are considering making to set up company-based family planning services for your employees and their families. In the space provided below, please prepare a short statement about the benefits you anticipate realizing from your investments. As you do so, be as specific as possible about the benefits and list them by order of importance to the management of your factory or plantation.

o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o-o

The benefits I anticipate or foresee from my company's investment in providing company-based family planning services include:

EVALUATION

EVALUATION EXERCISE: SECTION III

Participants are divided into groups of three or four and are asked to discuss their statements of anticipated benefits prepared in the previous exercise. Each small group prepares two lists of benefits -- one for employers and one for employees. Lists are recorded on pieces of newsprint. Each group's list is displayed and the trainer leads a discussion that pulls common elements from each to produce two composite lists, one for employers and one for employees.

Possible measures of the effectiveness of this section are:

- o level of participation in both the small and large group activities; and
- o inclusiveness of the composite lists reflecting information presented in this section of the manual.

Time: 30 minutes

REFERENCES:**How to Use the Reference Materials for this Section:**

A number of documents are listed here that may be helpful to trainers as they prepare for workshops and to participants as additional reference material on the topics presented in this section of the manual. While all the articles are useful, the following provide significant information about the benefits of family planning to either the employer, employee, and/or the nation.

Ainsworth, M. Family Planning Programs: The Clients' Perspective. (World Bank Staff Working Papers Number 676). Washington, D.C.: World Bank, 1985.

The gap between fertility preferences and contraceptive behavior is explained in this monograph in terms of the objective and subjective "costs" of fertility regulation to people, including: the cost of finding out about contraception and where it can be obtained; the time and money to travel to an outlet; and the cost of the stress provoked by social disapproval of contraception. For some couples who ideally would like to prevent a birth, these represent a greater burden than the cost of an additional child. Annex B looks specifically at the health benefits of family planning.

Centers for Disease Control. Family Planning Methods and Practice: Africa. (Chapter 1: Health Benefits of Family Planning). Atlanta, Georgia: Centers for Disease Control, 1983.

Chapter 1 of this book presents a brief and clearly written summary of the positive impact that family planning and birth spacing can have on the health of mothers and children and relationships between spouses. Numerous graphs and charts help to make this an easily understood presentation.

IMPACT Project. Family Planning Saves Lives: A Strategy for Maternal and Child Survival. Washington, DC: Population Reference Bureau, 1986.

This occasional paper discusses the ways in which family planning saves the lives of women and children. Five topics are discussed: birthspacing and child survival; family planning and maternal survival; low-risk childbearing for mothers; healthy mothers, healthy babies; and family planning and health costs. The paper contains a number of useful graphs and charts.

Maine, D. Family Planning: Its Impact on the Health of Women and Children. New York: The Center for Population and Family, Faculty of Medicine, Columbia University, 1981.

This document presents, in clear and concise language and with many graphs and charts, information that explains the positive effects of family planning on the health of women and children. This review of scientific research looks at the health risks of pregnancies for women who are younger than 18, older than 35, having more than four children and having children more frequently than every two years. The relationship of family size to nutrition and other health practices for children is also explored.

Maine, D., Rosefield, A. and M. Wallace. "Prevention of Maternal Deaths in Developing Countries: How Much Could Family Planning Help?" Paper prepared for Population Association of America, San Francisco, CA 1986.

A significant observation of this study, based on World Fertility survey data, is that maternal deaths could be reduced by almost one-third per year on average. This could be done by avoiding births to women who desire no more children but are now not using any family method. Providing more women with greater access to family planning services would contribute substantially to achieving this goal.

Population Information Program. "Employment-Based Family Planning Programs," Population Reports, (No. 34) September-October, 1987. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This issue presents up-to-date information on employment-based family planning programs. The bulletin outlines the different kinds of services being offered and attempts to project the costs and benefits from company-based services. Practical guidance is provided on how to set up services and promotion and publicity issues. Reviews of project experiences from several countries are included.

Population Information Program. "Healthier Mothers and Children Through Family Planning," Population Reports, (No. 27) May-June, 1984. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This issue presents information similar to that provided in the Maine document discussed above but expands upon it. More detailed information is provided on the relationship of family size and child spacing to rates of infectious disease, growth and development, birth defects, and intelligence and academic achievement. In addition, an extensive bibliography is provided.

World Federation of Public Health Associations. Family Planning for Maternal and Child Health: An Annotated Bibliography and Resource Directory. Washington, D.C.: WFPHA, 1986.

This pamphlet provides brief summaries of articles and books that focus on many aspects of family planning. Of interest for this Section is the first chapter, "The Impact of Family Planning on Maternal and Child Health." The last three chapters provide information on other sources of bibliographic information, journals and organizations that focus on family planning. Other chapters will be useful as references for later sections of the manual.

Other References

JSI. Family Planning Private Sector Programme. Annual Report, 1985. Nairobi, Kenya: Family Planning Private Sector Program, JSI, 1985.

Streegan, W.H.O. "Cost Benefits and Cost Effectiveness of Family Life and Family Planning Programmes in Hawaiian Philippine Company." in Family Planning in Industry in the Asian Region. Bangkok: ILO, 1979, pp. 140-156.

Sugathan, T.N. et al. "Impact of Family Planning Welfare Programmes in the Industrial Sector: An Estimate of Returns to Management," in Demography India 7(1-2):72-83, 1978.

Section IV: Population Dynamics, Socio-Economic Development and the For-Profit Sector

The effects of population dynamics on socio-economic development and the for-profit sector are reviewed to help participants further develop their rationale for offering family planning services through the private sector.

TRAINER'S NOTES

Objectives for this Section:

After completing activities in this section, workshop participants will:

1. be able to describe the effects of high population growth rates on their country's development and on prospects for business growth, particularly their own businesses.
2. have prepared a written rationale for the inclusion of family planning services in their enterprises.

Rationale:

An understanding of how population dynamics affect socio-economic development and, as a result, the for-profit sector will contribute to participants' commitment for family planning. This commitment provides the impetus for developing a written rationale for the family planning services that participants plan to implement in factories or on plantations.

PROCEDURES

- **Brainstorming Exercise: What is Meant by Population Dynamics?**

Participants brainstorm responses to the questions, "What is meant by population dynamics?" and "What does rapid population growth have to do with my business?"

Time: 10 minutes

- **Lecturette: The Consequences of Rapid Population Growth**

Participants learn more about current population growth issues which relate directly to their enterprises and their involvement in providing family planning services to workers and their families.

Time: 20 minutes

- **Evaluation: Preparing a Written Statement of Rationale for Company-Based Family Planning Services**

Participants prepare a written rationale statement, drawing on the lectures and discussions on the role of the private sector in promoting family planning (Section II), the benefits to be derived from family planning (Section III), and the consequences of rapid population growth (Section IV).

Time: 30 minutes

TO THE TRAINER:

A full set of materials for both trainer and participant use in Section IV follow immediately.

BRAINSTORMING EXERCISE:
WHAT IS MEANT BY POPULATION DYNAMICS ?

BRAINSTORMING EXERCISE: WHAT IS MEANT BY POPULATION DYNAMICS?

As an introductory activity to the discussion on population dynamics and the relationship between population issues on the macro-level and how those issues affect individual businesses, participants should be asked to respond to two questions:

- What is meant by population dynamics?
- What does population dynamics have to do with me and my business?

To start the discussion, you might want to call participants' attention to the one-page attachment which highlights the rate at which the world's population is growing. Used as a handout, the attached sheet should stimulate participants' thinking on some of the key terms related to population dynamics:

- population growth rate
- fertility rate
- birth rate
- mortality rate

Participants' responses to the two questions should be noted on large sheets of newsprint and posted in a place where all can see them for the remainder of the workshop. The discussion should probe for and establish linkages between population growth issues at the macro-level and reality at the micro-level.

TO THE TRAINER:

Articles dealing with population issues from local or national newspapers could be used in the place of the attached one-page handout to help participants make connections between population dynamics issues at the macro-level and how those issues affect or could affect their employees and thus, their businesses.

POPULATION DYNAMICS: In 30 seconds...

The demographic communities...are in a better position than almost any other group to add still another dimension to their work and devise the means not only of communicating with their peers, but also of disseminating information in intelligible forms so that people to be touched by population problems, which really means everyone, should understand the implications of population as a factor in daily life. (27 August 1973)

Just as effective development depends on a reliable knowledge of natural and other resources, so does effective development planning depend upon reliable knowledge of composition, growth, and movement of population. (21 May 1975)

Rafael Salas, Executive Director
United Nations Fund for
Population Activities

In the 30 seconds it took you to read the above population declaration, some 129 live babies were born into the world. Some 50 people died during the same half minute, and the world thus experienced a net increase of 79 new inhabitants. This translates into an addition of more than 83 million people each year, on a planet which on July 1, 1986, already had an estimated population of 4,942,000,000.

The "population explosion" -- overpopulation -- is not a catastrophe which will happen at some specific time in the future. Rather, it is a quiet day-to-day event that has already happened in some parts of the world with dismal results:

- overcrowding;
- depletion of available resources;
- chronic malnutrition; and
- starvation.

Adapted from:
Haupt and Kane. Population Handbook.
Washington, DC: Population Reference
Bureau, 1982/1986.

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LECTURETTE:
THE CONSEQUENCES OF RAPID POPULATION GROWTH

THE CONSEQUENCES OF RAPID POPULATION GROWTH

For many countries, rapid population growth is a problem. Experience has shown that rapid population growth can slow development and sharply reduce the possibilities of raising living standards. This has been particularly true in Sub-Saharan Africa. In the years between 1970 and 1982, both the gross domestic product and the population grew at about 3 percent per year.

World Bank standard projections show population continuing to grow at 3 percent in Sub-Saharan Africa until the end of this century, from about 460 million in 1985 to 730 million in the year 2000 and 1.8 billion by 2050. The population growth rate in Asia is currently 1.7%, while it stands at 2.3% in Latin America and in the Near East. These rates are unlikely to decline rapidly. The implications of high rates of population growth on education, health care, declining agricultural and food production and the environment in general are already in evidence in many countries.

When these problems are combined with staggeringly high unemployment, especially of young school leavers who are not being absorbed into the economy, the end results are those which we witness and read about in the newspapers on a daily basis. An understanding of population dynamics and the effects of high rates of population growth on the national and local economy in which your business functions might best be illustrated using more specific examples.

Why is rapid population growth a problem?

Both the private and public sector should be concerned about the question of why rapid population growth is a problem. We do not need economists to tell us that per capita income will rise only when people are equipped to work more productively. More than skills and technology are needed for economic growth. Good health, financial resources and natural resources must accumulate faster than the population grows. In many countries this is not happening.

In addition to lack of short-term per-capita growth, rapid population growth can lead to losses in long-term potential for economic growth and increased living standards. Rapid population growth also contributes to:

- high maternal and child mortality;
- continued degradation of the environment and misuse of natural resources;

- increased strain on the educational and social welfare systems; and
- the creation of a workforce which grows faster than the formal and informal sectors can absorb it.

What emerges from this brief discussion is an awareness that rapid population growth highlights the need for increased social and economic policies that will encourage development in an efficient way. These policies must take into consideration traditional and changing attitudes toward family planning and fertility. At the same time, new policies must reflect more than lip service from governments and the private sector if progress is to be achieved in reducing rapid population growth.

What does rapid population growth result from?

Sub-Saharan Africa is the only region of the world where population growth has not dropped. Growth in the industrialized countries has been on the decline for the past two decades. In some countries the growth rate is below zero. In Latin America, the growth rate peaked at 2.9 percent in 1960 and is currently at 2.4 percent. In Southeast Asia, the rate is currently 2.1 percent. Overhead 1 shows population growth rates for selected regions of the world for the period 1950-1985.

Rapid population growth results from a fall in death rates and no decrease in birth rates. Life expectancy has risen substantially in many countries over the past three decades. Major headway has been made in increasing child survival. According to a recent World Bank report, life expectancy of under 40 years and infant mortality rates of 200 or more per thousand were common in the 1950s. These figures had changed substantially by the 1980s. Life expectancy rates below 45 were rare and infant mortality rates of less than 100 were common.

Fertility remains high in Africa. Current estimates of total fertility rates are 6, and in some cases 7, in most African countries. This compares with 2-4 in China and southeast Asia. With the exception of one African country, Zimbabwe, (World Bank, 1986) there is no documented case of national fertility decline in Africa.

In Africa today, there is a very low prevalence of contraceptive use. Although this rate varies from country to country, the average is around ten percent of married women between the ages of 15-49 who use some form of contraception to space children or limit the number of pregnancies.

When low rates of contraceptive use are combined with decreases in the mortality rate, especially in the infant mortality rate which most countries have experienced in the past ten years, the end result has been increased population growth. To add to this phenomenon, there has also been a decrease in traditional birth control methods such as prolonged breast feeding and post partum abstinence. Thus, modernization itself may have caused a moderate increase in fertility.

Population growth is also affected by migration between countries, by urbanization and the general age structure of the population. In Asia, population densities tend to be high (42 to 600 persons per square kilometer) in comparison to Africa (1 to 200 persons per square kilometer). In the past, large scale migration between countries in Africa was a common means of relieving population tension. Such is not the case today where natural increases in population will have to be absorbed within the boundaries of a country much as it is in Indonesia.

In many countries the population is young, with children under 15 making up at least 45 percent of the population in several African countries. This means that a large portion of the available resources must be used to meet the education and health needs of this age group. It also means that population growth has a built in momentum. If the total fertility rate were to drop immediately to a replacement level of 2.2 births per woman, the World Bank estimates that it would take 100 years before Africa's population would stop growing.

What are the consequences of rapid population growth?

The consequences of rapid population growth fall into two areas: the effects of high fertility on maternal and child health and the effects of rapid population growth on the economy.

Fertility. For most people, the consequences of rapid population growth are felt most strongly at the individual and family level where the effects of high fertility are seen on maternal and child health. A woman's chances of illness or death during pregnancy and childbirth remain very high. As the discussion in Section III demonstrated, the risks are lower if a woman has had fewer than five births, and if she is between the ages of 20 and 35 when she has her children. The risks are also greatly increased for children if they are not born two years apart and if the mother is not between the ages of 20 and 35.

At the level of the family there is evidence of demand for family planning services. Contraceptive prevalence surveys, which offer a measure of existing use of and the demand for family planning services, have been conducted in Africa since 1974. Surveys of married women aged 15-44 in ten African countries showed that 44% of the women contacted indicated that they wanted to delay their next child or have no more children. This compares with 66% in Asia and the Near East and 90% in Latin America and the Caribbean.

The surveys indicate that there is a demand for family planning services in the poorest countries in the region and among rural and uneducated women. In one country, where only three percent of women are literate, 54% wanted to delay their next child or have no more children. In another country, where only about eight percent of women advance past primary school, a 1982 survey showed that 28% desired to space or limit future childbearing.

Even though the number of women who state an apparent desire to space children and who want to have access to family planning services, is high in many African countries, services remain almost non-existent. A fundamental challenge thus becomes one of how to close this gap between what people want and what is available to them in terms of family planning services.

Economy. The effects of rapid population growth on the economy are reflected in a nation's ability to raise per capita agricultural production, safeguard renewable resources and the environment, raise the productivity of employment and develop human resources through improvements in education and health services.

In many countries, over 60 percent of the work force is involved in agriculture. For this reason, the success or failure of the economies of many countries is linked directly to the success or failure of agriculture. When the distribution of good land does not always coincide with population distribution, when traditional methods of farming predominate, and where technology is still in its infancy, the potential for agriculture is limited. When this is coupled with widespread ecological damage, populations become vulnerable to droughts and other climate induced problems.

Resources are of two kinds--nonrenewable (exhaustible) and renewable (replenishable). Both are affected by rapid population growth. The former are finite and overuse or greater use in one period of a country's development means there will be less for future generations. The use of the latter does not necessarily affect their use in the future unless their use exceeds the process of replenishing them. The risk of overuse is naturally

greater when there is rapid population growth. The scarcity of fuelwood and the large increases in the price of fuelwood in Africa over the past two decades is an excellent example of what happens when a renewable resource is used at a greater rate than it is replenished.

In some countries, particularly in Asia and Latin America, there has been a gradual shift of the labor force out of agriculture into other sectors. In Latin America and parts of Asia, this decline began in the 1960s. In Africa, the decline will not begin until well into the next century. This shift of labor out of agriculture in other regions has been accompanied by higher productivity in the sector so that the transition has taken place without any loss in level of production.

What can be done? What can the private sector do?

Family planning services by themselves will not solve the problem of how to lower fertility. Those involved in family planning programs will have to confront a number of factors. These include:

- the need to change male attitudes;
- the important economic function that children continue to play, especially in rural areas; and
- the role of women and slow progress made in improving women's status and rights.

Many policy makers and family planning practitioners alike are convinced that decreases in fertility will take place once the basic message in family planning is established, that is, that people can control their fertility without endangering their social or economic well-being. An assumption that we must work from, and which is supported by the fertility prevalence surveys, is that there is a strong interest in family planning on the part of women and that need is as yet unmet by existing programs.

What then becomes the role of the private sector in providing family planning services? There are several answers to this question, some of which come from the historical role of the private sector in providing medical services and benefits to employees. In many countries there has long been an understanding that the government cannot, and perhaps, should not be the only provider of medical and family planning services. This has been based in part on an observation that even when government resources are abundant, the outreach capabilities have been low.

EVALUATION EXERCISE:
PREPARING A WRITTEN RATIONALE
FOR COMPANY-BASED FAMILY PLANNING SERVICES

**EVALUATION EXERCISE:
PREPARING A WRITTEN RATIONALE FOR SETTING UP
COMPANY-BASED FAMILY PLANNING SERVICES**

An important and early step in the process of planning company-based family planning services is the preparation of a written statement or rationale for the services. Section II of the manual discussed the role the private commercial sector is currently playing in promoting company-based services. In Section III, your attention was drawn to the benefits to be derived from private sector investment in setting up services for employees in factories and on plantations. In both of those sections, your awareness of a number of issues was increased.

At the end of Section II, you identified a number of issues related to setting up company-based services. These issues will be discussed in greater depth in the next three sections of the manual. Determining which of these issues is important in your situation and what you, in turn, decide to do about them, will be influenced by the benefits you anticipate from your investments.

At the end of Section III, you prepared a written statement of the benefits you would anticipate from an investment in family planning services in your enterprise. Please review it, asking yourself whether the statement is as inclusive as you want it to be. When you have completed that task, move on to the next paragraph.

What you should do now is prepare a rationale statement, in writing, which links population dynamics issues at the macro-level to the micro-level, and which incorporates:

- a broad statement of the issues you intend to address by providing family planning services on-site;
- a statement of the role your enterprise will play; and
- your statement of anticipated benefits from your investment in family planning services.

Use the attached sheet of paper to write your rationale statement.

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Use the attached sheet of paper to write your rationale statement.

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REFERENCES

How to Use the Reference Materials for the Section:

A number of documents are listed here that may be helpful to trainers as they prepare for workshops and to participants as additional reference material on the topics presented in this section of the manual. While all the articles are useful, the following provide a significant background about the relationship between population growth and socio-economic development with a special focus on the for-profit sector.

Haupt, A. and T.T. Kane. Population Handbook. Washington, D.C.: Population Reference Bureau, 1980. (75 pp.)

This book is a quick guide to the language of population dynamics. A glossary presents definitions of the commonly used terms and there are translations of each term into Spanish and French. Statistical indicators such as fertility rate, doubling time, prevalence rate and others are not only defined but formulae for calculating them are presented with examples.

IL0. Management and Population Questions. Geneva: IL0, 1975.

This monograph discusses the implications of population problems for employers and their organizations. It outlines the contributions they can make in dealing with these problems on their own, within the tripartite constituency and in cooperation with other agencies.

Population Information Program. "Fertility and Family Planning Surveys: An Update." Population Reports, Number 8, Series M, 1985. Baltimore, Maryland, Population Information Program, Johns Hopkins University.

This issue presents a summary of the findings of the World Fertility Survey and the Contraceptive Prevalence Surveys which interviewed almost 500,00 women world-wide. The results are presented under headings of knowledge of family planning, use of family planning, availability of family planning, fertility levels and trends, infant and child mortality, and policy and program applications. Extensive data tables, by country, can be useful in preparing presentations on population dynamics and their relation to other elements of development.

Population Reference Bureau. World Population Data Sheet, 1986. Washington, D.C.: Population Reference Bureau, 1986.

This wall chart presents population related data for all member countries of the UN. At a glance a trainer or trainee can see the relationship between population growth rate and other population indicators and per capita GNP, life expectancy, and infant mortality. A clear picture of the impact population dynamics has on health and income is quickly evident.

World Bank. Population Change and Economic Development. London: Oxford University Press, 1985.

This book provides an comprehensive analysis of the relationship between population growth rates and economic development. Information is presented in text, graphs, and charts. Many of the graphs and charts can be helpful in the presentation of this information to workshop participants. Data from all the countries of the world are presented in a summary form in a statistical appendix to the book.

. Population Growth and Policies in Sub-Saharan Africa. Washington, D.C.: World Bank, 1986.

This World Bank policy study provides a framework to help African policy makers recognize the complexities of the population issue and design approaches to deal with population problems. The report provides a comprehensive picture of the magnitude and underlying causes of Africa's rapid population growth and emphasizes that rapid population growth is neither desirable nor necessary.

Other References

Brown, L. State of the World. New York: Worldwatch Institute, 1984.

Harrison, P. and J. Rowley. Human Numbers, Human Needs: A People Handbook. New York: IPPF, 1984.

Maguire, E., S. Radloff and A. Allison. Population Policy Change in Africa. Washington, D.C.: Agency for International Development, Policy, Planning and Coordination, 1985.

Section V: Introduction to Contraceptive Technology and the Promotion of Family Planning Services

In this section, workshop participants are introduced to information on contraceptive technology and promotional activities to support company-based services.

TRAINER'S NOTES**Objectives for this Section:**

After completing the activities in this section, workshop participants will be able to:

1. communicate a basic understanding of the major traditional and modern methods of family planning or birth spacing used and/or available in the service area including natural family planning. This includes: the basic mechanism of the methods (barrier, hormonal, IUD and surgical); benefits (e.g., health, convenience, availability); risks (e.g., health, social); and, costs (e.g., financial, social, familial);
2. discuss common "misconceptions" regarding modern methods of contraception and provide explanations refuting these misconceptions;
3. understand the various factors to consider when developing a protocol for clinic staff to use when assisting patients in the selection of a method;
4. understand the various medical, social, cultural, and economic factors that may be related to selecting and promoting a mix of contraceptive methods in their particular setting;
5. identify mechanisms for promoting family planning services in their particular setting;
6. identify potential internal and external resources for promotional materials and activities;

Rationale:

In order to wisely plan and effectively manage company-based family planning services, factory management and health personnel need to understand what contraceptive options exist, know what kind of mix of services to offer, and identify mechanisms for promoting family planning services. An understanding of these issues will help factory management and health staff estimate the

material, personnel and financial resources needed for the efficient delivery of services in a factory or plantation setting.

PROCEDURES

- **Introduction**

Participants will complete a brief pre-test prior to the lecturette.

Time: 15 minutes

- **Lecturette: An Introduction to Contraceptive Technology**

Participants learn about, review and discuss the basic traditional and modern methods of family planning. Participant materials explain each method, the benefits of the method and the risks of each. Up-to-date, detailed information in each method is available in the accompanying reference set.

Time: 45 minutes

- **Lecturette: Factors to Consider When Evaluating Modern and Traditional Child Spacing Methods and Permanent Contraception Methods**

Participants are exposed to the factors they will need to consider when evaluating a method for inclusion in the services offered by their enterprise.

Time: 20 minutes

- **Exercise: Estimating Couple-Year of Protection (CYP)**

Participants are introduced to a method of measuring family planning output, the CYP index. This method summarizes the overall output of a program in terms of potential contraceptive protection provided by the program.

Time: 15 minutes

- **Exercise: Post-Test and Discussion**

Time: 15 minutes

- **Lecturette: The Role of IE&C in Promoting Family Planning Acceptance**

Participants are exposed to the role of IE&C in helping promote family planning acceptance and examine the process for planning IE&C efforts.

Time: 30 minutes

- **Case Studies: Getting the Message Out - IE&C Approaches Used in Promoting Family Planning Practices**

Through three case studies, participants develop an understanding of how IE&C promotional activities can have different objectives depending on the environment in which family planning activities take place.

Time: 1 hour

- **Exhibit of IE&C Promotional Materials**

Examples of IE&C efforts in other projects are presented and discussed. These will include folk media, posters, calendars, pamphlets, newspapers, radio and television spot announcements. Materials are on prominent display throughout the workshop.

Time: 30 minutes

- **Evaluation**

Participants discuss the potential objectives for IE&C promotional activities in their enterprises and consider how IE&C approaches might be most useful in their settings. This discussion includes the identification of existing IE&C resources in the country, where to look for other resources, and what some of the cost implications are for developing IE&C materials.

Time: 20 minutes

TO THE TRAINER: Experience with this section of the Module shows that it is often useful to divide workshop participants into medical and non-medical personnel for presentations on contraceptive technology. In doing so, presentations for medical personnel can take the form of an update while non-medical receive a more general introduction to contraceptive technology.

As an optional aid in evaluating the participant's understanding of the material on contraceptive technology, a brief questionnaire has been developed for use as a Pre/Post Test. The Pre-Test should be given during the Introduction Section. The Post-Test is designed to be administered following the exercise, "Estimating Couple-Year of Protection (CYP)." The questions are keyed to the lecture material presented in the two lecturettes.

PRE-TEST/POST-TEST ON FAMILY PLANNING METHODS

1. Mrs. T says: "The newspaper said the oral pills caused sterility."

Which answer is the best?

- () 1. That it is completely untrue. Don't trust the newspapers.
() 2. Pills often cause sterility.
(X) 3. Most women can have a baby soon after stopping the pills. A very few may have some difficulty.

2. Which is true?

A woman is most fertile (has the highest chance of getting pregnant)

- () 1. just before her period (menses) starts.
() 2. just after it ends.
(X) 3. during the middle of the cycle.

3. Sometimes a rumor begins with a true fact. It becomes a rumor when people exaggerate.

WRITE "fact" or "rumor" next to the sentences below.

Rumor: The oral pills make women permanently sterile.

Fact: A very few women have had some trouble getting pregnant after they stopped taking pills.

4. Breast-feeding is an effective method in preventing pregnancy, especially during the first few months following delivery.

Which is (are) true?

- (X) 1. The main reason women breast-feed is nutritional.
(X) 2. The effectiveness in preventing pregnancy decreases the longer a woman breast-feeds.
(X) 3. A woman is at more risk of pregnancy once her menses (period) has returned.

5. Which contraceptive methods can be safely combined with breast-feeding?
- 1. Condoms
 - 2. A diaphragm
 - 3. Oral pills containing estrogen and progesterin
 - 4. Foaming vaginal tablets
6. Mrs. T is tired of "morning sickness" with the oral contraceptive pills.
Should she ask her husband to take the pills for her?
- Yes
 - No
7. Mrs. T's husband says condoms are no good for preventing pregnancy?
Which answer is best?
- 1. Her husband is right because condoms often break.
 - 2. They have lots of side effects.
 - 3. Used correctly, condoms are effective in blocking pregnancy and also help prevent the spread of STDs (sexually-transmitted diseases).
8. The new IUDs such as the Copper T (TCu 380A) are more effective in preventing pregnancy than the older types.
Which of the following is true?
- They can be left in place indefinitely--more than five years.
 - They tend to cause less bleeding than older types.
9. In general, the operations used to provide permanent contraception (sterilization) in women are:
- (circle the correct answer)
- more or less difficult to perform, expensive and risky than the male operation (vasectomy)
10. In your country, which do you think is safer?
- for a woman to have a baby
 - for her to take oral pills and not get pregnant

PRE-TEST ON FAMILY PLANNING METHODS

1. Mrs. T says: "The newspaper said the oral pills caused sterility."
Which answer is the best?

- () 1. That it is completely untrue. Don't trust the newspapers.
() 2. Pills often cause sterility.
() 3. Most women can have a baby soon after stopping the pills. A very few may have some difficulty.

2. Which is true?
A woman is most fertile (has the highest chance of getting pregnant)

- () 1. just before her period (menses) starts.
() 2. just after it ends.
() 3. during the middle of the cycle.

3. Sometimes a rumor begins with a true fact. It becomes a rumor when people exaggerate.

WRITE "fact" or "rumor" next to the sentences below.

_____ The oral pills make women permanently sterile.

_____ A very few women have had some trouble getting pregnant after they stopped taking pills.

4. Breast-feeding is an effective method in preventing pregnancy, especially during the first few months following delivery.

Which is (are) true?

- () 1. The main reason women breast-feed is nutritional.
() 2. The effectiveness in preventing pregnancy decreases the longer a woman breast-feeds.
() 3. A woman is at more risk of pregnancy once her menses (period) has returned.

5. Which contraceptive methods can be safely combined with breast-feeding?
- () 1. Condoms
 - () 2. A diaphragm
 - () 3. Oral pills containing estrogen and progestin
 - () 4. Foaming vaginal tablets
6. Mrs. T is tired of "morning sickness" with the oral contraceptive pills.
Should she ask her husband to take the pills for her?
- () Yes
 - () No
7. Mrs. T's husband says condoms are no good for preventing pregnancy?
Which answer is best?
- () 1. Her husband is right because condoms often break.
 - () 2. They have lots of side effects.
 - () 3. Used correctly, condoms are effective in blocking pregnancy and also help prevent the spread of STDs (sexually-transmitted diseases).
8. The new IUDs such as the Copper T (TCu 380A) are more effective in preventing pregnancy than the older types.
Which of the following is true?
- () They can be left in place indefinitely--more than five years.
 - () They tend to cause less bleeding than older types.
9. In general, the operations used to provide permanent contraception (sterilization) in women are:
- (circle the correct answer)
- more or less difficult to perform, expensive and risky than the male operation (vasectomy)
10. In your country, which do you think is safer?
- () for a woman to have a baby
 - () for her to take oral pills and not get pregnant

POST-TEST ON FAMILY PLANNING METHODS

1. Mrs. T says: "The newspaper said the oral pills caused sterility."
Which answer is the best?

- () 1. That it is completely untrue. Don't trust the newspapers.
() 2. Pills often cause sterility.
() 3. Most women can have a baby soon after stopping the pills. A very few may have some difficulty.

2. Which is true?
A woman is most fertile (has the highest chance of getting pregnant)

- () 1. just before her period (menses) starts.
() 2. just after it ends.
() 3. during the middle of the cycle.

3. Sometimes a rumor begins with a true fact. It becomes a rumor when people exaggerate.

WRITE "fact" or "rumor" next to the sentences below.

_____ The oral pills make women permanently sterile.

_____ A very few women have had some trouble getting pregnant after they stopped taking pills.

4. Breast-feeding is an effective method in preventing pregnancy, especially during the first few months following delivery.

Which is (are) true?

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5. Which contraceptive methods can be safely combined with breast-feeding?

- 1. Condoms
- 2. A diaphragm
- 3. Oral pills containing estrogen and progestin
- 4. Foaming vaginal tablets

6. Mrs. T is tired of "morning sickness" with the oral contraceptive pills.
Should she ask her husband to take the pills for her?

- Yes
- No

7. Mrs. T's husband says condoms are no good for preventing pregnancy?
Which answer is best?

- 1. Her husband is right because condoms often break.
- 2. They have lots of side effects.
- 3. Used correctly, condoms are effective in blocking pregnancy and also help prevent the spread of STDs (sexually-transmitted diseases).

8. The new IUDs such as the Copper T (TCu 380A) are more effective in preventing pregnancy than the older types.
Which of the following is true?

- They can be left in place indefinitely--more than five years.
- They tend to cause less bleeding than older types.

9. In general, the operations used to provide permanent contraception (sterilization) in women are:

(circle the correct answer)

more or less difficult to perform, expensive and risky than the male operation (vasectomy)

10. In your country, which do you think is safer?

- for a woman to have a baby
- for her to take oral pills and not get pregnant

LECTURETTE:
AN INTRODUCTION TO CONTRACEPTIVE TECHNOLOGY

AN INTRODUCTION TO CONTRACEPTIVE TECHNOLOGY

Family Planning Perspectives

The desire and need to influence fertility is as old as man himself. Evidence exists in ancient writings that we have long understood some of the basic principles regarding spacing births and planning for the number of children desired. For example, the practice of coitus interruptus or withdrawal has been used for centuries and is referred to in the Bible, book of Genesis. It is described as being practiced during the two-year interval following a birth suggesting its (coitus interruptus) use as a child spacing method.

A linen sheath for coitus, forerunner of the condom, was first described in 1564 by Gabriele Fallopio in his De morbo gallicao. Penile sheaths were used initially for protection against venereal disease. Not until the 18th century did the membranous condom, usually fashioned from animal tissue, become popular for contraception. With the vulcanization of rubber in 1884, contraception achieved an explosive popularity because of the sudden cheapness of the new product. Thus, by mid-20th century, the condom was the most widely used of all child spacing methods.

The philosophy regarding ideal population and desired family size also can be traced to the ancients. The Greeks apparently were the first to give serious thought to population control. Most of the early Greek philosophers considered a stable population essential. They advocated that reproduction should be legally regulated, with overpopulation being checked and under population corrected by stimulating fertility and immigration.

Though the discussion to this point has been limited mainly to views expressed by ancient cultures and societies, attitudes regarding expression of our sexuality abound in many modern cultures. Even today in some regions of the world, family planning remains a sensitive subject. In most countries, fortunately, what constitutes acceptable family size, how societies create policy to reinforce this goal, and what methods are utilized, gradually have changed during the last 30 years. Through scientific advancement and enhanced communication systems has come the realization that lack of birth spacing and/or limiting family size can lead to ill health for the mother, new infant, young children, and, as a consequence, the whole family and society.

Despite increased knowledge regarding reproduction, family planning and sexuality, dissemination of information to the public in many countries has lagged. Thus, many misconceptions or myths regarding the safety, effectiveness, and action of most child spacing methods still exist. Community education is essential to dispel these rumors as well as provide basic health information.

Some misconceptions are based on partial evidence or stem from reference to side effects noted with one method which are then incorrectly attributed to all or some other methods. A few of these "misperceptions" include: it makes you feel pregnant; it interferes with spontaneity; or it decreases sexual drive. In past years when the dosage of sex hormones in oral contraceptive (OCs) pills was much higher, complaints that sexual drive was effected and you feel pregnant were common. With current low dose pills these complaints are much less common.

Three additional fears regarding OCs are that they are dangerous, cause cancer and cause blood to back up in the uterus. Over the years numerous large, prospective studies have demonstrated rather clearly that low dose pills given to healthy women carry a very small risk of serious complications. The risk of serious medical complications to a healthy woman using OCs is considerably less than that of delivering a child. Moreover, available evidence does not support the role of OCs as a causative agent in producing cancer. Finally, women on the pill develop less endometrium (lining tissue of the uterus) than women using other birth spacing methods. This tissue normally is shed during a woman's menses (period). Because women using OCs have less endometrial tissues, there is less to be cast off and consequently less bleeding.

[NOTE TO TRAINER: You may wish to add other myths regarding family planning methods which are typical of local populations.]

Model Systems Currently Being Used to Deliver Family Planning Services in the Developing World

Family planning services may be delivered to people in a variety of innovative ways. Various cultures and people find some ways more acceptable. Some factors which influence acceptability are: distance traveled to receive the service, cultural and religious beliefs, and ease of use.

Three typical ways of delivering family planning services are:

1. Community-Based Programs
2. Commercial Distribution Programs
3. Clinic-Based Programs

1. Community-Based Programs

These programs are usually based on the use of volunteers who have a strong sense of community responsibility and a desire to provide important information and service to family, friends, and neighbors. These volunteers, usually but not necessarily women, receive training about normal anatomy, physiology and sexual functioning. They learn how a variety of traditional and modern child spacing methods work. They then learn how to share this knowledge with others and how to best answer questions which will arise. These volunteers often serve as suppliers of some of the family planning methods which they sell at low cost.

It is important that these volunteers are connected to a health care worker. This linkage may be to a midwife, physician, or nurse working in a family planning clinic. It helps keep volunteers up-to-date, ensures that the advice they give is correct and safe and provides the volunteer with a referral source for men and women with problems. As a result of their service to the community these volunteers usually are well respected.

Many new, innovative ways of utilizing existing community resources are being developed. In many places, peer groups of adolescents are spreading information from teenager to teenager regarding the risks of early sexual activity, methods of child spacing, normal anatomy, and functioning of the reproductive system. The same networks that bring youth misinformation can be used to bring valuable health messages and dispel misinformation, rumors and myths.

Community-based programs (CBPs) can be used in urban or rural settings. They can be as simple as a one-to-one conversation with a neighbor or a small group meeting for the specific purpose of sharing new information. As these topics are very personal, it is important that volunteers respect the confidentiality of those served. Programs flourish or die depending on the respect and trust developed by their volunteers.

In some situations the CBP workers are paid health promoters or community health workers. One advantage of using these individuals is that often they are well-known and trusted within the community. One disadvantage is that frequently this worker has so many other responsibilities he/she is unable to devote a significant portion of his/her time to child spacing education and service delivery.

Some CBPs are creatively linked to various social or commercial programs. For example, in Thailand child spacing users may get discounts on such practical things as hair cuts or pig stud services. Also, free samples of condoms are distributed in factories and at sports events, while information regarding child spacing services is distributed by taxi cab drivers and others.

The types of CBPs and ways of advertising them that work will vary from community to community and culture to culture. Many times new things need to be introduced carefully in order to determine the acceptability and effectiveness of the message being presented.

2. Commercial Distribution

In commercial distribution programs retail outlets serve as the delivery source of modern child spacing methods. In most countries selling of OCs is limited to pharmacies. Barrier methods such as condoms, foams, sponges, and others are sold in many places including open markets, street hawkers, stores, and beauty parlors to name a few. Creative salespeople can think of many ways to provide supplies at places where people can easily find them.

One disadvantage of commercial-based systems is that the profit motive might influence the judgement of the provider. Proper warnings to people who should not use a particular method should be included in the advertising. In addition, instruction on proper use of the method should be given. These instructions should be provided in the language of the user or with pictures indicating clearly to the non-literate how the method is used.

3. Clinic-Based Services

Clinics which provide a variety of health services are the traditional providers of family planning services. These clinics are staffed with health workers, most typically midwives, physicians, and/or family planning nurses. An advantage of a clinic-based program is that it is frequently a source of care already well known to families in the area.

Clinic-based programs are able to offer a full range of services including intrauterine devices (IUDs) and sterilization. These services typically are not available in community-based or commercial programs. Another advantage of clinic-based services is that personnel are available to answer questions, handle complications, clarify instructions and provide emotional support to clients. The major disadvantage of clinic-based services is

that only clients in the immediate geographic area are served. If clients must travel long distances to receive supplies, or encounter long waiting times prior to being seen, a significant number will fail to return and may resort to using traditional methods or no method at all.

[NOTE TO TRAINER: Distribute Table 1, "Characteristics of Principal Approaches to Providing Family Planning Services", and review the chart with the participants at this time.]

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Review of Modern and Traditional Methods of Birth Spacing/Family Planning

The ability to control one's own reproductive destiny and to choose among child spacing methods on a completely voluntary basis is an important personal freedom. The variety of methods available will vary from country to country depending on cost, acceptability to clients, and the ability to maintain a continuous supply of the methods. Industry has a large role to play in improving our ability to produce and distribute needed supplies. Ideally clients should have a variety of methods available to them so they may exercise personal preference.

When evaluating a specific child spacing method, we are interested in finding out answers to a number of basic questions. These include:

- How does the method work?
- What is the correct use of the method?
- How effective is the method?
- What are the common side effects of the method?
- What are the danger signals that health and family planning staff need to look out for?
- What are the contraindications for the method; that is, who should not use the method?

In the paragraphs which follow, these questions, and many more, are answered. The material presented is designed to:

1. help you better understand the different methods of child spacing, their benefits and risks;
2. assist you in matching your clients with appropriate child spacing or permanent contraceptive methods; and,
3. guide you in determining the method mix which best meets your particular program needs and resources.

It is organized in the following manner: First, a brief review of the process by which pregnancy occurs is presented. Then, each method is described; the way it prevents pregnancy is explained; and its relative effectiveness discussed. Finally, factors to consider when selecting the particular mix of child spacing methods to be promoted in a program are presented.

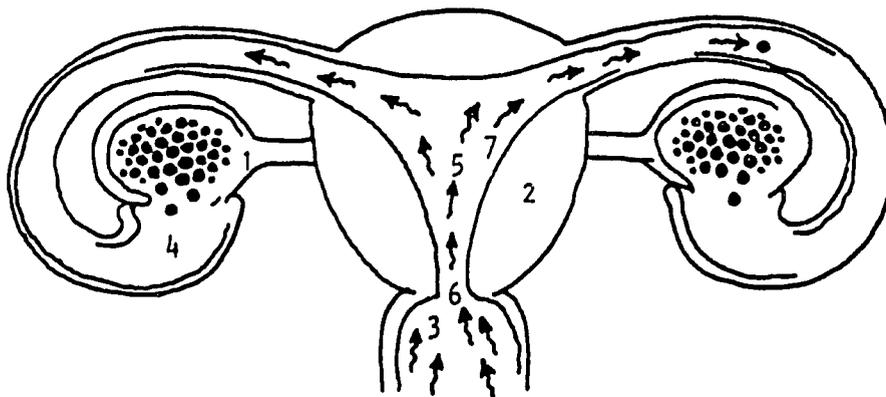
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The Process of Pregnancy

To prevent pregnancy the process by which it occurs - ovulation, fertilization and/or implantation - must be interrupted or avoided. To help you better understand just how the different child spacing methods work, the process of pregnancy is briefly reviewed.

Every month from the age of 12-15 to age 45-50, roughly thirty to forty years, a woman's body prepares itself for pregnancy. This cyclic reproductive process, called the menstrual cycle, averages about 29 days in length for most women, with a normal range of 25-36 days. The process starts in the ovaries (a pair of white, rather flat glands that are located in the lower part of the abdomen). Each month, inside one of the ovaries, an egg ripens inside a small sack or follicle (Figure 1, below). When the egg is ripe, around the middle of the menstrual cycle (about day 12-16), the follicle splits open releasing the egg. This process, called ovulation, is sometimes accompanied by a vaginal discharge and slight cramps, which may last for several hours.

FIGURE 1



- | | |
|--------------------|-----------------------------------|
| 1. Ovaries | 5. Uterine Cavity |
| 2. Uterus (womb) | 6. Cervix (entrance to uterus) |
| 3. Vagina | 7. Endometrium (lining of uterus) |
| 4. Fallopian tubes | |

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Following release of the egg, it is picked-up by one of the two fallopian tubes. Each tube is about 4 to 5 inches long. The end of the tube opening next to the ovary is wider than the rest of the tube and has a fringe-like edge which allows the egg to enter the tube more easily. Once inside, the muscular contractions of the fallopian tube push the egg along the tube toward the uterus. During intercourse, sperm enter the vagina, move through the cervix into the uterus, and then into the fallopian tubes. Unlike the egg, sperm can move by themselves, even "up stream" against the contractions of the fallopian tube. The egg and the sperm join in the fallopian tube; this is called fertilization. The fertilized egg then continues to be moved through the tube into the upper part of the uterus or womb.

The uterus is lined with a layer of tissue called the endometrium. While ovulation is taking place, a hormone (progesterone) is being released which increases the blood supply to the uterus. This additional blood supply makes the endometrium thicker, moist and soft, and ready to receive the fertilized egg. Once the fertilized egg (embryo) enters the upper portion of the uterus, it sticks to the endometrium. As it continues to grow the embryo becomes implanted in the wall of the uterus. Implantation usually occurs about 4 to 5 days after ovulation, and marks the beginning of the intrauterine portion of the pregnancy.

If the egg is not fertilized, the endometrium is not needed and about 12-15 days after ovulation, roughly 25-35 days after the beginning of the cycle, it is slowly discharged from the uterus via the cervix and vagina. This process of shedding the endometrium is called menstruation. Also during this time the unfertilized egg disintegrates and is discharged.

[NOTE TO TRAINER: Refer to TABLE 2, "First Year Failure Rates of Child Spacing and Permanent Methods" when discussing the next section.]

Contraceptive Effectiveness

The effectiveness of various child spacing methods depends on both the method and the user. Consequently, effectiveness rates usually are given in two forms. The terms method effectiveness and user effectiveness (or method failure and user failure) are used to differentiate between pregnancy occurring with correct use (method failure) and that occurring with incorrect use (user failure) of the birth spacing method. Method effectiveness is always better than user effectiveness for all child spacing methods; however, the latter rate more clearly

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represents what can be expected to happen in the real world. Because of this difference it is important in your reading (or discussions) that you know which rate the author (or speaker) is using. For example, it is unfair to compare two methods, employing "user" effectiveness for one and "method" effectiveness for the other.

It is difficult to accurately determine the effectiveness of various child spacing methods because of the large number of factors that cause contraceptive failure. However, reasonable estimates of these two rates are presented in Table 2, "First Year Failure Rates of Child Spacing and Permanent Methods". The rates listed in the first column, "Lowest Observed Failure Rate", approximate the "method" effectiveness rate (i.e. they are based on the method having been used "correctly and consistently" by all acceptors). Similarly the failure rates presented in the second column approximate the "user" effectiveness rate because, in this instance, the "typical" users may (or may not) have used the method correctly.

Of the various reversible methods available, the theoretical effectiveness of combined OCs is second only to that of long-acting injectable progestins or implants. As the data in this table illustrate, the "method" effectiveness rate is over 99 per cent (i.e. less than 1 pregnancy per 100 women who correctly and consistently used the method during the first year); however, the actual "user" failure rate is higher (i.e., 1-8). Furthermore, in developing countries user failure rates may be even higher than those listed in Table 2.

Several other factors which influence the effectiveness of a particular child spacing method are:

- Contraceptive failure, especially for a coitus-related method, is more likely to occur among couples seeking to delay a wanted pregnancy than among those seeking to prevent pregnancy altogether.
- Older women, women of higher social class and those with more education tend to use child spacing methods more successfully than younger, poorer and less educated women.

Continuation Rate

The overall value of a birth spacing method as used by a couple (or group of couples), however, is based not only on the actual (observed) effectiveness, but also on the length of time the couple(s) use the method (i.e. the continuation rate). Actuarial methods such as the life table method are used to

determine this rate. As is the case for user effectiveness, continuation rates vary considerably for each method and from country to country. Not unexpectedly, they tend to be lower in developing countries and in younger, poorer and less educated individuals. In some areas of South Asia and Africa 50 per cent continuation rates (i.e. the length of time that 50 per cent of the users continue to use the method) for pills, condoms and vaginal spermicides are only 3-6 months; for IUDs only about 7-9 months and for injectables about a year. If the method is being used to prevent any further pregnancies, not just child spacing, providers must make every effort to encourage acceptors to continue to use the method. Using a less effective method, but one which is used correctly, is well tolerated and used for prolonged periods of time, is far better in limiting family size than a more effective method used sporadically and briefly!

From the above discussion it can be seen that many variables - not just the particular method's effectiveness - must be considered in helping a couple select the best method for them. Moreover, as the data demonstrate no child spacing method, regardless of its effectiveness, can be expected to be successful unless it is used correctly, consistently and for a prolonged period of time.

[NOTE TO TRAINER: Before discussing the following paragraph, review TABLE 3, "Mortality Associated with Contraceptive Use in Developed and Developing Countries".]

Contraceptive Risks and Benefits

Despite more than two decades of research in developed countries it remains difficult to precisely assess the risks of using a reversible contraceptive method versus that of pregnancy and child birth. However, in developing countries, where the maternal mortality associated with pregnancy is 10 to 20 times higher than in developed countries, the risk of using any modern method, even oral contraceptive (OCs) pills by women smokers over age 35, is much lower than that associated with pregnancy (Table 3.) In fact, as the data in Table 3 illustrate, for women in developing countries the pregnancies resulting from contraceptive failure, through use of less effective methods, such as condoms, account for more maternal deaths than from the hazards of IUDs or OCs! Clearly, in most developing countries, until there is a significant reduction in maternal mortality the use of modern contraceptive methods will remain far safer than pregnancy and child birth. Moreover, the use of reliable child spacing methods do more than just prevent the birth of unwanted children, who can be both economic and emotional burdens. They also eliminate the ever present fear of pregnancy, which may harm marital relations.

Finally contraceptive use, by increasing the birth interval and reducing the total number of pregnancies a woman has, can in itself, result in improved maternal health, and for the working mother, less time lost from work.

Reversible Methods

1. Abstinence

In some societies abstinence is practiced intermittently or continuously by adult members of the population. For example, certain cultures prescribe a period of abstinence after child birth. This allows time for mother and baby to recover and flourish without the threat of a new infant prematurely pushing the weanling infant off the breast. In addition, couples often experience periods of abstinence due to separations for work, schooling, or for spiritual renewal.

In certain parts of the world, where adolescent or single parent pregnancy is a frequent problem, programs encouraging youths to say "no" to sexual relationships are gaining popularity. Pregnancy before the individual or family are ready for it, creates great hardship. Sometimes it ruins the reputation of the girl. It frequently means an end to educational opportunities thereby limiting her options for the future. In developed countries young mothers and their children are more likely to remain poor and need financial and health care assistance from governmental and/or private agencies. The costs to society to provide this assistance are great.

The advantages of using abstinence are that it requires no supplies, no distribution system, no warning labels regarding safety, and costs no money. Moreover abstinence is the only method that is 100 per cent effective in preventing pregnancy.

2. Lactation

Breast-feeding is still a common practice in most societies, particularly in those with traditional attitudes. In some countries, such as Bangladesh, India, and those in equatorial Africa, a large percentage of women breast-feed for periods of more than 12 months. In Latin America the figures are lower, but still an important number of women breast-feed for more than six months. The main reasons women in these areas breast-feed is nutritional.

Increasingly, both individual women and family planning programs are coming to realize that breast-feeding protects against pregnancy in the early postpartum as effectively as modern contraceptive methods. A recent study in Mexico found

that less than four percent (4%) of women who breast-fed on demand had resumed ovulating at three months after delivery. However, contraceptive effectiveness of breast-feeding does decline over time. The longer the time before the first postpartum menses, the less a woman should rely on breast-feeding solely for contraception.

Because of regional differences in breast-feeding practice and performance, rules about breast-feeding and the use of contraception should be tailor made to fit the cultural practices of the specific area. However, as a general rule, once the menses have returned or supplemental feeding introduced or the baby sleeps through the night (a sign of reduced frequency of suckling), a woman is at more risk of pregnancy and should begin using contraception.

When recommending contraception for breast-feeding women, family planners need to give careful consideration to the choice of method. For most women, combining breast-feeding with another method such as condoms, a diaphragm, foaming vaginal tablets, progestin-only pills or long-acting progestins (injectables or implants) provides reliable contraception without affecting her milk production, her infant or the interruption caused from an unplanned pregnancy.

3. Coitus Interruptus or Withdrawal

This traditional method has enjoyed popularity in parts of Europe, Africa and Asia for a long time. With this method the man withdraws his penis from the vagina prior to ejaculation, while at the same time being careful not to ejaculate on or near the external genitalia (tissue surrounding the opening to the vagina) of his partner.

As a method of child spacing coitus interruptus has a number of advantages. It requires no devices or equipment, causes no side effects, and costs nothing. The major disadvantage however is that failure rates run from 16 to 23 percent during the first year. The high failure rate is a result of several factors. One important reason is that a small amount of semen, which contains sufficient numbers of sperm to cause a pregnancy, may escape from the end of the penis just prior to ejaculation. Another reason is that most men lack the self-control demanded by this method. For most men, as the moment of ejaculation approaches, there is an increasing urge to penetrate deeper. As a result withdrawal of the penis in sufficient time to prevent ejaculation does not happen.

To improve the user effectiveness of this method it may be combined with other methods such as spermicidal foams or foaming vaginal tablets around the mid-cycle (days 9 to 20) - the time of peak fertility for most women. Finally it should be remembered that although withdrawal is not one of the most effective methods, it is considerably better than using no method where the failure rate is about 90 per 100 woman-years.

[NOTE TO TRAINER: Samples of the following methods should be available for participants to see and handle. Which of the methods included will likely depend on local availability. Handout A, "Guide to Modern Contraceptive Methods", which lists the effectiveness, user instructions, etc., should be handed out at this time. Also refer to Table A, "AID-Supplied Contraceptive Commodities," for the common names of the products and their unit costs.]

4. Fertility Awareness or Natural Family Planning

Fertility awareness (periodic abstinence) as a child spacing method currently is experiencing increasing attention. It requires no devices or medication and there is nothing to swallow or insert. However, it does require considerable time and effort on the part of the couple to learn how to use the method correctly.

The rationale for natural family planning methods is based on three biological assumptions: first, the egg can be fertilized only for about 12-48 hours after ovulation; second, sperm are capable of fertilizing an egg only for about 48 hours after intercourse; and finally, ovulation usually occurs 12 to 16 days (14 \pm 2 days) before the onset of the next menses. Based on these assumptions being correct, theoretically there should only be about 96 hours during any month when intercourse could lead to pregnancy: the 48 hours before the egg is released and the 48 hours afterwards. Thus by avoiding intercourse during this critical period the probability of pregnancy should be decreased.

In actual practice the time interval when intercourse must be avoided is considerably longer than 96 hours (four days). The reason for this is that at present there is no absolutely sure method of predicting when ovulation will occur - even in women who have normally regular cycles. In women with irregular cycles the situation is even less predictable. Furthermore, sperm survival after intercourse in some instances is longer than 48 hours.

For couples electing to use natural family planning (periodic abstinence) there are three methods to choose from - calendar, basal temperature and cervical mucus. Each one uses a different biologic indicator to estimate when ovulation will occur so that the risk of pregnancy can be avoided. Of the three, the calendar method is the least effective with failure rates of 14 to 47 for every 100 women using it for one year. To increase the effectiveness of the calendar method a woman can record her basal (morning) temperature daily during the cycle. In most women who ovulate the basal temperature will rise several tenths of a degree just after ovulation (24-48 hours) and remain elevated until the ensuing menses. If the couple abstains from intercourse from the start of menses until at least 48 hours after the temperature rise, presumably two days after ovulation, the egg should no longer be capable of being fertilized. (It should be noted that for couples who are infertile the basal temperature method can be used to estimate when to have intercourse.) When the basal temperature method is used correctly and consistently to determine the days of periodic abstinence, the lowest observable failure rate reported has been 1 to 7 per cent - considerably better than with the calendar method.

The third and fairly new natural family planning method is based on a woman being able to detect changes in the quality and quantity of her cervical mucus just prior to ovulation. Although initially thought to be more effective than the basal temperature method, recent reports suggest this is not the case with pregnancy rates ranging from 1 to 30 per 100 women during the first year.

The major disadvantage of natural family planning methods, aside from the time commitment required to learn to use them properly, is the number of days a couple must avoid intercourse - roughly a third to one half of the days each month - 10 to 15 days!

5. Vaginal Foams, Tablets, Suppositories and Sponges

These substances all contain a spermicidal ingredient, usually nonoxynol 9, which immobilizes or kills sperm on contact. Because they also provide a mechanical barrier to sperm they need to be placed in the vagina before coitus. Foams come in aerosol containers with nozzles or are inserted into the vagina via a plastic applicator. Vaginal spermicidal suppositories and foaming tablets are inserted by hand into the vagina and dissolve on contact with the vaginal fluid. There are no reliable studies comparing the effectiveness of the various types of vaginal spermicides. Used alone "user" failure rates tend to average about 10 to 18%, but when combined with condoms failure rates can be considerably lowered - 1 to 7 per cent. Laboratory studies have shown that spermicides offer some protection against

sexually-transmitted diseases (STDs), such as gonorrhea, chlamydia, and syphilis. Their effectiveness in actual use by couples is less clear. Because spermicides also have been found to kill the AIDS virus, the use of vaginal spermicides as well as spermicidally lubricated condoms may help to prevent transmission of AIDS.

Recently a new vehicle for delivering the spermicidal agent to the vagina has been approved for use. Called the vaginal sponge, it consists of a two inch in diameter soft, polyurethane disc impregnated with nonoxynol 9. The sponge is activated by moistening it with water just prior to insertion into the vagina. Because one size sponge fits all women, no clinic visit is needed to fit it. In addition it may be marketed in any store or shop which sells condoms and other vaginal spermicides. The sponge provides good protection for up to twenty-four hours regardless of the number of times the couple may have intercourse during this interval. Unlike other spermicides which must be re-applied with each sexual act, the sponge does not have to be changed; however, it should be left in place for at least six hours after the last exposure to assure that all sperm are killed. Sponges are discarded after a single use.

The failure rate for the vaginal sponge is roughly the same as for other vaginal spermicides and slightly higher than for the diaphragm. Side effects for all vaginal spermicides are limited to occasional vaginal or penile irritation. The foaming vaginal tablets and suppositories all cause a warming sensation in the vagina as they dissolve.

6. Diaphragms

Diaphragms are shallow rubber cups ranging from 2.5 to 4 inches in diameter. When correctly inserted into the vagina the diaphragm covers the cervix, mechanically blocking the sperm from gaining entrance to the uterus via the cervix. To enhance its effectiveness, the diaphragm should always be used together with a spermicidal agent. After intercourse the diaphragm should be left in place for at least 6 hours. Following removal it should be washed with clean water and air dried. (In areas where water is not readily available, this may restrict the use of diaphragms and cervical caps.) With careful handling diaphragms can last for several years. Diaphragms must be individually fitted by a qualified family planning practitioner. When a woman is wearing her diaphragm correctly, neither she nor her partner should be aware of its presence nor have any discomfort.

The lowest observed "method" failure rate with the diaphragm plus spermicide is 2.4 per cent with typical "user" rates ranging up to 25.

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7. Condoms

Condoms, also called rubbers or prophylactics, are shaped like the finger of a glove and are made of rubber. The man or woman unrolls the condom over the erect penis prior to intercourse or any contact between penis and the vaginal area. The purpose of using a condom is to prevent the ejaculated semen, containing the motile sperm, from entering the cervix (mouth of the uterus). To prevent spillage after ejaculation, the man grasps the condom at the base of the penis before withdrawing it from the vagina.

Used correctly and consistently by well motivated couples, pregnancy rates as low as 2 per 100 woman-years have been reported. Typical "user" failure rates range from 3 to 15. As mentioned previously the "user" effectiveness rate can be improved if combined with any other barrier method, such as vaginal spermicidal tablets or foam. There are no serious side effects associated with using a condom. Rarely a man or woman may be sensitive to the material from which the condom is made.

An added benefit of using condoms is their proven effectiveness in reducing the spread of sexually-transmitted diseases (STDs). It is reported that the conscientious use of condoms, especially when combined with a vaginal spermicidal agent, can reduce transmission of the AIDS virus by about 80 percent.

8. The Pill or Oral Contraceptive

Since the early 1960s oral contraceptive pills (OCs) have been marketed world wide. Currently nearly 100 million women use the Pill for child spacing. The Pill or oral method of child spacing consists of taking a pill at about the same time each day on a regular basis.

There are two simple pill-taking programs: the 21-day regimen and the 28-day regimen. With the 21-day regimen, a woman takes one pill each day for three weeks (21 days) and then for one week doesn't take any pills. This cycle is then repeated: three weeks on, one week off. With the 28-day regimen, she takes 21 active pills first, then seven placebos which contain no active drug. Using this regimen a pill is taken every day of the year. Some women prefer the 28-day regimen method because they find it easier to remember.

There are only two types of OCs, combination and progestin-only. Combination OCs contain both estrogen and progestin - the two sex hormones produced by a woman's ovaries. Because the natural hormones produced in the body are not effective when taken by mouth, each pill contains a fixed amount of synthetic versions of these two sex hormones.

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Combination pills prevent pregnancy in at least three ways. First, and most importantly, the estrogen and progesterone both act to prevent the ovaries from developing and releasing an egg (ovulation). Second, the progestin changes the cervical mucus helping to prevent sperm from passing through the cervix and into the body of the uterus. Third, the two hormones alter the development of the endometrium (lining of the uterus) so that even if an egg is released and fertilized, implantation may not occur. Because progestin-only pills, also called mini-pills, lack estrogen and contain only about one third the amount of progestin as combination pills, they do not as consistently block ovulation (release of an egg) as combination pills do. In general, however, the same mechanisms work to prevent pregnancy with mini-pills as with combined pills.

As with all methods of child spacing, OCs have drawbacks. To minimize the number and seriousness of side effects, over the years the amount of estrogen and progestin in combination pills has been gradually decreased. This has been accomplished without a loss of effectiveness but with considerable decrease in side effects.

With these new, lower dose pills women are experiencing fewer and less severe side effects than in past years. Some women initially, still may experience vaginal spotting between periods, nausea, weight gain or breast tenderness. These often disappear after two to three months use. Major but very rare (all less than 1-10 per 100,000 users) side effects from the pill are blood clots, high blood pressure, gall bladder disease, heart attacks, or liver tumors. Chances of serious problems increase with age (over 35) and certain other health problems such as existing high blood pressure, 25 percent or more above ideal body weight and smoking more than 15 cigarettes per day.

The method failure rate with combination OCs is less than one pregnancy per 100 woman-years during the first year. For the progestin-only pill (mini-pill) it is somewhat higher, 1-2.5 percent. For both combination and progestin-only OCs the "user" rate is considerably higher (2-5 percent), depending on how correctly and consistently the woman takes her pills. In developing countries the user failure rate may be even higher. For example, a 1976 national survey in the Philippines reported 8 pregnancies per 100 women-years during the first year of pill use, 9.2 during the second year and 5.1 in the third. In several South Asian countries user failure rates as high as 11 to 25 percent have been observed.

Because combination OCs may interfere with the production of breast milk, it is advised that women use a non-hormone method of contraception, progestin-only mini-pills or long-acting progestins (injectables or implants).

9. Long-acting Progestin Injectables

In more than 80 countries of the world cyclic injections of long-acting progestins (one of the two female sex hormones) are used for contraception. With a single injection pregnancy can be prevented for two to three months depending on the amount and type of synthetic progestin: Depo-Provera (medroxyprogesterone acetate) or NET-ET (norethindrone enanthate). Prior to receiving injections of long-acting progestins, a woman should be carefully evaluated by a qualified health practitioner.

Because injectables contain a long-acting progestin similar to that in OCs, their contraceptive action and side effects are similar to those described above. However, because they do not contain estrogen, the risk of serious problems such as heart attack or stroke may be slightly less than for combination pills. Furthermore, unlike combination pills, injectables and implants do NOT seem to effect milk production.

With injectables some women (10-15 percent) will experience vaginal spotting between periods and up to 40 percent will cease having periods (amenorrhea). Neither of these problems are serious and if women are reassured about this, the vast majority (more than 90 percent) will continue to use this method.

10. Long-Acting Progestin Implants

A new method of delivering long-acting progestins is being evaluated in several countries. This new agent, NORPLANT^R, consists of six flexible, nonbiodegradable plastic tubes filled with levonorgestrel, a synthetic hormone of the progestin family. The implants are placed under the skin on the inside of a woman's upper arm. The hormone is slowly released at an almost constant daily rate and provides contraception for up to five years. Developed by the Population Council, NORPLANT^R has been tested in more than 44,000 women in 31 countries. It has proved to be highly effective, safe, and well-liked by its users. By 1987, a 6-capsule NORPLANT^R system had been approved for marketing in seven countries - Finland, Sweden, Indonesia, Thailand, Ecuador, the Dominican Republic, and Columbia.

NORPLANT^R implants provide almost complete protection against pregnancy. In the first five years of use of the NORPLANT^R 6-capsule system, the chances of pregnancy are less than one per 100 women per year. Precisely how NORPLANT^R prevents pregnancy is not fully understood. Like other progestin-only contraceptives, NORPLANT^R implants appear to prevent pregnancy in several ways. NORPLANT^R suppresses ovulation in at least half the menstrual cycles. Even when ovulation does occur, levonorgestrel makes cervical mucus thick and scanty, and sperm cannot easily pass through it into the uterus to fertilize ova. Levonorgestrel also suppresses the

cyclic development of the endometrium in over 50 percent of users. The side effects, risks, and benefits of NORPLANT^R are similar to that observed with other long-acting progestins.

11. The IUD or Intrauterine Device

The IUD is a small, flexible device that is inserted into the uterus by a qualified health practitioner. It is made of plastic or plastic wrapped with copper wire (TCu-380A) or impregnated with a hormone progesterone. IUD's come in different sizes and shapes. All have a "tail" of plastic thread that extends through the cervix into the upper vagina. How the IUD prevents pregnancy is not completely understood. Some believe that the presence of the IUD speeds up the normal contractions of the fallopian tubes so that when the fertilized egg reaches the uterus, the endometrium is not ready to receive it and implantation does not occur.

Addition of a metal (copper) or sex hormone (progesterone) increases the effectiveness of an IUD. Again, how these metal and hormone IUDs work is not completely understood.

The IUD is inserted by a health practitioner only after a pelvic examination. It should **NOT** be inserted when the following conditions exist: pregnancy or suspicion of pregnancy, any abnormality of the uterus which distorts the uterine cavity, pelvic inflammatory disease (PID), vaginal bleeding of unknown origin, suspected malignancy including an unresolved, abnormal "Pap" smear, and vaginal or uncontrolled uterine infection. IUDs must be inserted carefully because of the possibility of perforation (breaking-through) of the wall of the uterus. Even following **CORRECT** placement of an IUD, a woman may experience lower abdominal discomfort and/or cramping for a day or two afterwards. Thereafter she should not be aware of the IUD at any time and neither she nor her partner should feel it during intercourse. Once the IUD is inserted, a woman is protected against pregnancy and need not use any other method of contraception.

The all-plastic IUD can be left in place for several years if a health practitioner feels that it is medically sound. IUDs with copper or progesterone must be replaced at regular intervals. Many women continue to use an IUD for many years. When a user wishes to change her method of contraception, or to become pregnant, the IUD must be removed by a qualified health practitioner.

Next to the pill and injectables, the IUD is generally recognized as the most effective reversible method of child spacing. The reported method failure rate for the older IUDs, such as the Lippes Loop is 1.5 percent and the user rate is higher, 3-5 percent. For the newer, more advanced copper T IUDs

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(TCu 380A) the method failure rate is lower, 1 percent or less. Unlike OCs and coitus-related methods such as condoms, diaphragms and spermicides, where often there is a large difference between the method failure rate and the user rate, with IUDs both are nearly the same.

Because use of IUDs is associated with a slight increased risk of pelvic infection, which can lead to infertility, IUDs are recommended only for older women in stable relationships who have completed their families.

Permanent Contraception

12. Voluntary Surgical Contraception (VSC)

For couples wishing no more children, voluntary surgical contraception (sterilization) of either the man or woman provides a very high level of effectiveness. However, sterilization should never be considered reversible, so it is important that couples be confident of their decision prior to taking this important step.

Male Sterilization

The sterilization operation for men is called vasectomy. When performed by a well-trained, experienced practitioner the procedure is simple (requiring only local anesthesia), safe and takes only about 10 minutes. The operation consists of first finding the small tube in the scrotum that carries the sperm from each testes to the penis. Next, the tube (vas deferens) is typically cut and a small section (about one half inch) removed.

This procedure serves only to prevent sperm from entering the ejaculatory fluid (semen). It does not interfere with sperm production or male hormone (testosterone) production by the testes. Following the operation most men are able to return to work the same day, experiencing only minimal discomfort in the scrotal area and perhaps a bit of swelling.

When fully recovered, about one week, men are able to reach orgasm, ejaculate (the amount of fluid remains the same) and enjoy intercourse. After surgery the testes continue to produce sperm which now are reabsorbed rather than being ejaculated. One disadvantage of the operation, however, is that a man will not be sterile (unable to cause a pregnancy) for up to six weeks. The reason for this is that some sperm will remain in the tube below where it was cut (or blocked) for up to 6-8 weeks or until the remaining sperm are ejaculated (6-10 ejaculations are required). Therefore until a semen specimen has been checked and found not to contain any sperm, condoms or another contraceptive method must be used by the couple.

The failure rate for vasectomy is about 1 per 1,000. Although vasectomy can be reversed (i.e., each vas hooked-up again) the operation (vasovasotomy) is difficult to perform, expensive (\$500 to \$2,000) and often not successful. Thus the decision to have a vasectomy always should be considered permanent.

Female Sterilization

Unlike the male, the female reproductive organs - uterus, tubes and ovaries - lie deep inside the abdomen. As a consequence the operations developed to sterilize women are more complicated, expensive and less safe than vasectomy. The two most common female sterilization operations are:

1. Minilaparotomy (mini-lap)
2. Laparoscopic tubal occlusion

With minilaparotomy, a small cut (about one inch long) is made in the lower abdomen just above the pubic bone. The cut is then extended inward and the abdominal cavity entered. Once inside the tubes are identified, isolated and then either tied and cut (Pomeroy method) or elastic bands (Falope rings) are placed around them. When performed by a qualified practitioner the procedure takes about 15-20 minutes. Local anesthesia and mild sedation are used to minimize abdominal discomfort. Usually the woman can return to her home 2-4 hours after the operation and resume most activities within 24-48 hours. Full recovery can, in some instances, take upwards to one week.

Laparoscopic tubal occlusion involves passing a small metal telescope into the woman's abdomen through a tiny cut (less than one half inch) just below the navel. Looking through the lighted telescope, called a laparoscope, the surgeon locates and isolates the tubes. The tubes are then blocked by placing an elastic band (Falope ring) or a clip around them. The tubes also can be blocked by electrocautery.

Two advantages of laparoscopy over minilaparotomy are:

1. less discomfort during the procedure, and
2. a shorter recovery interval.

Major disadvantages of laparoscopy are:

1. The equipment is very expensive (\$4,000 to \$6,000 per laparoscopy set. Whereas, minilaparotomy kits cost less than \$200).

2. The equipment and instruments are difficult to maintain in good working order and expensive to repair.
3. Considerably more skill and experience are required by the surgeon to safely perform laparoscopy than minilaparotomy.

Following a tubal ligation by either method, women will continue to produce normal amounts of sex hormones from their ovaries, have periods and enjoy intercourse just as before the operation. Furthermore, having a tubal ligation does not affect the age of menopause (change of life).

With both minilaparotomy and laparoscopic tubal occlusion failures are very low (less than 1 per 100). As with all surgical procedures there is a small risk of minor skin (wound) infections (2-5 per cent) and rarely (<0.5 per cent) a serious abdominal or pelvic infection. The lowest observed mortality rate for either procedure is about 1 per 100,000 cases but rates as high as 10-16 have been reported.

Reversal to "hook-up" the tubes can be done but the operation is very difficult, requires general (asleep) anesthesia and is very expensive (\$2,000 to \$7,000 in a developed country). The success rate is even less than for reversal of male sterilization. Thus as mentioned previously, the decision to have a sterilization operation, male or female, always should be considered permanent.

LECTURETTE:

**FACTORS TO CONSIDER WHEN EVALUATING MODERN AND TRADITIONAL
CHILD SPACING METHODS AND PERMANENT CONTRACEPTION METHODS**

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**Factors to Consider When Evaluating
Modern and Traditional Child Spacing and
Permanent Contraception Methods**

In introducing child spacing services into the work place a number of issues need to be considered. Offering such services are of tremendous value to workers who otherwise might be unable to attend clinics due to work hours and family responsibilities. Having services conveniently available encourages workers to continue with methods already chosen. Staff are readily available for questions, problems, or obtaining new supplies. This encourages workers to enjoy a higher standard of health and more control over their personal lives. Less time is lost from work when attending clinics at the work place. Real benefits to both worker and employer are evident.

For the best results a number of issues need to be dealt with in setting up a program. Family planning is a very personal and private issue. Services should be provided by well trained personnel in a quiet, private area. No one should feel obligated to choose any of the methods available. Some workers may wish to simply learn about the available options, slowly think about them and then choose to participate or not.

In setting up an on-site clinic or service it is important that health professionals are available at times when workers can be free from work responsibilities to seek counseling as well as direct services. Programs that are sensitive to the need for ongoing support for its users have much higher continuation rates (users who stay with their method) and client satisfaction.

It is very important that a variety of options are offered to couples as individual situations vary. A free and easy choice encourages people to choose and then choose again if dissatisfied.

In choosing which methods to offer in your clinic a number of factors should be considered. Are other services available locally? How might you cooperate with existing services? Are your health workers competent to provide all methods? Are there methods which are not acceptable in your locale due to religious factors, rumors, or other cultural factors unique to your situation? Would including this method initially jeopardize acceptance of your new program?

[NOTE TO TRAINER: When discussing this section refer to the following additional material, Handout A, "A Guide to Modern Contraceptive Methods." This handout is published by the Population Crisis Committee, Washington, D.C.]

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Selecting the Type and Number of Oral Contraceptives to Stock

Currently there are more than 30 brands of OCs available in the USA and nearly 100 worldwide. Deciding on how many brands to supply and which ones depend on several factors:

1. Composition versus effectiveness of the various OCs is related to:
 - type of estrogen and amount in each pill
 - type of progestin and amount in each pill
2. Characteristics of the client population to be served such as:
 - age
 - general health (+ malnourished)
 - specific risk factors (smoking, high blood pressure, etc.)
 - educational level
 - socio-economic status
 - ratio of male to female employees
 - extent of company/plantation health benefits (e.g., is spouse covered? children?)
3. Logistics and supply capability of the service program
 - Number of brands of OCs the program can reliably stock and supply on a regular basis
5. Training and experience of staff
 - Can staff provide accurate instructions to clients for several different brands, types (fixed dose, multiphasic and progestin-only mini-pill), and different regimens.
6. Cost of OCs (subsidized versus non-subsidized programs)
 - Cost per unit (21 or 28 pill packet) is \$0.27 (subsidized program), but the over-the-counter price to a consumer in a developed country ranges from \$10 to \$15 per cycle (non-subsidized)

Most of these factors are covered in other sections of the module and will not be dealt with here. In the following paragraphs we will focus on the pharmacologic factors and their role in determining the types of OCs to stock.

Composition versus Effectiveness

The goal of OC use is to provide the client with a preparation having the highest degree of effectiveness (i.e., the lowest chance for failure) coupled with fewest side effects and serious problems. Both types of combination OCs (fixed and multiphasic dose) contain one of 2 synthetic estrogens and one of 10 progestins. Fortunately not all 10 progestins are available in most countries. The estrogen dose in these OCs ranges from 20 mcg to 100 mcg while the amount of progestin ranges from 0.15 to 10 mg. However, at the present time most combination OCs contain only 1 mg or less of the progestin. By contrast progestin-only OCs contain only 0.08 to 0.5 mg, a tenth to a half as much progestin as in combination OCs.

Contraceptive effectiveness of combination pills is a result of both the estrogen and progestin. Pregnancy while taking OCs may be due to method failure (lack of efficacy), user failure (forgetting to take the OC) or other factors such as the nutritional status of the client or the concurrent use of other drugs. The overall failure rate is that due to all causes. In countries where the general health (nutritional status) of women is good, most studies have shown no statistical difference in the overall failure rate between combination OCs containing 50 mcg estrogen and those containing 30-35 mcg (e.g., failure rates of from 2.0-2.5 pregnancies per 100 women who correctly and consistently use this method during the first year). For those combination OCs containing only 20 mcg estrogen the failure rate is higher, 3.0-5.0. This is thought to be due to the lack of carry-over effect of the lower dose pills (i.e., forgetting to take a pill will more likely result in a pregnancy with the 20 mcg OC than with one containing 30-50 mcg.)

In developing countries the overall failure rate even with the moderate dose (30 -50 mcg) combination pills is considerably higher than in developed countries. For example, a 1976 national survey in the Philippines reported 8 pregnancies per 100 woman-years during the first year of pill use, 9.2 during the second year and 5.1 in the third. In several South Asian countries user failure rates as high as 11 to 25 percent have been observed. The two major reasons for the higher failure rates in LDCs are "irregular pill taking" and "poor nutrition." Most women in LDCs are not accustomed to taking pills on a regular (daily) schedule and do not understand that skipping a pill(s) reduces its contraceptive effect. According to WHO studies, in some areas as many as 53 percent of users do not take OCs regularly.

Poor nutritional status of the OC user also contributes to reduced effectiveness. Comparative studies in five developed countries and 11 LDCs have shown national and individual

differences in absorption of the hormones in the pill and subsequent storage in the body. Less hormone is absorbed and stored by malnourished women because their levels of body fat are so low. Thus for most women in LDCs where nutrition is poor and the prevalence of chronic diarrhea high, a moderate dose OC (with at least 30 mcg estrogen should be used rather than the lowest dose OC (only 20 mcg)).

Based on the above, suggestions as to the type and number of different OCs to supply are as follows:

1. Small-size Service Program

- Type of child spacing methods limited to barrier methods, vaginal spermicides and OCs.
- Staff are limited to providing method counseling, do not perform pelvic exams and all client method problems are referred.

Recommendations

- Combination pill (fixed dose type) containing 30-50 mcg estrogen and 0.15 to 1.0 mg progestin (NOTE: Where economics permit, supply is not a problem and staff are well-trained, stocking 2 different "brands" of moderate dose OCs (e.g., Noriday and Lo-femenal) may be desirable to permit client selection and switch-over if there are minor side effects.)
- Progestin-only mini-pill (NOTE: Do not use this pill for start-up in new, non-breast feeding clients.)

Suggested Preparations

<u>Brand</u>	<u>Estrogen</u>	<u>mcg</u>	<u>Progestin</u>	<u>mg</u>
<u>Combination OCs</u>				
Noriday	mestranol	50	norethindrone	1.0
Lo-femenal	ethinyl estradiol	30	norgestrel	0.3
Norminest	ethinyl estradiol	35	norethindrone	0.5
<u>Progestin-only OCs</u>				
Nor Q.D.	-		norethindrone	0.35
Ovrette	-		norgestrel	0.075

2. Intermediate-size Service Program

- Child spacing methods limited to barrier methods, vaginal spermicides, OCs, injectables and \pm IUDs.
- Staff limited to method counseling (all child spacing methods), perform pelvic exams, manage most method problems and refer for \pm IUDs, NORPLANT^R (if available) and VSC.

Recommendations

- Combination pill (fixed dose type) containing 30-50 mcg estrogen and 0.15 to 1.0 mg progestin (NOTE: Where economics permit, supply is not a problem and staff are well-trained, stocking 2 different "brands" of moderate dose OCs (e.g., Noriday and Lo-femenal) may be desirable to permit client selection and switch-over if there are minor side effects.)
- Progestin-only mini-pill (NOTE: Do not use this pill for start-up in new, non-breast feeding clients.)
- Long-acting progestin injectable contraceptive

Suggested Preparations

<u>Brand</u>	<u>Estrogen</u>	<u>mcg</u>	<u>Progestin</u>	<u>mg</u>
<u>Combination OCs</u>				
Noriday	mestranol	50	norethindrone	1.0
Lo-femenal	ethinyl estradiol	30	norgestrel	0.3
Norminest	ethinyl estradiol	35	norethindrone	0.5

Progestin-only OCs

Ovrette	-		norgestrel	0.075
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Injectable contraceptives

Depo-Provera	-		medroxyproges- terone acetate	150
Norethindrone enanthate (NET-EN)	-		norethindrone enanthate	100

- IUDs, the more advanced copper T IUD (TCu-380A) is recommended.

[NOTE: Depo-Provera (150 mg) is given as an intramuscular injection, every three months and Norethindrone Enanthate (100 mg) intramuscularly every two months.]

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3. Full-size Service Program

- All child spacing and permanent contraception methods provided.
- Staff are fully qualified and can handle all method problems or complications.

Recommendations

- combination OC, progestin-only mini-pill, injectable contraceptive and NORPLANT^R (if available)
- IUD (TCu 380A)

Suggested Preparations

Same as for Intermediate-size Service Program with addition of NORPLANT^R

In summary, there is no need to stock more than one or, at most, two "brands" of combination OCs (30-50 mcg estrogen), one progestin-only mini-pill and one injectable contraceptive regardless of the size of the family planning service program. In fact stocking several brands of combination pills serves only to confuse staff and clients as well as complicate the logistics and supply problems. Recently USAID/W has decided to stop supplying combination OCs with 50 mcg estrogen (Femenal). OCs with estrogen doses of 50 mcg or more are associated with increased risk of serious complications and troublesome side effects such as nausea and cyclic edema. Moreover their effectiveness is no better than that of moderate dose combination OCs. Rarely is the use of a high dose OCs indicated. At the other end of the spectrum are the low dose (20 mcg estrogen) combination OCs. The rationale for not recommending these OCs was discussed above and consists of the following considerations:

1. Low dose pills have limited tolerance and decreased effectiveness in countries where malnutrition is prevalent and chronic diarrhea common.
2. Low dose pills have a higher rate of nuisance side effects such as break-through bleeding and failure to have any bleeding or spotting during the 7 days off the pill or when the 7 placebo pills are being taken.
3. The overall failure rate for low estrogen pills, even in developed countries, is higher than for moderate dose (30-50 mcg estrogen) OCs and no better than for progestin-only mini-pills.

Matching the Client to the Method

Listed below are guidelines for assisting clients to select a suitable family planning method. For each client category the recommended methods are ranked in descending order. The recommendations are for discussion purposes only and should not be considered as the only options or, in some situations, even the best ones. When helping clients choose a child spacing or permanent contraceptive method you must always respect their concerns and expectations while at the same time critically assessing their ability to understand and correctly use the method(s) being considered.

Group A. Couples who desire child spacing only

Examples are:

- young couples wishing to delay the onset of their first pregnancy, and
- couples wishing to space their second or subsequent pregnancy.

Recommendations:

1. OCs - combination type, fixed dosage, 21 or 28 pill regimen
2. Condom plus vaginal spermicide
3. Diaphragm (if available) plus vaginal spermicide
4. Natural family planning (NFP) - temperature or mucus rhythm method
5. Withdrawal plus vaginal spermicide

Comments:

In certain LDCs there is a reluctance to recommend OCs to couples with no or less than 2 children under the age of 5. This is based, in part, on the mistaken belief that OCs can adversely effect subsequent fertility and largely on social and cultural considerations. In some countries, injectable contraceptives and NORPLANT^R are now being used as a child spacing method for couples with one or more children.

Group B. Couples with 2 or more children and the youngest age 5 or more who want contraception (no more pregnancies) but do not want a permanent method - voluntary surgical contraception (VSC)

Examples are:

- couples opposed to VSC,
- couples not eligible for VSC because of age restrictions (minimum age varies from country to country so check local health regulations), or
- couples who are not emotionally ready for VSC.

Recommendations:

1. Long-acting progestin injectable (if available) or NORPLANT^R subdermal implant
2. OCs (combination type)
3. IUD (TCu 380A)
4. Barrier method (condom or, if available, diaphragm) with spermicide
5. NFP (temperature or mucus method)

Comments:

Long-acting progestins (injectables and implants) are highly effective and well tolerated. Added benefits are that the risk of iron-loss anemia is less and real weight gain (2-5 lbs) not edema (swelling of legs, etc.) occurs during the first year of use. REMEMBER: Return of fertility will be delayed 3-4 months after the last injection of Depo-Provera (DMPA) or 2-3 months with norethindrone enanthate (NET-EN). This represents the time it takes for the last dose of DMPA or NET-EN to be removed from the body. By contrast with progestin implants, once they are removed the contraceptive effect ceases.

Group C. Couples who have completed their families and desire permanent contraception (VSC)

Recommendations:

1. Male sterilization operation (vasectomy)
2. Female sterilization (minilaparotomy or laparoscopic tubal occlusion)

Comments:

All things considered (i.e., equal accessibility to services, quality of care, etc,) vasectomy is simpler and easier to perform, safer, and less expensive than either of the female operations. Moreover in the unlikely event of a family disaster (loss of some or all of the children by accident or disease) vasectomy can be reversed more easily and with a higher success rate.

Local conditions will dictate whether minilaparotomy or laparoscopy is the preferred female procedure. In addition in some countries other female procedures such as vaginal tubal ligation may be the preferred technique.

Both minilaparotomy and laparoscopy are recommended only as interval VSC procedures (i.e., the woman is more than 10 to 12 weeks from her last pregnancy and delivery). The technique of postpartum tubal ligation differs somewhat from the minilaparotomy procedure (e.g., the skin incision is higher on the abdomen due to the enlarged uterus).

Group D. Couples/clients with special problems

Examples are:

- **breast-feeding women**
- **combination OCs contraindicated or possible increased risk if used**
- **couple desires child spacing only**

Recommendations:

1. Condom or diaphragm plus vaginal spermicide
2. Progestin-only mini-pill
3. NFP (temperature or mucus method)
4. Vaginal spermicide alone
5. Withdrawal with spermicide

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- **Couple desires contraception (no more pregnancies) but is not ready for a permanent method**

Recommendations:

1. IUD (TCu 380A)
2. Progestin-only mini-pill
3. Injectable or implants (use only if no problems with mini-pill)
4. Condom or diaphragm with spermicide
5. NFP (temperature or mucus method)

- **Couple desires permanent contraception**

Recommendations:

1. Vasectomy
2. Female procedure (only after evaluation and correction of health problem if possible)

Group E. Couples where IUD is contraindicated or where there is possible increased risk if used.

- **Couples who desire contraception (no more children) but are not ready for VSC**

Recommendations:

1. Long-acting progestin injectable (if available) or NORPLANT^R subdermal implant
2. OCs (combination type)
3. Condom or, if available, diaphragm with spermicide
4. NFP (temperature or mucus method)

Comments:

Conditions where an IUD is contraindicated or would be associated with an increased risk are as follows:

- history of pelvic infection (PID), uterine infection (endometritis), postpartum infection or complication of caesarean section

- uncontrolled vaginal/cervical infection
- undiagnosed vaginal/uterine bleeding
- abnormal Pap smear
- positive culture or test for STD such as gonorrhea, chlamydia, mycoplasma or herpes
- multiple sex partners

ESTIMATING COUPLE-YEAR OF PROTECTION (CYP)

[TO THE TRAINER: Based on the experience and background of the participants this exercise may be included.]

Statistical systems for family planning program services often produce inaccurate data on "active users" of a program, which is one of the most important measures of program output. In this section, another method of measuring family planning output is described: the CYP index, which summarizes the overall output of a program in terms of potential contraceptive protection dispensed by the program.

The CYP index provides a way to determine the total contraceptive protection offered by different methods issued by a program during a certain time period. One CYP is equal to 12 couple-months of protection, which could be attributed to any person-time combination, from one couple practicing birth control for one year to 12 couples practicing birth control for one month each. Thus, 12,000 CYPs of oral contraceptives dispensed to users is enough to meet the contraceptive needs of 12,000 couples for one year, or 24,000 couples for six months, etc. Thus, CYP indicates how much contraceptive protection time could result from the quantity of contraceptive dispensed.

[TO THE TRAINER: The material on the accompanying two pages is to be distributed to the participants. The information contained on the first page should be carefully reviewed with the participants. Then they are asked to complete the missing numbers in the table on the second page.]

Exercise: Estimating Couple-Year of Protection (CYP)

In actual practice the procedure for estimating CYP consists of three steps:

1. From the inventory control cards, the quantities for each method dispensed during the time period are obtained. In the present exercise, it is assumed that this data is available (see Sample Problem on the next page, Column 2).
2. Next, the amount of each method needed to provide one CYP is determined. This may vary from country to country, program to program, and from region to region. In practice, the program manager will compute these factors for himself or herself from local studies. For the Sample Problem, the following estimates will be used:
 - a. Without counting wastage, it takes 13 cycles of oral contraceptives to protect a couple from the risk of pregnancy for one year.
 - b. On the average, couples use 120 condoms per year.
 - c. On the average, an IUD is kept in place about 2.5 years. Therefore, the average use per year is 1 divided by 2.5 = 0.4 units (IUDs).
 - d. On the average, one tube of cream, jelly, or foam confers 3 months of protection. Thus, it takes four units to provide one CYP.
 - e. On the average, one tube of Neo-Sampon (20 tablets) confers two months of protection. Therefore, six units are needed for one CYP.
 - f. Each contraceptive injection confers 3 months of protection. Thus, four injections provide one CYP.
3. To calculate CYP for each method, simply divide the quantity of each contraceptive method dispensed by the average quantity of each method used by a couple in a year, or its conversion factor.

SAMPLE PROBLEM: Determine the CYP for each method and the factor CYP for all problems

Contraceptive Method (1)	Amount Issued (2)	Average Number Needed Per Couple Per Year (3)	CYP Achievement (4)=(2)÷(3)
Pill	290,416	13 cycles =	22,340
Condom	193,596	120 units =	1,613
IUD	540	0.4 units =	1,350
Cream, (including diaphragms)	1,116	4 tubes =	279
Neo-Sampon	2,491	6 tubes =	415
Injection	9,260	4 injections =	<u>2,315</u>
		TOTAL	28,312

Source: CDC. Logistical Guidelines for Family Planning Programs. Atlanta: Center for Health Promotion and Education Division of Reproductive Health, June, 1985.

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TABLE 1: Characteristics of Principal Approaches to Providing Family Planning Services.

DESCRIPTION	ADVANTAGES	DISADVANTAGES
<p>I. COMMUNITY-BASED Local volunteers, usually village women, are recruited to educate their neighbors. The volunteers are also responsible for distributing the family planning methods to users. In their training, the volunteers learn the basic concepts of family planning, how each method must be used, what the contraindications and adverse effects are for each method, and how to maintain simple data collections systems. A physician midwife, or family planning nurse supervises the volunteer's activities to manage any problems that may occur.</p>	<p>Users can obtain methods more cheaply. More convenient for patients, who need not travel long distances. Supplies are distributed by someone the patient knows and trusts. Postpartum mothers can be identified and visited. Follow-up is easier. User motivation is maintained at high level through continuous interaction with volunteer.</p>	<p>Initial program costs to user are high. Full maternal and child health/family planning services are not offered. No immediate access to clinical staff for management of problems Some health professionals resist volunteers services. User may lack confidentiality. User may lack confidence in nonmedical workers.</p>
<p>II. COMMERCIAL DISTRIBUTION Commercial distribution was begun with the knowledge that remote areas having no access to medical care somehow seem to have other types of consumer items available in retail outlets. If other supplies can reach these very remote areas, then so can family planning supplies. Most countries limit commercial distribution of oral contraceptives to pharmacies. Barrier methods, however, are sold in nearly every place: groceries, markets, and streets by hawkers.</p>	<p>Can reach very remote areas not reached by other programs. Users need not travel long distances. Distributors are motivated by profit from sales. Availability of methods is well publicized. User does not need to wait in lines to receive methods. User has privacy. Costs to the government can be low. Usually resupply to distribution points is reliable.</p>	<p>Patients must go to clinic for management of problems. It can be costly to start a program. Full services are not offered. Promotion and advertising of contraceptives may be subject to criticisms. Public health officials do not have control over resupply system.</p>

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TABLE 1: continued

DESCRIPTION	ADVANTAGES	DISADVANTAGES
<p>III. CLINIC-BASED SERVICES Clinic-based service is a reasonable approach in areas where health workers are available and users do not live are from the clinic. With some physician supervision, trained nurses and midwives examine women, prescribe the appropriate family planning methods, and manage problems.</p>	<p>Patients are seen at each visit by health care professionals. Problems can be spotted and treated at visit. A switch in contraceptive method can be quickly done at the clinic. Start-up costs low if Maternal Child Health (MCH) services already available. More complete services are offered.</p>	<p>Patients are primarily limited to those living close by. Follow-up depends upon user's returning to clinic. The nurse or midwife may not be familiar to the patient. Patients are expected come on their own Patients may have to wait in long lines. The doctor or nurse may be a male, which would not be acceptable to women in some cultures.</p>
<p>a) MATERNAL CHILD HEALTH/FAMILY PLANNING SERVICES As a starting point, the Maternal Child Health/ Family Planning program is preferred by many African governments because mothers can obtain several related services at one site, thus providing continuity of care, and because family planning can be provided for child spacing as part of maternal and child care, and not as a measure to to "control fertility."</p>	<p>Can attract large numbers of mothers coming for other services. Users can receive pediatric, obstetric, and gynecologic care in one setting, along with family planning services. In theory, it offers an easier transition from postpartum to family planning, and the reverse. Patients uncomfortable with the social stigma of birth control are not so easily identified as users of family planning. Family planning can be established as an important element in the health of women and children.</p>	<p>Family planning users seen only after child maternal health pro- are attended to. Workers may be over-worked and under-staffed. Administrative functions are more complicated especially if the re-supply and reporting service statistics for family planning are not integrated with the support systems and the MCH program. Workers not always specifically trained in family planning may be able to accommodate the integration of family planning services.</p>

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TABLE 1: continued

DESCRIPTION	ADVANTAGES	DISADVANTAGES
<p>b) FAMILY PLANNING ONLY Clinics offering only family planning services are often established in urban areas or large towns to meet an existing demand for contraceptives.</p>	<p>The family planning workers are more motivated to deliver family planning. More time can be spent counseling and educating each user. Generally, a better worker-to-user ratio exists for family planning. Workers who have received special training in family planning may be more effective. Unmarried women without children are more comfortable in this type of facility.</p>	<p>Users must be motivated to come on their own for family planning services. A smooth transition does not exist from the partum period to the time a woman needs family planning services or to the time when she needs antenatal care. Women must visit other facilities to receive other health service. Clinics lack the additional incentive of offering services that attract many mothers.</p>

Source: CDC. Family Planning Methods and Practice: Africa. 1983, pp. 283-284.

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TABLE 2: FIRST YEAR FAILURE RATES OF CHILD SPACING
AND PERMANENT CONTRACEPTIVE METHODS

Method	Lowest Observed Failure Rate* (%)	Failure Rate in Typical Users** (%)
Tubal sterilization, females	0.2	0.2-1
Vasectomy, male	0.15	0.5-1
Injectable progestin	0.25	1
Combined birth control pills	0.5	1-8
Progestin-only pills	1	3-10
IUD (TCu 380A)	1-3	1-5
Condom	1-2	3-15
Diaphragm (with spermicide)	2	4-25
Sponge (with spermicide)	11	15-30
Foams, creams, jellies, and vaginal suppositories	3-5	10-30
Coitus interruptus	16	23
Fertility awareness techniques (basal body temperature, mucous method, calendar, and "rhythm")	1-50	10-30
Chance (no method of birth control)	35-90	90-125

*Designed to complete the sentence: "In 100 users who start out the year using a given method and who use it correctly and consistently, the lowest observed failure rate has been ____."

**Designed to complete the sentence: "In 100 typical users who start out the year using a given method, the number of pregnancies by the end of the year will be ____."

Source: Contraceptive Technology, 1986-1987, 13th Revised Edition, p. 102.

TABLE 3: MORTALITY ASSOCIATED WITH CONTRACEPTIVE USE
IN DEVELOPED AND DEVELOPING COUNTRIES

Method and User Status	No. of Pregnancies (per 100,000 fertile women at risk ¹)	No. of Maternal Deaths	No. of Method-Related Deaths
DEVELOPED COUNTRIES			
No Method			
Under 35	60,000	12	0
35 and over	40,000	22	0
Oral Contraceptives			
Non-smoker under 35	3,000	0.6	1
Smoker under 35	3,000	0.6	10
Non-smoker 35 & over	2,000	1.1	15
Smoker 35 & over	2,000	1.1	48
IUDs			
Under 35	5,000	1	1
35 and over	3,000	1.8	2
Condoms, diaphragm, etc.			
Under 35	14,000	2.8	0
35 and over	7,000	5.6	0
DEVELOPING COUNTRIES			
No Method			
Under 35	60,000	60	0
35 and over	40,000	160	0
Oral Contraceptives			
Non-smoker under 35	12,000	12	1
Smoker under 35	12,000	12	1
Non-smoker 35 and over	6,000	24	15
Smoker 35 and over	6,000	24	48
IUDs			
Under 35	8,000	8	2
35 and over	3,000	12	4
Condoms, diaphragm, etc.			
Under 35	20,000	20	0
35 and over	10,000	40	0

¹ Women sterilized or breast feeding and without menses not included.

Source: Tietze and Lewit, International Journal of Gynecology and Obstetrics. 16:456, 1979.

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TABLE 4: AID-SUPPLIED CONTRACEPTIVE COMMODITIES

<u>COMMODITY</u>	<u>CASE</u>	<u>COST/UNIT</u>
<u>CONTRACEPTIVE FOAM</u>		
EMKO	3 dozen	\$17.04/dozen
<u>ORAL CONTRACEPTIVES</u>		
LO-FEMENAL 0.3 mg Norgestrel 0.03 mg Ethinyl estradiol 75 mg Ferrous fumarate (BLUE LADY PACKAGING)	1200 monthly cycles	\$.13/cycle
OVRETTE (PROGESTIN-ONLY MINI-PILL) .075 mg Norgestrel (PINK LADY PACKAGING)	1200 cycles 28 tablets each	\$.13/cycle
NORIDAY 1+50 FE 1.0 mg Norethindrone 0.05 mg Mestranol 75 mg Ferrous fumarate (SOCIAL MARKETING PACKAGING ONLY)	1200 monthly cycles	\$.27/cycle
NORMINEST FE 0.5 Norethindrone 0.035 mg Ethinyl estradiol 75 mg Ferrous fumarate (SOCIAL MARKETING PACKAGING ONLY)	1200 monthly	\$.27/cycle
NORQUEST 1.0 mg Norethindrone 0.035 mg Ethinyl estradiol 75 mg Ferrous fumarate (SOCIAL MARKETING PACKAGING ONLY)	1200 monthly cycles	\$.27/cycle
<u>IUD</u>		
MODEL TCu 380A	200 units	\$.05/unit

TABLE 4: page 2

<u>COMMODITY</u>	<u>CASE</u>	<u>COST/UNIT</u>
<u>VAGINAL FOAMING TABLETS</u>		
CONCEPTROL	4800 units	\$.095/unit
<u>CONDOMS</u>		
	6000 pieces	\$ 4.24/100 pieces
49mm Colored (Sultan)		
49mm RAJA (red only)		
52mm Colored Tahiti		
52mm Colored (Sultan)		
52mm Non-Colored (Sultan)		
52mm Colored Panther		
52mm Non-Colored Panther		
52mm Colored, no trade logo (Made in U.S.A.)		
52mm Non-Colored, no trade logo (Made in U.S.A.)		
52mm Colored Blue & Gold Coin		
52mm Non-Colored Majestic ULTRA THIN		

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LECTURETTE:
AN INTRODUCTION TO CONTRACEPTIVE TECHNOLOGY

AN INTRODUCTION TO CONTRACEPTIVE TECHNOLOGY

Family Planning Perspectives

The desire and need to influence fertility is as old as man himself. Evidence exists in ancient writings that we have long understood some of the basic principles regarding spacing births and planning for the number of children desired. For example, the practice of coitus interruptus or withdrawal has been used for centuries and is referred to in the Bible, book of Genesis. It is described as being practiced during the two-year interval following a birth suggesting its (coitus interruptus) use as a child spacing method.

A linen sheath for coitus, forerunner of the condom, was first described in 1564 by Gabriele Fallopio in his De morbo gallicao. Penile sheaths were used initially for protection against venereal disease. Not until the 18th century did the membranous condom, usually fashioned from animal tissue, become popular for contraception. With the vulcanization of rubber in 1884, contraception achieved an explosive popularity because of the sudden cheapness of the new product. Thus, by mid-20th century, the condom was the most widely used of all child spacing methods.

The philosophy regarding ideal population and desired family size also can be traced to the ancients. The Greeks apparently were the first to give serious thought to population control. Most of the early Greek philosophers considered a stable population essential. They advocated that reproduction should be legally regulated, with overpopulation being checked and under population corrected by stimulating fertility and immigration.

Though the discussion to this point has been limited mainly to views expressed by ancient cultures and societies, attitudes regarding expression of our sexuality abound in many modern cultures. Even today in some regions of the world, family planning remains a sensitive subject. In most countries, fortunately, what constitutes acceptable family size, how societies create policy to reinforce this goal, and what methods are utilized, gradually have changed during the last 30 years. Through scientific advancement and enhanced communication systems has come the realization that lack of birth spacing and/or limiting family size can lead to ill health for the mother, new infant, young children, and, as a consequence, the whole family and society.

Despite increased knowledge regarding reproduction, family planning and sexuality, dissemination of information to the public in many countries has lagged. Thus, many misconceptions or myths regarding the safety, effectiveness, and action of most child spacing methods still exist. Community education is essential to dispel these rumors as well as provide basic health information.

Some misconceptions are based on partial evidence or stem from reference to side effects noted with one method which are then incorrectly attributed to all or some other methods. A few of these "misperceptions" include: it makes you feel pregnant; it interferes with spontaneity; or it decreases sexual drive. In past years when the dosage of sex hormones in oral contraceptive (OCs) pills was much higher, complaints that sexual drive was effected and you feel pregnant were common. With current low dose pills these complaints are much less common.

Three additional fears regarding OCs are that they are dangerous, cause cancer and cause blood to back up in the uterus. Over the years numerous large, prospective studies have demonstrated rather clearly that low dose pills given to healthy women carry a very small risk of serious complications. The risk of serious medical complications to a healthy woman using OCs is considerably less than that of delivering a child. Moreover, available evidence does not support the role of OCs as a causative agent in producing cancer. Finally, women on the pill develop less endometrium (lining tissue of the uterus) than women using other birth spacing methods. This tissue normally is shed during a woman's menses (period). Because women using OCs have less endometrial tissues, there is less to be cast off and consequently less bleeding.

Model Systems Currently Being Used to Deliver Family Planning Services in the Developing World

Family planning services may be delivered to people in a variety of innovative ways. Various cultures and people find some ways more acceptable. Some factors which influence acceptability are: distance traveled to receive the service, cultural and religious beliefs, and ease of use.

Three typical ways of delivering family planning services are:

1. Community-Based Programs
2. Commercial Distribution Programs
3. Clinic-Based Programs

1. Community-Based Programs

These programs are usually based on the use of volunteers who have a strong sense of community responsibility and a desire to provide important information and service to family, friends, and neighbors. These volunteers, usually but not necessarily women, receive training about normal anatomy, physiology and sexual functioning. They learn how a variety of traditional and modern child spacing methods work. They then learn how to share this knowledge with others and how to best answer questions which will arise. These volunteers often serve as suppliers of some of the family planning methods which they sell at low cost.

It is important that these volunteers are connected to a health care worker. This linkage may be to a midwife, physician, or nurse working in a family planning clinic. It helps keep volunteers up-to-date, ensures that the advice they give is correct and safe and provides the volunteer with a referral source for men and women with problems. As a result of their service to the community these volunteers usually are well respected.

Many new, innovative ways of utilizing existing community resources are being developed. In many places, peer groups of adolescents are spreading information from teenager to teenager regarding the risks of early sexual activity, methods of child spacing, normal anatomy, and functioning of the reproductive system. The same networks that bring youth misinformation can be used to bring valuable health messages and dispel misinformation, rumors and myths.

Community-based programs (CBPs) can be used in urban or rural settings. They can be as simple as a one-to-one conversation with a neighbor or a small group meeting for the specific purpose of sharing new information. As these topics are very personal, it is important that volunteers respect the confidentiality of those served. Programs flourish or die depending on the respect and trust developed by their volunteers.

In some situations the CBP workers are paid health promoters or community health workers. One advantage of using these individuals is that often they are well-known and trusted within the community. One disadvantage is that frequently this worker has so many other responsibilities he/she is unable to devote a significant portion of his/her time to child spacing education and service delivery.

Some CBPs are creatively linked to various social or commercial programs. For example, in Thailand child spacing users may get discounts on such practical things as hair cuts or pig stud services. Also, free samples of condoms are distributed in factories and at sports events, while information regarding child spacing services is distributed by taxi cab drivers and others.

The types of CBPs and ways of advertising them that work will vary from community to community and culture to culture. Many times new things need to be introduced carefully in order to determine the acceptability and effectiveness of the message being presented.

2. Commercial Distribution

In commercial distribution programs retail outlets serve as the delivery source of modern child spacing methods. In most countries selling of OCs is limited to pharmacies. Barrier methods such as condoms, foams, sponges, and others are sold in many places including open markets, street hawkers, stores, and beauty parlors to name a few. Creative salespeople can think of many ways to provide supplies at places where people can easily find them.

One disadvantage of commercial-based systems is that the profit motive might influence the judgement of the provider. Proper warnings to people who should not use a particular method should be included in the advertising. In addition, instruction on proper use of the method should be given. These instructions should be provided in the language of the user or with pictures indicating clearly to the non-literate how the method is used.

3. Clinic-Based Services

Clinics which provide a variety of health services are the traditional providers of family planning services. These clinics are staffed with health workers, most typically midwives, physicians, and/or family planning nurses. An advantage of a clinic-based program is that it is frequently a source of care already well known to families in the area.

Clinic-based programs are able to offer a full range of services including intrauterine devices (IUDs) and sterilization. These services typically are not available in community-based or commercial programs. Another advantage of clinic-based services is that personnel are available to answer questions, handle complications, clarify instructions and provide emotional support to clients. The major disadvantage of clinic-based services is

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that only clients in the immediate geographic area are served. If clients must travel long distances to receive supplies, or encounter long waiting times prior to being seen, a significant number will fail to return and may resort to using traditional methods or no method at all.

Review of Modern and Traditional Methods of Birth Spacing/Family Planning

The ability to control one's own reproductive destiny and to choose among child spacing methods on a completely voluntary basis is an important personal freedom. The variety of methods available will vary from country to country depending on cost, acceptability to clients, and the ability to maintain a continuous supply of the methods. Industry has a large role to play in improving our ability to produce and distribute needed supplies. Ideally clients should have a variety of methods available to them so they may exercise personal preference.

When evaluating a specific child spacing method, we are interested in finding out answers to a number of basic questions. These include:

- How does the method work?
- What is the correct use of the method?
- How effective is the method?
- What are the common side effects of the method?
- What are the danger signals that health and family planning staff need to look out for?
- What are the contraindications for the method; that is, who should not use the method?

In the paragraphs which follow, these questions, and many more, are answered. The material presented is designed to:

1. help you better understand the different methods of child spacing, their benefits and risks;
2. assist you in matching your clients with appropriate child spacing or permanent contraceptive methods; and,
3. guide you in determining the method mix which best meets your particular program needs and resources.

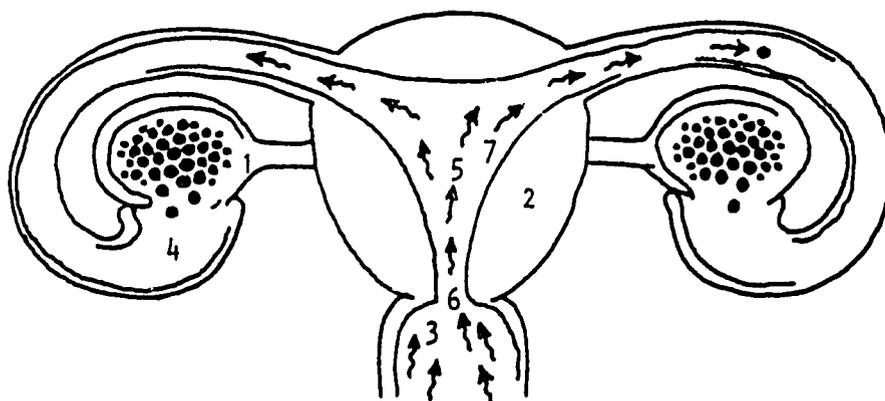
It is organized in the following manner: First, a brief review of the process by which pregnancy occurs is presented. Then, each method is described; the way it prevents pregnancy is explained; and its relative effectiveness discussed. Finally, factors to consider when selecting the particular mix of child spacing methods to be promoted in a program are presented.

The Process of Pregnancy

To prevent pregnancy the process by which it occurs - ovulation, fertilization and/or implantation - must be interrupted or avoided. To help you better understand just how the different child spacing methods work, the process of pregnancy is briefly reviewed.

Every month from the age of 12-15 to age 45-50, roughly thirty to forty years, a woman's body prepares itself for pregnancy. This cyclic reproductive process, called the menstrual cycle, averages about 29 days in length for most women, with a normal range of 25-36 days. The process starts in the ovaries (a pair of white, rather flat glands that are located in the lower part of the abdomen). Each month, inside one of the ovaries, an egg ripens inside a small sack or follicle (Figure 1, below). When the egg is ripe, around the middle of the menstrual cycle (about day 12-16), the follicle splits open releasing the egg. This process, called ovulation, is sometimes accompanied by a vaginal discharge and slight cramps, which may last for several hours.

FIGURE 1



- | | |
|--------------------|-----------------------------------|
| 1. Ovaries | 5. Uterine Cavity |
| 2. Uterus (womb) | 6. Cervix (entrance to uterus) |
| 3. Vagina | 7. Endometrium (lining of uterus) |
| 4. Fallopian tubes | |

Following release of the egg, it is picked-up by one of the two fallopian tubes. Each tube is about 4 to 5 inches long. The end of the tube opening next to the ovary is wider than the rest of the tube and has a fringe-like edge which allows the egg to enter the tube more easily. Once inside, the muscular contractions of the fallopian tube push the egg along the tube toward the uterus. During intercourse, sperm enter the vagina, move through the cervix into the uterus, and then into the fallopian tubes. Unlike the egg, sperm can move by themselves, even "up stream" against the contractions of the fallopian tube. The egg and the sperm join in the fallopian tube; this is called fertilization. The fertilized egg then continues to be moved through the tube into the upper part of the uterus or womb.

The uterus is lined with a layer of tissue called the endometrium. While ovulation is taking place, a hormone (progesterone) is being released which increases the blood supply to the uterus. This additional blood supply makes the endometrium thicker, moist and soft, and ready to receive the fertilized egg. Once the fertilized egg (embryo) enters the upper portion of the uterus, it sticks to the endometrium. As it continues to grow the embryo becomes implanted in the wall of the uterus. Implantation usually occurs about 4 to 5 days after ovulation, and marks the beginning of the intrauterine portion of the pregnancy.

If the egg is not fertilized, the endometrium is not needed and about 12-15 days after ovulation, roughly 25-35 days after the beginning of the cycle, it is slowly discharged from the uterus via the cervix and vagina. This process of shedding the endometrium is called menstruation. Also during this time the unfertilized egg disintegrates and is discharged.

Contraceptive Effectiveness

The effectiveness of various child spacing methods depends on both the method and the user. Consequently, effectiveness rates usually are given in two forms. The terms method effectiveness and user effectiveness (or method failure and user failure) are used to differentiate between pregnancy occurring with correct use (method failure) and that occurring with incorrect use (user failure) of the birth spacing method. Method effectiveness is always better than user effectiveness for all child spacing methods; however, the latter rate more clearly represents what can be expected to happen in the real world. Because of this difference it is important in your reading (or discussions) that you know which rate the author (or speaker) is using. For example, it is unfair to compare two methods, employing "user" effectiveness for one and "method" effectiveness for the other.

It is difficult to accurately determine the effectiveness of various child spacing methods because of the large number of factors that cause contraceptive failure. However, reasonable estimates of these two rates are presented in Table 2, "First Year Failure Rates of Child Spacing and Permanent Methods". The rates listed in the first column, "Lowest Observed Failure Rate", approximate the "method" effectiveness rate (i.e. they are based on the method having been used "correctly and consistently" by all acceptors). Similarly the failure rates presented in the second column approximate the "user" effectiveness rate because, in this instance, the "typical" users may (or may not) have used the method correctly.

Of the various reversible methods available, the theoretical effectiveness of combined OCs is second only to that of long-acting injectable progestins or implants. As the data in this table illustrate, the "method" effectiveness rate is over 99 per cent (i.e. less than 1 pregnancy per 100 women who correctly and consistently used the method during the first year); however, the actual "user" failure rate is higher (i.e., 1-8). Furthermore, in developing countries user failure rates may be even higher than those listed in Table 2.

Several other factors which influence the effectiveness of a particular child spacing method are:

- Contraceptive failure, especially for a coitus-related method, is more likely to occur among couples seeking to delay a wanted pregnancy than among those seeking to prevent pregnancy altogether.
- Older women, women of higher social class and those with more education tend to use child spacing methods more successfully than younger, poorer and less educated women.

Continuation Rate

The overall value of a birth spacing method as used by a couple (or group of couples), however, is based not only on the actual (observed) effectiveness, but also on the length of time the couple(s) use the method (i.e. the continuation rate). Actuarial methods such as the life table method are used to determine this rate. As is the case for user effectiveness, continuation rates vary considerably for each method and from country to country. Not unexpectedly, they tend to be lower in developing countries and in younger, poorer and less educated individuals. In some areas of South Asia and Africa 50 per cent continuation rates (i.e. the length of time that 50 per cent of

the users continue to use the method) for pills, condoms and vaginal spermicides are only 3-6 months; for IUDs only about 7-9 months and for injectables about a year. If the method is being used to prevent any further pregnancies, not just child spacing, providers must make every effort to encourage acceptors to continue to use the method. Using a less effective method, but one which is used correctly, is well tolerated and used for prolonged periods of time, is far better in limiting family size than a more effective method used sporadically and briefly!

From the above discussion it can be seen that many variables - not just the particular method's effectiveness - must be considered in helping a couple select the best method for them. Moreover, as the data demonstrate no child spacing method, regardless of its effectiveness, can be expected to be successful unless it is used correctly, consistently and for a prolonged period of time.

Contraceptive Risks and Benefits

Despite more than two decades of research in developed countries it remains difficult to precisely assess the risks of using a reversible contraceptive method versus that of pregnancy and child birth. However, in developing countries, where the maternal mortality associated with pregnancy is 10 to 20 times higher than in developed countries, the risk of using any modern method, even oral contraceptive (OCs) pills by women smokers over age 35, is much lower than that associated with pregnancy (Table 3.) In fact, as the data in Table 3 illustrate, for women in developing countries the pregnancies resulting from contraceptive failure, through use of less effective methods, such as condoms, account for more maternal deaths than from the hazards of IUDs or OCs! Clearly, in most developing countries, until there is a significant reduction in maternal mortality the use of modern contraceptive methods will remain far safer than pregnancy and child birth. Moreover, the use of reliable child spacing methods do more than just prevent the birth of unwanted children, who can be both economic and emotional burdens. They also eliminate the ever present fear of pregnancy, which may harm marital relations. Finally contraceptive use, by increasing the birth interval and reducing the total number of pregnancies a woman has, can in itself, result in improved maternal health, and for the working mother, less time lost from work.

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Reversible Methods

1. Abstinence

In some societies abstinence is practiced intermittently or continuously by adult members of the population. For example, certain cultures prescribe a period of abstinence after child birth. This allows time for mother and baby to recover and flourish without the threat of a new infant prematurely pushing the weanling infant off the breast. In addition, couples often experience periods of abstinence due to separations for work, schooling, or for spiritual renewal.

In certain parts of the world, where adolescent or single parent pregnancy is a frequent problem, programs encouraging youths to say "no" to sexual relationships are gaining popularity. Pregnancy before the individual or family are ready for it, creates great hardship. Sometimes it ruins the reputation of the girl. It frequently means an end to educational opportunities thereby limiting her options for the future. In developed countries young mothers and their children are more likely to remain poor and need financial and health care assistance from governmental and/or private agencies. The costs to society to provide this assistance are great.

The advantages of using abstinence are that it requires no supplies, no distribution system, no warning labels regarding safety, and costs no money. Moreover abstinence is the only method that is 100 per cent effective in preventing pregnancy.

2. Lactation

Breast-feeding is still a common practice in most societies, particularly in those with traditional attitudes. In some countries, such as Bangladesh, India, and those in equatorial Africa, a large percentage of women breast-feed for periods of more than 12 months. In Latin America the figures are lower, but still an important number of women breast-feed for more than six months. The main reasons women in these areas breast-feed is nutritional.

Increasingly, both individual women and family planning programs are coming to realize that breast-feeding protects against pregnancy in the early postpartum as effectively as modern contraceptive methods. A recent study in Mexico found that less than four percent (4%) of women who breast-fed on demand had resumed ovulating at three months after delivery. However, contraceptive effectiveness of breast-feeding does decline over time. The longer the time before the first postpartum menses, the less a woman should rely on breast-feeding solely for contraception.

Because of regional differences in breast-feeding practice and performance, rules about breast-feeding and the use of contraception should be tailor made to fit the cultural practices of the specific area. However, as a general rule, once the menses have returned or supplemental feeding introduced or the baby sleeps through the night (a sign of reduced frequency of suckling), a woman is at more risk of pregnancy and should begin using contraception.

When recommending contraception for breast-feeding women, family planners need to give careful consideration to the choice of method. For most women, combining breast-feeding with another method such as condoms, a diaphragm, foaming vaginal tablets, progestin-only pills or long-acting progestins (injectables or implants) provides reliable contraception without affecting her milk production, her infant or the interruption caused from an unplanned pregnancy.

3. Coitus Interruptus or Withdrawal

This traditional method has enjoyed popularity in parts of Europe, Africa and Asia for a long time. With this method the man withdraws his penis from the vagina prior to ejaculation, while at the same time being careful not to ejaculate on or near the external genitalia (tissue surrounding the opening to the vagina) of his partner.

As a method of child spacing coitus interruptus has a number of advantages. It requires no devices or equipment, causes no side effects, and costs nothing. The major disadvantage however is that failure rates run from 16 to 23 percent during the first year. The high failure rate is a result of several factors. One important reason is that a small amount of semen, which contains sufficient numbers of sperm to cause a pregnancy, may escape from the end of the penis just prior to ejaculation. Another reason is that most men lack the self-control demanded by this method. For most men, as the moment of ejaculation approaches, there is an increasing urge to penetrate deeper. As a result withdrawal of the penis in sufficient time to prevent ejaculation does not happen.

To improve the user effectiveness of this method it may be combined with other methods such as spermicidal foams or foaming vaginal tablets around the mid-cycle (days 9 to 20) - the time of peak fertility for most women. Finally it should be remembered that although withdrawal is not one of the most effective methods, it is considerably better than using no method where the failure rate is about 90 per 100 woman-years.

4. Fertility Awareness or Natural Family Planning

Fertility awareness (periodic abstinence) as a child spacing method currently is experiencing increasing attention. It requires no devices or medication and there is nothing to swallow or insert. However, it does require considerable time and effort on the part of the couple to learn how to use the method correctly.

The rationale for natural family planning methods is based on three biological assumptions: first, the egg can be fertilized only for about 12-48 hours after ovulation; second, sperm are capable of fertilizing an egg only for about 48 hours after intercourse; and finally, ovulation usually occurs 12 to 16 days (14 + 2 days) before the onset of the next menses. Based on these assumptions being correct, theoretically there should only be about 96 hours during any month when intercourse could lead to pregnancy: the 48 hours before the egg is released and the 48 hours afterwards. Thus by avoiding intercourse during this critical period the probability of pregnancy should be decreased.

In actual practice the time interval when intercourse must be avoided is considerably longer than 96 hours (four days). The reason for this is that at present there is no absolutely sure method of predicting when ovulation will occur - even in women who have normally regular cycles. In women with irregular cycles the situation is even less predictable. Furthermore, sperm survival after intercourse in some instances is longer than 48 hours.

For couples electing to use natural family planning (periodic abstinence) there are three methods to choose from - calendar, basal temperature and cervical mucus. Each one uses a different biologic indicator to estimate when ovulation will occur so that the risk of pregnancy can be avoided. Of the three, the calendar method is the least effective with failure rates of 14 to 47 for every 100 women using it for one year. To increase the effectiveness of the calendar method a woman can record her basal (morning) temperature daily during the cycle. In most women who ovulate the basal temperature will rise several tenths of a degree just after ovulation (24-48 hours) and remain elevated until the ensuing menses. If the couple abstains from intercourse from the start of menses until at least 48 hours after the temperature rise, presumably two days after ovulation, the egg should no longer be capable of being fertilized. (It should be noted that for couples who are infertile the basal temperature method can be used to estimate when to have intercourse.) When the basal temperature method is used correctly and consistently to determine the days of periodic abstinence, the lowest observable failure rate reported has been 1 to 7 per cent - considerably better than with the calendar method.

The third and fairly new natural family planning method is based on a woman being able to detect changes in the quality and quantity of her cervical mucus just prior to ovulation. Although initially thought to be more effective than the basal temperature method, recent reports suggest this is not the case with pregnancy rates ranging from 1 to 30 per 100 women during the first year.

The major disadvantage of natural family planning methods, aside from the time commitment required to learn to use them properly, is the number of days a couple must avoid intercourse - roughly a third to one half of the days each month - 10 to 15 days!

5. Vaginal Foams, Tablets, Suppositories and Sponges

These substances all contain a spermicidal ingredient, usually nonoxynol 9, which immobilizes or kills sperm on contact. Because they also provide a mechanical barrier to sperm they need to be placed in the vagina before coitus. Foams come in aerosol containers with nozzles or are inserted into the vagina via a plastic applicator. Vaginal spermicidal suppositories and foaming tablets are inserted by hand into the vagina and dissolve on contact with the vaginal fluid. There are no reliable studies comparing the effectiveness of the various types of vaginal spermicides. Used alone "user" failure rates tend to average about 10 to 18%, but when combined with condoms failure rates can be considerably lowered - 1 to 7 per cent. Laboratory studies have shown that spermicides offer some protection against sexually-transmitted diseases (STDs), such as gonorrhea, chlamydia, and syphilis. Their effectiveness in actual use by couples is less clear. Because spermicides also have been found to kill the AIDS virus, the use of vaginal spermicides as well as spermicidally lubricated condoms may help to prevent transmission of AIDS.

Recently a new vehicle for delivering the spermicidal agent to the vagina has been approved for use. Called the vaginal sponge, it consists of a two inch in diameter soft, polyurethane disc impregnated with nonoxynol 9. The sponge is activated by moistening it with water just prior to insertion into the vagina. Because one size sponge fits all women, no clinic visit is needed to fit it. In addition it may be marketed in any store or shop which sells condoms and other vaginal spermicides. The sponge provides good protection for up to twenty-four hours regardless of the number of times the couple may have intercourse during this interval. Unlike other spermicides which must be re-applied with each sexual act, the sponge does not have to be changed; however, it should be left in place for at least six hours after the last exposure to assure that all sperm are killed. Sponges are discarded after a single use.

The failure rate for the vaginal sponge is roughly the same as for other vaginal spermicides and slightly higher than for the diaphragm. Side effects for all vaginal spermicides are limited to occasional vaginal or penile irritation. The foaming vaginal tablets and suppositories all cause a warming sensation in the vagina as they dissolve.

6. Diaphragms

Diaphragms are shallow rubber cups ranging from 2.5 to 4 inches in diameter. When correctly inserted into the vagina the diaphragm covers the cervix, mechanically blocking the sperm from gaining entrance to the uterus via the cervix. To enhance its effectiveness, the diaphragm should always be used together with a spermicidal agent. After intercourse the diaphragm should be left in place for at least 6 hours. Following removal it should be washed with clean water and air dried. (In areas where water is not readily available, this may restrict the use of diaphragms and cervical caps.) With careful handling diaphragms can last for several years. Diaphragms must be individually fitted by a qualified family planning practitioner. When a woman is wearing her diaphragm correctly, neither she nor her partner should be aware of its presence nor have any discomfort.

The lowest observed "method" failure rate with the diaphragm plus spermicide is 2.4 per cent with typical "user" rates ranging up to 25.

7. Condoms

Condoms, also called rubbers or prophylactics, are shaped like the finger of a glove and are made of rubber. The man or woman unrolls the condom over the erect penis prior to intercourse or any contact between penis and the vaginal area. The purpose of using a condom is to prevent the ejaculated semen, containing the motile sperm, from entering the cervix (mouth of the uterus). To prevent spillage after ejaculation, the man grasps the condom at the base of the penis before withdrawing it from the vagina.

Used correctly and consistently by well motivated couples, pregnancy rates as low as 2 per 100 woman-years have been reported. Typical "user" failure rates range from 3 to 15. As mentioned previously the "user" effectiveness rate can be improved if combined with any other barrier method, such as vaginal spermicidal tablets or foam. There are no serious side effects associated with using a condom. Rarely a man or woman may be sensitive to the material from which the condom is made.

An added benefit of using condoms is their proven effectiveness in reducing the spread of sexually-transmitted diseases (STDs). It is reported that the conscientious use of condoms, especially when combined with a vaginal spermicidal agent, can reduce transmission of the AIDS virus by about 80 percent.

8. The Pill or Oral Contraceptive

Since the early 1960s oral contraceptive pills (OCs) have been marketed world wide. Currently nearly 100 million women use the Pill for child spacing. The Pill or oral method of child spacing consists of taking a pill at about the same time each day on a regular basis.

There are two simple pill-taking programs: the 21-day regimen and the 28-day regimen. With the 21-day regimen, a woman takes one pill each day for three weeks (21 days) and then for one week doesn't take any pills. This cycle is then repeated: three weeks on, one week off. With the 28-day regimen, she takes 21 active pills first, then seven placebos which contain no active drug. Using this regimen a pill is taken every day of the year. Some women prefer the 28-day regimen method because they find it easier to remember.

There are only two types of OCs, combination and progestin-only. Combination OCs contain both estrogen and progestin - the two sex hormones produced by a woman's ovaries. Because the natural hormones produced in the body are not effective when taken by mouth, each pill contains a fixed amount of synthetic versions of these two sex hormones.

Combination pills prevent pregnancy in at least three ways. First, and most importantly, the estrogen and progesterone both act to prevent the ovaries from developing and releasing an egg (ovulation). Second, the progestin changes the cervical mucus helping to prevent sperm from passing through the cervix and into the body of the uterus. Third, the two hormones alter the development of the endometrium (lining of the uterus) so that even if an egg is released and fertilized, implantation may not occur. Because progestin-only pills, also called mini-pills, lack estrogen and contain only about one third the amount of progestin as combination pills, they do not as consistently block ovulation (release of an egg) as combination pills do. In general, however, the same mechanisms work to prevent pregnancy with mini-pills as with combined pills.

As with all methods of child spacing, OCs have drawbacks. To minimize the number and seriousness of side effects, over the years the amount of estrogen and progestin in combination pills has been gradually decreased. This has been accomplished without a loss of effectiveness but with considerable decrease in side effects.

With these new, lower dose pills women are experiencing fewer and less severe side effects than in past years. Some women initially, still may experience vaginal spotting between periods, nausea, weight gain or breast tenderness. These often disappear after two to three months use. Major but very rare (all less than 1-10 per 100,000 users) side effects from the pill are blood clots, high blood pressure, gall bladder disease, heart attacks, or liver tumors. Chances of serious problems increase with age (over 35) and certain other health problems such as existing high blood pressure, 25 percent or more above ideal body weight and smoking more than 15 cigarettes per day.

The method failure rate with combination OCs is less than one pregnancy per 100 woman-years during the first year. For the progestin-only pill (mini-pill) it is somewhat higher, 1-2.5 percent. For both combination and progestin-only OCs the "user" rate is considerably higher (2-5 percent), depending on how correctly and consistently the woman takes her pills. In developing countries the user failure rate may be even higher. For example, a 1976 national survey in the Philippines reported 8 pregnancies per 100 women-years during the first year of pill use, 9.2 during the second year and 5.1 in the third. In several South Asian countries user failure rates as high as 11 to 25 percent have been observed.

Because combination OCs may interfere with the production of breast milk, it is advised that women use a non-hormone method of contraception, progestin-only mini-pills or long-acting progestins (injectables or implants).

9. Long-acting Progestin Injectables

In more than 80 countries of the world cyclic injections of long-acting progestins (one of the two female sex hormones) are used for contraception. With a single injection pregnancy can be prevented for two to three months depending on the amount and type of synthetic progestin: Depo-Provera (medroxyprogesterone acetate) or NET-ET (norethindrone enanthate). Prior to receiving injections of long-acting progestins, a woman should be carefully evaluated by a qualified health practitioner.

Because injectables contain a long-acting progestin similar to that in OCs, their contraceptive action and side effects are similar to those described above. However, because they do not contain estrogen, the risk of serious problems such as heart attack or stroke may be slightly less than for combination pills. Furthermore, unlike combination pills, injectables and implants do NOT seem to effect milk production.

With injectables some women (10-15 percent) will experience vaginal spotting between periods and up to 40 percent will cease having periods (amenorrhea). Neither of these problems are serious and if women are reassured about this, the vast majority (more than 90 percent) will continue to use this method.

10. Long-Acting Progestin Implants

A new method of delivering long-acting progestins is being evaluated in several countries. This new agent, NORPLANT^R, consists of six flexible, nonbiodegradable plastic tubes filled with levonorgestrel, a synthetic hormone of the progestin family. The implants are placed under the skin on the inside of a woman's upper arm. The hormone is slowly released at an almost constant daily rate and provides contraception for up to five years. Developed by the Population Council, NORPLANT^R has been tested in more than 44,000 women in 31 countries. It has proved to be highly effective, safe, and well-liked by its users. By 1987, a 6-capsule NORPLANT^R system had been approved for marketing in seven countries - Finland, Sweden, Indonesia, Thailand, Ecuador, the Dominican Republic, and Columbia.

NORPLANT^R implants provide almost complete protection against pregnancy. In the first five years of use of the NORPLANT^R 6-capsule system, the chances of pregnancy are less than one per 100 women per year. Precisely how NORPLANT^R prevents pregnancy is not fully understood. Like other progestin-only contraceptives, NORPLANT^R implants appear to prevent pregnancy in several ways. NORPLANT^R suppresses ovulation in at least half the menstrual cycles. Even when ovulation does occur, levonorgestrel makes cervical mucus thick and scanty, and sperm cannot easily pass through it into the uterus to fertilize ova. Levonorgestrel also suppresses the cyclic development of the endometrium in over 50 percent of users. The side effects, risks, and benefits of NORPLANT^R are similar to that observed with other long-acting progestins.

11. The IUD or Intrauterine Device

The IUD is a small, flexible device that is inserted into the uterus by a qualified health practitioner. It is made of plastic or plastic wrapped with copper wire (TCu-380A) or impregnated with a hormone progesterone. IUD's come in different sizes and shapes. All have a "tail" of plastic thread that extends through the cervix into the upper vagina. How the IUD prevents pregnancy is not completely understood. Some believe that the presence of the IUD speeds up the normal contractions of the fallopian tubes so that when the fertilized egg reaches the uterus, the endometrium is not ready to receive it and implantation does not occur.

Addition of a metal (copper) or sex hormone (progesterone) increases the effectiveness of an IUD. Again, how these metal and hormone IUDs work is not completely understood.

The IUD is inserted by a health practitioner only after a pelvic examination. It should **NOT** be inserted when the following conditions exist: pregnancy or suspicion of pregnancy, any abnormality of the uterus which distorts the uterine cavity, pelvic inflammatory disease (PID), vaginal bleeding of unknown origin, suspected malignancy including an unresolved, abnormal "Pap" smear, and vaginal or uncontrolled uterine infection. IUDs must be inserted carefully because of the possibility of perforation (breaking-through) of the wall of the uterus. Even following **CORRECT** placement of an IUD, a woman may experience lower abdominal discomfort and/or cramping for a day or two afterwards. Thereafter she should not be aware of the IUD at any time and neither she nor her partner should feel it during intercourse. Once the IUD is inserted, a woman is protected against pregnancy and need not use any other method of contraception.

The all-plastic IUD can be left in place for several years if a health practitioner feels that it is medically sound. IUDs with copper or progesterone must be replaced at regular intervals. Many women continue to use an IUD for many years. When a user wishes to change her method of contraception, or to become pregnant, the IUD must be removed by a qualified health practitioner.

Next to the pill and injectables, the IUD is generally recognized as the most effective reversible method of child spacing. The reported method failure rate for the older IUDs, such as the Lippes Loop is 1.5 percent and the user rate is higher, 3-5 percent. For the newer, more advanced copper T IUDs (TCu 380A) the method failure rate is lower, 1 percent or less. Unlike OCs and coitus-related methods such as condoms, diaphragms and spermicides, where often there is a large difference between the method failure rate and the user rate, with IUDs both are nearly the same.

Because use of IUDs is associated with a slight increased risk of pelvic infection, which can lead to infertility, IUDs are recommended only for older women in stable relationships who have completed their families.

Permanent Contraception

12. Voluntary Surgical Contraception (VSC)

For couples wishing no more children, voluntary surgical contraception (sterilization) of either the man or woman provides a very high level of effectiveness. However, sterilization should never be considered reversible, so it is important that couples be confident of their decision prior to taking this important step.

Male Sterilization

The sterilization operation for men is called vasectomy. When performed by a well-trained, experienced practitioner the procedure is simple (requiring only local anesthesia), safe and takes only about 10 minutes. The operation consists of first finding the small tube in the scrotum that carries the sperm from each testes to the penis. Next, the tube (vas deferens) is typically cut and a small section (about one half inch) removed.

This procedure serves only to prevent sperm from entering the ejaculatory fluid (semen). It does not interfere with sperm production or male hormone (testosterone) production by the testes. Following the operation most men are able to return to work the same day, experiencing only minimal discomfort in the scrotal area and perhaps a bit of swelling.

When fully recovered, about one week, men are able to reach orgasm, ejaculate (the amount of fluid remains the same) and enjoy intercourse. After surgery the testes continue to produce sperm which now are reabsorbed rather than being ejaculated. One disadvantage of the operation, however, is that a man will not be sterile (unable to cause a pregnancy) for up to six weeks. The reason for this is that some sperm will remain in the tube below where it was cut (or blocked) for up to 6-8 weeks or until the remaining sperm are ejaculated (6-10 ejaculations are required). Therefore until a semen specimen has been checked and found not to contain any sperm, condoms or another contraceptive method must be used by the couple.

The failure rate for vasectomy is about 1 per 1,000. Although vasectomy can be reversed (i.e., each vas hooked-up again) the operation (vasovasotomy) is difficult to perform, expensive (\$500 to \$2,000) and often not successful. Thus the decision to have a vasectomy always should be considered permanent.

Female Sterilization

Unlike the male, the female reproductive organs - uterus, tubes and ovaries - lie deep inside the abdomen. As a consequence the operations developed to sterilize women are more complicated, expensive and less safe than vasectomy. The two most common female sterilization operations are:

1. Minilaparotomy (mini-lap)
2. Laparoscopic tubal occlusion

With minilaparotomy, a small cut (about one inch long) is made in the lower abdomen just above the pubic bone. The cut is then extended inward and the abdominal cavity entered. Once inside the tubes are identified, isolated and then either tied and cut (Pomeroy method) or elastic bands (Falope rings) are placed around them. When performed by a qualified practitioner the procedure takes about 15-20 minutes. Local anesthesia and mild sedation are used to minimize abdominal discomfort. Usually the woman can return to her home 2-4 hours after the operation and resume most activities within 24-48 hours. Full recovery can, in some instances, take upwards to one week.

Laparoscopic tubal occlusion involves passing a small metal telescope into the woman's abdomen through a tiny cut (less than one half inch) just below the navel. Looking through the lighted telescope, called a laparoscope, the surgeon locates and isolates the tubes. The tubes are then blocked by placing an elastic band (Falope ring) or a clip around them. The tubes also can be blocked by electrocautery.

Two advantages of laparoscopy over minilaparotomy are:

1. less discomfort during the procedure, and
2. a shorter recovery interval.

Major disadvantages of laparoscopy are:

1. The equipment is very expensive (\$4,000 to \$6,000 per laparoscopy set. Whereas, minilaparotomy kits cost less than \$200).

2. The equipment and instruments are difficult to maintain in good working order and expensive to repair.
3. Considerably more skill and experience are required by the surgeon to safely perform laparoscopy than minilaparotomy.

Following a tubal ligation by either method, women will continue to produce normal amounts of sex hormones from their ovaries, have periods and enjoy intercourse just as before the operation. Furthermore, having a tubal ligation does not affect the age of menopause (change of life).

With both minilaparotomy and laparoscopic tubal occlusion failures are very low (less than 1 per 100). As with all surgical procedures there is a small risk of minor skin (wound) infections (2-5 per cent) and rarely (<0.5 per cent) a serious abdominal or pelvic infection. The lowest observed mortality rate for either procedure is about 1 per 100,000 cases but rates as high as 10-16 have been reported.

Reversal to "hook-up" the tubes can be done but the operation is very difficult, requires general (asleep) anesthesia and is very expensive (\$2,000 to \$7,000 in a developed country). The success rate is even less than for reversal of male sterilization. Thus as mentioned previously, the decision to have a sterilization operation, male or female, always should be considered permanent.

LECTURETTE:

**FACTORS TO CONSIDER WHEN EVALUATING MODERN AND TRADITIONAL
CHILD SPACING METHODS AND PERMANENT CONTRACEPTION METHODS**

**Factors to Consider When Evaluating
Modern and Traditional Child Spacing and
Permanent Contraception Methods**

In introducing child spacing services into the work place a number of issues need to be considered. Offering such services are of tremendous value to workers who otherwise might be unable to attend clinics due to work hours and family responsibilities. Having services conveniently available encourages workers to continue with methods already chosen. Staff are readily available for questions, problems, or obtaining new supplies. This encourages workers to enjoy a higher standard of health and more control over their personal lives. Less time is lost from work when attending clinics at the work place. Real benefits to both worker and employer are evident.

For the best results a number of issues need to be dealt with in setting up a program. Family planning is a very personal and private issue. Services should be provided by well trained personnel in a quiet, private area. No one should feel obligated to choose any of the methods available. Some workers may wish to simply learn about the available options, slowly think about them and then choose to participate or not.

In setting up an on-site clinic or service it is important that health professionals are available at times when workers can be free from work responsibilities to seek counseling as well as direct services. Programs that are sensitive to the need for ongoing support for its users have much higher continuation rates (users who stay with their method) and client satisfaction.

It is very important that a variety of options are offered to couples as individual situations vary. A free and easy choice encourages people to choose and then choose again if dissatisfied.

In choosing which methods to offer in your clinic a number of factors should be considered. Are other services available locally? How might you cooperate with existing services? Are your health workers competent to provide all methods? Are there methods which are not acceptable in your locale due to religious factors, rumors, or other cultural factors unique to your situation? Would including this method initially jeopardize acceptance of your new program?

Selecting the Type and Number of Oral Contraceptives to Stock

Currently there are more than 30 brands of OCs available in the USA and nearly 100 worldwide. Deciding on how many brands to supply and which ones depend on several factors:

1. Composition versus effectiveness of the various OCs is related to:
 - type of estrogen and amount in each pill
 - type of progestin and amount in each pill
2. Characteristics of the client population to be served such as:
 - age
 - general health (+ malnourished)
 - specific risk factors (smoking, high blood pressure, etc.)
 - educational level
 - socio-economic status
 - ratio of male to female employees
 - extent of company/plantation health benefits (e.g., is spouse covered? children?)
3. Logistics and supply capability of the service program
 - Number of brands of OCs the program can reliably stock and supply on a regular basis
5. Training and experience of staff
 - Can staff provide accurate instructions to clients for several different brands, types (fixed dose, multiphasic and progestin-only mini-pill), and different regimens.
6. Cost of OCs (subsidized versus non-subsidized programs)
 - Cost per unit (21 or 28 pill packet) is \$0.27 (subsidized program), but the over-the-counter price to a consumer in a developed country ranges from \$10 to \$15 per cycle (non-subsidized)

Most of these factors are covered in other sections of the module and will not be dealt with here. In the following paragraphs we will focus on the pharmacologic factors and their role in determining the types of OCs to stock.

Composition versus Effectiveness

The goal of OC use is to provide the client with a preparation having the highest degree of effectiveness (i.e., the lowest chance for failure) coupled with fewest side effects and serious problems. Both types of combination OCs (fixed and multiphasic dose) contain one of 2 synthetic estrogens and one of 10 progestins. Fortunately not all 10 progestins are available in most countries. The estrogen dose in these OCs ranges from 20 mcg to 100 mcg while the amount of progestin ranges from 0.15 to 10 mg. However, at the present time most combination OCs contain only 1 mg or less of the progestin. By contrast progestin-only OCs contain only 0.08 to 0.5 mg, a tenth to a half as much progestin as in combination OCs.

Contraceptive effectiveness of combination pills is a result of both the estrogen and progestin. Pregnancy while taking OCs may be due to method failure (lack of efficacy), user failure (forgetting to take the OC) or other factors such as the nutritional status of the client or the concurrent use of other drugs. The overall failure rate is that due to all causes. In countries where the general health (nutritional status) of women is good, most studies have shown no statistical difference in the overall failure rate between combination OCs containing 50 mcg estrogen and those containing 30-35 mcg (e.g., failure rates of from 2.0-2.5 pregnancies per 100 women who correctly and consistently use this method during the first year). For those combination OCs containing only 20 mcg estrogen the failure rate is higher, 3.0-5.0. This is thought to be due to the lack of carry-over effect of the lower dose pills (i.e., forgetting to take a pill will more likely result in a pregnancy with the 20 mcg OC than with one containing 30-50 mcg.)

In developing countries the overall failure rate even with the moderate dose (30-50 mcg) combination pills is considerably higher than in developed countries. For example, a 1976 national survey in the Philippines reported 8 pregnancies per 100 woman-years during the first year of pill use, 9.2 during the second year and 5.1 in the third. In several South Asian countries user failure rates as high as 11 to 25 percent have been observed. The two major reasons for the higher failure rates in LDCs are "irregular pill taking" and "poor nutrition." Most women in LDCs are not accustomed to taking pills on a regular (daily) schedule and do not understand that skipping a pill(s) reduces its contraceptive effect. According to WHO studies, in some areas as many as 53 percent of users do not take OCs regularly.

Poor nutritional status of the OC user also contributes to reduced effectiveness. Comparative studies in five developed countries and 11 LDCs have shown national and individual differences in absorption of the hormones in the pill and subsequent storage in the body. Less hormone is absorbed and stored by malnourished women because their levels of body fat are so low. Thus for most women in LDCs where nutrition is poor and the prevalence of chronic diarrhea high, a moderate dose OC (with at least 30 mcg estrogen should be used rather than the lowest dose OC (only 20 mcg).

ESTIMATING COUPLE-YEAR OF PROTECTION (CYP)

Statistical systems for family planning program services often produce inaccurate data on "active users" of a program, which is one of the most important measures of program output. In this section, another method of measuring family planning output is described: the CYP index, which summarizes the overall output of a program in terms of potential contraceptive protection dispensed by the program.

The CYP index provides a way to determine the total contraceptive protection offered by different methods issued by a program during a certain time period. One CYP is equal to 12 couple-months of protection, which could be attributed to any person-time combination, from one couple practicing birth control for one year to 12 couples practicing birth control for one month each. Thus, 12,000 CYPs of oral contraceptives dispensed to users is enough to meet the contraceptive needs of 12,000 couples for one year, or 24,000 couples for six months, etc. Thus, CYP indicates how much contraceptive protection time could result from the quantity of contraceptive dispensed.

Exercise: Estimating Couple-Year of Protection (CYP)

In actual practice the procedure for estimating CYP consists of three steps:

1. From the inventory control cards, the quantities for each method dispensed during the time period are obtained. In the present exercise, it is assumed that this data is available (see Sample Problem on the next page, Column 2).
2. Next, the amount of each method needed to provide one CYP is determined. This may vary from country to country, program to program, and from region to region. In practice, the program manager will compute these factors for himself or herself from local studies. For the Sample Problem, the following estimates will be used:
 - a. Without counting wastage, it takes 13 cycles of oral contraceptives to protect a couple from the risk of pregnancy for one year.
 - b. On the average, couples use 120 condoms per year.
 - c. On the average, an IUD is kept in place about 2.5 years. Therefore, the average use per year is 1 divided by 2.5 = 0.4 units (IUDs).
 - d. On the average, one tube of cream, jelly, or foam confers 3 months of protection. Thus, it takes four units to provide one CYP.
 - e. On the average, one tube of Neo-Sampon (20 tablets) confers two months of protection. Therefore, six units are needed for one CYP.
 - f. Each contraceptive injection confers 3 months of protection. Thus, four injections provide one CYP.
3. To calculate CYP for each method, simply divide the quantity of each contraceptive method dispensed by the average quantity of each method used by a couple in a year, or its conversion factor.

SAMPLE PROBLEM: Determine the CYP for each method and the factor CYP for all problems

Contraceptive Method (1)	Amount Issued (2)	Average Number Needed Per Couple Per Year (3)	CYP Achievement (4)=(2)÷(3)
Pill	290,416	13 cycles =	22,340
Condom	193,596	120 units =	1,613
IUD	540	0.4 units =	1,350
Cream, (including diaphragms)	1,116	4 tubes =	279
Neo-Sampon	2,491	6 tubes =	415
Injection	9,260	4 injections =	<u>2,315</u>
TOTAL			28,312

Source: CDC. Logistical Guidelines for Family Planning Programs. Atlanta: Center for Health Promotion and Education Division of Reproductive Health, June, 1985.

TABLE 1: Characteristics of Principal Approaches to Providing Family Planning Services.

DESCRIPTION	ADVANTAGES	DISADVANTAGES
I. COMMUNITY-BASED		
<p>Local volunteers, usually village women, are recruited to educate their neighbors. The volunteers are also responsible for distributing the family planning methods to users. In their training, the volunteers learn the basic concepts of family planning, how each method must be used, what the contraindications and adverse effects are for each method, and how to maintain simple data collections systems. A physician midwife, or family planning nurse supervises the volunteer's activities to manage any problems that may occur.</p>	<p>Users can obtain methods more cheaply. More convenient for patients, who need not travel long distances. Supplies are distributed by someone the patient knows and trusts. Postpartum mothers can be identified and visited. Follow-up is easier. User motivation is maintained at high level through continuous interaction with volunteer.</p>	<p>Initial program costs to user are high. Full maternal and child health/family planning services are not offered. No immediate access to clinical staff for management of problems. Some health professionals resist volunteers services. User may lack confidentiality. User may lack confidence in nonmedical workers.</p>
II. COMMERCIAL DISTRIBUTION		
<p>Commercial distribution was begun with the knowledge that remote areas having no access to medical care somehow seem to have other types of consumer items available in retail outlets. If other supplies can reach these very remote areas, then so can family planning supplies. Most countries limit commercial distribution of oral contraceptives to pharmacies. Barrier methods, however, are sold in nearly every place: groceries, markets, and streets by hawkers.</p>	<p>Can reach very remote areas not reached by other programs. Users need not travel long distances. Distributors are motivated by profit from sales. Availability of methods is well publicized. User does not need to wait in lines to receive methods. User has privacy. Costs to the government can be low. Usually resupply to distribution points is reliable.</p>	<p>Patients must go to clinic for management of problems. It can be costly to start a program. Full services are not offered. Promotion and advertising of contraceptives may be subject to criticisms. Public health officials do not have control over resupply system.</p>

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TABLE 1: continued

DESCRIPTION	ADVANTAGES	DISADVANTAGES
<p>III. CLINIC-BASED SERVICES Clinic-based service is a reasonable approach in areas where health workers are available and users do not live far from the clinic. With some physician supervision, trained nurses and midwives examine women, prescribe the appropriate family planning methods, and manage problems.</p>	<p>Patients are seen at each visit by health care professionals. Problems can be spotted and treated at visit. A switch in contraceptive method can be quickly done at the clinic. Start-up costs low if Maternal Child Health (MCH) services already available. More complete services are offered.</p>	<p>Patients are primarily limited to those living close by. Follow-up depends upon user's returning to clinic. The nurse or midwife may not be familiar to the patient. Patients are expected come on their own Patients may have to wait in long lines. The doctor or nurse may be a male, which would not be acceptable to women in some cultures.</p>
<p>a) MATERNAL CHILD HEALTH/FAMILY PLANNING SERVICES As a starting point, the Maternal Child Health/Family Planning program is preferred by many African governments because mothers can obtain several related services at one site, thus providing continuity of care, and because family planning can be provided for child spacing as part of maternal and child care, and not as a measure to "control fertility."</p>	<p>Can attract large numbers of mothers coming for other services. Users can receive pediatric, obstetric, and gynecologic care in one setting, along with family planning services. In theory, it offers an easier transition from postpartum to family planning, and the reverse. Patients uncomfortable with the social stigma of birth control are not so easily identified as users of family planning. Family planning can be established as an important element in the health of women and children.</p>	<p>Family planning users seen only after child maternal health program are attended to. Workers may be overworked and understaffed. Administrative functions are more complicated especially if the record-keeping and reporting service statistics for family planning are not integrated with the support systems and the MCH program. Workers not always specifically trained in family planning may be able to accommodate the integration of family planning services.</p>

TABLE 1: continued

DESCRIPTION	ADVANTAGES	DISADVANTAGES
<p>b) FAMILY PLANNING ONLY Clinics offering only family planning services are often established in urban areas or large towns to meet an existing demand for contraceptives.</p>	<p>The family planning workers are more motivated to deliver family planning. More time can be spent counseling and educating each user. Generally, a better worker-to-user ratio exists for family planning. Workers who have received special training in family planning may be more effective. Unmarried women without children are more comfortable in this type of facility.</p>	<p>Users must be motivated to come on their own for family planning services. A smooth transition does not exist from the partum period to the time a woman needs family planning services or to the time when she needs antenatal care. Women must visit other facilities to receive other health service. Clinics lack the additional incentive of offering services that attract many mothers.</p>

Source: CDC. Family Planning Methods and Practice: Africa. 1983, pp. 283-284.

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TABLE 2: FIRST YEAR FAILURE RATES OF CHILD SPACING
 AND PERMANENT CONTRACEPTIVE METHODS

Method	Lowest Observed Failure Rate (%)	Failure Rate in Typical Users** (%)
Tubal sterilization, females	0.2	0.2-1
Vasectomy, male	0.15	0.5-1
Injectable progestin	0.25	1
Combined birth control pills	0.5	1-8
Progestin-only pills	1	3-10
IUD (TCu 380A)	1-3	1-5
Condom	1-2	3-15
Diaphragm (with spermicide)	2	4-25
Sponge (with spermicide)	11	15-30
Foams, creams, jellies, and vaginal suppositories	3-5	10-30
Coitus interruptus	16	23
Fertility awareness techniques (basal body temperature, mucous method, calendar, and "rhythm")	1-50	10-30
Chance (no method of birth control)	35-90	90-125

*Designed to complete the sentence: "In 100 users who start out the year using a given method and who use it correctly and consistently, the lowest observed failure rate has been _____."

**Designed to complete the sentence: "In 100 typical users who start out the year using a given method, the number of pregnancies by the end of the year will be _____."

Source: Contraceptive Technology, 1986-1987, 13th Revised Edition, p. 102.

TABLE 3: MORTALITY ASSOCIATED WITH CONTRACEPTIVE USE
 IN DEVELOPED AND DEVELOPING COUNTRIES

Method and User Status	No. of Pregnancies (per 100,000 fertile women at risk ¹)	No. of Maternal Deaths	No. of Method-Related Deaths
DEVELOPED COUNTRIES			
No Method			
Under 35	60,000	12	0
35 and over	40,000	22	0
Oral Contraceptives			
Non-smoker under 35	3,000	0.6	1
Smoker under 35	3,000	0.6	10
Non-smoker 35 & over	2,000	1.1	15
Smoker 35 & over	2,000	1.1	48
IUDs			
Under 35	5,000	1	1
35 and over	3,000	1.8	2
Condoms, diaphragm, etc.			
Under 35	14,000	2.8	0
35 and over	7,000	5.6	0
DEVELOPING COUNTRIES			
No Method			
Under 35	60,000	60	0
35 and over	40,000	160	0
Oral Contraceptives			
Non-smoker under 35	12,000	12	1
Smoker under 35	12,000	12	1
Non-smoker 35 and over	6,000	24	15
Smoker 35 and over	6,000	24	48
IUDs			
Under 35	8,000	8	2
35 and over	3,000	12	4
Condoms, diaphragm, etc.			
Under 35	20,000	20	0
35 and over	10,000	40	0

¹ Women sterilized or breast feeding and without menses not included.

Source: Tietze and Lewit, International Journal of Gynecology and Obstetrics. 16:456, 1979.

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TABLE 4: AID-SUPPLIED CONTRACEPTIVE COMMODITIES

<u>COMMODITY</u>	<u>CASE</u>	<u>COST/UNIT</u>
<u>CONTRACEPTIVE FOAM</u>		
EMKO	3 dozen	\$17.04/dozen
<u>ORAL CONTRACEPTIVES</u>		
LO-FEMENAL 0.3 mg Norgestrel 0.03 mg Ethinyl estradiol 75 mg Ferrous fumarate (BLUE LADY PACKAGING)	1200 monthly cycles	\$.13/cycle
OVRETTE (PROGESTIN-ONLY MINI-PILL) .075 mg Norgestrel (PINK LADY PACKAGING)	1200 cycles 28 tablets each	\$.13/cycle
NORIDAY 1+50 FE 1.0 mg Norethindrone 0.05 mg Mestranol 75 mg Ferrous fumarate (SOCIAL MARKETING PACKAGING ONLY)	1200 monthly cycles	\$.27/cycle
NORMINEST FE 0.5 Norethindrone 0.035 mg Ethinyl estradiol 75 mg Ferrous fumarate (SOCIAL MARKETING PACKAGING ONLY)	1200 monthly	\$.27/cycle
NORQUEST 1.0 mg Norethindrone 0.035 mg Ethinyl estradiol 75 mg Ferrous fumarate (SOCIAL MARKETING PACKAGING ONLY)	1200 monthly cycles	\$.27/cycle
<u>IUD</u>		
MODEL TCu 380A	200 units	\$.05/unit

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TABLE 4: page 2

<u>COMMODITY</u>	<u>CASE</u>	<u>COST/UNIT</u>
<u>VAGINAL FOAMING TABLETS</u>		
CONCEPTROL	4800 units	\$.095/unit
<u>CONDOMS</u>		
	6000 pieces	\$ 4.24/100 pieces
49mm Colored (Sultan)		
49mm RAJA (red only)		
52mm Colored Tahiti		
52mm Colored (Sultan)		
52mm Non-Colored (Sultan)		
52mm Colored Panther		
52mm Non-Colored Panther		
52mm Colored, no trade logo (Made in U.S.A.)		
52mm Non-Colored, no trade logo (Made in U.S.A.)		
52mm Colored Blue & Gold Coin		
52mm Non-Colored Majestic ULTRA THIN		

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LECTURETTE:

**INFORMATION, EDUCATION AND COMMUNICATION STRATEGIES
TO PROMOTE FAMILY PLANNING ACCEPTANCE**

INFORMATION, EDUCATION AND COMMUNICATION STRATEGIES TO PROMOTE FAMILY PLANNING ACCEPTANCE

The philosophy behind Information, Communication and Education (IE&C) efforts in support of family planning services is a simple one. People do not necessarily accept information or services because they are there. IE&C activities are designed to maximize usage of safe and efficient supplies and contraceptive services offered through good delivery systems. IE&C efforts should foster a demand for what family planning services hope to supply - and ensure that the supply matches the demand for services.

Communication can be defined as the process of sharing information, ideas and attitudes. The term sharing is important, particularly in the field of family planning IE&C efforts. Sharing implies that at least two people are involved in the communication and that successful communication depends on both the sender and the receiver of the communication. Feedback is a crucial component of the communication process. It helps the sender determine whether the communication was successful or not.

There are two major ways of communicating information on family planning to an audience: mass communication and face-to-face communication. A factory-based family planning program can make use of both. By linking factory efforts to a national program, factory-based IE&C activities can be used to reinforce the national or large scale message. But, face-to-face communication will be the major avenue open to factory programs.

Planning IE&C Efforts

As the name IE&C implies, the intent in family planning messages and materials is both educational and promotional. There is an information function, an educational function and a communications element. Clients should be provided with information on a range of contraceptive options, be educated in the use of contraceptive measures, and be given the power of decision making on the kinds of contraceptive methods they choose. Services should be reflective of people's contraceptive needs.

As a part of a factory-based family planning program, IE&C activities should have at least four objectives if they are to help increase the effectiveness of contraceptive services and distribution systems. These include:

- increasing employees' knowledge about family planning;
- persuading employees and their spouses of the personal and societal benefits of family planning;
- motivating employees to make informed choices about family planning and how to use family planning methods correctly; and
- changing employees' attitudes about family planning and helping them convince others of the importance of using family planning methods.

IE&C activities should be well planned, communicate clear messages and be tailored to a specific audience. The following sections provide basic information about how to go about planning IE&C efforts, selection of IE&C motivators for factory-based programs, and the use of focus groups to guide the development of IE&C materials and activities.

In almost all family planning programs, a major goal is to bring about or promote changes in behaviors. Although there is considerable overlap between IE&C strategies, there are at least six different strategies which have emerged over the past 25 years.

- use of traditional medical and communication channels including traditional midwives, folk media, and traditional medical networks;
- social marketing/demand creation - or the application of marketing theory and techniques to family planning innovations;
- population education to inform youth about family planning issues;
- use of mass media including radio, television, newspapers and other print media;
- integration of family planning and population planning with other development issues; and

- use of incentives and disincentives
including adopter and diffuser incentives,
individual and group incentives, monetary
and non-monetary incentives among others.

For our purposes here, we want to examine what is involved in the process of planning IE&C messages and materials.

The Population Communications Service (PCS) of the Population Information Program at Johns Hopkins University has developed a comprehensive planning guide for population communication activities. While developed with national level communications programs in mind, the elements of the process are appropriate for small scale IE&C efforts of factory-based programs as well.

The basic elements of the IE&C planning process are:

1. Analysis

- review potential audience
- assess existing IE&C programs, or if there are no examples, look at IE&C efforts elsewhere to see what has been done in similar situations
- identify potential collaborating institutions
- evaluate communication resources

2. Design

- decide on objectives for IE&C efforts
- identify audiences
- develop messages
- select media
- plan for interpersonal reinforcement
- draw up action plan

3. Development, Pretesting and Revision

- develop family planning messages
- pretest with audience
- complete messages/materials
- pretest with audience
- revise

4. Implementation

- implement action plan
- monitor outputs
- measure impact

5. Review and Replanning
 - analyze overall impact
 - replan future activities

6. Continuity over Time
 - plan for continuity
 - adjust to changing audience need

The guide stresses a number of basic principles of communication:

1. enlist support and participation of local leaders, policy makers.
2. consult with a variety of people representing a range of disciplines (physicians, educators, health personnel, etc.).
3. coordinate with those delivering family planning services to reinforce service availability and share resources and ideas.
4. separate audiences and be in regular contact with each group.
5. develop messages that are compatible with your audience's religious beliefs about family planning, which emphasize personal benefits derived from family planning, and that attract and hold the acceptor's attention.
6. pretest family planning messages and support materials with the audiences for which they are designed and be prepared to make changes.
7. use multiple interpersonal channels to reinforce family planning messages and strategies.
8. inform and involve family planning service providers in the active use of IE&C materials.
9. provide training in the use of family planning messages and materials.
10. monitor outputs and make corrections as necessary paying close attention to audience impact.
11. continue use of materials in conjunction with total service delivery.

In planning IE&C activities to support a factory-based family planning program, a decision will have to be made as to which communications methods are to be used. This choice should be made on the basis of the nature of the family planning message to be communicated, local conditions and conditions within the enterprise, available resources and audience characteristics. Three methods of IE&C communication which should be considered are: individual approaches, group approaches and mass media approaches.

Individual approaches can consist of direct contact between a family planning motivator or a service provider and an employee during workhours or afterhours. The individual approach is very effective in enlisting cooperation and participation of specific members of the target audience in becoming family planning acceptors. An individualized approach to IE&C offers confidentiality to all users of family planning services. Simple IE&C materials can be used in this kind of face-to-face contact.

In a group approach, one family planning motivator can reach a larger number of people with the family planning message, use a group demonstration to explain how to use a particular family planning method, and answer questions related to contraceptive methods.

Mass media methods that are particularly useful in factory settings are posters, printed materials and folk media such as songs and drama. Larger scale communications activities can help employees learn about family planning in a non-threatening and entertaining way. Using the mass media to increase social support and legitimization for family planning is also important, especially when it comes to endorsements from satisfied users, respected officials and enterprise management.

No matter which IE&C methods or activities are used, their success, and the success of the family planning services being offered, are highly dependent on the use of a participatory approach in developing and disseminating family planning communication. In planning an IE&C component to a factory program, one should remember that:

- employees are the most important resource in the development of the program. Their support and active participation will determine how successful the family planning program is.

- employees should be involved in making decisions about programs which are designed to affect their lives. They should be viewed as partners rather than targets in IE&C activities.
- employees should be actively involved in the creation of IE&C materials and in carrying out IE&C activities. Motivation created by one's peers is often many times stronger than that created by one's superiors.
- local IE&C resources may already exist in the immediate environment. Those in charge of factory-based services should find out what has already been produced, how effective it is in communicating the family planning message, and inquire about using the material in their program.

Selecting and Training Worker Motivators

In addition to developing IE&C strategies and materials, attention must also be given to the selection and training of staff who will do family planning promotion work on-site with employees and with their families. The following material adapted from Population Welfare Education for Workers: A Resource Book for Trainers (ILO, Bangkok, 1980) provides guidelines on the selection and training of volunteer worker motivators and a checklist on the qualities of a communicator.

Volunteer Worker Motivators

Volunteer worker motivators are often essential parts of company-based family planning services and IE&C efforts. Motivators, who are rank-and-file workers themselves, can provide the close person-to-person contact with their co-workers that is needed to persuade many workers of the need for a small family and then to adopt a method of family planning. Because they belong to the specific community, the voluntary worker motivators are part of its internal communication system. These co-worker motivators can spread family planning messages informally and personally among their colleagues during working time, during breaks, on the journey home, or in the living quarters of workers.

The task of a volunteer worker motivator is a specialized one, requiring special personal communication talents. It may involve visiting fellow employees' homes, putting them at their ease, steering the conversation to matters of family welfare and encouraging a change in behavior which may be different from traditional beliefs and practices in an area which is usually considered highly personal.

One quality which will affect the success of a volunteer motivator is his or her enthusiasm. A high level of motivation and social consciousness on their part is of the greatest importance. Volunteer worker motivators should generally be sought from among those who are popular and able to get along with their fellow workers. Another important characteristic is that they should be the same in age, sex, and education as those they set out to motivate. They should be able to relate to others as equals, not superiors, and be able to sympathize with the problems of their fellow workers.

Experience has shown that in order to make a volunteer worker motivator program a success, some sort of incentive system could be helpful. Obviously, no volunteer can be expected to implement a program at his own personal financial cost. It may, therefore, be necessary to make out-of-pocket allowances available. In some cases, additional financial incentives have been offered to motivators, elsewhere meritorious and badge awards have been a sufficient incentive. In other programs, study tour and travel incentives have been offered. In short, enthusiasm and a high level of motivation when reinforced with some system of incentives can produce highly satisfactory results. Without an incentive scheme enthusiasm is likely to wane over time.

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Qualities of a Communicator

For a communicator to be effective, he should be a recognized and acceptable member of the community being served by the factory-based program. He must have a personality which enables him or her to identify not only with fellow workers but also with individual members as equals.

Communication is meaningless unless the communicator establishes a two-way process. It is vitally important that the communicator regards himself as a member of the group. Rather than teach, he will exchange ideas; rather than lecture he will discuss; rather than preach he will debate. It is important that the communicator is not only master of his message but also capable of positively countering arguments presented by his opponents. In fact, it is more than likely that he will gain more converts by successfully countering the arguments of others than by presenting his own prepared message. This applies equally to his ability to participate in two-way discussion sessions as well as in individual face-to-face conversations with his fellow workers.

Knowledge cannot and should not be forcibly crammed into any group since it is only an exchange of ideas and views that can bring conviction.

The main task of the communicator is helping every worker to be conscious of his creative potential and understand that he can improve his environment and himself. Each man and woman has creative ability and knowledge and experience of value needed for development of self and the society at large.

There are three stages in the development of a good communicator in the context of IE&C promotional activities. In the first stage the motivator frees himself from preconceived views and prejudices. The second stage involves being sensitive to the group and listening to other views and ideas. In the third stage, the motivator begins to perform assigned duties as a change agent having distilled the thoughts of others.

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Adapted from:

ILO. Population Welfare Education
for Workers: A Resource Book for
Trainers. Bangkok: ILO, 1980,
p. 56.

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**INFORMATION, EDUCATION & COMMUNICATION
STRATEGIES TO PROMOTE FAMILY PLANNING ACCEPTANCE
(SUMMARY NOTES)**

- IE&C activities are designed to maximize contraceptive usage.
- The intent of IE&C activities is both educational and promotional.
- Planning for IE&C activities can be as sophisticated or simple as you want it to be but should include:
 - a review of the target audience's knowledge, attitudes and practices;
 - an assessment of existing IE&C resources;
 - the involvement and support of local leaders, factory management, and/or union leaders;
 - a design stage where objectives are specified, messages are developed and an action plan is drawn up;
 - pretesting and revision of messages and materials on the basis of audience response;
 - close monitoring of outcomes and impact which messages/materials have on your audience; and
 - a review process to periodically assess effectiveness/impact of messages.

CASE STUDIES:

Case 1:

Developing Generic IE&C Materials

Case 2:

Popular Music and Social Responsibility

Case 3:

Attracting Long-Term Users for Temporary Contraceptive Measures

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DEVELOPING GENERIC MATERIALS

Many of the educational materials (posters, pamphlets) that promote family planning are designed to be used in several countries by members of different cultural groups. While this strategy can reduce the cost of materials development, it may also reduce the materials' effectiveness; messages designed within the context of one culture may not be understood within the context of another culture. In an ongoing project, technical personnel and private sector managers and clinical staff discovered that the educational materials available in Kenya were inadequate and, in some cases, inappropriate for the targeted population that was being targeted for services. The problem seemed particularly acute in rural areas, where abstract drawings and generalized messages ("A small family is a happy family") developed for urban populations were often not understood by large segments of the rural population.

In order to address this concern, funding to develop new materials was obtained from a private voluntary organization. The first step in the process was to develop culturally appropriate messages. This was accomplished by organizing a seminar for representatives from organizations which provide family planning services in Kenya. The second step was to select artists to create the artwork which would serve as the basis for the family planning posters. Kenyan and Kenya-based artists were invited to submit samples of their work. Based on these samples, fifteen local artists were invited to attend a day long seminar. They were briefed on the population situation in Kenya and given information on Kenya's population policies and programs. They were also informed about the relationship between family planning and other development issues. They reviewed the characteristics of the people targeted to view the artwork as well as family planning educational materials that were currently available. The artists also reviewed and in some cases modified the family planning and development messages that were developed in the first seminar.

Near the end of the seminar the artists were given materials and asked to prepare draft ideas and sketches. These were discussed and alternatives suggested. Two weeks later a second workshop was held. In the interim period the artists had prepared over 60 posters and paintings which were displayed, discussed and modified. These posters and paintings were then brought to eight different private sector family planning sites for pretesting. The pretesting process was designed to provide answers to the following questions:

1. Clarity of the poster content: how well does the target audience understand the theme and the message?

2. Relevance of the theme and message: does the poster deal with an issue related to the individual's and the local community's need, problems, and interests?
3. Acceptability in the cultural setting: did any aspect of the poster depict issues or have words which were likely to be offensive, unacceptable, or untrue?
4. Attractiveness: Did the respondents like or dislike the poster; did they think that any changes were needed?

Based on the pretesting results, several of the works of art have been turned into family planning educational/promotional posters which have been distributed to both private and public sector family planning clinics throughout Kenya.

DISCUSSION QUESTIONS:

1. What family planning messages would be acceptable in the area where your enterprise is located? What types of messages would be unacceptable?
2. Are you aware of local resources that could be drawn upon to help you promote family planning activities in your enterprise?
3. What art forms are prevalent in your area: painting? drama? music?
4. Are you aware of promotional materials that have been developed by the public sector family planning agencies in your area? Are these appropriate for your company's use and do you know how to go about getting them?

POPULAR MUSIC AND SOCIAL RESPONSIBILITY*

As in other parts of the world, most Latin American countries are experiencing high and continually increasing rates of adolescent pregnancy. These rates are disturbing for a number of reasons: infants born to adolescent mothers are more likely to have health and developmental problems; childbearing is more dangerous for adolescents than for women in their twenties; early childbearing severely limits an adolescent's options for education; adolescents are less likely to have the financial resources to care for a child; and, many of the births take place without the support of a stable relationship.

There are many explanations for the high rate of adolescent childbearing. One theory is that the media (radio, television, magazines, newspapers, advertisements) promote early sexual activity in both subtle and nonsubtle ways but do not provide corresponding messages of sexual responsibility. This concern is being addressed by an innovative activity undertaken by Population Communications Services (PCS) and a Mexican marketing company named Fuentes y Fomento Intercontinentales (FFI). PCS and FFI have developed and packaged a multi-media pop music campaign around the concept of "responsible loving" which is receiving significant attention in 11 Latin American countries.

The package includes a 45-rpm record of two pop tunes which encourage young people to be sexually responsible, a music video for each song, two television commercials for each song, two radio commercials for each song, a large poster, and a press kit that includes photographs, color slides, lyric sheets, and a news release. The package has been provided to radio stations, television stations, newspapers, and magazines throughout the region. The launching of the project was accompanied by press conferences, visits to radio and television stations by the musicians, record giveaways, and monthly press bulletins. An indication of the project's success is that the songs are receiving a great deal of airtime because they are popular with the youth who listen to the radio stations.

*Source: "The Power of Popular Music," People 13 (2), 11-12, 1986.

A key to the success of the project was enlisting the participation of two singers who were popular, available, and interested in the project. After a lengthy search process, two singers were identified who were very popular with young people throughout the region and had the right type of image to promote a social responsibility message. After the artists were selected, words and music were composed and the songs, videos, television commercials, and marketing support materials were produced.

Although a large, complex undertaking, the project is cost-effective because it provides a product that is attractive to its intended market (adolescents) and therefore receives "free" attention and airtime that a less attractively packaged message would not receive. Program implementers point to the following lessons that can be learned from this project: choose the most appropriate medium to reach your target audience; utilize the best available human and material resources so that you have a high quality product; a high quality product will attract the attention and support of the commercial sector which will defray the cost and provide for wider distribution of social responsibility messages; use a medium that has as large an audience as possible to spread the cost over as large a group as possible.

DISCUSSION QUESTIONS:

1. What is the major function of the project described in this case study?
2. How can the lessons that were learned from this large scale project be adapted to an IE&C strategy for your firm?
3. What resources for motivational materials exist in your area? How would you go about identifying and using them?

**ATTRACTING LONG-TERM USERS FOR
TEMPORARY CONTRACEPTIVE MEASURES***

The Nepal CRS Company Pvt. Ltd. distributes several types of condoms, contraceptive foam, foaming tablets, and oral contraceptive pills using a system of retail stores. Since the company's formation in 1978 it has effectively established and supported a network that includes more than 80 percent of the retail stores in the country. The distribution system has been particularly effective; stores are continually stocked. The Nepal CRS Company has also developed communication and advertising campaigns to stimulate awareness of CRS products.

Despite its distribution successes, the CRS Company is not particularly successful at attracting long-term users of temporary methods; high dropout rates for most methods are particularly disturbing. Company management realized that the program could not continue to operate effectively without information about consumer attitudes towards its product line, product features, marketing strategies, and advertising strategies. Various alternatives were suggested for obtaining this information, including surveys of current users, surveys of potential users, one-on-one interviews with current and/or potential users, and interviews with retail shopkeepers.

A marketing consultant hired by the firm recommended that a series of focus groups be conducted. A focus group is a qualitative market research technique which is one of the most powerful methods of gathering useful and timely information on consumer attitudes. It is essentially a group interview composed of 6-8 individuals who are from a targeted consumer segment such as young mothers, community men, or leaders of the medical community. General discussion questions dealing with the topic of concern are prepared ahead of time and the group is led by an experienced moderator who helps to keep the group "focused" on the topic while probing with topic-oriented questions. A skilled group leader can draw out a wealth of information from the group. Typically, a focus group meets for one to two hours in a convenient, comfortable place. Proceedings are recorded through two methods: handwritten notes of an observer and audio-tape recording.

*NOTE TO TRAINER: Although this case is not of a factory-based family planning program, the research methods used by this distribution company could be appropriate for shaping IE&C activities in factory programs.

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Under the direction of the consultant, several individuals were trained to conduct the focus groups. Due to the sensitive nature of the topic of discussion, female group leaders were trained to conduct focus groups with females and males were trained to conduct focus groups with males. The following results were noted from the first series of focus groups, which were held with several different groups of community men:

1. All participants were hesitant to discuss the topic.
2. In general, participants equated family planning with sterilization and about half of the group participants were unaware of temporary contraceptive methods.
3. Most participants knew about the family planning concept and restriction of family size.
4. Several participants said that the correct time to worry about family planning was after the family had all of the children they wanted. Then sterilization (male or female) was considered appropriate. There was a general lack of concern about family planning for younger couples.
5. About half of the participants had heard of the CRS Company's main brand of condoms, but only a few reported ever using them.
6. None of the participants stated regular use of temporary contraceptive methods.

DISCUSSION QUESTIONS:

1. How could your company use focus groups to promote contraceptive use?
2. How could the information obtained during the first series of interviews be used to make programmatic/management decisions about IE&C programs?
3. If a different research methodology were used (such as a survey), would a different type of information been obtained?

DEVELOPING GENERIC MATERIALS

Many of the educational materials (posters, pamphlets) that promote family planning are designed to be used in several countries by members of different cultural groups. While this strategy can reduce the cost of materials development, it may also reduce the materials' effectiveness; messages designed within the context of one culture may not be understood within the context of another culture. During the initial stage of development of the Kenya Family Planning Private Sector Programme (FPPS), both JSI technical personnel and private sector managers and clinical staff discovered that the educational materials available in Kenya were inadequate and, in some cases, inappropriate for the targeted population that was being targeted for services. The problem seemed particularly acute in rural areas, where abstract drawings and generalized messages ("A small family is a happy family") developed for urban populations were often not understood by large segments of the rural population.

In order to address this concern, funding to develop new materials was obtained from a private voluntary organization. The first step in the process was to develop culturally appropriate messages. This was accomplished by organizing a seminar for representatives from organizations which provide family planning services in Kenya. The second step was to select artists to create the artwork which would serve as the basis for the family planning posters. Kenyan and Kenya-based artists were invited to submit samples of their work. Based on these samples, fifteen local artists were invited to attend a day long seminar. They were briefed on the population situation in Kenya and given information on Kenya's population policies and programs. They were also informed about the relationship between family planning and other development issues. They reviewed the characteristics of the people targeted to view the artwork as well as family planning educational materials that were currently available. The artists also reviewed and in some cases modified the family planning and development messages that were developed in the first seminar.

Near the end of the seminar the artists were given materials and asked to prepare draft ideas and sketches. These were discussed and alternatives suggested. Two weeks later a second workshop was held. In the interim period the artists had prepared over 60 posters and paintings which were displayed, discussed and modified. These posters and paintings were then brought to eight different private sector family planning sites for pretesting. The pretesting process was designed to provide answers to the following questions:

1. Clarity of the poster content: how well does the target audience understand the theme and the message?
2. Relevance of the theme and message: does the poster deal with an issue related to the individual's and the local community's need, problems, and interests?
3. Acceptability in the cultural setting: did any aspect of the poster depict issues or have words which were likely to be offensive, unacceptable, or untrue?
4. Attractiveness: Did the respondents like or dislike the poster; did they think that any changes were needed?

Based on the pretesting results, several of the works of art have been turned into family planning educational/promotional posters which have been distributed to both private and public sector family planning clinics throughout Kenya.

DISCUSSION QUESTIONS:

1. What family planning messages would be acceptable in the area where your enterprise is located? What types of messages would be unacceptable?
2. Are you aware of local resources that could be drawn upon to help you promote family planning activities in your enterprise?
3. What art forms are prevalent in your area: painting? drama? music?
4. Are you aware of promotional materials that have been developed by the public sector family planning agencies in your area? Are these appropriate for your company's use and do you know how to go about getting them?

POPULAR MUSIC AND SOCIAL RESPONSIBILITY*

As in other parts of the world, most Latin American countries are experiencing high and continually increasing rates of adolescent pregnancy. These rates are disturbing for a number of reasons: infants born to adolescent mothers are more likely to have health and developmental problems; childbearing is more dangerous for adolescents than for women in their twenties; early childbearing severely limits an adolescent's options for education; adolescents are less likely to have the financial resources to care for a child; and, many of the births take place without the support of a stable relationship.

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1. How could your company use focus groups to promote contraceptive use?
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EVALUATION

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EVALUATION EXERCISE: SECTION V

Each participant is asked to think about the IE&C materials displayed throughout the workshop and decide which kind of material might be most appropriate for his or her enterprise. The participant is asked to write down the objectives that the material will be used to achieve, how and who will use the materials and when it will be used. Participants are asked to report on what they have written. The trainer then leads a discussion on where additional materials might be located and the cost implications of each enterprise producing its own materials.

The effectiveness of this section can be judged by whether or not:

- each participant can state a reasonable objective for the material chosen;
- an appropriate communicator (person) to use it; and
- an appropriate time and way in which to use it.

Time: 20 minutes

REFERENCES

How to Use the Reference Materials for the Section

A number of documents are listed here that may be helpful to trainers as they prepare for workshops and to participants as additional reference material on the topics presented in this section of the manual. While all the articles are useful, the following provide important additional background information about contraceptive technology and the promotion of family planning services through Information, Education and Communication (IE&C) activities.

Contraceptive Technology

Centers for Disease Control. Family Planning Methods and Practice: Africa. ("Section II: What You Need to Know to Use Contraceptives Effectively," and "Section III: Contraceptive Technology"). Atlanta, GA: Centers for Disease Control, 1983.

Section II of this book presents a simple and brief overview of the physiology of menstruation, pregnancy and the general decision criteria for choosing a contraceptive. Common questions are posed and answered and the chapter on contraceptive choice is logical and simple.

Section III of this book presents each of the common methods of contraception and provides a quick review of the various methods. The benefits and side effects for each are presented, usually in a summary fashion.

Hatcher, et al. Contraceptive Technology 1986-1987. 13th Edition. New York: Irvington Publishers, 1986.

This book has served as a standard reference on family planning methods in the United States for many years. It contains chapters on most elements of a family planning program and in-depth information on each method of contraception. This book provides an expert level of background about the methods of contraception in that much greater detail is presented than in the book reviewed above with more technical language being used.

Population Information Program. "Oral Contraceptives in the 1980s." Population Reports, Number 6, Series A, 1982. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This issue discusses oral contraceptives and contains sections on rates of usage in different countries, the physiology of the pharmaceuticals used, their side effects, and other risks and benefits.

. "Update on Condoms -- Products, Protection, Promotion." Population Reports, Number 6, Series A, 1982. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This issue discusses one of the easiest, safest and most effective methods of contraception that has the added benefit of preventing the transmittal of several diseases. There are sections on effectiveness, disease protection, simple instructions for use, distribution, market research and promotion, manufacture and quality control.

. "After Contraception: Dispelling Rumors About Later Childbearing." Population Reports, Number 28, Series J, 1984. Baltimore, Maryland: Population Information Program, Johns Hopkins University.

This issue looks at the effects of modern contraceptive methods on later childbearing. Oral contraceptives, injectables, condoms, spermicides and IUDs are all temporary methods about which myths have developed. This issue examines the research on contraceptive method and fertility and presents suggestions on how to avoid complications that might cause infertility. A general discussion of the causes of infertility is presented with a section on how to control rumors.

Porter, C.W., Waife, R. S. and H. R. Holtrop. The Health Providers' Guide to Contraception (International Edition). Chestnut Hill, Massachusetts: The Pathfinder Fund, 1983.

This book is a comprehensive presentation of all aspects of non-surgical contraception -- counseling and education, methods of contraception, and related health problems. The book has provided the basis for clinical guidelines for hundreds of projects around the world. The usefulness of the book is enhanced by drawings, charts and graphs which help explain technical content.

Information, Education and Communication

Centers for Disease Control. Family Planning Methods and Practice: Africa. (Section IV: Providing Family Planning Services) Atlanta, GA: Centers for Disease Control, 1983.

This section of the book has four chapters that focus on the day to day issues, both human and logistical, of providing family planning services. Of interest for trainers and participants are the chapters on managing the interaction between clients and staff, integrating family planning with other health services and keeping family planning voluntary. Each chapter is short and simply written, and provides a quick overview of these subjects.

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Elkamel, F. Developing Communication Strategies and Programs: A Systematic Approach. Cairo, Egypt: The Center for Development Communication, 1986.

This manual is a guide to the planning and implementation of communications and social marketing programs. It offers a logical step-by-step approach with check lists and other useful tools presented in each chapter or in appendices. These tools can be useful to trainers as examples or to participants as models to adapt to their own situation. The manual is clear and concise and easy to follow.

Favin, M. Health Education. Geneva, Switzerland: World Federation of Public Health Associations, 1986.

This issue paper provides a review of health education. Chapters focus on approaches, communication channels, educational materials, planning and organizing and changing behavior. The appendices contain an annotated bibliography with a list of journals, project summaries, and a list of organizations that are resources in health education. Throughout the special inserts cover specific health education methods and materials.

Gillespie, R. A Manual on Evaluation of Population Communication Programmes. Paris: Unesco, 1981.

This manual provides simple guidelines for evaluating population communication programs. It has chapters on pre-testing materials and evaluating mass-media campaigns, field worker's activities, and other aspects of communications programs. There are also chapters on setting priorities and on planning evaluation. The appendices have examples of questionnaires, and recordkeeping forms which may be of use to workshop participants.

Green, Cynthia. "Making Messages Matter," in People: IPPF Review of Population and Development, Volume 13, Number 2, 1986, pp. 5-8.

This article provides guidelines on how to make a family planning communications program effective. Each important decision point in the process is spelled out and advice learned from experience is provided. This article can serve as the basis for a presentation in training, a hand out to trainees or a model to follow in designing communications activities.

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Maine, D. and R. MacNamara. Birth Spacing and Child Survival. New York: Center for Population and Family Health, Columbia University, 1985.

This is a teaching aid that provides information on the relationship between birth spacing and child health. It is useful as a model of IE&C materials that can be produced for use by individuals or in small groups. It could be used in a training session or could serve as an example of IE&C materials.

ILO. Population and Family Welfare Education for Workers: A Resource Book for Trainers. Bangkok: ILO, 1980. (64pp.)

This booklet contains a comprehensive presentation of material for workers about family planning. It can serve as an example for training, as written materials for use with workers, and could be adapted to a number of specific settings. It can also serve as a curriculum and short reading for a workers education project.

Trade Union Leader's Compendium on Family Welfare In Organized Industry. Bangkok: ILO.

This booklet was prepared to provide labor management with comprehensive background coordination on the role of unions and other labor organizations in industry-based family welfare activities. Family planning is only one part of this program, but the general areas discussed are important to family planning. This booklet can be used as part of a curriculum for a training of labor leaders or with industrial managers to make them aware of their role in family planning.

Population Communication Services. Basic Processes and Principles for Population/Family Planning Communications. Baltimore, Maryland: PSC, Population Information Program, The Johns Hopkins University, n.d.

This brochure summarizes the basic processes and principles required to communicating clear IE&C messages to a well-defined audience. Six steps are outlined: analysis; design; development, pre-testing, and revision; implementation, monitoring, and assessment; review and replanning; and continuity over time.

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Section VI: Planning, Implementing, Managing and Evaluating Company-Based Family Planning Services

This section first identifies the decision points that factory management must consider in planning for company-based family planning services. Then, the steps involved in setting up, managing and evaluating such services are reviewed.

TRAINER'S NOTES**Objectives for this Section:**

After completing the activities in this section of the module, workshop participants will be able to:

1. implement a methodology to determine the needs/wants for family planning services among their employee population.
2. identify members of their community and/or factory who are important "players" in setting up family planning services and determine if a committee should be formed to help with the design and implementation of the family planning services.
3. determine the most appropriate model for providing family planning services based on the needs/wants of the client population, the availability of other health care and family planning services in the area, and the resources available to the company.
4. select an appropriate service mix based on the needs/wants of the target population, the availability of other services in the area, the availability of trained family planning personnel, the availability of a supply channel for contraceptive methods, and the resources of the company.
5. determine if additional record keeping systems must be set up to monitor the family planning program. Design the systems so that the information is readily available for monitoring and evaluation purposes.
6. determine the level of promotional activities that are necessary to assure appropriate utilization of the family planning services.
7. assess the resources that will be necessary to design, initiate and maintain the family planning program. This includes human resources, facilities, equipment, materials, supplies, IE&C materials. The participants will also be able to assess if these resources can be obtained within their organization or if outside assistance must be sought.

8. identify simple mechanisms for calculating the quantities of family planning staff, equipment, supplies, and commodities according to the mix of methods to be used in a company setting and the targeted acceptance rates of the population to be served.
9. design an organizational structure for the family planning program that assures on-going monitoring and evaluation. This depends on the type of services that will be provided and how they are delivered (on-site, by referral, as part of the maternal and child health program, as a free-standing service).
10. learn about evaluative procedures for assessing the effectiveness of the family planning services offered and the systems used in providing those services to the target population.

Rationale:

The success of company-based or plantation family planning services is related to a number of management decisions made prior to the inception of services. Identification of the decision points, the information needed for making decisions and the resources needed to act on those decisions enhance the likelihood of family planning services being designed around the needs and wants of the population being served.

PROCEDURES**o Introduction**

An introduction to the "nuts and bolts" issues that factory management and health personnel need to know, what questions they need to ask and where they can go to get the information and resources they need while planning and setting up family planning services in factories or on plantations.

Time: 10 minutes

o Establishing a Process for Planning and Setting Up Factory or Plantation-Based Family Planning Services

Participants review the possible components of a family planning service and the key tasks and decision points involved in planning and setting up enterprise-based family planning services. These tasks, and others which participants may add to the list, form the basis for examining the management and resource needs involved in providing family planning services. Tasks fall under seven headings: services, management, training, IE&C, commodities, evaluation and cost considerations.

Time: 45 minutes

o Lecturette: Examining Your Audience and Deciding on the Mix of Services to Offer

Participants review the issues of client needs analysis and learn how to translate information they gather or generate themselves into preliminary decisions on service delivery model and mix of family planning methods for their target audience.

Time: 1 hour

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o **Evaluating the Need for Integration of Services**

Issues surrounding the integration of family planning services with an enterprise's existing health services or the creation of free-standing family planning services on-site are reviewed in light of preliminary decisions about audience, service delivery model and mix of services.

Time: 30 minutes

o **Determining Staff Needs**

Staff needs and job descriptions are considered as a function of the objectives an enterprise establishes for its family planning services, the audience to be served, the service delivery model, mix of methods to be offered to clients, and whether or not family planning services are to be integrated with existing health services. Sample job descriptions are presented in the context of an Asian company-based free-standing family planning clinic.

Time: 45 minutes

o **Projecting Needs for Commodities**

Methods for projecting acceptor rates are reviewed. Basic procedures for estimating needs for contraceptive supplies are discussed. Procedures for projecting needs for supplies are presented as a function of the delivery model chosen and the mix of services to be offered.

Time: 45 minutes

o **Basic Furniture and Clinical Equipment**

A list of basic clinic furniture, clinical supplies and equipment is presented.

Time: 30 minutes

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o Clinic Design and Storage Inventory and of Contraceptive Supplies

Clinic design is presented as a function of several factors: integration of family planning with other health services, service delivery model, mix of services to be offered, and the budget available for family planning services. Basic procedures for inventorying and storing contraceptive supplies are discussed.

Time: 30 minutes

o Record Keeping and Evaluation

The need to monitor actual versus expected outcomes of company-based family planning services is stressed prior to examining various record keeping and assessment forms. Sample forms which could be used to monitor the performance and quality of company-based services are presented.

Time: 45 minutes

o Evaluation

Participants evaluate the usefulness of the task/decision checklist in setting up their own company-based services.

Time: 20 minutes

TO THE TRAINER:

A full set of trainer and participant materials follows. The materials provided here are suggestive only, and are best used as models which workshop participants can adapt to the specific needs of their factory or enterprise.

INTRODUCTION

THE "NUTS AND BOLTS" OF ESTABLISHING COMPANY-BASED FAMILY PLANNING SERVICES

In this section of the manual, the presentation turns to the "nuts and bolts" of setting up, managing and evaluating factory or plantation-based family planning services. Attention is focused on a set of tasks which are central not only to the planning process but also to the delivery of family planning services.

The presentation in this section is based on a number of assumptions. The most important of these is that as managers of a private enterprise or of existing health services in a private enterprise, workshop participants have already made the decision to seriously consider providing family planning services to their employees. Other assumptions include the enterprise's willingness to consider a full range of service delivery options and mix of family planning methods, the need for family planning services to reflect the contraceptive needs of their employees or employees' families, and a commitment on management's part to provide employees with free choice in the contraceptive methods which they elect to use.

The sequence of activities in this section of the manual follows that of the task checklist and decision points presented in the next exercise. The topics to be discussed are:

- o establishing a process for planning and setting up company-based services;
- o examining the target audience and deciding on the mix of services to offer;
- o evaluating the need for integration of family planning with existing health services;
- o determining staff needs and job descriptions;
- o projecting needs for commodities;
- o basic clinic furniture, equipment and supplies;
- o clinic design and storage of contraceptive supplies; and
- o record keeping and evaluation.

ESTABLISHING A PROCESS FOR PLANNING AND SETTING UP
COMPANY OR PLANTATION-BASED FAMILY PLANNING SERVICES

ESTABLISHING A PROCESS FOR PLANNING AND SETTING UP COMPANY OR
PLANTATION-BASED FAMILY PLANNING SERVICES

In this part of Section VI, the goal is to introduce workshop participants to the range of components that could be included in a family planning service and then to examine a set of tasks to be considered in planning and operating company-based family planning services. While the tasks listed in the accompanying "Task Checklist/Decision Points in Setting Up Company-Based Family Planning Services" are not meant to be exhaustive, they do constitute those which are thought to be of major importance.

For purposes of our presentation here, and as a reflection of a logical sequence which workshop participants might want to follow, tasks are grouped under two major headings:

- o I: Clientele and Services to Be Offered
- o II: Support Needs.

As you review the task list and decision points with workshop participants, frequent reference should be made to the activities in earlier sections of the manual. Company management and managers of existing health services should, as they participate in workshop activities, develop a full understanding of the relationship between the rationale and objectives they have established for the services they plan to offer, and decisions about the clientele to be served, the service delivery model to be used, the mix of services to be offered, and the kinds of support needed for effective and efficient family planning services. A checklist of typical costs involved in setting up factory-based family planning programs is included for participants' review.

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COMPONENTS OF A FAMILY PLANNING SERVICE

Before moving into a discussion of the tasks and decision points involved in setting up and managing a company-based family planning service, we should first list out and discuss the various components that could be included in such a service.

[NOTE TO TRAINER: List these eight points on newsprint or on a chalkboard.]

1. Providing contraceptives
2. Counselling and Family Welfare Education
3. Laboratory Testing (for sexually transmitted diseases, wet smear for vaginal discharges, Hbg, VDRL, and urinalysis)
4. Complete Family Planning History and Physical Examinations (Pap Smear, etc.)
5. Pregnancy Assessment (includes pregnancy testing)
6. Infertility Screening and Counselling
7. Referral Services
8. Screening of Risk Groups

We will not go into a full discussion of these points at this time, as they are dealt with in other sections of the manual. An important point at this time is the need to see family planning services as more than the provision of contraceptives and information on their use.

**TASK CHECKLIST/DECISION POINTS
IN
SETTING UP COMPANY-BASED FAMILY PLANNING SERVICES**

I. CLIENTELE AND SERVICES TO BE OFFERED

<u>Tasks</u>	<u>Decision Points</u>
a. Study population to be served (prevalence surveys; knowledge, attitudes, and practice surveys; focus groups; company health records)	Decide who is to be served.
b. Examine organization and usage rates of enterprise's current health services.	
c. Examine family planning service delivery models in light of population to be served and need for adaptation to work place.	
d. Identify local/national family planning resources.	Decide what model is to be used with what mix of services. Decide whether family planning services will be integrated with existing health services or free-standing.

II. SUPPORT NEEDS

Management

1. Identify in-house management team for family planning services.
2. Identify potential needs in designing layout of family planning services.

Decide who will manage and what outside assistance may be required.

Forecast Client Loads

1. Make realistic estimates of initial client loads on monthly basis.
2. Estimate how client load will be changed over time. (E.g., constant increase levelling off, seasonal variation, etc.)
3. Estimate method mix.

Decide monthly/quarterly estimate of client load by method for first year of program.

Service Delivery

1. Identify personnel and skills needed to deliver family planning services included in chosen model and mix.
2. Examine skills/capabilities of current health services staff.
3. Identify gaps.

Decide job descriptions and recruitment procedures.

Decide where and how to train staff to provide family planning services.

2/8/82

Clinic Operations

1. Estimate space needs on basis of delivery model, mix of services and estimated client load.
2. Examine existing facilities run by others.

Decide layout of clinic and hours which clinic will be open.

Equipment and Materials

1. Inventory materials and equipment used in health services.
2. Identify staff, equipment, materials and supplies needed in light of delivery model and mix of services.
3. Identify local/national sources for materials, equipment and supplies.
4. Assess current procurement and inventorying procedures.

Decide what materials/equipment to purchase, how procure, how to stock, how to inventory, who is responsible for reporting.

Contraceptive Supplies

1. Identify sources for contraceptive supplies. Quantify lead times for obtaining contraceptives.
2. Estimate needs based on projected client loads and method mix.
3. Establish storage and inventory control procedures.

Decide which source to use and ordering procedures.

Decide inventory procedures.

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IE&C

1. Identify existing materials/
practices of other local or national
groups.
2. Examine potential role of
motivators and field workers.

Decide level of initial
IE&C efforts.

Evaluation and Record Keeping

1. Identify and examine current health
service reporting procedures.
2. Examine suggested reporting procedures
for family planning services.
3. Identify gaps in current procedures.

Decide what procedures to
use; who reports and with
what frequency; and to whom
reports are provided.

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2/8/81

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**CHECKLIST OF TYPICAL
FACTORY-BASED FAMILY PLANNING PROGRAM COSTS**

Personnel

MDs - General Practitioners
- OB/Gyns
RNs, Nurse-Midwives
Motivators
Counselors
Social Worker
Clerical/Administrative
Lost employee time (if services provided during work hours)

Facilities

Rent
Utilities (electricity, water, phone)
Mobile clinic/vehicles (fuel, lubricants, maintenance)

Equipment and Supplies

Clinical equipment for:
- examinations
- surgical contraception methods
- IUD insertions
- follow-up
Office equipment

Commodities

Purchasing
Storage space
Inventory management

IE&C

Purchased materials
Self-produced materials
Motivational or informational activities
Miscellaneous staff training
Miscellaneous acceptor training

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LECTURETTE:
EXAMINING YOUR AUDIENCE AND DECIDING ON MIX
OF SERVICES TO OFFER

DETERMINING THE KINDS OF SERVICES TO OFFER

TO THE TRAINER:

After completing this section of the module, workshop participants will understand the issues involved in:

1. Determining the needs/wants for family planning services among their employee population;
2. Determining the most appropriate model for providing family planning services based on the needs/wants of the client population, the availability of other health care and family planning services in the area, and the resources available to the company.
3. Selecting an appropriate service mix based on the needs/wants of the target population, the availability of other services in the area, the availability of a supply channel for contraceptive methods, and the resources of the company.
4. Identify members of the community and/or factory who are important "players" in setting up family planning services and determine if a committee should be formed to help with the design, implementation, and evaluation of the family planning services.

Accompanying Handouts

1. Approaches for Determining Wants/Needs for Family Planning Services. (Handout A)
2. Issues to Consider in Selecting a Model for Family Planning Service Delivery. (Handout B)
3. Factors to Consider in the Selection of a Mix of Contraceptive Methods. (Handout C)
4. Dealing with Obstacles to the Delivery of Services. (Table 3)
5. Characteristics of Principal Approaches to Providing Family Planning Services. (Table 1, Section V)
6. Guidelines for the Use of Contraceptive Methods with Alternative Delivery Strategies. (from Section V)

The purpose of this lecture is to provide you with the tools that you will need to determine the kind of family planning services to offer in your particular setting. The presentation is built on the following basic concepts:

1. The structure of the family planning clinic and the type of contraceptive methods offered by the clinic should be based on the needs and wants ("perceived needs") of the target population;
2. You need to be knowledgeable about the type and quality of other family planning services that might be available to your target population so that you understand why these services are or are not being used and how you can link up with the existing family planning network.
3. Your goal should be to provide the widest range of choice to potential family planning users; no method is perfect and the more options that are available, the more people whose family planning needs will be met. However, you may need to make compromises in setting up your services. These compromises may be due to the politically sensitive nature of family planning in some areas, to the logistical difficulties associated with providing some methods, or to quality of care concerns. Some of these compromises can be avoided through education or the involvement of influential people. Others cannot be avoided. All compromises should be made with full awareness of what you are gaining and what you are giving up.

During this lecture reference will be made to six handouts listed on the previous page. You have seen two of the handouts before: one is on the characteristics of the basic models for providing family planning services (Table 1, Section V) and the other summarizes the types of contraceptives that can be provided with each model (the large chart from Section V). The four new handouts include:

Handout A: Information to Help the Private Enterprise Manager Determine the Need and Demand for Family Planning Services.

Handout B: Issues to Consider in Selecting Models for Family Planning Service Delivery.

Handout C: Factors to Consider in the Selection of a Mix of Contraceptive Methods

Table 3: Dealing with Obstacles to the Delivery of Services

[Note to Trainer: Refer to Handout A for this section of the lecture]

The first step in determining the kinds of services to offer is to identify the "target group" for the family planning services. Your definition of who the target group includes may change over time, but it is important to start the planning process with a preliminary definition. You will want to answer the following questions:

1. Whom do you employ? Mostly men? Mostly women (Source: personnel records)?
2. Do you already provide health services to your employees? (Source: budget, employee benefits) What is included in this fringe benefit?
3. Do you already provide health services to your employees' dependents? What are the reasons you do or do not want to provide family planning services for this group?
4. Are your health or other social services available to members of the community who are not employees or employees' dependents? What are the reasons you do or do not want to provide family planning services for this group?

By answering these questions you have broadly defined the "target group" for your family planning services. The next step is to estimate the total number of people in the target population. This is not the total number of expected users (not every one will elect to use family planning, of course) but rather the population from which users will be drawn.

Handout A provides a simple framework for determining the target population. You may want to assume that only one partner in a couple will be a user of family planning services.

[NOTE TO TRAINER: See Handout A, Step I for additional lecture material]

The second step is to gather data on the number of births among the target population. These data provide insight into the need for family planning services, particularly when compared with the birthrates for other areas in the region or country. These data are also useful in estimating some of the costs associated with not providing family planning services (maternity leave for employees, nursery school, health care for dependents, etc.)

[NOTE TO TRAINER: See discussion of Step II in Handout A for additional lecture material]

The third step is to identify the family planning knowledge, attitudes, and practices of the target population.

[NOTE TO TRAINER: See discussion of Step III in Handout A for lecture content on KAP surveys, and focus groups]

The fourth step is to obtain information on other sources of family planning services in the area.

[NOTE TO TRAINER: See discussion of Step IV in Handout A for lecture content on how to evaluate existing sources of family planning]

At the end of the four step process you should have the following information:

1. A profile of your target population;
2. A measurement of the need for family planning services in your area;
3. The family planning knowledge, attitudes and practices of your service area population; and
4. A profile of other family planning services (if any) in your service area.

This information should serve as the basis for all of your decisions about the structure of the family planning program and the mix of contraceptives that will be provided.

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[NOTE TO TRAINER: Briefly review the handout "Characteristics of Principal Approaches to Providing Family Planning Services" (Table 1, Section V). This has been presented in the previous lecture. You might ask for a volunteer from the group to review each type. Particular attention should be focused on the advantages and disadvantages of each.]

In selecting a basic model for providing family planning in your factory you will need to answer the following questions:

[NOTE TO TRAINER: The following material is contained in Handout B.]

1. Do you already provide health services to some or all of your family planning target population? If so, a clinic-based program (either separate from or in combination with MCH services) may be feasible and/or desirable: the target population is already using the facility, medical personnel are already in place, etc.
2. Is the target population concentrated in one area or widely dispersed? A widely dispersed population can be served in a number of ways: using community-based distribution (CBD); commercial distribution; or satellite clinics.
3. What level of financial resources are available to start up the family planning program and to support it on an ongoing basis? If adequate start-up money is available a CBD or clinic-based program may be feasible. In the appropriate setting a smoothly functioning commercial distribution system may be the least costly in the long run. The cost-effectiveness of various approaches will depend on each program's circumstances; start-up costs for a clinic-based program will be lower if health services are already being provided.
4. What level of human resources is available? A CBD program requires a pool of community volunteers. A commercial distribution program requires the cooperation of retail outlet owners. A clinic-based program requires the availability of trained medical personnel.
5. What other sources of family planning services are available to the target population? Could the enterprise supplement an existing clinic-based MCH program by paying the salary of a family planning provider or by organizing a CBD program with referrals to the existing clinic?
6. Does the target population indicate a preference for a particular type of program? Clinic-based programs may be perceived as providing higher quality services. A commercial-based or community-based program may be perceived as more convenient and/or confidential. The target population's perceptions will, of course, be based on a number of factors, including the performance of other similar programs.

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It is important to remember that you are not locked into one particular model. A clinic-based program can be supplemented by a CBD program. A commercial distribution program can be part of the referral network of a comprehensive MCH program.

Mix of Services

The type of family planning methods that can be provided will depend on a number of factors, including the service delivery model that has been selected.

[NOTE TO TRAINER: Briefly review the large chart from Section V: A Guide to Modern Contraceptive Methods]

In addition, there are a number of other factors to be considered; these can be divided into three major categories:

1. Quality of Care/Medical Soundness
2. Practicality
3. Political Acceptability

[NOTE TO TRAINER: Refer to Handout C: Factors to Consider in the Selection of a Mix of Contraceptive Methods.]

Throughout the process of determining the kind of services to offer you may run into one or more obstacles to setting up and running a high quality family program. Some of the major problems, constraints and possible solutions are described in Table 3: Dealing with Obstacles to the Delivery of Services.

[NOTE TO TRAINER: Select and discuss two or three of the problems: numbers 3 and 8 would be good choices. If there is time, ask trainees to share their experiences]

Many of the problems family planning programs face have to do with the acceptability of family planning. Many programs have found that these types of problems can be effectively dealt with by asking representatives from both the "problem groups" (men, political leaders, church members, etc.) and the "supportive groups" (women, unions, management, etc.) to participate in a planning/steering committee for the family planning services. This committee can take a number of forms and serve a number of purposes but its basic functions are to:

1. Help structure a program that will be acceptable to as many of the members of the community as possible;

2. Provide a mechanism for members of the community to "buy into" and feel a sense of ownership toward the family planning program;
3. Advertise the program among influential members of the community; and
4. Provide a quality control mechanism for the program: the committee can review program performance on an ongoing basis and work to resolve consumer complaints.

The exact composition of the committee will depend on the composition of your community and target population and the problems that you have encountered or anticipate encountering. In general, it is best to form the committee before any problems become blown out of proportion. Involving people from the beginning tends to make them into program advocates rather than adversaries.

Summary:

We have discussed the following issues:

1. How to determine the needs and wants for family planning services among your target population.
2. How to determine the most appropriate model for providing family planning services in your area.
3. How to select an appropriate service mix for your target population.
4. How to determine if a community committee is needed.

The selection of the appropriate mix of services based on the need and wants of your target population will do much to enhance the potential impact of your program - even before it gets underway.

**INFORMATION TO HELP THE PRIVATE ENTERPRISE MANAGER
DETERMINE THE NEED AND DEMAND FOR
FAMILY PLANNING SERVICES: A METHODOLOGY**

**STEP I. A Demographic Profile of the Potential User Pool of the
Family Planning Services**

The first step in the Need/Demand process is to broadly define the potential users (target population) of the company-sponsored family planning program. The definition can be modified as more detailed information is gathered and analyzed, but it is useful to have baseline information. The pool from which users will be drawn can be estimated using the following framework:

A. Total Number of Employees

1. Number of unmarried male and female employees
2. Number of married male employees with wives ages 15-49
3. Number of female employees ages 15-49

Source: company personnel records

B. Current non-employee users of company-sponsored health services

1. Number of males 15 years or older
2. Number of females 15-49 years

Source: company health clinic summary records; medical records review

C. Residents of the surrounding area

1. Number of males 15 years or older
2. Number of females 15-49 years

Sources: local, regional or national statistics base (population census, taxation records) school records, estimates made by local leaders

STEP II: Birth Rates in the Local Area

Ideally, this information will be available for each of the groups of females identified above. It would also be useful to know the employee family size according to the employees' age group. Sources of data include: company personnel records (maternity leave records); records of local hospitals, health departments or birth attendants; government records. At a minimum, managers should obtain an accurate estimate of the number of births in the area during a recent year. This information is useful for a number of reasons:

- When compared with rates from other areas of the country or the country as a whole it can provide important insight into possible "unwanted" fertility in the area.
- When compared with information on desired family size it can identify particular groups of clients who are prime candidates for family planning services.
- It can be used to calculate the need for pregnancy-related health care by the target population. This will be particularly important to know if any integrated family planning/maternal and child health program is being considered.

STEP III: The Family Planning Knowledge, Attitudes, and Practices of the Target Population

A family planning program⁹ will be successful only if it is designed to meet the needs (and perceived needs) of the people that it is intended to serve. Identifying these needs is partially achieved in Steps I and II, above. The composition of the target population (mostly male? mostly female? mostly young females with few children? mostly older females with many children?) and the current birth rates provide important insight into the level and type of services that should be offered. Equally important are the needs expressed directly by the target population. Information about the target population's knowledge of, attitudes toward, and practice of family planning will help family planning program designers answer the following types of questions:

- What educational and motivational activities will be necessary?
 - What contraceptive methods are acceptable to the target population?
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- What contraceptive methods are currently used by the target population?
- What percentage of the target population currently uses a traditional or modern method of contraception?
- What is the average family size of the target population?
- What is the average desired family size of the target population?

Two basic techniques are available to measure the target population's knowledge of, attitudes toward, and practice of (KAP) family planning: the KAP survey and the focus group.

1. KAP Surveys have been implemented throughout the world on both a large and a small scale. It is likely that one or more KAP surveys have been conducted in your country and/or region by researchers from a local university, government agency, or international organization. If the results of these surveys are available they can provide important comparative data and insight into the issues that need to be addressed. They cannot replace asking members of your target groups the same questions. However, because KAP surveys are widely used, there is no need to design a new survey for every enterprise. Location-specific questions can be added as necessary to a standard survey form.

KAP surveys can be relatively short (10-15 questions) or very lengthy (100 or more questions), depending on the objectives of the survey and the resources that are available. In most cases the surveys are administered on a one-to-one basis by a trained interviewer, but, with a literate population, it is also possible to have members of the target population complete a written questionnaire. As with any data that is collected for management decision-making, only data that is going to be used should be collected.

2. The Focus Group is a semi-structured group discussion that is used in marketing research to obtain detailed information about a consumer group's response to a particular product. A focus group usually includes 6-10 members and a trained focus group leader who directs the group through a series of open-ended questions. The leader's job is to elicit detailed information about the participant's perceptions of the product, in this case family planning services. Generally more detailed information is gathered than would be possible using a survey. Unexpected information is also more common because of the open-ended nature of the questions and the group setting.

Information about the following sources of family planning services should be collected:

- Government-sponsored family planning services, which may be provided as either separate clinic or as part of a comprehensive health care unit;
- Services sponsored by a non-governmental organization, such as a national family planning association, church group, etc.;
- Private medical practitioners who provide family planning services;
- Community-Based Distribution (CBD) programs where non-medical personnel trained in family planning distribute contraceptives to people's homes or work sites; and
- Retail sales of contraceptives (pharmacies, grocery stores, etc.)

The following questions should be answered about each of the identified sources of family planning; the fact that a family planning service exists does not mean that it can meet the family planning needs of the target populations:

1. Is the service accessible to the target population?
 - Is it a reasonable distance from the place of employment?
 - Is it open when employees are not in work?
 - Is reliable and frequent transportation available?
 - Can clients be seen when they want or need to be seen?
 - Do the family planning service providers speak the client's language?
 - Are the services affordable?

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2. Are the services acceptable to clients?

- Are services provided privately and confidentially?
- Are clients treated with respect?
- Do clients receive appropriate education so that they understand the options available to them?
- Are all of the services provided that clients want?

3. Are high quality services provided?

- Are the staff members appropriately trained to provide the family planning services that are offered?
- Is a complete range of services offered?
- Is a medical history taken and a physical exam (when necessary) performed to assess each patient's risk factors?
- Is a referral network in place for emergencies or for services that are not offered?
- Do clients select a family planning method based on voluntary informed choice (free from coercion)?

STEP IV: Other Sources of Family Planning Services in the Area

This information will be crucial in helping the manager make a decision about the type of family planning services to provide. The objective, of course, is to match the client population's wants/needs with an appropriate mix of services. A secondary objective is to make the match as efficiently as possible. Services that are not needed/wanted should not be provided, nor should services be duplicated. A possible outcome of this step is that managers may decide to facilitate their employees' use of existing services (time off from work to receive services, company-sponsored transportation to the clinic) rather than starting a family planning clinic at the enterprise. At a minimum, managers need to be aware of existing services so that an appropriate referral network can be established.

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- o What is the average desired family size of the target population?

Two basic techniques are available to measure the target population's knowledge of, attitudes toward, and practice of (KAP) family planning: the KAP survey and the focus group.

1. KAP Surveys have been implemented throughout the world on both a large and a small scale. It is likely that one or more KAP surveys have been conducted in your country and/or region by researchers from a local university, government agency, or international organization. If the results of these surveys are available they can provide important comparative data and insight into the issues that need to be addressed. They cannot replace asking members of your target groups the same questions. However, because KAP surveys are widely used, there is no need to design a new survey for every enterprise. Location-specific questions can be added as necessary to a standard survey form.

KAP surveys can be relatively short (10-15 questions) or very lengthy (100 or more questions), depending on the objectives of the survey and the resources that are available. In most cases the surveys are administered on a one-to-one basis by a trained interviewer, but, with a literate population, it is also possible to have members of the target population complete a written questionnaire. As with any data that is collected for management decision-making, only data that is going to be used should be collected.

2. The Focus Group is a semi-structured group discussion that is used in marketing research to obtain detailed information about a consumer group's response to a particular product. A focus group usually includes 6-10 members and a trained focus group leader who directs the group through a series of open-ended questions. The leader's job is to elicit detailed information about the participant's perceptions of the product, in this case family planning services. Generally more detailed information is gathered than would be possible using a survey. Unexpected information is also more common because of the open-ended nature of the questions and the group setting.

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Information about the following sources of family planning services should be collected:

- o Government-sponsored family planning services, which may be provided as either separate clinic or as part of a comprehensive health care unit;
- o Services sponsored by a non-governmental organization, such as a national family planning association, church group, etc.;
- o Private medical practitioners who provide family planning services;
- o Community-Based Distribution (CBD) programs where non-medical personnel trained in family planning distribute contraceptives to people's homes or work sites; and
- o Retail sales of contraceptives (pharmacies, grocery stores, etc.)

The following questions should be answered about each of the identified sources of family planning; the fact that a family planning service exists does not mean that it can meet the family planning needs of the target populations:

1. Is the service accessible to the target population?
 - o Is it a reasonable distance from the place of employment?
 - o Is it open when employees are not in work?
 - o Is reliable and frequent transportation available?
 - o Can clients be seen when they want or need to be seen?
 - o Do the family planning service providers speak the client's language?
 - o Are the services affordable?

2. Are the services acceptable to clients?
 - o Are services provided privately and confidentially?
 - o Are clients treated with respect?
 - o Do clients receive appropriate education so that they understand the options available to them?
 - o Are all of the services provided that clients want?

3. Are high quality services provided?
 - o Are the staff members appropriately trained to provide the family planning services that are offered?
 - o Is a complete range of services offered?
 - o Is a medical history taken and a physical exam (when necessary) performed to assess each patient's risk factors?
 - o Is a referral network in place for emergencies or for services that are not offered?
 - o Do clients select a family planning method based on voluntary informed choice (free from coercion)?

STEP IV: Other Sources of Family Planning Services in the Area

This information will be crucial in helping the manager make a decision about the type of family planning services to provide. The objective, of course, is to match the client population's wants/needs with an appropriate mix of services. A secondary objective is to make the match as efficiently as possible. Services that are not needed/wanted should not be provided, nor should services be duplicated. A possible outcome of this step is that managers may decide to facilitate their employees' use of existing services (time off from work to receive services, company-sponsored transportation to the clinic) rather than starting a family planning clinic at the enterprise. At a minimum, managers need to be aware of existing services so that an appropriate referral network can be established.

**ISSUES TO CONSIDER IN SELECTING
A MODEL FOR FAMILY PLANNING
SERVICE DELIVERY**

1. Do you already provide health services to some or all of your family planning target population? If so, a clinic-based program (either separate from or in combination with MCH services) may be feasible and/or desirable: the target population is already using the facility, medical personnel are already in place, etc.
2. Is the target population concentrated in one area or widely dispersed? A widely dispersed population can be served in a number of ways: using community-based distribution (CBD); commercial distribution; or satellite clinics.
3. What level of financial resources is available to start-up the family planning program and to support it on an ongoing basis? If adequate start-up money is available a CBD or clinic-based program may be feasible. In the appropriate setting a smoothly functioning commercial distribution system may be the least costly in the long run. The cost-effectiveness of various approaches will depend on each program's circumstances; start-up costs for a clinic-based program will be lower if health services are already being provided.
4. What level of human resources is available? A CBD program requires a pool of community volunteers. A commercial distribution program requires the cooperation of retail outlet owners. A clinic-based program requires the availability of trained medical personnel.
5. What other sources of family planning services are available to the target population? Could the enterprise supplement an existing clinic-based MCH program by paying the salary of a family planning provider or by organizing a CBD program with referrals to the existing clinic?
6. Does the target population indicate a preference for a particular type of program? Clinic-based programs may be perceived as providing higher quality services. A commercial-based or community-based program may be perceived as more convenient and/or confidential. The target population's perceptions will, of course, be based on a number of factors, including the performance of other similar programs.

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**FACTORS TO CONSIDER IN THE SELECTION OF
A MIX OF CONTRACEPTIVE METHODS**

Decisions regarding the mix of contraceptive methods to provide in a particular setting involve the consideration of and a compromise among a number of factors:

I. Quality of Care/Medical Soundness

- a. The availability of trained personnel to evaluate the appropriateness of particular methods given known risks and side effects;
- b. The risk of serious side effects and their relative importance given the alternative (e.g., high rates of maternal and infant mortality);
- c. The availability of trained personnel and medical facilities to manage any of the medical complications resulting from the use of a method;
- d. The availability of adequate sanitation and the appropriate equipment and supplies to permit the use of some methods (e.g., sterilization, IUD insertions);
- e. The degree of prevalence of a disease that contradicts the use of a particular method (e.g., high rates of sexually transmitted disease (STDs) and the IUD);
- f. The ages of the women receiving family planning services: women will have different contraceptive needs at different points in their reproductive lives.
- g. The prevalence of marital relations that result in multiple sex partners (e.g., oral contraceptives appear to provide some protection against sexually transmitted pelvic inflammatory disease and barrier methods such as the condom decrease transmission of STDs).

II. Practicality

- a. The availability of the method, including the reliability of the transportation system;
- b. The cost to the clinic of providing a method, including the cost of the associated equipment and supplies;

- c. The cost to the individual client of using a particular method (cost of the method itself and the frequency with which the cost is repeated; travel cost; and opportunity costs - time away from work and home).
- d. The acceptability of the method among the user population (will enough clients request the method to warrant keeping it in stock? Will a lot of the users "drop out" or request another method?);
- e. The frequency with which users who have selected the method must return to the clinic, the availability of transportation for them to do so, and the availability of clinic staff to see them.
- f. The method's shelf life and storage requirements;
- g. The complexity of the staff training associated with providing the method and the availability of training programs;
- h. The complexity of patient education associated with the method and the availability of trained staff to provide that education; and,
- i. The amount of cooperation regarding family planning that is likely to exist between men and women in a particular setting.

III. Political Acceptability

- a. The positions held about specific methods by influential individuals or interest groups;
- b. The scientific opinions of international and national experts and groups;
- c. Other programmatic commitments that could limit the clinic's ability to develop an adequate delivery mechanism for a specific method.

Using these factors as a framework, each family planning program can evaluate the feasibility of offering various methods of contraception. The overriding concern, of course, should always be to meet the family planning needs of the target population. In most situations this concern dictates the provision of the widest range of methods possible. A particular method should be excluded only if strong evidence exists that it compromises the quality of care, that practical obstacles cannot be overcome, or that it is totally unacceptable from a political or religious standpoint.

Source: CDC. Family Planning Methods and Practice: Africa. 1983, pp. 122-123.

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TABLE 3: DEALING WITH OBSTACLES TO DELIVERY OF SERVICES

Problems and Constraints	Solutions
1. Lack of services (particularly in rural areas but also in urban areas)	<ul style="list-style-type: none">a) Increase policymakers' knowledge of the health and economic benefits of family planning.b) Increase the priority given to family planning in maternal child health units, particularly among nurses, and nurse midwives.c) Place higher priority on family planning in training of physicians and nurses.d) Strengthen staff and outreach services in clinics already offering family planning.e) Develop, improve, or expand community-based and/or commercial retail distribution systems.
2. Resistance of women to the concept of family planning.	<ul style="list-style-type: none">a) Compare contraceptive complications with risks of pregnancy; allay fears of contraception.b) Provide higher quality, more comprehensive family planning services.c) Use child health and well-baby clinics as sources of referrals for family planning services.d) Emphasize the health benefits of family planning and its voluntary nature.
3. Male opposition to birth control and to the concept of women playing an important role in decisions governing how many children a couple should have.	<ul style="list-style-type: none">a) Educate community leaders about benefits of family planning.b) Involve important men in the initial planning and promotion of contraceptive services.c) Provide methods women can use without knowledge of men if necessary.

- d) Educate school children about the family in today's society and the importance of planning it.

TABLE 3: DEALING WITH OBSTACLES TO DELIVERY OF SERVICES (p.2)

Problems and Constraints	Solutions
4. Destruction of traditional institutions that encourage effective methods of birth control.	<p>a) Retain those traditional approaches that are safe and effective.</p> <p>b) Explain carefully the reasons why some traditional approaches may not be safe or effective.</p> <p>c) Encourage local involvement in establishing effective child-spacing services.</p> <p>d) Use neighbors in community-based distribution programs who can effectively communicate family planning concepts.</p>
5. Lack of trained back-up medical personnel in staff, hospital, and clinics and a lack of trained lower-level staff to act as village educators, recruiters, and distributors of contraceptives.	<p>a) Retrain physicians, nurses, and midwives in family planning skills through intensive, short programs.</p> <p>b) Encourage and train nurses and then train community-based paramedical personnel.</p> <p>c) Emphasize family planning in training programs for midwives, nurses, and doctors.</p> <p>d) Thoroughly train supervisors of maternal-child health/family planning workers to manage problems and reinforce training of lower-level family planning workers.</p>
6. Privacy is unavailable in certain clinic settings.	<p>a) Provision of services in a private setting.</p> <p>b) Alter the flow of patients in maternal-child health/family planning workers to manage problems and reinforce training of lower-level family planning workers.</p>

- c) Initiate commercial distribution (including the use of street vendors) of certain contraceptives.

TABLE 3: DEALING WITH OBSTACLES TO DELIVERY OF SERVICES (p.3)

Problems and Constraints	Solutions
7. Inaccessibility and lack of acceptability in some quarters of sterilization services.	<ul style="list-style-type: none">a) Training of nurse midwives, physicians, and health assistants to perform mini-laparotomy procedures.b) Acquire necessary equipment.c) Set up a system to insure a constant supply of spare parts and other needed supplies for laparoscopic equipment.
8. Failure of influential leaders to recognize the importance of voluntary means of child spacing to the health of the individual and society as a whole.	<ul style="list-style-type: none">a) Explain to leaders the health benefits of family planning.b) Demonstrate that family planning leads to reduced health care costs.c) Increase the education of politicians on the implications of rapid population growth.
9. Law prohibiting or customs discouraging the provision of voluntary contraceptive services for unmarried women.	<ul style="list-style-type: none">a) Initiate services that do not conflict directly with laws or customs of the land.b) Develop public information programs regarding health and social consequences of adolescent pregnancies.c) Ask national leaders to interpret laws according to present conditions and to communicate with leaders of other countries.

Source: CDC. Family Planning Methods and Practice: Africa. 1983, pp. 289-291.

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- c) Provide methods women can use without knowledge of men if necessary.
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EVALUATING THE NEED FOR INTEGRATION

How well would integrated family planning services work within the context of your factory's present health services program? The answer depends on the needs of your users, the availability of trained personnel and other resources, and the policies and ideologies of your government. Ask yourself the following questions to evaluate whether your present program needs some change:

1. How many people live in the area served by my program?
2. Where do they live?
3. Can I reach them with family planning services with my system of services as it exists today?
4. What do people need most today?
5. What will people accept today, tomorrow, if more information is made available to them?
6. What resources, both from my program and from the community, are available to them?
7. Are they willing to come to my clinic or outreach sessions?
8. Are there people who are reluctant to use services because of how they are offered? Example: Married women who don't want to go to family-planning-only clinics.
9. Am I making the best use of my own time, the time of my colleagues and staff?
10. Are there ways in which I could reorganize my staff and resources to provide better services to more people?

Adapted from:

CDC. Family Planning Methods and Practices: Africa. 1983,
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DETERMINING STAFF NEEDS

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In determining staff needs for company-based family planning services, the following factors should be considered:

- the objectives and goals established for the services;
- the service delivery model to be used and the frequency of services;
- the mix of contraceptive methods to be offered;
- capabilities of current health care providers and potential for training or re-training;
- level of anticipated IE&C promotional efforts to be undertaken;
- estimated number of employees or spouses to be seen daily;
 - initial start-up stage
 - at point of full operations

You or your health care personnel might want to visit a family planning clinic similar to your projected clinic and observe as many of the on-site tasks as possible. In each instance identify who performs the task. Be prepared to ask specific questions about who does what and with what frequency. Try to find out what kind of training clinic staff members have and, if possible, where they were trained. This can be very helpful in determining what the staff needs will be for your enterprise.

Once you have determined what your staff needs are, you will want to develop job descriptions for each level of staff.

Job descriptions are necessary because they define the areas of responsibility and tasks which are to be performed in each area. Job descriptions also provide guidelines for the desired qualifications for each position.

In developing job descriptions for the staff of your family planning service:

- first list the tasks to be performed for each position (some people prefer to do this in descending order of priority);

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- make a list of the personality traits that will enhance potential acceptance of the contraceptive services to be offered; and
- then review the two lists and establish the qualifications needed for each position.

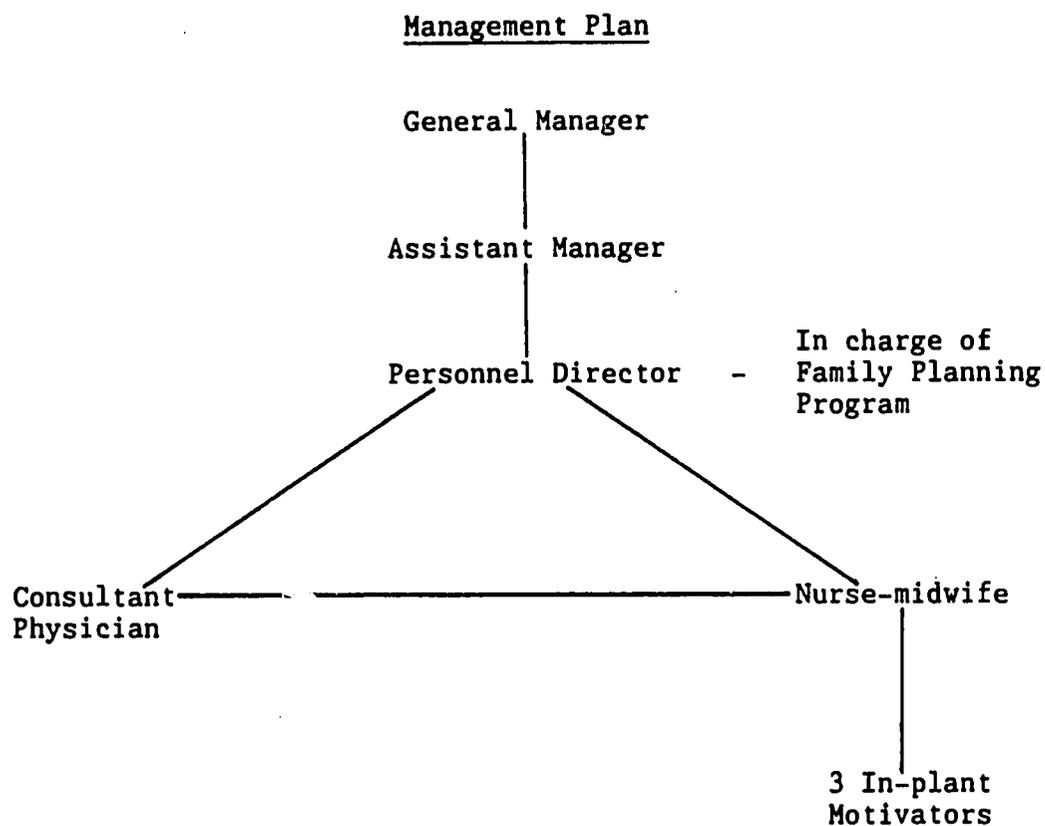
The attached job descriptions for a nurse-midwife and a consultant obstetrician/gynecologist were developed by the Enterprise Program for an Asian company-based free-standing family planning service program. The nurse-midwife is responsible for the daily operations of the family planning clinic, serving clients, conducting home visits as appropriate, and performing management tasks such as the maintenance of contraceptive supplies, equipment, materials and record keeping systems. These activities are directed towards the effective and efficient organization and operation of the family planning clinic.

She will develop and implement a health education and family planning motivational program with the concurrence of in-plant motivators, consultant physician and Personnel Director. The activities of the in-plant motivators are directed and supervised by the nurse-midwife.

The consultant physician will provide back-up for the nurse-midwife's practice, manage all cases referred by her and assume responsibility for all nurse-midwifery and medical practices ongoing in the clinic.

The nurse-midwife, and if necessary the consultant physician, will have monthly meetings with the Personnel Director who is in charge of the family planning program and report on progress and family planning activities. She will inform the Personnel Director of problems, issues or constraints that may arise in delivery of services and implement strategies to overcome service delivery obstacles. Finally, the nurse-midwife will coordinate all family planning activities in the factory so that the system functions smoothly and provides high quality, accessible family planning services to the workers and their spouses.

The overall management plan is as follows:



Source: Enterprise Program, 1986.

JOB DESCRIPTION: MIDWIFE

The midwife will be responsible for the following activities:

- counsel and educate clients on all contraceptive options, correct use of child spacing methods and promotion of family health;
- conduct physical examinations in relation to contraception;
- provide contraceptive of choice or refer to appropriate agency;
- manage common side effects;
- refer complications to consultant physician or hospital;
- manage the family planning clinic;
- maintain accurate records, complete reports and organize equipment, supplies and commodities;
- inform management and physician on clinic activities on a regular basis;
- conduct health education talks in the factory to motivate and recruit new acceptors and maintain continuing users; and
- participate as appropriate in seminars/workshops that promote concept of company-based family planning/family health services.

Qualifications

- registered midwife with certificate in family planning from an officially recognized family planning training school;
- technical experience in providing all aspects of clinical family planning services including IUD insertion and management;
- commitment to the promotion of family planning services in an industrial setting; and
- experience in public health nursing and teaching an asset.

Source: Enterprise Program, 1986.

JOB DESCRIPTION: CONSULTANT OBSTETRICIAN/GYNECOLOGIST

The consultant obstetrician/gynecologist will be responsible for the following activities:

- assist management and the midwife in making policy and family planning decisions in order to establish protocols for practice that will ensure safety and competency in delivery of services;
- assume over-all responsibility for the midwife's practice and provide back-up for her services;
- manage clients referred by the midwife and take appropriate action; and
- participate in seminars/workshops that promote the concept of company-based family planning/family health services.

Qualifications

- registered obstetrician/gynecologist with knowledge and experience in clinical family planning service delivery;
- familiarity with community-based and other family planning programs; and
- liaise with management and government health system as appropriate for the successful operation of the company-based clinic.

Source: Enterprise Program, 1986.

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- capabilities of current health care providers and potential for training or re-training;
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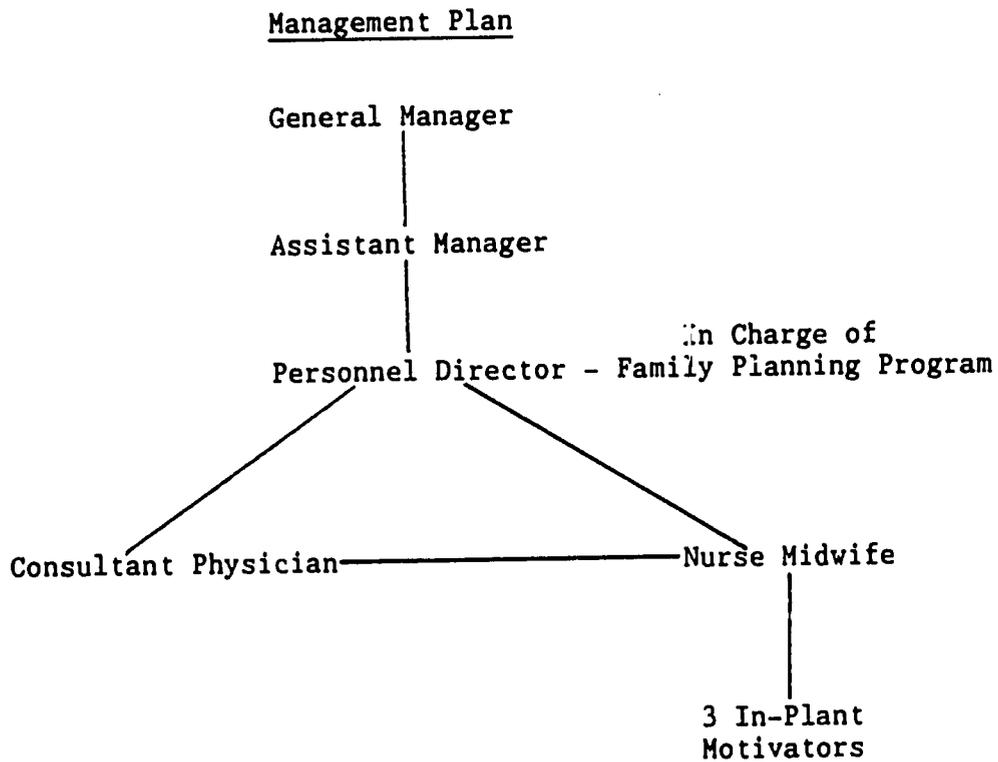
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She will develop and implement a health education and family planning motivational program with the concurrence of in-plant motivators, consultant physician and Personnel Director. The activities of the in-plant motivators are directed and supervised by the nurse-midwife.

The consultant physician will provide back-up for the nurse-midwife's practice, manage all cases referred by her and assume responsibility for all nurse-midwifery and medical practices ongoing in the clinic.

The nurse-midwife, and if necessary the consultant physician, will have monthly meetings with the Personnel Director who is in charge of the family planning program and report on progress and family planning activities. She will inform the Personnel Director of problems, issues or constraints that may arise in delivery of services and implement strategies to overcome service delivery obstacles. Finally, the nurse-midwife will coordinate all family planning activities in the factory so that the system functions smoothly and provides high quality, accessible family planning services to the workers and their spouses.

The overall management plan is as follows:



Source: Enterprise Program, 1986.

JOB DESCRIPTION: MIDWIFE

The midwife will be responsible for the following activities:

- counsel and educate clients on all contraceptive options, correct use of child spacing methods and promotion of family health;
- conduct physical examinations in relation to contraception;
- provide contraceptive of choice or refer to appropriate agency;
- manage common side effects;
- refer complications to consultant physician or hospital;
- manage the family planning clinic;
- maintain accurate records, complete reports and organize equipment, supplies and commodities;
- inform management and physician on clinic activities on a regular basis;
- conduct health education talks in the factory to motivate and recruit new acceptors and maintain continuing users; and
- participate as appropriate in seminars/workshops that promote concept of company-based family planning/family health services.

Qualifications

- registered midwife with certificate in family planning from an officially recognized family planning training school;
- technical experience in providing all aspects of clinical family planning services including IUD insertion and management;
- commitment to the promotion of family planning services in an industrial setting; and
- experience in public health nursing and teaching an asset.

JOB DESCRIPTION: CONSULTANT OBSTETRICIAN/GYNECOLOGIST

The consultant obstetrician/gynecologist will be responsible for the following activities:

- assist management and the midwife in making policy and family planning decisions in order to establish protocols for practice that will ensure safety and competency in delivery of services;
- assume over-all responsibility for the midwife's practice and provide back-up for her services;
- manage clients referred by the midwife and take appropriate action; and
- participate in seminars/workshops that promote the concept of company-based family planning/family health services.

Qualifications

- registered obstetrician/gynecologist with knowledge and experience in clinical family planning service delivery;
- familiarity with community-based and other family planning programs; and
- liaise with management and government health system as appropriate for the successful operation of the company-based clinic.

Source: Enterprise Program, 1986.

PROJECTING NEEDS FOR COMMODITIES

COMMODITIES PLANNING CHECKLIST

In planning for an adequate supply of commodities (pills, condoms, IUD's, etc.) factory management and health personnel will want to:

1. Review program objectives
2. Determine service objectives in light of program objectives:
 - What percent of the population are: Women of reproductive age? Married (in-union) women of reproductive age?
 - What is the size of the service area?
 - What is the contraceptive prevalence rate?
3. Estimate service breakdown:
 - If no precise data are available, use a rule of thumb such as (50% pills; 20% IUD; 10% condom; 20% other); or as in one Asian setting national use statistics were employed for a 1/3, 1/3, 1/3 mix.
 - Conduct research on the legality and cultural, religious, social acceptability of various methods.
4. Calculate supplies required:
 - Remember full range of considerations, including legal requirements and logistical aspects (e.g. keeping the "pipeline" full).
 - Figure contraceptive requirements by formula: (e.g., a new acceptor for the pill uses 6.5 cycles in the first year; a continuing user of the pill uses 13 cycles per year; a new acceptor for condoms uses 72 in the first year; a continuing acceptor uses 144 per year.)

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TOTALS

new PILL acceptors x 6.5 cycles =
plus continuing PILL acceptors x 13 cycles = }

new CONDOM acceptors x 72 condoms =
plus continuing CONDOM acceptors x 144 condoms = }

new FOAM acceptors x 1 bottle =
plus continuing FOAM acceptors x 2.5 bottles = }

new JELLY acceptors x 3 tubes of jelly =
plus continuing JELLY acceptors x 6 tubes = }

IUD acceptors (x 1) _____ =

DIAPHRAGM acceptors (x 1) _____ =

5. Determine other equipment, supplies and materials needed:

- Will sterilizations be performed? Males and female? Which procedures?
- Are IE&C materials required? (topic, language, format?)

6. Identify various options for procuring contraceptives (i.e., determine availability):

- What are the relevant laws (e.g., regarding sale of donated commodities)?
- What are the customs regulations and duties?
- What are the pricing considerations, remembering both policy and practical aspects?
- Does the government have contraceptive commodities available?
- Are commodities available through the local or national family planning affiliates?
- What other channels are there for contraceptive supply (e.g., foreign donors)?

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VI Commodities
Trainer's Copy

- What is the availability of commodities on the open market (U.S. and in-country)?
 - What are the regulations regarding AID-supplied commodities (approvals, duty-free procedures)?
 - What other logistical considerations exist (storage requirements/existing facilities, inventory control procedures)?
7. Determine costs of commodities and who will pay:
- Locally procured? Imported? Donated?
 - Shipping costs.
 - Set prices, if clients will be charged.

Source: Enterprise Program, 1986.

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COMMODITIES PLANNING CHECKLIST

In planning for an adequate supply of commodities (pills, condoms, IUD's, etc.) factory management and health personnel will want to:

1. Review program objectives
2. Determine service objectives in light of program objectives:
 - What percent of the population are: Women of reproductive age? Married (in-union) women of reproductive age?
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3. Estimate service breakdown:
 - If no precise data are available, use a rule of thumb such as (50% pills; 20% IUD; 10% condom; 20% other); or as in one Asian setting national use statistics were employed for a 1/3, 1/3, 1/3 mix.
 - Conduct research on the legality and cultural, religious, social acceptability of various methods.
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 - Remember full range of considerations, including legal requirements and logistical aspects (e.g., keeping the "pipeline" full).
 - Figure contraceptive requirements by formula: (e.g., A new acceptor for the pill uses 6.5 cycles in the first year; A continuing user of the pill uses 13 cycles per year; A new acceptor for condoms uses 72 in the first year; A continuing acceptor uses 144 per year.)

TOTALS

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- Will sterilizations be performed? Males and female? Which procedures?
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- What are the relevant laws (e.g., regarding sale of donated commodities)?
- What are the customs regulations and duties?
- What are the pricing considerations, remembering both policy and practical aspects?
- Does the government have contraceptive commodities available?
- Are commodities available through the local or national family planning affiliates?
- What other channels are there for contraceptive supply (e.g., foreign donors)?
- What is the availability of commodities on the open market (U.S. and in-country)?

- What are the regulations regarding AID-supplied commodities (approvals, duty-free procedures, etc.)?
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7. Determine costs of commodities and who will pay:
- Locally procured? Imported? Donated?
 - Shipping costs.
 - Set prices, if clients will be charged.

Source: Enterprise Program, 1986.

BASIC FURNITURE AND CLINICAL EQUIPMENT LIST

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BASIC FURNITURE AND CLINICAL EQUIPMENT LIST

The type of furniture and equipment and the quantity of supplies you keep on hand will generally be determined by the number of service providers you have on staff and the types of family planning services you intend to offer. The following considerations should be taken into account:

- the amount of money in your budget for equipment and supplies;
- the general availability of equipment and supplies (locally and nationally);
- the frequency with which equipment is used;
- availability of storage facilities;
- amount of time required for ordering and delivery of equipment and supplies; and
- local maintenance capabilities.

As you prepare a list of basic furniture and clinical equipment, try to obtain a list of equipment and supplies from a family planning clinic similar to the one you intend to set up.

Make a list of each service you plan to offer. Under each heading list the specific equipment you will need - as well as the consumables needed for service delivery (gauze, tape, cotton balls, disinfectants, syringes, etc.). Where possible, include prices.

Discuss your list with someone else who is providing a similar service or with individuals working for government sponsored services. Then, determine what quantities you think you will need to get started.

BASIC FURNITURE LIST

The following furniture is suggested for a small, on-site family planning clinic:

- 2 desks
- chairs
- table
- filing cabinet for client records
- storage cupboard for commodities
- bookcase for IE&C materials
- cabinet to store equipment and supplies
- blackboard

BASIC CLINICAL EQUIPMENT LIST

The following is a suggested list of basic clinical equipment. Remember that the numbers of items are directly related to the level of services and number of clients to be served. This list assumes that a full range of services including IUD insertions are to be offered in a factory setting with over 400 potential acceptors in a two-year period.

Examination table
Examining stool
Pedal bin
Angle poised lamp
Flash light
Screen
Instrument trolleys (2)
Blood pressure cuff and stethoscope
Thermometer
Weighing scale (kilograms)
Electric sterilizer, (large)
Stove (gas or charcoal)
Covered pot (large)
Tray
Refuse containers (large)
Pail
Baby cot
Tickler file box
Commodities storage cabinet
Rubber sheet
Pillow and cover
Washable sheets (6)
Washable gowns (6)
Towels (2)
Vaginal specula (1 sm, 4 med, 1 lg)
Sponge holding forceps, straight, (9.5 inches) (6)
Straight tenacula (9.5 inches) (6)
Artery forceps, curved, (Bozeman-8.5 inches) (6)
Uterine sounds (12.5 inches) (6)
IUD removal hook (retriever 10 inches)
Alligator Forceps (8 inches)
Curved Scissors (8 inches) (2)
Kidney dishes, (8 inches) (2)
Large stainless steel forceps containers (2)
Large lifting forceps (cheattles) (2)
Large stainless steel containers with lids (4)

Source: Enterprise Program, 1986.

BASIC FURNITURE AND CLINICAL EQUIPMENT LIST

The type of furniture and equipment and the quantity of supplies you keep on hand will generally be determined by the number of service providers you have on staff and the types of family planning services you intend to offer. The following considerations should be taken into account:

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Examination table
Examining stool
Pedal bin
Angle poised lamp
Flash light
Screen
Instrument trolleys (2)
Blood pressure cuff and stethoscope
Thermometer
Weighing scale (kilograms)
Electric sterilizer, (large)
Stove (gas or charcoal)
Covered pot (large)
Tray
Refuse containers (large)
Pail
Baby cot
Tickler file box
Commodities storage cabinet
Rubber sheet
Pillow and cover
Washable sheets (6)
Washable gowns (6)
Towels (2)
Vaginal specula (1 sm, 4 med, 1 lg)
Sponge holding forceps, straight, (9.5 inches) (6)
Straight tenacula (9.5 inches) (6)
Artery forceps, curved, (Bozeman-8.5 inches) (6)
Uterine sounds (12.5 inches) (6)
IUD removal hook (retriever 10 inches)
Alligator Forceps (8 inches)
Curved Scissors (8 inches) (2)
Kidney dishes, (8 inches) (2)
Large stainless steel forceps containers (2)
Large lifting forceps (cheattles) (2)
Large stainless steel containers with lids (4)

Source: Enterprise Program, 1986.

CLINIC DESIGN AND GUIDELINES FOR
INVENTORYING AND STORING CONTRACEPTIVES

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CLINIC DESIGN AND INVENTORY AND STORAGE OF CONTRACEPTIVE SUPPLIES

In designing a family planning clinic for an enterprise or plantation setting, management will want to consider:

- the size of the population to be served;
- the service delivery model to be used;
- the mix of family planning services to be offered at the site; and
- the number of family planning service providers.

If family planning services are to be integrated with existing health services, consideration should be given to maximizing existing investments while assuring that all facilities which are needed for the efficient and effective delivery of family planning services are available. (Workshop participants will want to refer back to several of the questions posed during the discussion on integration of services.)

Family planning services should be offered in facilities which are designed in consideration of the clientele to be reached and the mix of services to be provided. In addition, facilities should be easily accessible and non-threatening to clients. The planning of clinical services should provide for efficient patient flow, the privacy of the clinic's users, and their comfort.

The basic physical components of a family planning clinic include the following:

1. a client reception area;
2. an area for private consultation and group health talks;
3. examination room(s);
4. a storage space for contraceptive supplies;
5. a place for cleaning and storage of instruments and equipment;
6. bathroom facilities; and
7. running water.

In situations where surgical procedures are to be performed, facilities should conform to acceptable local standards for such facilities. Special construction and equipment will also be needed if the clinic is to contain laboratory facilities. If IE&C promotional activities and client education are a part of the clinic's function, a meeting room or area sufficiently large to accommodate a group of at least 20 persons will be needed.

The Client Reception Area--often provides the client's first contact with family planning services and the client's first impressions are extremely important. The reception area should be spacious enough that it can accommodate all visitors, especially during peak periods of service. Ideally, the reception area should contain a place for IE&C materials to be prominently displayed.

A Private Consultation Area--is used by family planning service providers as a place to counsel or explain treatments or procedures to clinic users. As these exchanges tend to be confidential in nature, the private consultation area should be a distinct area within the clinic. If space is not available for a separate consultation area, consultation can be provided in the privacy of an examination room.

Examination Rooms--need to be equipped with proper lighting, proper equipment, storage cabinets for both equipment and contraceptive supplies, and an examination table. A list of clinical equipment, patterned after the one provided in an earlier section of the manual, should reflect the kinds of services provided and the number of service providers present in the clinic at any one time. Examination rooms should be designed with the clinic user's privacy in mind.

Storage Facilities--for contraceptive supplies are an important part of on-site family planning facilities in factories or on plantations. The guidelines on the next few pages should prove helpful in drawing up procedures for storing supplies as well as keeping the inventory current.

Housekeeping Facilities--are necessary for cleaning examination equipment and for storing general cleaning equipment used in the up-keep of the clinic. Some provision must be made for sterilizing equipment (either autoclave and boiling).

INVENTORY RECORDS

Whether your program's family planning commodities are provided directly by the Enterprise Program, purchased with Enterprise Program subproject funds, or obtained through other means, they are valuable and must be well managed. Care must be taken to control their distribution and to maintain proper inventory records. Proper inventory records are required so that additional commodities can be requested on a timely basis and a steady supply of necessary items is assured.

INVENTORY CONTROL

An individual Inventory Control Card (ICC) like the one on the next page is used for each type or kind of commodity item in inventory. The ICC shows all the activity for the given item. It should be filled out at follows:

1. Describe the item (size, color, stock number, etc.)
2. Note where the inventory item is stored.
3. Indicate on the ICC the re-order point for the item. The re-order point for contraceptives is normally when the inventory level drops to a six-month supply. It is then necessary to order additional supplies.
4. Make a chronological entry each time anything is added to or taken out of inventory. Note the date and quantities for every addition to inventory and every distribution from inventory.
5. Record the balance on hand after each addition or distribution.
6. Information from the individual Inventory Control Cards is summarized onto the Inventory Report at the end of every month.

The example on the next page shows a completed Inventory Control Card.

INVENTORY CONTROL CARD

INVENTORY CONTROL CARD

Item: _____

Storage location: _____ Re-order point: _____

Date	Quantity received in inventory	Quantity taken out of inventory	Balance

INVENTORY CONTROL CARD

Item: 49 mm colored/lubricated condoms

Storage location: Clinic storeroom shelf 3 Re-order point: 6,000

Date	Quantity received in inventory	Quantity taken out of inventory	Balance
Jan. 3 '80	11,000		11,000
1/10/80		2,000	9,000
2/6/80		950	8,050
3/25/80		1,000	7,050
4/11/80		2,000	5,050
4/28/80	14,000		19,050

Source: Enterprise Program, 1986.

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INVENTORY REPORT

The Inventory Report is a monthly compilation of the information off of the Inventory Control Cards (ICC). While a separate ICC is used to record all activity for each kind of commodity or stock item, the Inventory Report summarizes one month's activity for all commodities.

The Inventory Record should be filled out at the end of every month, as follows:

1. Write the month and year covered by the report.
2. Write the name and address of the agency or project supported by the Enterprise Program.
3. Write the name of the person filling out the report and the date the report is being prepared.
4. Complete one line of the form for every different commodity item handled by your program. For example, condoms of different sizes or pills of different kinds should each be entered individually.
5. For each item, enter the quantity on hand at the beginning of the month covered by this report.
6. Next, enter the total quantity distributed during the month. This number should be available from service records (e.g., clinic logs, community-based distribution records, etc.).
7. If any stocks were received during the month, enter the quantity in the column headed "Quantity Added to Inventory."
8. "Quantity on Hand (end of month)" is calculated as "Quantity on Hand (first of month)" minus "Quantity Distributed" plus "Quantity Added to Inventory." This number will carry forward to the next month's Inventory Report as "Quantity on Hand (first of the month)."

These calculations can be made directly from inventory records, but at least once every three months a physical count of stocks should be taken to allow for correction of any possible recordkeeping errors.

9. The last column, "Re-Order Point," is determined for each commodity jointly by your agency/project and the Enterprise Program. It is generally a six-months' supply of the item. Dipping below the re-order point indicates it is time to requisition more of that item.

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Here is an example of a completed Inventory Report:

Inventory Report for the Month of Month Year

Agency: Agency or
Project name
and address

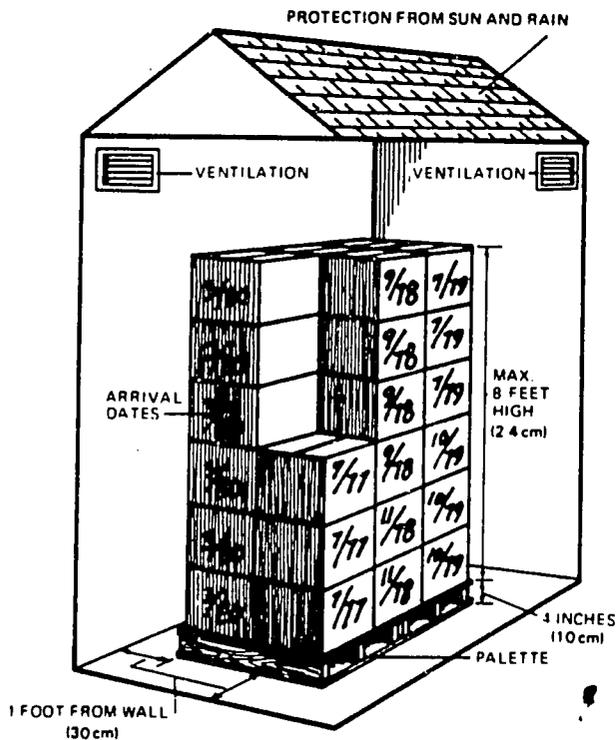
Name of person filling out report: Name

Date: Day / month / year

Item	Quantity on hand (first of the month)	Quantity distributed	Quantity added to inventory	Quantity on hand (end of the month)	Re-order point
49mm Condoms	12,100	1,100	—	11,000	6,000
Noriday's	19,300	3,080	—	16,220	17,000
52mm Condoms	6,000	1,000	6,000	11,000	6,000
Lippes Loop C	350	81	—	269	200

Source: Enterprise Program, 1986.

GUIDELINES FOR PROPER STORAGE OF CONTRACEPTIVES



GUIDELINES FOR PROPER STORAGE

1. CLEAN ROOM AND WHITEWASH WALLS
2. CHECK ROOF FOR WATER LEAKAGES
3. NO DIRECT SUNLIGHT ON THE SUPPLIES.
4. STOREROOM NOT SUBJECT TO WATER PENETRATION
5. SUPPLIES TO BE STACKED AT LEAST 4 INCHES (10 cm) FROM FLOOR (Arrange dunnage of wood or steel).
6. SUPPLIES TO BE STACKED AT LEAST 1 FOOT (30 cm) FROM ANY WALL
7. SEPARATE STACKS ACCESSIBLE FOR "FIRST IN FIRST OUT" (FIFO), COUNTING, AND GENERAL MANAGEMENT
8. STACKS NOT MORE THAN 8 FEET HIGH (2.4 m).
9. IDENTIFICATION MARKS AND OTHER LABELS VISIBLE.
10. SUPPLIES TO BE ISSUED BY CARTON OR BOX LOT, IF POSSIBLE
11. WELL VENTILATED.
12. WELL LIGHTED.
13. FIRE EXTINGUISHERS NOT BLOCKED.
14. VACCINES AND SERAS MUST BE STORED IN REFRIGERATOR.
15. OLD FILES, INFORMATION MATERIAL, OFFICE SUPPLIES, ETC. SHOULD BE STORED SEPARATELY.
16. INSECTICIDES AND OTHER CHEMICALS NOT TO BE STORED TOGETHER WITH CONTRACEPTIVES AND MEDICAL SUPPLIES
17. STOREROOM TO BE DISINFECTED AND SPRAYED AGAINST INSECTS EVERY THIRD MONTH.
18. DAMAGED AND CONDEMNED SUPPLIES TO BE SEPARATED AND DISPOSED OF WITHOUT DELAY.
19. STORE KEYS MUST BE AVAILABLE AT ALL TIMES.
20. DAILY CLEANING OF STOREROOM.

Source: CDC. Family Planning Methods and Practice: Africa, 1983.

CLINIC DESIGN AND INVENTORY AND STORAGE OF CONTRACEPTIVE SUPPLIES

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- the size of the population to be served;
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Family planning services should be offered in facilities which are designed in consideration of the clientele to be reached and the mix of services to be provided. In addition, facilities should be easily accessible and non-threatening to clients. The planning of clinical services should provide for efficient patient flow, the privacy of the clinic's users, and their comfort.

The basic physical components of a family planning clinic include the following:

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4. a storage space for contraceptive supplies;
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6. bathroom facilities; and
7. running water.

In situations where surgical procedures are to be performed, facilities should conform to acceptable local standards for such facilities. Special construction and equipment will also be needed if the clinic is to contain laboratory facilities. If IE&C promotional activities and client education are a part of the clinic's function, a meeting room or area sufficiently large to accommodate a group of at least 20 persons will be needed.

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Storage Facilities--for contraceptive supplies are an important part of on-site family planning facilities in factories or on plantations. The guidelines on the next few pages should prove helpful in drawing up procedures for storing supplies as well as keeping the inventory current.

Housekeeping Facilities--are necessary for cleaning examination equipment and for storing general cleaning equipment used in the up-keep of the clinic. Some provision must be made for sterilizing equipment (either autoclave and boiling).

INVENTORY RECORDS

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INVENTORY CONTROL

An individual Inventory Control Card (ICC) like the one on the next page is used for each type or kind of commodity item in inventory. The ICC shows all the activity for the given item. It should be filled out at follows:

1. Describe the item (size, color, stock number, etc.)
2. Note where the inventory item is stored.
3. Indicate on the ICC the re-order point for the item. The re-order point for contraceptives is normally when the inventory level drops to a six-month supply. It is then necessary to order additional supplies.
4. Make a chronological entry each time anything is added to or taken out of inventory. Note the date and quantities for every addition to inventory and every distribution from inventory.
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INVENTORY CONTROL CARD

INVENTORY CONTROL CARD

Item: _____

Storage location: _____ Re-order point: _____

Date	Quantity received in inventory	Quantity taken out of inventory	Balance

INVENTORY CONTROL CARD

Item: 49mm colored/lubricated condoms

Storage location: Clinic store room shelf 8-3 Re-order point: 6,000

Date	Quantity received in inventory	Quantity taken out of inventory	Balance
Jan. 3 '80	11,000		11,000
1/10/80		2,000	9,000
2/6/80		950	8,050
3/25/80		1,000	7,050
4/11/80		2,000	5,050
4/28/80	14,000		19,050

Source: Enterprise Program, 1986.

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INVENTORY REPORT

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The Inventory Record should be filled out at the end of every month, as follows:

1. Write the month and year covered by the report.
2. Write the name and address of the agency or project supported by the Enterprise Program.
3. Write the name of the person filling out the report and the date the report is being prepared.
4. Complete one line of the form for every different commodity item handled by your program. For example, condoms of different sizes or pills of different kinds should each be entered individually.
5. For each item, enter the quantity on hand at the beginning of the month covered by this report.
6. Next, enter the total quantity distributed during the month. This number should be available from service records (e.g., clinic logs, community-based distribution records, etc.).
7. If any stocks were received during the month, enter the quantity in the column headed "Quantity Added to Inventory."
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Here is an example of a completed Inventory Report:

Inventory Report for the Month of Month Year

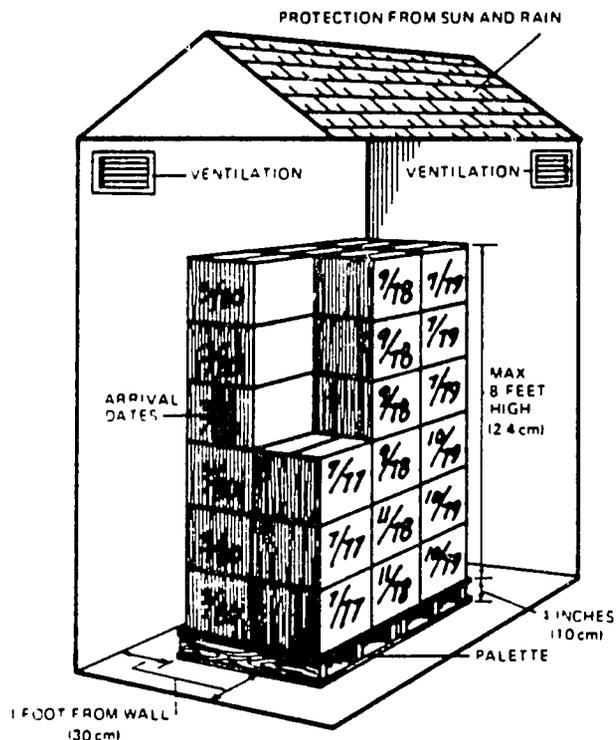
Agency: Agency w
Project name
and address

Name of person filling out report: Name

Date: Day / month / year

Item	Quantity on hand (first of the month)	Quantity distributed	Quantity added to inventory	Quantity on hand (end of the month)	Re-order point
49mm Condens	12,100	1,100	—	11,000	6,000
Novidag/50	19,300	3,080	—	16,220	17,000
52mm Condens	6,000	1,000	6,000	11,000	6,000
Lippes 130pC	350	81	—	269	200

GUIDELINES FOR PROPER STORAGE OF CONTRACEPTIVES



GUIDELINES FOR PROPER STORAGE

1. CLEAN ROOM AND WHITEWASH WALLS.
2. CHECK ROOF FOR WATER LEAKAGES.
3. NO DIRECT SUNLIGHT ON THE SUPPLIES.
4. STOREROOM NOT SUBJECT TO WATER PENETRATION
5. SUPPLIES TO BE STACKED AT LEAST 4 INCHES (10 cm) FROM FLOOR (Arrange dunnage of wood or steel).
6. SUPPLIES TO BE STACKED AT LEAST 1 FOOT (30 cm) FROM ANY WALL
7. SEPARATE STACKS ACCESSIBLE FOR "FIRST IN FIRST OUT" FIFO COUNTING, AND GENERAL MANAGEMENT
8. STACKS NOT MORE THAN 8 FEET HIGH (2.4 m)
9. IDENTIFICATION MARKS AND OTHER LABELS VISIBLE
10. SUPPLIES TO BE ISSUED BY CARTON OR BOX LOT IF POSSIBLE
11. WELL VENTILATED
12. WELL LIGHTED.
13. FIRE EXTINGUISHERS NOT BLOCKED.
14. VACCINES AND SERAS MUST BE STORED IN REFRIGERATOR
15. OLD FILES, INFORMATION MATERIAL, OFFICE SUPPLIES ETC SHOULD BE STORED SEPARATELY
16. INSECTICIDES AND OTHER CHEMICALS NOT TO BE STORED TOGETHER WITH CONTRACEPTIVES AND MEDICAL SUPPLIES
17. STOREROOM TO BE DISINFECTED AND SPRAYED AGAINST INSECTS EVERY THIRD MONTH.
18. DAMAGED AND CONDEMNED SUPPLIES TO BE SEPARATED AND DISPOSED OF WITHOUT DELAY
19. STORE KEYS MUST BE AVAILABLE AT ALL TIMES.
20. DAILY CLEANING OF STOREROOM.

Source: CDC. Family Planning Methods and Practice: Africa, 1983.

RECORD KEEPING AND EVALUATION

MONITORING ACTUAL VERSUS EXPECTED PROGRESS

It is important to monitor the "actual" versus "expected" progress of company-based family planning services. To do this, a range of basic information must be collected. These data include:

1. targeted number of acceptors
2. number of family planning acceptors
3. type of family planning acceptor
 - new acceptor (first time user)
 - previous acceptor (has used in past but not currently)
 - transfer acceptor (previously using another source)
 - continuing acceptor (new or transfer acceptor who renews)
4. acceptor characteristics
 - sex
 - age
 - parity
 - educational level
 - marital status
5. method mix selected
6. length of time using services
 - date begun
 - date ended

Prevalence rates and drop-out rates can be calculated from these data. Most data can be extracted from patient records, daily logs and intake forms.

(In addition to the forms provided in this section, trainers should gather examples of patient records, daily logs, etc. from local or national programs and share them with participants.)

Prevalence rates from newly established company-based family planning services should be periodically compared with data from national prevalence and fertility surveys as well as with data from other nationally or privately supported family planning services.

Now, let's look at the three sample forms.

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Now, let's look at the three sample forms.

RECORD KEEPING AND EVALUATION

This section of the manual includes record keeping systems/forms developed for use in company-based family planning programs. These forms were developed for use in Enterprise Program sub-projects and provide information which is useful for managers who are also service providers. The forms are:

- Form A -- sample client record
- Form B -- a clinic recording/reporting system for use in monitoring subproject clinics (one write system).
- Form C -- Enterprise Program Quarterly Report

While these forms may exceed your own client record and recording/reporting needs, you may find them of use in developing a record keeping system. Or, you may be required to use national government family planning record systems.

Before looking at the forms, let's first look at the kind of information which you will need to measure the impact/level of use of the services you want to set up.

Family Planning Client Record

The items contained in the family planning record (Form A) are briefly outlined on the following pages.

After completing this section workshop participants will:

1. better understand the need for collecting and recording adequate medical data on their clients,
2. be able to design their own client family planning record, if none exists, or
3. be able to modify existing records, if they are incomplete or inadequate.

Deciding What to Include in Your Family Planning Client Record

Everyone agrees that assessing the health status of a potential family planning acceptor and duly recording it is essential, but the content - what data to obtain - and the format for recording it are hotly debated. For example, in most developed countries a complete medical history, physical

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VI Records
Trainer's Copy

examination (including a pelvic), and laboratory tests such as hemoglobin, GC, VDRL and Pap smear are required before providing services. However, throughout much of the world, most of the currently available modern child spacing methods, such as condoms, vaginal spermicides, oral contraceptives (OCs) and injectables, have been safely provided to millions of acceptors with only minimal health data recorded and no physical examination or laboratory studies. Thus, the type of client record system required by each Enterprise subproject will depend on local health practices and government regulations as well as other factors.

Because there is no clearly defined "ideal" family planning client record, the items included in the sample record (Form A) are neither mandatory nor all-inclusive. Each Enterprise subproject will have to decide what to include. This decision will depend on a number of factors such as the age and sex of the subproject's target population (females only, males only or both); type of delivery system (clinic-based services versus community- or commercial-based distribution programs); and most importantly, the type of services provided (e.g., all methods including IUDs and sterilization versus services limited to condoms, spermicides and OCs).

[NOTE TO TRAINER: In discussing the sample record (Form A) refer to the material contained in Handout A, "Outline of Items to be Included in a Comprehensive Family Planning Client Record".]

The sample Family Planning Client Record (Form A) was developed by the Enterprise Program staff. The items selected are those which most health providers consider should be included in a comprehensive family planning record. Taken together the material contained in the outline (Handout A) and the sample record (Form A) provide a framework for the development of a subproject record system. Each subproject can modify the sample record to meet existing local health and family planning informational requirements.

It is recommended that the family planning record system of each country should be utilized if one already exists. However, these existing record systems may need to be modified (or expanded) to ensure that the data collected is adequate. Only in this way can each subproject clinic be assured that prospective clients are receiving safe, effective and appropriate family planning services tailored to their individual needs. Should assistance be required by subprojects attempting to design a new client record or modify existing ones, Enterprise Program staff can provide technical assistance.

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Procedure for Collecting and Recording Client Health Data

All family planning clients should have a health record. At the first visit, the record should be completed in its entirety. This information is required by both the client and health provider in order to make an effective and informed decision on the child spacing method he/she may safely use. An experienced family planning practitioner (physician or nurse) can complete this activity for a new client in approximately twenty minutes. Alternatively, a trained assistant can obtain the historical data (Sections I-III, Handout A and Form A) and the health practitioner then can perform the physical examination, assist the client select an appropriate method, and instruct him/her on its correct use.

The categories in which information are to be collected and recorded (Form A) include the following:

- Client identification data: name, address, etc.
- Demographic data: age, number of living children, marital status, and KAP data such as prior use of family planning and desire for additional children in the future
- Reproductive health data: pregnancy, menstrual, gynecologic and sexual history
- General medical data: cardiovascular, neurovascular, pulmonary, renal, allergy and current medications, etc.
- Family history: diabetes, hypertension, breast and genital tract cancer, etc.

A client number system or some other means of anonymously identifying each client should be set up by each subproject. In addition, all clients should be informed that the information on their record is confidential and will NOT be released without prior consent.

Ideally a complete physical examination should be performed on all female clients and those males requesting permanent contraception (vasectomy). For many reasons, e.g., religious, social, economic, often this is not possible. Certainly for all females having an IUD inserted, a complete pelvic examination must be performed. And, for those women requesting sterilization a complete physical examination, including a pelvic is mandatory.

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VI Records
Trainer's Copy

Because screening for breast lesions (cancer) is important, clients should be taught to perform self breast examination (SBE) whenever and wherever possible. The technique is easy to learn, simple to teach and requires no equipment.

Laboratory investigations can be performed if facilities are available. The need for sophisticated (expensive) laboratory testing of clients requesting child spacing methods is rarely necessary. At a minimum (and where available) all female clients should have a urinalysis (sugar and protein) and hematocrit or hemoglobin. If Pap smear testing is available this also is indicated. If a vaginal infection is suspected, a wet prep, looking for yeast, trichomonads or gardnerella is easy to perform - provided a microscope is readily at hand. Screening for other sexually transmitted diseases (STDs) is generally too expensive to be cost-effective in most LDCs.

When continuing family planning acceptors return for their regularly scheduled follow-up visits, basic data, i.e, last menstrual period (LMP), weight and blood pressure (BP), and any problems, side effects or complications of the method they are using should be recorded. It is extremely important that all IUD users routinely be queried regarding symptoms suggestive of pelvic infection. They also should be checked periodically for abdominal/pelvic tenderness. The conscientious collection and recording of this information will help to ensure the provision of high quality and safe services to all clients.

For logistical purposes, it is necessary to note the quantity of supplies provided clients using condoms, vaginal spermicides or OCs. In addition each subproject should develop a plan for managing clients who fail to keep their return appointments. Several systems are available such as a "tickler" file system, telephone or outreach (home or work) contacts. Unless clients continue to regularly use their child spacing method, success in preventing undesired pregnancies can not be expected.

ALL clients coming to the clinic who desire family planning should be able to receive some type of child spacing method at their first visit. Even if the method they choose can not be started at this visit, they should not be told to return next month to have their IUD inserted or begin taking OCs. Clients in this situation should be offered a barrier method, vaginal spermicide, or at a minimum be counseled to abstain or use a traditional method until they can start the pill or have an IUD inserted.

Again, technical assistance can be provided by the Enterprise Program to subprojects regarding the purpose and correct use of the sample Family Planning Client Record (Form A).

**OUTLINE OF ITEMS TO BE INCLUDED IN A COMPREHENSIVE
FAMILY PLANNING CLIENT RECORD**

I. CLIENT DATA

A. IDENTIFICATION

DATE: Record the date the client was seen.

CLIENT NAME AND ADDRESS: Record the client's name and an address sufficient for follow-up if such information is not already included in the employee's record system or general health record. You should assure the client that this information will be used ONLY for contact in the event that he/she misses the next return appointment, and that such contact will be made DISCREETLY. If the client prefers not to be contacted, you should not do so; such information should be recorded in the client's family planning record.

CLIENT NUMBER: Record the client's patient number from the employee record system so that you can refer back to his/her complete records later, if necessary. If you do not have such a numbering system already, The Enterprise Program staff can help you decide how to establish one.

CONTACT PERSON: In case of emergency and for outreach purposes it is useful to have the name and address of the nearest relative and/or friend of the client. The client should be assured that this person(s) would be contacted only with his/her permission.

SOURCE(S) OF MEDICAL CARE: If the client is receiving or has received medical care from other health clinics, this information may be useful in facilitating their family planning care.

B. DEMOGRAPHIC INFORMATION

AGE: Record the client's age in WHOLE YEARS only.

EDUCATION: Record the total years of schooling in WHOLE YEARS only.

LOCAL USE: Space should be left for items which individual subprojects may want to collect (e.g., marital status, occupation, race, religion, referral source, etc.)

II. REPRODUCTIVE HEALTH DATA

A. FAMILY PLANNING HISTORY: Record information relevant to:

Prior use of birth spacing method (and source)

Current method and duration of use

Use of traditional methods including breast feeding

Desire for additional children; if yes, number

B. PREGNANCY HISTORY: Record information relevant to:

Number of pregnancies and outcome

Number of living children

Date last pregnancy ended

Outcome of last pregnancy

Complications of any pregnancy (e.g. ectopic², caesarean section, uterine perforation or rupture², toxemia, genetic abnormality, jaundice during pregnancy¹, etc.) or abortion

Pregnant now or suspected pregnancy

Breast feeding now¹

Known or suspected fertility problem

C. MENSTRUAL HISTORY: Record information relevant to:

Date of LMP (by day/month if known)

Age of onset of menses (by WHOLE YEAR)

Character of menses:

- interval: by days, if known, or by estimating number of weeks from onset of one menses to first day of next)

- frequency: regular if interval between menses >24 days and <35 days; amenorrhea if interval >6 months

- duration: number of days of menses

- amount: light/normal/heavy, + clotting

- discomfort: + severe cramping

Undiagnosed abnormal genital bleeding: specify type and site^{1,2}

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D. GYNECOLOGIC HISTORY: Record information relevant to:

Breast disease: If malignant¹

Ovarian disease: Cyst/tumor (if malignant¹)

Uterine disease: Fibromyomata^{1,2}, malignancy of
cervix or endometrium^{1,2}

Pelvic infection: If positive²

Sexually transmitted disease(STD): Gonorrhea², chlamydia²,
mycoplasma², herpes, AIDS, syphilis, etc.

Cervicitis: Only if Pap smear abnormal^{1,2}

Vaginitis: Yeast, trichomonads, gardnerella, etc.²

DES exposure and physical findings: If positive^{1,2}

E. SEXUAL HISTORY: Record information relevant to:

Age first coitus

Frequency of intercourse

Number of sexual partners

Problems such as infertility, impotency, vaganismus,
dysparunia, etc.

Possible increased risk of complication or known contraindication
if this method is recommended:

¹Combination (estrogen/progestin) OCs; less risk with progestin-
only or injectables (DMPA or NORPLANT^R)

²IUD (evaluate and correct condition before inserting)

³Barrier methods (condom, diaphragm or cervical cap)

⁴Vaginal spermicides

⁵Breast feeding, traditional methods or periodic abstinence
(natural family planning)

III. GENERAL MEDICAL DATA

A. MEDICAL HISTORY: Record information relevant to:

Cardiovascular disease: Coronary heart disease, hypertension, stroke, thrombophlebitis, varicose veins, seizures, migraines^{1,6}

Kidney disease: Benign (chronic)^{1,2,6}

Lung disease: Benign (e.g. asthma, chronic bronchitis, or emphysema, etc.,⁶)

Liver disease: Benign or malignant liver tumors, if developed during the use of OCs or other estrogen-containing product; impaired liver function, acute or chronic (active) hepatitis¹

Gallbladder disease¹

Diabetes¹

Obesity: If client >25% over ideal body weight, OCs should be used with caution

Smoker: 35 years of age or older and currently a heavy smoker (15 or more cigarettes per day)¹

Psychic depression¹

Anemia: All types^{2,6}; sickle cell disease(SS), sickle C disease(SC) or folate deficiency¹

Possible increased risk of complication or known contraindication if this method recommended:

¹Combination (estrogen/progestin) OCs; less risk with progestin-only or injectables (DMPA or NORPLANT^R)

²IUD (evaluate and correct condition before inserting)

³Barrier methods (condom, diaphragm or cervical cap)

⁴Vaginal spermicides

⁵Breast feeding, traditional methods or periodic abstinence (natural family planning)

⁶Female sterilization (evaluate condition and correct before surgery)

Drug or alcohol problem

Immunization status: Check the following: DT/booster (date), OPV/booster (date), rubella titer, if available, tbc test (date, outcome). Also check immunization status of client's children.

Surgery: Type and date

Drug allergy: Specify (e.g, antibiotics, local anesthetics⁶, etc.)

Medications (current): Sedatives, antibiotics and seizure medications all alter OCs metabolism and decrease effectiveness.

B. FAMILY HISTORY: Record information relevant to:

Diabetes¹ (parents/sibs): Client is at increased risk of developing diabetes or being prediabetic.

Early heart attack/stroke in parents (under age 50)¹

Hypertension¹

Breast cancer (mother/aunts and sibs): Increased risk to client.

Birth defects (parents, sibs and children)

Cancer: Specify site (organ) if known.

Possible increased risk of complication or known contraindication if this method recommended:

¹Combination (estrogen/progestin) OCs; less risk with progestin-only or injectables (DMPA or NORPLANT^R)

²IUD (evaluate and correct condition before inserting)

³Barrier methods (condom, diaphragm or cervical cap)

⁴Vaginal spermicides

⁵Breast feeding, traditional methods or periodic abstinence (natural family planning)

⁶Female sterilization (evaluate condition and correct before surgery)

IV. PHYSICAL EXAMINATION DATA

Initial and annual visit; Complete physical examination including pelvic and instruction in self breast examination (SBE)

Follow-up visit: As indicated

NOTE: Physical examination may be omitted if clinic is not using IUDs or performing sterilizations and historical data are negative (normal). Check local family planning health policies.

V. LABORATORY DATA

Important:

Urinalysis (sugar/protein): Screening for diabetes, kidney disease and urinary tract infection

Hematocrit/Hemoglobin: Screening for anemia

Wet Prep: Screening for vaginitis caused by trichomonads, yeast or gardnerella

Less important and/or more expensive/difficult:

Pap smear: Screening for genital (cervical) cancer

STD tests: VDRL (serology), GC, chlamydia and mycoplasma

VI. OUTCOME AND PLAN

Diagnosis (if pathologic condition noted)

Type of birth spacing method provided: If client given OCs, condoms or vaginal spermicides, specify amount.

Referral (e.g., for sterilization, natural family planning, counseling, etc.)

Return appointment: Write the DATE the client is supposed to come to the clinic again. Normally, follow-up visits will be for resupply of contraceptives. The date selected should allow a few weeks to spare in case the client has trouble keeping the appointment. For example, if you give an OC patient three cycles of pills, write a date two and one-half months in the future; if you give a man enough condoms for two months, select the date of the next appointment five to six weeks in the future.

Return appointment: (continued)

For clients referred for sterilization or natural family planning, a future follow-up appointment should be given to verify that everything is OK.

For clients who do NOT want to be contacted for follow up, write "NC", no contact or put ("--") for the next appointment date.

End-of-visit interview: If exit interview conducted, summarize outcome of the visit. Examples:

- attended lecture/demonstration
- counseled on child spacing methods
- taught self-breast examination (SBE)
- consent forms signed: IUDs, sterilization, release of patient information, etc.)
- given emergency information

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FORM A: SAMPLE FAMILY PLANNING CLIENT RECORD

THE ENTERPRISE PROGRAM
Arlington, VA

FAMILY PLANNING CLIENT RECORD

I. CLIENT DATA

A. IDENTIFICATION Client No. _____

Date ____:____:____
(Day Mo . Yr)

Name _____
(Family/Last) (Given/First)

Address _____
(or directions to work/home)

Phone _____ (Office) _____ (Work)

May contact for follow up? :Yes :No :Careful

Nearest Relative/Friend

Name _____ Relationship _____

Address _____

Sources of Medical Care _____

Reason for Visit _____

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B. DEMOGRAPHIC INFORMATION

Page 2

Age _____ Marital Status S M W S/D
(Whole Years) (Circle One)

Language _____ Education _____
(Whole Years)

School/Occupation _____

Other _____

II. REPRODUCTIVE HEALTH DATA

A. FAMILY PLANNING HISTORY

Prior FP No
method Yes _____
(Specify last method)

Using FP No
method Now Yes _____
(Specify method and months/years)

Currently No How
Breast feeding Yes Long? _____
(Mo Yr)

Desires more children Yes (How many) _____
in the future No Maybe

B. PREGNANCY HISTORY

Number of
Pregnancies _____ LB _____ SBs _____ ABs _____

Number Living _____ Date Last
Children _____ Pregnancy Ended _____
(Mo Yr)

Outcome
Last Pregnancy _____ LB _____ SBs _____ ABs _____

Complications of Pregnancy or Abortion

Ectopic _____ C/Section _____ Toxemia _____
Birth _____ Postpartum _____ Uterine _____
Defect _____ Infection _____ Perforation _____

Other _____

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C. MENSTRUAL HISTORY

Page 3

Age of onset _____
(Whole Years)

LMP	____	____	____
	(Day	Mo	Yr)

Cycle < 23 days Cycles regular
Length > 24 but < 35 irregular
 > 36 days
 > 6 Months (Amenorrhea)

Days of flow _____ Amount of flow L N H
(Circle One)

Discomfort
with periods No Yes: Mild Moderate Severe
(Circle One)

Abnormal No
Bleeding? Yes (Specify) _____

D. GYNECOLOGIC HISTORY (If YES; explain)

Infection: No Yes Now

Pelvic Infection Vaginitis STD/VD
 Endometritis Cervicitis

Tumor/cyst: No Yes Now

Breast Ovary Uterus Cervix

Abn. Pap: No Yes Now

Comments:

E. SEXUAL HISTORY

Age first coitus _____
(Years)

Problems _____

Infertility No Yes (Specify) _____

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III. GENERAL MEDICAL DATA

Page 4

A. MEDICAL HISTORY (IF YES, explain)

Vascular Disorder: No Yes Now

Heart Stroke High BP Diabetes
 Thrombophlebitis Migraine Seizures

Systemic Disorder: No Yes Now

Kidney Lung Liver/jaundice GB
 Anemia Obesity Smoker
 Drug/Alcohol Abuse (# cig. per day _____)

Cancer: No Yes Now

Kidney Lung Liver Brain

Reproductive organs (Specify) _____

Other (Specify) _____

Allergy: No Yes (Specify) _____

Immunization:

Client No Yes (Specify) _____

Children No Yes (Specify) _____

Surgery: No Yes _____
(Type/Date)

Comments:

B. FAMILY HISTORY.

Diabetes in Parents/Sibs No Yes
Heart attack/stroke, Parents age <50 No Yes
Hypertension No Yes
Breast Cancer, Mother/Aunts/sibs No Yes

2/8/11

IV. PHYSICAL EXAMINATION DATA Page 5

Ht: _____ Wt: _____ BP: _____ TEMP: _____

System	Normal	Other	Describe
Thyroid			
Heart			
Lungs			
Breasts			
Abdomen			
Perineum			
CX/Vagina			
Uterus			
Adnexa			
Rectum			

Other Systems (Specify) _____

Comments:

Return Appt. ____ : ____ : ____ Refer _____
 (Day Mo Yr)

Clinician's Signiture _____

V. LABORATORY DATA Urine _____ Hct/Hgb _____

Pap Smear _____ Other _____

VI. OUTCOME AND PLAN

Method supplied _____ Taught SBE ____
 (Type and quantity)

Counseled and given info. on FP method _____

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CLINIC RECORDING AND REPORTING FORMS

The following pages document a simple clinic recording and reporting system, which is to be used by Enterprise Program projects that do not already have a clinic management system to keep track of work performed, contraceptives distributed, and follow-up for family planning clients. All recording is done on a "One-Write" system which automatically produces two stubs which can be used for follow-up of clients that are CONTINUING USERS. Simple tallies from the Daily Log Sheet can be used to prepare monthly or quarterly management reports for use both by clinic managers and by Enterprise Program evaluation team staff.

Each component of this recording and reporting system is discussed in turn below.

ONE-WRITE SYSTEM DAILY LOG SHEET

The One-Write Daily Log Sheet is the basic form which is used to keep track of work performed, contraceptives distributed to program ACCEPTORS, and follow-up for clients that are CONTINUING USERS. The system is so named because it is designed in such a way that each item of data need be written only once. The system consists of a peg board with small pegs along the left-hand side, a large Daily Log Sheet which fits onto the pegs, and a series of pairs of small Revisit Slips which fit onto the pegs on top of the Daily Log Sheet. The Revisit Slips have carbon on the back, and are fitted onto the pins so that as you write, you automatically complete one pair of Revisit Slips and one line of the Log Sheet at the same time. The Enterprise Program can provide technical assistance and all the supplies necessary to design and establish a One-Write System.

You must complete one line of the Log Sheet (and one pair of Revisit Slips at the same time) for each client seen at your family planning clinic, WHETHER OR NOT the client decides to take a contraceptive method. You should also complete a line when you distribute CONDOMS as discussed below. Each Log Sheet has room at the bottom for totaling all the figures on the sheet. You should USE A BALL POINT PEN when entering data on the One-Write System, since you are making multiple copies at once. Use as many Log Sheets and Revisit Slips as you need each month to record all your clients; when one sheet is full, just continue with another. At the beginning of each month, however, you should start with a new Log Sheet. DO NOT record two months' activities on a single sheet.

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Instructions for completing each line of the One-Write Daily Log Sheet are as follows:

DATE: Record the date the client was seen, or use ditto marks ("") when several clients are seen on the same day.

CLIENT NUMBER: Record the client's patient number from your medical or employee record system, so that you can refer back to his/her complete records later if necessary.

If you do not have such a numbering system already, Enterprise can help you decide on how to establish one.

CLIENT NAME AND ADDRESS: Record the client's name, and an address sufficient for follow-up if such information is not already included in your medical record. You should assure the client that this information will be used ONLY for contact in the event that he/she misses the next appointment, and that such contact will be made DISCREETLY. Of course, if the client prefers NOT to be contacted, you should not do so: such information can be recorded in the NOTES/COMMENTS section of the Daily Log Sheet, and should also be written into the client's medical record if you keep one.

NEXT APPOINTMENT DATE: Write the date that the client is supposed to come to the clinic again. Normally, next visits will be resupply of contraceptives, and you should write a date that gives a few weeks to spare in case the client has trouble keeping the appointment. For example, if you give a pill patient three cycles of pills, write a date two and one-half months in the future. If you give a man enough condoms for two months, write a date five or six weeks in the future.

For clients you refer for VSC, NATURAL FP or other reasons such as hypertension, etc., you should agree on a date for them to return to you for a follow-up visit to make sure everything is satisfactory and record this date.

For clients who do NOT want you to contact them for follow-up, write "NC": for "No Contact", or put a dash ("--") for the NEXT APPOINTMENT DATE.

Of course, you probably will not know what NEXT APPOINTMENT DATE to use when a client first arrives at the clinic. It is good practice to have each client stop at the front desk on the way out, so that you can find out whether he/she has any questions or complaints and settle on an appropriate date for the next visit at the same time.

CLIENT TYPE:

Write a code for the type of client. Codes are shown along the bottom of the Daily Log Sheet, they are: NF for New Female Acceptor, NM for New Male Acceptor, TF for Transfer Female Acceptor, TM for Transfer Male Acceptor, and CU for Continuing User (either male or female).

Note that a client visiting the clinic for the first time is coded as NEW (Acceptor) if he/she is not currently using a family planning method. A client who has until now received services at another facility is coded as TRANSFER (Acceptor), (i.e., a current user who is transferring to this clinic). For every visit after the first, clients are coded as CONTINUING (Users) when they come for family planning services.

At this point, you have completed the pair of Revisit Slips for this client. Use of these Revisit Slips is discussed below. The remainder of the data items are written only on to the Daily Log sheet itself.

Certain data needed for management purposes, such as age or education, relates to the client and not to the family planning visit. Such data should be counted ONLY ONCE for each unique individual client who visits the clinic. Accordingly, the Daily Log provides space for several data items which are collected ONLY for NEW or TRANSFER acceptor clients, (i.e., First-Time Clients only). These data items SHOULD BE LEFT BLANK for CONTINUING USER clients.

LAST SOURCE:

Only TRANSFER client acceptors should be asked this question. (Ask the client from what source of supply he/she last obtained his/her family planning method.

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Record a "P" in the column if the source is Public; a "C" if the source is private or Commercial, for example, private doctor, private midwife, pharmacy.

(It may be helpful to develop a list of all the local family planning sources by Public and Private/Commercial categories. The receptionist can find the source name from one of these two lists and mark the column appropriately.)

LAST METHOD:

Ask all NEW client acceptors whether they have used a family planning method in the past, and if they have, which was the LAST method they used. Record the method in this column; if he/she has never used a family planning method, record an N (for NONE).

Ask TRANSFER client acceptors which method they are currently using, and record the name of this method in this column.

BRAND NAME:

Only TRANSFER client acceptors should be asked this question. Write in the brand name of the contraceptive. (It might be helpful to develop a list of brand names available in your area.)

The following questions (AGE, EDUCATION, LIVING CHILDREN, AND MARITAL STATUS) are asked of all NEW AND TRANSFER (FIRST-TIME) CLIENTS:

AGE:

Record the client's age in WHOLE YEARS only.

EDUCATION:

Record the total number of years of schooling completed.

LIVING CHILDREN:

Record the total number of children the client has had who are now living.

MARITAL STATUS:

Record whether the new or transfer client is Single, Married, In Union, Separated, Divorced, or Widowed.

LOCAL USE:

An additional column has been left for items which individual projects may want to collect (e.g., referral source, etc.). This column can be used continuously if project managers desire, or could be used on a periodic or sampling basis for special survey purposes.

The remaining items on the Log Sheet should be collected for ALL clients. The items are:

**CONTRACEPTIVE
METHODS:**

Six columns of the Log Sheet are used to record contraceptive methods dispensed. For PILLS, FOAMING TABLETS, or CONDOMS, record the actual quantities dispensed, since this information is needed for reordering of contraceptive supplies, and for determining the NEXT APPOINTMENT DATE and Enterprise Program service statistics. For PILLS, record cycles dispensed; for FOAMING TABLETS, record tablets for CONDOMS, record pieces.

For INJECTABLES, IUD INSERTIONS, or IUD CHECK-UPS, write a "1" or a checkmark in the appropriate column. Two additional blank columns have been left for other methods that individual clinics may provide (e.g. NORPLANT, VSC). If you give more than one method (e.g., PILLS, plus enough CONDOMS to last until the client's next period), record all that apply. Of course, if a client declines to take any of these methods, just check NO METHOD.

If a male comes in for CONDOMS, and you give them directly to him without providing any other service, you DO NOT need to fill out the whole line of the Log Sheet. Just write "Condom Distribution": in the CLIENT NAME column, and the number of pieces you distribute. You need not make male CONDOM clients wait for you to fill out the rest of the record. The Revisit Slips for these condom-only clients can just be discarded.

REFERRALS:

If you refer a client for Voluntary Surgical Contraception (VSC), NATURAL FP, or other reasons, such as referral for hypertension, anemia, severe varicosities, etc., check the

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appropriate column. Again, a blank column has been left for local use in tracking other referral services. Note that you might very well distribute contraceptive supplies at the same time you refer for VSC or other services. In such cases, complete all columns which apply.

NOTES/COMMENTS:

Use this space to record any other information that you need for local management purposes. Information which will be needed the next time the client visits the clinic should be recorded in the medical record rather than on the One-Write Log, since the Daily Log sheet will probably not be available the next time the client comes to the clinic.

Whenever a Log Sheet is full, simply continue on with another. On the bottom line of each sheet, you should tally the number of clients by each CLIENT TYPE (NF, NM, TF, TM, CU), and total the amounts of contraceptives distributed and referrals made, since this data will be needed for management and logistical reporting.

Save the completed Log Sheets as your permanent record of the services you have provided. Those projects which have been requested to keep duplicate copies of the Daily Log Sheet should simply include the duplicates (which will have the NAME AND ADDRESS column blacked out for confidentiality purposes) in their regular Quarterly Report to Enterprise.

USE OF REVISIT SLIPS AS APPOINTMENT REMINDERS

Now, tear off the part of Revisit Slips you have just completed. Give the top copy to the client to serve as a reminder of the next appointment date, and ask him/her to bring the slip back on the next appointment. It is not absolutely necessary that the client do this, but if he/she does not want to be contacted outside the clinic, you should write "No contact" on your copy of the Slip.

Your copy of the Revisit Slip can be used as your appointment reminder, or "tickler" system. Enterprise can help you construct such a system if you do so desire. All that is needed is a file box or drawer with cardboard dividers for each week of the year.

You should file your copies of all Revisit Slips in the box, behind the divider corresponding to the week of each client's NEXT APPOINTMENT DATE. For example, if a client is seen on January 1, and given a three month's supply of pills, you would give her a NEXT APPOINTMENT DATE of March 15th, so that she is supposed to come back two weeks before she runs out of pills. You would then file her Revisit Slip in the section for the third week of March. In this way, at the beginning of each week, you will have in one section of the box Slips for all CONTINUING clients who are supposed to return that week.

When a CONTINUING client comes in for his/her appointment, you take his/her old Revisit Slip out of the box and THROW IT AWAY. Any slips remaining at the end of the week represent clients who have missed their appointments.

If a CONTINUING user fails to return to the clinic for six months after his/her last scheduled appointment he/she is considered a DROP OUT. DO NOT throw the Revisit slip away. Instead, you should keep a separate file of such slips in date order, so that you can from time to time calculate the number of DROP-OUTS your program is experiencing. You will be asked to forward the Revisit Slips for clients who have dropped out to Enterprise with each quarterly report.

This procedure seems a little backwards, so don't forget: THROW AWAY the slips for clients who DO return, but KEEP the slips for those who DON'T!

**MANAGEMENT REPORTING - ENTERPRISE PROGRAM QUARTERLY PROGRESS REPORT
FOR SERVICE DELIVERY SUBPROJECTS***

The One-Write Daily Log Sheet quickly and simply collects data on numbers and types of clients seen, demographic characteristics of NEW or TRANSFER client acceptors, services rendered, and contraceptives distributed. Most of the service statistics data needed for clinic management can therefore easily be extracted from the One-Write Log. Enterprise can provide technical assistance in designing management reporting systems which address specific local needs to projects as desired.

A sample reporting format, showing the data which Enterprise requires quarterly for evaluation purposes, is attached. Much of the data required for this report can be extracted directly from the Daily Log sheet tallies, as follows:

- A. TOTAL TARGET ACCEPTORS TO PROGRAM:** This is the total number of first time client acceptors (NEW and TRANSFERS) for the life expected to be reached by the project.
- B. NUMBER OF NEW CLIENT ACCRPTORS THIS QUARTER:** This is the total number of first time male or female clients who are not currently using a family planning method (coded NM or NF on daily log sheet).
- C. NUMBER OF TRANSFER CLIENT ACCEPTORS THIS QUARTER:** This is the number of first time male or female visits made by transfer clients coded TM or TF on the daily log sheets. These clients have received family planning at another facility.
- D. NUMBER OF ACCEPTORS THIS QUARTER (ALL FIRST TIME CLIENTS, NEW AND TRANSFER):** This is simply the total number of clients coded as NF, NM, TF, or TM on the Daily Log Sheets for this time period. Projects' targets for services will generally be expressed as numbers of client acceptors to be recruited.
- E. TOTAL ACCEPTORS FROM PREVIOUS QUARTERLY REPORT:** This is the total figure from Line I.F. from the previous quarter's report. For the first report, record 0.
- F. TOTAL ACCEPTORS TO DATE:** This is the sum of lines D and E.
- G. PERCENTAGE OF TOTAL ACCEPTOR TARGET ACHIEVED TO DATE:** This is simply Line F divided by the TOTAL ACCEPTOR TARGET for the project, multiplied by 100 (F/A x 100).

* Form to be completed by subprojects.

- H. NUMBER OF CONTINUING USER VISITS THIS QUARTER:** This is the number of visits made by male or female coded CU on the Daily Log Sheets.
- I. TOTAL CONTINUING USER VISITS TO DATE:** This is the total figure from Line I.I. from the previous quarter's report AND Line I.H. of this report.
- J. TOTAL VISITS THIS QUARTER:** This is simply the sum of Lines D and H.

The remaining data items for the Quarterly Report are direct tallies from the Daily Log Sheet, and are based on All visits, not just on NEW and TRANSFER clients.

CONTRACEPTIVES DISPENSED: The total for each method (including NO METHOD) can be taken directly from the totals for the appropriate line on the Daily Log.

REFERRALS: The totals for each type of referral can be taken directly from the totals for the appropriate line on the Daily Log.

DROPOUT: This is the total number of male or female acceptors and users who fail to return for family planning services six months after their last scheduled appointment.

LAST SOURCE: This information is obtained from TRANSFER client acceptors only. Record the total number of transfer clients that received family planning services from a public source (government, hospital/ clinic, etc.) or from a private source (private doctor, pharmacist, midwife, etc.)

SECTIONS VII AND VIII:

The last two sections of the Quarterly Progress Report are in narrative or list form, and ask projects to describe any major issues or constraints encountered in implementation of the program, along with any efforts made to address such constraints. Assistance which is needed from Enterprise can also be described.

ENTERPRISE PROGRAM QUARTERLY PROGRESS REPORT
FOR SERVICE DELIVERY SUBPROJECTS

PROJECT NAME: _____

THIS QUARTERLY REPORTING PERIOD: _____ day/month/year through _____ day/month/year

PROJECT START DATE: _____ day/month/year PROJECT COMPLETION DATE: _____ day/month/year

TOTAL TARGET POPULATION TO BE SERVED _____

TYPE OF FAMILY PLANNING SERVICES PROVIDED (check appropriate column)

- Type 1: Pills, condoms, and spermicides only _____
- Type 2: IUDs and/or injectables/implants (+ Type 1 services) _____
- Type 3: Voluntary Surgical Contraception (VSC) (+ Type 1 and 2 services) _____

If services #2 or #3 are checked, Section VI (Family Planing Methods Summary Report) mus completed.

I. SERVICES PROVIDED:

- A. Total Target Acceptors to Program: _____
- B. Number of New Client Acceptors This Quarter: _____
- C. Number of Transfer Client Acceptors This Quarter: _____
- D. Total Number of Acceptors This Quarter: (All First Time Clients - New and Transfer) _____
- E. Total Acceptors From Line I.F. from Previous Quarterly Report: _____
- F. Total Acceptors to Date (D + E): _____
- G. Percentage of Total Acceptor Target Achieved to Date (F/A x 100): _____
- H. Number of Continuing User Visits This Quarter: _____
- I. Total Continuing User Visits To Date: _____
- J. Total Visits This Quarter (D + H): _____

	<u>FIRST MONTH</u>	<u>SECOND MONTH</u>	<u>THIRD MONTH</u>	<u>TOTAL</u>
	* * M F	M F	M F	M F
	M F	M F	M F	M F
				M F
				M F
				M F
	M F	M F	M F	M F
				M F

*Male *Female

**II. CONTRACEPTIVES DISPENSED:
(BASED ON TOTAL VISITS PER MONTH)**

- Pills (Cycles):
- Injectables (Doses):
- IUD Insertions:
- Foaming Tablets (pieces):
- Condoms (Pieces):
- Laparoscopies
- Minilaparotomies
- Vasectomies
- Other:

<u>FIRST MONTH</u>	<u>SECOND MONTH</u>	<u>THIRD MONTH</u>	<u>TOTAL</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

I. REFERRALS:

- VSC
- Natural Family Planning
- Other

<u>FIRST MONTH</u>	<u>SECOND MONTH</u>	<u>THIRD MONTH</u>	<u>TOTAL</u>
M ___ F ___	M ___ F ___	M ___ F ___	M ___ F ___
_____	_____	_____	_____
_____	_____	_____	_____

PROGRAM DROPOUTS

M ___ F ___			
-------------	-------------	-------------	-------------

LAST SOURCE OF TRANSFER ACCEPTORS TO DATE

Of the total transfer acceptors listed in I C on page V-12, how many came from the following sources: Public _____ Private _____ Unknown _____

FAMILY PLANNING METHODS SUMMARY REPORT

INSTRUCTIONS: Subprojects providing IUDs and/or injectables/implants (Service #2) must complete Part A (below). Subprojects providing VSC services (Service #3) must complete Parts A and B as well.

A. IUDs AND/OR INJECTABLES/IMPLANTS

S

Clients discontinuing method during this reporting interval

- Complications
 - Uterine perforation (complete or incomplete)
 - Post-insertion bleeding requiring treatment or IUD removal
 - Post-insertion infection requiring treatment or IUD removal

<u>NUMBER</u>

Other complications (specify): _____

3. For each complication reported, briefly describe the management and current status of patient: _____

Injectables/Implants (Long-acting Progestins)

Number

1. Clients discontinuing method during this reporting interval

2. Complications

Bleeding requiring treatment or discontinuation/
removal
Amenorrhea (no spotting/bleeding for 60 days
or more)

Other complications (specify): _____

3. For each complication reported, briefly describe the management and current status of the patient: _____

Part B: VOLUNTARY SURGICAL CONTRACEPTION (VSC)

1. Complications (only those requiring additional hospitalization and/or surgery)

Number

Intra-operative

Immediate post-operative (within 48 hours):

Late (up to 60 days post-surgery)

2. For each complication reported, briefly describe the circumstances, management and current status of the patient: _____

3. Death related to male or female surgical procedure (number) _____

(NB: EP/Washington, D.C. must be notified by telephone/telex within 24 hours following a death.)

VII. MAJOR ISSUES AND CONSTRAINTS:

(Describe any major issues and constraints which you have encountered in trying to provide family planning services, implement project plans and accomplish subproject objectives during this time period. Briefly list any steps you have taken to overcome problems encountered.)

VIII. ASSISTANCE REQUESTED OF ENTERPRISE:

(Describe any assistance that you would like to receive from the Enterprise Program in continued implementation of your project. Attach extra pages as necessary).

* Please send daily log sheets and client dropout stubs to Enterprise Program along with the quarterly report.

Source: Enterprise Program 2/89

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RECORD KEEPING AND EVALUATION

This section of the manual includes record keeping systems/forms developed for use in company-based family planning programs. These forms were developed for use in Enterprise Program sub-projects and provide information which is useful for managers who are also service providers. The forms are:

Form A -- sample client record

Form B -- a clinic recording/reporting system for use in monitoring subproject clinics (one write system).

Form C -- Enterprise Program Quarterly Report

While these forms may exceed your own client record and recording/reporting needs, you may find them of use in developing a record keeping system. Or, you may be required to use national government family planning record systems.

Before looking at the forms, let's first look at the kind of information which you will need to measure the impact/level of use of the services you want to set up.

Family Planning Client Record

The items contained in the family planning record (Form A) are briefly outlined on the following pages.

After completing this section workshop participants will:

1. better understand the need for collecting and recording adequate medical data on their clients,
2. be able to design their own client family planning record, if none exists, or
3. be able to modify existing records, if they are incomplete or inadequate.

Deciding What to Include in Your Family Planning Client Record

Everyone agrees that assessing the health status of a potential family planning acceptor and duly recording it is essential, but the content - what data to obtain - and the format for recording it are hotly debated. For example, in most

developed countries a complete medical history, physical examination (including a pelvic), and laboratory tests such as hemoglobin, GC, VDRL and Pap smear are required before providing services. However, throughout much of the world, most of the currently available modern child spacing methods, such as condoms, vaginal spermicides, oral contraceptives (OCs) and injectables, have been safely provided to millions of acceptors with only minimal health data recorded and no physical examination or laboratory studies. Thus, the type of client record system required by each Enterprise subproject will depend on local health practices and government regulations as well as other factors.

Because there is no clearly defined "ideal" family planning client record, the items included in the sample record (Form A) are neither mandatory nor all-inclusive. Each Enterprise subproject will have to decide what to include. This decision will depend on a number of factors such as the age and sex of the subproject's target population (females only, males only or both); type of delivery system (clinic-based services versus community- or commercial-based distribution programs); and most importantly, the type of services provided (e.g., all methods including IUDs and sterilization versus services limited to condoms, spermicides and OCs).

The sample Family Planning Client Record (Form A) was developed by the Enterprise Program staff. The items selected are those which most health providers consider should be included in a comprehensive family planning record. Taken together the material contained in the outline (Handout A) and the sample record (Form A) provide a framework for the development of a subproject record system. Each subproject can modify the sample record to meet existing local health and family planning informational requirements.

It is recommended that the family planning record system of each country should be utilized if one already exists. However, these existing record systems may need to be modified (or expanded) to ensure that the data collected is adequate. Only in this way can each subproject clinic be assured that prospective clients are receiving safe, effective and appropriate family planning services tailored to their individual needs. Should assistance be required by subprojects attempting to design a new client record or modify existing ones, Enterprise Program staff can provide technical assistance.

Procedure for Collecting and Recording Client Health Data

All family planning clients should have a health record. At the first visit, the record should be completed in its entirety. This information is required by both the client and health provider in order to make an effective and informed decision on the child spacing method he/she may safely use. An experienced family planning practitioner (physician or nurse) can complete this activity for a new client in approximately twenty minutes. Alternatively, a trained assistant can obtain the historical data (Sections I-III, Handout A and Form A) and the health practitioner then can perform the physical examination, assist the client select an appropriate method, and instruct him/her on its correct use.

The categories in which information are to be collected and recorded (Form A) include the following:

- Client identification data: name, address, etc.
- Demographic data: age, number of living children, marital status, and KAP data such as prior use of family planning and desire for additional children in the future
- Reproductive health data: pregnancy, menstrual, gynecologic and sexual history
- General medical data: cardiovascular, neurovascular, pulmonary, renal, allergy and current medications, etc.
- Family history: diabetes, hypertension, breast and genital tract cancer, etc.

A client number system or some other means of anonymously identifying each client should be set up by each subproject. In addition, all clients should be informed that the information on their record is confidential and will NOT be released without prior consent.

Ideally a complete physical examination should be performed on all female clients and those males requesting permanent contraception (vasectomy). For many reasons, e.g., religious, social, economic, often this is not possible. Certainly for all females having an IUD inserted, a complete pelvic examination must be performed. And, for those women requesting sterilization a complete physical examination, including a pelvic is mandatory.

Because screening for breast lesions (cancer) is important, clients should be taught to perform self breast examination (SBE) whenever and wherever possible. The technique is easy to learn, simple to teach and requires no equipment.

Laboratory investigations can be performed if facilities are available. The need for sophisticated (expensive) laboratory testing of clients requesting child spacing methods is rarely necessary. At a minimum (and where available) all female clients should have a urinalysis (sugar and protein) and hematocrit or hemoglobin. If Pap smear testing is available this also is indicated. If a vaginal infection is suspected, a wet prep, looking for yeast, trichomonads or gardnerella is easy to perform - provided a microscope is readily at hand. Screening for other sexually transmitted diseases (STDs) is generally too expensive to be cost-effective in most LDCs.

When continuing family planning acceptors return for their regularly scheduled follow-up visits, basic data, i.e, last menstrual period (LMP), weight and blood pressure (BP), and any problems, side effects or complications of the method they are using should be recorded. It is extremely important that all IUD users routinely be queried regarding symptoms suggestive of pelvic infection. They also should be checked periodically for abdominal/pelvic tenderness. The conscientious collection and recording of this information will help to ensure the provision of high quality and safe services to all clients.

For logistical purposes, it is necessary to note the quantity of supplies provided clients using condoms, vaginal spermicides or OCs. In addition each subproject should develop a plan for managing clients who fail to keep their return appointments. Several systems are available such as a "tickler" file system, telephone or outreach (home or work) contacts. Unless clients continue to regularly use their child spacing method, success in preventing undesired pregnancies can not be expected.

ALL clients coming to the clinic who desire family planning should be able to receive some type of child spacing method at their first visit. Even if the method they choose can not be started at this visit, they should not be told to return next month to have their IUD inserted or begin taking OCs. Clients in this situation should be offered a barrier method, vaginal spermicide, or at a minimum be counseled to abstain or use a traditional method until they can start the pill or have an IUD inserted.

Again, technical assistance can be provided by the Enterprise Program to subprojects regarding the purpose and correct use of the sample Family Planning Client Record (Form A).

**OUTLINE OF ITEMS TO BE INCLUDED IN A COMPREHENSIVE
FAMILY PLANNING CLIENT RECORD**

I. CLIENT DATA

A. IDENTIFICATION

DATE: Record the date the client was seen.

CLIENT NAME AND ADDRESS: Record the client's name and an address sufficient for follow-up if such information is not already included in the employee's record system or general health record. You should assure the client that this information will be used **ONLY** for contact in the event that he/she misses the next return appointment, and that such contact will be made **DISCREETLY**. If the client prefers not to be contacted, you should not do so; such information should be recorded in the client's family planning record.

CLIENT NUMBER: Record the client's patient number from the employee record system so that you can refer back to his/her complete records later, if necessary. If you do not have such a numbering system already, The Enterprise Program staff can help you decide how to establish one.

CONTACT PERSON: In case of emergency and for outreach purposes it is useful to have the name and address of the nearest relative and/or friend of the client. The client should be assured that this person(s) would be contacted only with his/her permission.

SOURCE(S) OF MEDICAL CARE: If the client is receiving or has received medical care from other health clinics, this information may be useful in facilitating their family planning care.

B. DEMOGRAPHIC INFORMATION

AGE: Record the client's age in **WHOLE YEARS** only.

EDUCATION: Record the total years of schooling in **WHOLE YEARS** only.

LOCAL USE: Space should be left for items which individual subprojects may want to collect (e.g., marital status, occupation, race, religion, referral source, etc.)

II. REPRODUCTIVE HEALTH DATA

A. FAMILY PLANNING HISTORY: Record information relevant to:

- Prior use of birth spacing method (and source)
- Current method and duration of use
- Use of traditional methods including breast feeding
- Desire for additional children; if yes, number

B. PREGNANCY HISTORY: Record information relevant to:

- Number of pregnancies and outcome
- Number of living children
- Date last pregnancy ended
- Outcome of last pregnancy
- Complications of any pregnancy (e.g. ectopic², caesarean section, uterine perforation or rupture², toxemia, genetic abnormality, jaundice during pregnancy¹, etc.) or abortion
- Pregnant now or suspected pregnancy
- Breast feeding now¹
- Known or suspected fertility problem

C. MENSTRUAL HISTORY: Record information relevant to:

- Date of LMP (by day/month if known)
- Age of onset of menses (by WHOLE YEAR)
- Character of menses:
 - interval: by days, if known, or by estimating number of weeks from onset of one menses to first day of next)
 - frequency: regular if interval between menses >24 days and <35 days; amenorrhea if interval >6 months
 - duration: number of days of menses
 - amount: light/normal/heavy, ± clotting
 - discomfort: ± severe cramping

Undiagnosed abnormal genital bleeding: specify type and site^{1,2}

- D. GYNECOLOGIC HISTORY: Record information relevant to:
- Breast disease: If malignant¹
 - Ovarian disease: Cyst/tumor (if malignant¹)
 - Uterine disease: Fibromyomata^{1,2}, malignancy of cervix or endometrium^{1,2}
 - Pelvic infection: If positive²
 - Sexually transmitted disease(STD): Gonorrhea², chlamydia², mycoplasma², herpes, AIDS, syphilis, etc.
 - Cervicitis: Only if Pap smear abnormal^{1,2}
 - Vaginitis: Yeast, trichomonads, gardnerella, etc.²
 - DES exposure and physical findings: If positive^{1,2}
- E. SEXUAL HISTORY: Record information relevant to:
- Age first coitus
 - Frequency of intercourse
 - Number of sexual partners
 - Problems such as infertility, impotency, vaganismus, dysparunia, etc.

Possible increased risk of complication or known contraindication if this method is recommended:

- ¹Combination (estrogen/progestin) OCs; less risk with progestin-only or injectables (DMPA or NORPLANT^R)
- ²IUD (evaluate and correct condition before inserting)
- ³Barrier methods (condom, diaphragm or cervical cap)
- ⁴Vaginal spermicides
- ⁵Breast feeding, traditional methods or periodic abstinence (natural family planning)

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III. GENERAL MEDICAL DATA

A. MEDICAL HISTORY: Record information relevant to:

Cardiovascular disease: Coronary heart disease, hypertension, stroke, thrombophlebitis, varicose veins, seizures, migraines^{1,6}

Kidney disease: Benign (chronic)^{1,2,6}

Lung disease: Benign (e.g. asthma, chronic bronchitis, or emphysema, etc.,⁶)

Liver disease: Benign or malignant liver tumors, if developed during the use of OCs or other estrogen-containing product; impaired liver function, acute or chronic (active) hepatitis¹

Gallbladder disease¹

Diabetes¹

Obesity: If client >25% over ideal body weight, OCs should be used with caution

Smoker: 35 years of age or older and currently a heavy smoker (15 or more cigarettes per day)¹

Psychic depression¹

Anemia: All types^{2,6}; sickle cell disease(SS), sickle C disease(SC) or folate deficiency¹

Possible increased risk of complication or known contraindication if this method recommended:

¹Combination (estrogen/progestin) OCs; less risk with progestin-only or injectables (DMPA or NORPLANT^R)

²IUD (evaluate and correct condition before inserting)

³Barrier methods (condom, diaphragm or cervical cap)

⁴Vaginal spermicides

⁵Breast feeding, traditional methods or periodic abstinence (natural family planning)

⁶Female sterilization (evaluate condition and correct before surgery)

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Drug or alcohol problem

Immunization status: Check the following: DT/booster (date), OPV/booster (date), rubella titer, if available, tbc test (date, outcome). Also check immunization status of client's children.

Surgery: Type and date

Drug allergy: Specify (e.g., antibiotics, local anesthetics⁶, etc.)

Medications (current): Sedatives, antibiotics and seizure medications all alter OCs metabolism and decrease effectiveness.

B. FAMILY HISTORY: Record information relevant to:

Diabetes¹ (parents/sibs): Client is at increased risk of developing diabetes or being prediabetic.

Early heart attack/stroke in parents (under age 50)¹

Hypertension¹

Breast cancer (mother/aunts and sibs): Increased risk to client.

Birth defects (parents, sibs and children)

Cancer: Specify site (organ) if known.

Possible increased risk of complication or known contraindication if this method recommended:

¹Combination (estrogen/progestin) OCs; less risk with progestin-only or injectables (DMPA or NOR/LANT^R)

²IUD (evaluate and correct condition before inserting)

³Barrier methods (condom, diaphragm or cervical cap)

⁴Vaginal spermicides

⁵Breast feeding, traditional methods or periodic abstinence (natural family planning)

⁶Female sterilization (evaluate condition and correct before surgery)

IV. PHYSICAL EXAMINATION DATA

Initial and annual visit; Complete physical examination including pelvic and instruction in self breast examination (SBE)

Follow-up visit: As indicated

NOTE: Physical examination may be omitted if clinic is not using IUDs or performing sterilizations and historical data are negative (normal). Check local family planning health policies.

V. LABORATORY DATA

Important:

Urinalysis (sugar/protein): Screening for diabetes, kidney disease and urinary tract infection

Hematocrit/Hemoglobin: Screening for anemia

Wet Prep: Screening for vaginitis caused by trichomonads, yeast or gardnerella

Less important and/or more expensive/difficult:

Pap smear: Screening for genital (cervical) cancer

STD tests: VDRL (serology), GC, chlamydia and mycoplasma

VI. OUTCOME AND PLAN

Diagnosis (if pathologic condition noted)

Type of birth spacing method provided: If client given OCs, condoms or vaginal spermicides, specify amount.

Referral (e.g., for sterilization, natural family planning, counseling, etc.)

Return appointment: Write the DATE the client is supposed to come to the clinic again. Normally, follow-up visits will be for resupply of contraceptives. The date selected should allow a few weeks to spare in case the client has trouble keeping the appointment. For example, if you give an OC pill patient three cycles of pills, write a date two and one-half months in the future; if you give a man enough condoms for two months, select the date of the next appointment five to six weeks in the future.

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VI Handout A
Participant's Copy

Return appointment: (continued)

For clients referred for sterilization or natural family planning, a future follow-up appointment should be given to verify that everything is OK.

For clients who do NOT want to be contacted for follow up, write "NC", no contact or put ("--") for the next appointment date.

End-of-visit interview: If exit interview conducted, summarize outcome of the visit. Examples:

- attended lecture/demonstration
- counseled on child spacing methods
- taught self-breast examination (SBE)
- consent forms signed: IUDs, sterilization, release of patient information, etc.)
- given emergency information

FORM A: SAMPLE FAMILY PLANNING CLIENT RECORD

THE ENTERPRISE PROGRAM
Arlington, VA

FAMILY PLANNING CLIENT RECORD
(Sample Form)

I. CLIENT DATA

A. IDENTIFICATION

Client No. _____

Date ____:____:____
(Day Mo. Yr)

Name _____
(Family/Last) (Given/First)

Address _____
(or directions to work/home)

Phone _____ (Office) _____ (Work)

May contact for follow up? Yes No Careful

Nearest Relative/Friend

Name _____ Relationship _____

Address _____

Sources of Medical Care _____

Reason for Visit _____

B. DEMOGRAPHIC INFORMATION

Page 2

Age _____ Marital Status S M W S/D
(Whole Years) (Circle One)

Language _____ Education _____
(Whole Years)

School/Occupation _____

Other _____

II. REPRODUCTIVE HEALTH DATA

A. FAMILY PLANNING HISTORY

Prior FP : No
method : Yes _____
(Specify last method)

Using FP : No
method Now : Yes _____
(Specify method and months/years)

Currently : No How
Breast feeding : Yes Long? _____
(Mo Yr)

Desires more children : Yes (How many) _____
in the future : No : Maybe

B. PREGNANCY HISTORY

Number of
Pregnancies _____ LB _____ SBs _____ ABs _____

Number Living _____ Date Last
Children _____ Pregnancy Ended _____
(Mo Yr)

Outcome
Last Pregnancy _____ LB _____ SBs _____ ABs _____

Complications of Pregnancy or Abortion

Ectopic _____ C/Section _____ Toxemia _____
Birth _____ Postpartum _____ Uterine _____
Defect _____ Infection _____ Perforation _____

Other _____

C. MENSTRUAL HISTORY

Page 3

Age of onset _____
(Whole Years)

LMR _____
(Day Mo Yr)

Cycle Length < 23 days Cycles regular
 24 but < 35 irregular
 36 days
 > 6 Months (Amenorrhea)

Days of flow _____ Amount of flow L N H
(Circle One)

Discomfort with periods No Yes: Mild Moderate Severe
(Circle One)

Abnormal Bleeding? No
 Yes (Specify) _____

D. GYNECOLOGIC HISTORY (If YES, explain)

Infection: No Yes Now
 Pelvic Infection Vaginitis STD/VD
 Endometritis Cervicitis

Tumor/cyst: No Yes Now
 Breast Ovary Uterus Cervix

Abn. Pap: No Yes Now

Comments:

E. SEXUAL HISTORY

Age first coitus _____
(Years)

Problems _____

Infertility No Yes (Specify) _____

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III. GENERAL MEDICAL DATA

Page 4

A. MEDICAL HISTORY (IF YES, explain)

Vascular Disorder: No Yes Now

Heart Stroke High BP Diabetes
 Thrombophlebitis Migraine Seizures

Systemic Disorder: No Yes Now

Kidney Lung Liver/jaundice GB
 Anemia Obesity Smoker
 Drug/Alcohol Abuse (# cig. per day _____)

Cancer: No Yes Now

Kidney Lung Liver Brain
 Reproductive organs (Specify) _____
 Other (Specify) _____

Allergy: No Yes (Specify) _____

Immunization:

Client No Yes (Specify) _____
Children No Yes (Specify) _____

Surgery: No Yes _____
(Type/Date)

Comments:

B. FAMILY HISTORY

Diabetes in Parents/Sibs No Yes
Heart attack/stroke, Parents age <50 No Yes
Hypertension No Yes
Breast Cancer, Mother/Aunts/sibs No Yes

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IV. PHYSICAL EXAMINATION DATA Page 5

Ht: _____ Wt: _____ BP: _____ TEMP: _____

System	Normal	Other	Describe
Thyroid			
Heart			
Lungs			
Breasts			
Abdomen			
Perineum			
CX/Vagina			
Uterus			
Adnexa			
Rectum			

Other Systems (Specify) _____

Comments:

Return Appt. _____ Refer _____
 (Day Mo Yr)

Clinician's Signiture _____

V. LABORATORY DATA Urine _____ Hct/Hgb _____

Pap Smear _____ Other _____

VI. OUTCOME AND PLAN

Method supplied _____ Taught SBE _____
 (Type and quantity)

Counseled and given info. on FP method _____

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CLINIC RECORDING AND REPORTING FORMS

The following pages document a simple clinic recording and reporting system, which is to be used by Enterprise Program projects that do not already have a clinic management system to keep track of work performed, contraceptives distributed, and follow-up for family planning clients. All recording is done on a "One-Write" system which automatically produces two stubs which can be used for follow-up of clients that are CONTINUING USERS. Simple tallies from the Daily Log Sheet can be used to prepare monthly or quarterly management reports for use both by clinic managers and by Enterprise Program evaluation team staff.

Each component of this recording and reporting system is discussed in turn below.

ONE-WRITE SYSTEM DAILY LOG SHEET

The One-Write Daily Log Sheet is the basic form which is used to keep track of work performed, contraceptives distributed to program ACCEPTORS, and follow-up for clients that are CONTINUING USERS. The system is so named because it is designed in such a way that each item of data need be written only once. The system consists of a peg board with small pegs along the left-hand side, a large Daily Log Sheet which fits onto the pegs, and a series of pairs of small Revisit Slips which fit onto the pegs on top of the Daily Log Sheet. The Revisit Slips have carbon on the back, and are fitted onto the pins so that as you write, you automatically complete one pair of Revisit Slips and one line of the Log Sheet at the same time. The Enterprise Program can provide technical assistance and all the supplies necessary to design and establish a One-Write System.

You must complete one line of the Log Sheet (and one pair of Revisit Slips at the same time) for each client seen at your family planning clinic, WHETHER OR NOT the client decides to take a contraceptive method. You should also complete a line when you distribute CONDOMS as discussed below. Each Log Sheet has room at the bottom for totaling all the figures on the sheet. You should USE A BALL POINT PEN when entering data on the One-Write System, since you are making multiple copies at once. Use as many Log Sheets and Revisit Slips as you need each month to record all your clients; when one sheet is full, just continue with another. At the beginning of each month, however, you should start with a new Log Sheet. DO NOT record two months' activities on a single sheet.

Instructions for completing each line of the One-Write Daily Log Sheet are as follows:

DATE: Record the date the client was seen, or use ditto marks ("") when several clients are seen on the same day.

CLIENT NUMBER: Record the client's patient number from your medical or employee record system, so that you can refer back to his/her complete records later if necessary.

If you do not have such a numbering system already, Enterprise can help you decide on how to establish one.

CLIENT NAME AND ADDRESS: Record the client's name, and an address sufficient for follow-up if such information is not already included in your medical record. You should assure the client that this information will be used ONLY for contact in the event that he/she misses the next appointment, and that such contact will be made DISCREETLY. Of course, if the client prefers NOT to be contacted, you should not do so: such information can be recorded in the NOTES/COMMENTS section of the Daily Log Sheet, and should also be written into the client's medical record if you keep one.

NEXT APPOINTMENT DATE: Write the date that the client is supposed to come to the clinic again. Normally, next visits will be resupply of contraceptives, and you should write a date that gives a few weeks to spare in case the client has trouble keeping the appointment. For example, if you give a pill patient three cycles of pills, write a date two and one-half months in the future. If you give a man enough condoms for two months, write a date five or six weeks in the future.

For clients you refer for VSC, NATURAL FP or other reasons such as hypertension, etc., you should agree on a date for them to return to you for a follow-up visit to make sure everything is satisfactory and record this date.

For clients who do NOT want you to contact them for follow-up, write "NC": for "No Contact", or put a dash "--") for the NEXT APPOINTMENT DATE.

Of course, you probably will not know what NEXT APPOINTMENT DATE to use when a client first arrives at the clinic. It is good practice to have each client stop at the front desk on the way out, so that you can find out whether he/she has any questions or complaints and settle on an appropriate date for the next visit at the same time.

CLIENT TYPE:

Write a code for the type of client. Codes are shown along the bottom of the Daily Log Sheet, they are: NF for New Female Acceptor, NM for New Male Acceptor, TF for Transfer Female Acceptor, TM for Transfer Male Acceptor, and CU for Continuing User (either male or female).

Note that a client visiting the clinic for the first time is coded as NEW (Acceptor) if he/she is not currently using a family planning method. A client who has until now received services at another facility is coded as TRANSFER (Acceptor), (i.e., a current user who is transferring to this clinic). For every visit after the first, clients are coded as CONTINUING (Users) when they come for family planning services.

At this point, you have completed the pair of Revisit Slips for this client. Use of these Revisit Slips is discussed below. The remainder of the data items are written only on to the Daily Log sheet itself.

Certain data needed for management purposes, such as age or education, relates to the client and not to the family planning visit. Such data should be counted ONLY ONCE for each unique individual client who visits the clinic. Accordingly, the Daily Log provides space for several data items which are collected ONLY for NEW or TRANSFER acceptor clients, (i.e., First-Time Clients only). These data items SHOULD BE LEFT BLANK for CONTINUING USER clients.

LAST SOURCE:

Only TRANSFER client acceptors should be asked this question. (Ask the client from what source of supply he/she last obtained his/her family planning method.

Record a "P" in the column if the source is Public; a "C" if the source is private or Commercial, for example, private doctor, private midwife, pharmacy.

(It may be helpful to develop a list of all the local family planning sources by Public and Private/Commercial categories. The receptionist can find the source name from one of these two lists and mark the column appropriately.)

LAST METHOD:

Ask all NEW client acceptors whether they have used a family planning method in the past, and if they have, which was the LAST method they used. Record the method in this column; if he/she has never used a family planning method, record an N (for NONE).

Ask TRANSFER client acceptors which method they are currently using, and record the name of this method in this column.

BRAND NAME:

Only TRANSFER client acceptors should be asked this question. Write in the brand name of the contraceptive. (It might be helpful to develop a list of brand names available in your area.)

The following questions (AGE, EDUCATION, LIVING CHILDREN, AND MARITAL STATUS) are asked of all NEW AND TRANSFER (FIRST-TIME) CLIENTS:

AGE: Record the client's age in WHOLE YEARS only.

EDUCATION: Record the total number of years of schooling completed.

LIVING CHILDREN: Record the total number of children the client has had who are now living.

MARITAL STATUS: Record whether the new or transfer client is Single, Married, In Union, Separated, Divorced, or Widowed.

LOCAL USE:

An additional column has been left for items which individual projects may want to collect (e.g., referral source, etc.). This column can be used continuously if project managers desire, or could be used on a periodic or sampling basis for special survey purposes.

The remaining items on the Log Sheet should be collected for ALL clients. The items are:

**CONTRACEPTIVE
METHODS:**

Six columns of the Log Sheet are used to record contraceptive methods dispensed. For PILLS, FOAMING TABLETS, or CONDOMS, record the actual quantities dispensed, since this information is needed for reordering of contraceptive supplies, and for determining the NEXT APPOINTMENT DATE and Enterprise Program service statistics. For PILLS, record cycles dispensed; for FOAMING TABLETS, record tablets for CONDOMS, record pieces.

For INJECTABLES, IUD INSERTIONS, or IUD CHECK-UPS, write a "1" or a checkmark in the appropriate column. Two additional blank columns have been left for other methods that individual clinics may provide (e.g. NORPLANT, VSC). If you give more than one method (e.g., PILLS, plus enough CONDOMS to last until the client's next period), record all that apply. Of course, if a client declines to take any of these methods, just check NO METHOD.

If a male comes in for CONDOMS, and you give them directly to him without providing any other service, you DO NOT need to fill out the whole line of the Log Sheet. Just write "Condom Distribution": in the CLIENT NAME column, and the number of pieces you distribute. You need not make male CONDOM clients wait for you to fill out the rest of the record. The Revisit Slips for these condom-only clients can just be discarded.

REFERRALS:

If you refer a client for Voluntary Surgical Contraception (VSC), NATURAL FP, or other reasons, such as referral for hypertension, anemia, severe varicosities, etc., check the

appropriate column. Again, a blank column has been left for local use in tracking other referral services. Note that you might very well distribute contraceptive supplies at the same time you refer for VSC or other services. In such cases, complete all columns which apply.

NOTES/COMMENTS:

Use this space to record any other information that you need for local management purposes. Information which will be needed the next time the client visits the clinic should be recorded in the medical record rather than on the One-Write Log, since the Daily Log sheet will probably not be available the next time the client comes to the clinic.

Whenever a Log Sheet is full, simply continue on with another. On the bottom line of each sheet, you should tally the number of clients by each CLIENT TYPE (NF, NM, TF, TM, CU), and total the amounts of contraceptives distributed and referrals made, since this data will be needed for management and logistical reporting.

Save the completed Log Sheets as your permanent record of the services you have provided. Those projects which have been requested to keep duplicate copies of the Daily Log Sheet should simply include the duplicates (which will have the NAME AND ADDRESS column blacked out for confidentiality purposes) in their regular Quarterly Report to Enterprise.

USE OF REVISIT SLIPS AS APPOINTMENT REMINDERS

Now, tear off the part of Revisit Slips you have just completed. Give the top copy to the client to serve as a reminder of the next appointment date, and ask him/her to bring the slip back on the next appointment. It is not absolutely necessary that the client do this, but if he/she does not want to be contacted outside the clinic, you should write "No contact" on your copy of the Slip.

Your copy of the Revisit Slip can be used as your appointment reminder, or "tickler" system. Enterprise can help you construct such a system if you do so desire. All that is needed is a file box or drawer with cardboard dividers for each week of the year.

You should file your copies of all Revisit Slips in the box, behind the divider corresponding to the week of each client's NEXT APPOINTMENT DATE. For example, if a client is seen on January 1, and given a three month's supply of pills, you would give her a NEXT APPOINTMENT DATE of March 15th, so that she is supposed to come back two weeks before she runs out of pills. You would then file her Revisit Slip in the section for the third week of March. In this way, at the beginning of each week, you will have in one section of the box Slips for all CONTINUING clients who are supposed to return that week.

When a CONTINUING client comes in for his/her appointment, you take his/her old Revisit Slip out of the box and THROW IT AWAY. Any slips remaining at the end of the week represent clients who have missed their appointments.

If a CONTINUING user fails to return to the clinic for six months after his/her last scheduled appointment he/she is considered a DROP OUT. DO NOT throw the Revisit slip away. Instead, you should keep a separate file of such slips in date order, so that you can from time to time calculate the number of DROP-OUTS your program is experiencing. You will be asked to forward the Revisit Slips for clients who have dropped out to Enterprise with each quarterly report.

This procedure seems a little backwards, so don't forget: THROW AWAY the slips for clients who DO return, but KEEP the slips for those who DON'T!

**MANAGEMENT REPORTING - ENTERPRISE PROGRAM QUARTERLY PROGRESS REPORT
FOR SERVICE DELIVERY SUBPROJECTS***

The One-Write Daily Log Sheet quickly and simply collects data on numbers and types of clients seen, demographic characteristics of NEW or TRANSFER client acceptors, services rendered, and contraceptives distributed. Most of the service statistics data needed for clinic management can therefore easily be extracted from the One-Write Log. Enterprise can provide technical assistance in designing management reporting systems which address specific local needs to projects as desired.

A sample reporting format, showing the data which Enterprise requires quarterly for evaluation purposes, is attached. Much of the data required for this report can be extracted directly from the Daily Log sheet tallies, as follows:

- A. TOTAL TARGET ACCEPTORS TO PROGRAM:** This is the total number of first time client acceptors (NEW and TRANSFERS) for the life expected to be reached by the project.
- B. NUMBER OF NEW CLIENT ACCEPTORS THIS QUARTER:** This is the total number of first time male or female clients who are not currently using a family planning method (coded NM or NF on daily log sheet).
- C. NUMBER OF TRANSFER CLIENT ACCEPTORS THIS QUARTER:** This is the number of first time male or female visits made by transfer clients coded TM or TF on the daily log sheets. These clients have received family planning at another facility.
- D. NUMBER OF ACCEPTORS THIS QUARTER (ALL FIRST TIME CLIENTS, NEW AND TRANSFER):** This is simply the total number of clients coded as NF, NM, TF, or TM on the Daily Log Sheets for this time period. Projects' targets for services will generally be expressed as numbers of client acceptors to be recruited.
- E. TOTAL ACCEPTORS FROM PREVIOUS QUARTERLY REPORT:** This is the total figure from Line I.F. from the previous quarter's report. For the first report, record 0.
- F. TOTAL ACCEPTORS TO DATE:** This is the sum of lines D and E.
- G. PERCENTAGE OF TOTAL ACCEPTOR TARGET ACHIEVED TO DATE:** This is simply Line F divided by the TOTAL ACCEPTOR TARGET for the project, multiplied by 100 ($F/A \times 100$).

* Form to be completed by subprojects.

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H. NUMBER OF CONTINUING USER VISITS THIS QUARTER: This is the number of visits made by male or female coded CU on the Daily Log Sheets.

I. TOTAL CONTINUING USER VISITS TO DATE: This is the total figure from Line I.I. from the previous quarter's report AND Line I.H. of this report.

J. TOTAL VISITS THIS QUARTER: This is simply the sum of Lines D and H.

The remaining data items for the Quarterly Report are direct tallies from the Daily Log Sheet, and are based on All visits, not just on NEW and TRANSFER clients.

CONTRACEPTIVES DISPENSED: The total for each method (including NO METHOD) can be taken directly from the totals for the appropriate line on the Daily Log.

REFERRALS: The totals for each type of referral can be taken directly from the totals for the appropriate line on the Daily Log.

DROPOUT: This is the total number of male or female acceptors and users who fail to return for family planning services six months after their last scheduled appointment.

LAST SOURCE: This information is obtained from TRANSFER client acceptors only. Record the total number of transfer clients that received family planning services from a public source (government, hospital/ clinic, etc.) or from a private source (private doctor, pharmacist, midwife, etc.)

SECTIONS VII AND VIII:

The last two sections of the Quarterly Progress Report are in narrative or list form, and ask projects to describe any major issues or constraints encountered in implementation of the program, along with any efforts made to address such constraints. Assistance which is needed from Enterprise can also be described.

**ENTERPRISE PROGRAM QUARTERLY PROGRESS REPORT
FOR SERVICE DELIVERY SUBPROJECTS**

PROJECT NAME: _____

THIS QUARTERLY REPORTING PERIOD: _____ day/month/year through _____ day/month/year

PROJECT START DATE: _____ day/month/year PROJECT COMPLETION DATE: _____ day/month/year

TOTAL TARGET POPULATION TO BE SERVED _____

TYPE OF FAMILY PLANNING SERVICES PROVIDED (check appropriate column)

- Type 1: Pills, condoms, and spermicides only _____
- Type 2: IUDs and/or injectables/implants (+ Type 1 services) _____
- Type 3: Voluntary Surgical Contraception (VSC) (+ Type 1 and 2 services) _____

If services #2 or #3 are checked, Section VI (Family Planing Methods Summary Report) must be completed.

I. SERVICES PROVIDED:

	<u>FIRST MONTH</u>	<u>SECOND MONTH</u>	<u>THIRD MONTH</u>	<u>TOTAL</u>
A. Total Target Acceptors to Program:				
B. Number of New Client Acceptors This Quarter:	* M F	M F	M F	M F
C. Number of Transfer Client Acceptors This Quarter:	M F	M F	M F	M F
D. Total Number of Acceptors This Quarter: (All First Time Clients - New and Transfer)				M F
E. Total Acceptors From Line I.F. from Previous Quarterly Report:				M F
F. Total Acceptors to Date (D + E):				M F
G. Percentage of Total Acceptor Target Achieved to Date (F/A x 100):				
H. Number of Continuing User Visits This Quarter:	M F	M F	M F	M F
I. Total Continuing User Visits To Date:				M F
J. Total Visits This Quarter (D + H):				

*Male *Female

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**II. CONTRACEPTIVES DISPENSED:
(BASED ON TOTAL VISITS PER MONTH)**

- Pills (Cycles):
- Injectables (Doses):
- IUD Insertions:
- Foaming Tablets (pieces):
- Condoms (Pieces):
- Laparoscopies
- Minilaparotomies
- Vasectomies
- Other:

<u>FIRST MONTH</u>	<u>SECOND MONTH</u>	<u>THIRD MONTH</u>	<u>TOTAL</u>
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

III. REFERRALS:

- VSC
- Natural Family Planning
- Other

<u>FIRST MONTH</u>	<u>SECOND MONTH</u>	<u>THIRD MONTH</u>	<u>TOTAL</u>
M ___ F ___	M ___ F ___	M ___ F ___	M ___ F ___
_____	_____	_____	_____
_____	_____	_____	_____

IV. PROGRAM DROPOUTS

M ___ F ___			
-------------	-------------	-------------	-------------

V. LAST SOURCE OF TRANSFER ACCEPTORS TO DATE

Of the total transfer acceptors listed in I C on page V-12, how many came from the following sources: Public _____ Private _____ Unknown _____

VI. FAMILY PLANNING METHODS SUMMARY REPORT

INSTRUCTIONS: Subprojects providing IUDs and/or injectables/implants (Service #2) must complete Part A (below). Subprojects providing VSC services (Service #3) must complete Parts A and B as well.

A. IUDs AND/OR INJECTABLES/IMPLANTS

JS

NUMBER

1. Clients discontinuing method during this reporting interval

- Complications
 - Uterine perforation (complete or incomplete)
 - Post-insertion bleeding requiring treatment or IUD removal
 - Post-insertion infection requiring treatment IUD removal

Other complications (specify): _____

3. For each complication reported, briefly describe the management and current status of patient: _____

Injectables/Implants (Long-acting Progestins)

Number

1. Clients discontinuing method during this reporting interval

2. Complications

Bleeding requiring treatment or discontinuation/
 removal

Amenorrhea (no spotting/bleeding for 60 days
 or more)

Other complications (specify): _____

3. For each complication reported, briefly describe the management and current status of the patient: _____

Part B: VOLUNTARY SURGICAL CONTRACEPTION (VSC)

1. Complications (only those requiring additional hospitalization and/or surgery)

Number

Intra-operative

Immediate post-operative (within 48 hours):

Late (up to 60 days post-surgery)

2. For each complication reported, briefly describe the circumstances, management and current status of the patient: _____

3. Death related to male or female surgical procedure (number) _____

(NB: EP/Washington, D.C. must be notified by telephone/telex within 24 hours hours following a death.)

VII. MAJOR ISSUES AND CONSTRAINTS:

(Describe any major issues and constraints which you have encountered in trying to provide family planning services, implement project plans and accomplish subproject objectives during this time period. Briefly list any steps you have taken to overcome problems encountered.)

VIII. ASSISTANCE REQUESTED OF ENTERPRISE:

(Describe any assistance that you would like to receive from the Enterprise Program in continued implementation of your project. Attach extra pages as necessary).

* Please send daily log sheets and client dropout stubs to Enterprise Program along with the quarterly report.

Source: Enterprise Program 2/89

3/89

EVALUATION

EVALUATION EXERCISE: SECTION VI

Participants are asked to look at the "Task Checklist/Decision Points" (see VI, page 11-14) again and answer the following questions:

1. How will this checklist be of use to you when you return to your enterprise and begin setting up family planning services?
2. Which (a) tasks or (b) decision points do you feel should be added?
3. Which (a) tasks or (b) decision points do you feel could be deleted?
4. In what other ways could this checklist be improved?

The usefulness of the checklist is central to Section VI. The answers to these questions will be used in improving the checklist for further training. But more important in the short-term is the need for each participant to leave the workshop with a checklist that meets his or her needs.

Time: 20 minutes

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Section VII: Developing an Actionable Work Plan

In this section, participants are involved in preparing a work plan for setting up family planning services in their factories, companies or plantations.

TRAINER'S NOTE**Objectives of this Section:**

After completing the activities in this section of the module, workshop participants will have:

1. developed a plan for implementing company-based family planning services in their enterprise.
2. shared plans with other participants and offered critiques based on the information presented during the workshop.

Rationale:

In completing a work plan, participants will identify, with assistance from workshop organizers and trainers, the major steps in designing family planning services for their factories or plantations. Company management and health personnel will then be able to proceed with further planning and gather the necessary information to carry out the tasks identified in the work plan in a systematic fashion.

PROCEDURES

- **Developing a Work Plan for Setting Up, Managing and Evaluating Company-Based Family Planning Services**

Workshop participants review the basic issues in setting up company-based services, examine work plans developed in factory settings similar to their own, and review the rationale for the services they plan to offer prior to developing a work plan for their own factory or company.

Time: 3 hours

TO THE TRAINER:

Examples of work plans from private sector enterprises in Asia are included in this section.

DEVELOPING A WORK PLAN FOR SETTING UP, MANAGING
AND EVALUATING COMPANY-BASED FAMILY PLANNING SERVICES

An understanding of the elements of the planning process are central to the development of a work plan. The last section of the manual discussed one approach to examining the tasks involved in setting up company-based family planning services, while identifying the major decision points you and your staff will need to consider.

In developing your work plan, you will want to

- **FIRST** look over the set of planning questions in this section and identify those for which you already have the necessary data;

- ● **THEN**, look over the sample work plan developed by company management and Enterprise Program staff for an Asian enterprise.
Note:

- what delivery model is being suggested,

- what kind of services are to be offered,

- how large the client population is,

- what the staffing pattern is, and

- what kind of time line was established.

• • • THEN, you will need to jot down data based on your own situation in response to each of the following points:

- the service delivery model that you are thinking about using

- the mix of services that you plan to offer

- the target audience for the services (sex, age, etc)

- the staffing pattern that you are thinking about using

- the time you think it will take between this initial planning phase and when services will start up

With this information in hand, along with that you reviewed in Section VI, you should be ready to begin drafting your work plan. Refer back to these notes, the task/decision list from Section VI, and to the sample work plans contained in this section. You should also make full use of the questions which follow on the next three pages. These questions will help you assess what your information needs are prior to proceeding with the planning process. In reviewing the list of questions, you will note that you already have some of the information on hand for the planning process. For other questions, you will need to identify sources to which you can turn for further information.

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Questions to be Answered in Establishing and
Managing Family Planning Services in
Factories or on Plantations

Services

1. What specific services are to be provided?
2. What is currently provided?
3. Who is the target population?
4. How large is the target population?
5. What is the target acceptance rate?
6. Who will provide services?
7. How adequate are existing facilities and equipment for proposed service delivery?
8. What facilities, equipment, furniture, and supplies are needed to provide services?
9. What is the projected mix of methods?
10. What are the current (or required) record-keeping systems and their adequacy?
11. What kind of educational materials are needed? What costs are involved?

Management

1. What does the enterprise's organizational chart look like? What are the levels of staff? How does health care fit into the chart?
2. In planning and setting up services, who are the important players? on staff? in unions? in the community? in the government?
3. Who will be responsible for the over all direction of family planning services? Who keeps quality up to date?

4. Who will be responsible for the day-to-day management of family planning services? for fiscal management? for medical back-up?
5. Who is in charge of preparing protocols?
6. Who will be in charge of ordering commodities?
7. What are the government regulations for setting up services? government registration procedures?

Training

1. What family planning training courses exist locally?
2. Who can use them? How good are they?
3. Can training be done on site?
4. Who will be trained? In what skills?
5. How can in-service training needs be identified?

IE&C

1. What form will the IE&C component take?
2. What IE&C materials exist locally? By whom are they used? Who distributes them? How adequate are they? Are they available for purchase or use?

Commodities

1. What kinds of commodities are needed?
2. What are the potential sources for commodities?
3. Which kinds of commodities are available?
4. On what terms are commodities available from international donors, local IPPF affiliate, UNFPA, social marketing programs, the commercial sector?
5. Where will they be stored?
6. How will they be inventoried? by whom?
7. What are the initial projections for commodities?

Budgetary Considerations

1. What are the costs of:
 - staff training
 - equipment, materials, supplies
 - commodities
 - IE&C promotional activities
 - worker participation in family planning activities

2. What kind of assistance is available?
 - cofinancing
 - subsidized commodities
 - free commodities
 - in-kind services
 - user fees

3. What level of initial assistance is necessary?

Evaluation

1. What is the overall evaluation strategy? for acceptance? for IE&C? for service delivery?
2. Who evaluates what and whom?
3. How are costs monitored? by whom?
4. How will management disseminate information on the program? to whom? for what purposes?

Source: Enterprise Program, 1986.

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DEVELOPING A WORK PLAN FOR SETTING UP, MANAGING
AND EVALUATING COMPANY-BASED FAMILY PLANNING SERVICES

An understanding of the elements of the planning process are central to the development of a work plan. The last section of the manual discussed one approach to examining the tasks involved in setting up factory based family planning services, while identifying the major decision points you and your staff will need to consider.

In developing your work plan, you will want to

- **FIRST** look over the set of planning questions in this section and identify those for which you already have the necessary data;

- ● **THEN**, look over the sample work plan developed by factory management in an Asian country, noting:

- what delivery model is being suggested,

- what kind of services are to be offered,

- how large the client population is,

- what the staffing pattern is, and

- what kind of time line was established.

• • • THEN, you will need to jot down data based on your own situation in response to each of the following points:

- the service delivery model that you are thinking about using

- the mix of services that you plan to offer

- the target audience for the services (sex, age, etc)

- the staffing pattern that you are thinking about using

- the time you think it will take between this initial planning phase and when services will start up

With this information in hand, along with that you reviewed in Section VI, you should be ready to begin drafting your work plan. Refer back to these notes, the task/decision list from Section VI, and to the sample work plans contained in this section. You should also use the set of questions on the next three pages to guide your collection of information for the planning process. As you review the questions, you will find that you already have some of this information on hand. For other questions, you will need to identify information sources.

Questions to be Answered in Establishing and
Managing Family Planning Services in
Factories or on Plantations

Services

1. What specific services are to be provided?
2. What is currently provided?
3. Who is the target population?
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6. Who will provide services?
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 - user fees

3. What level of initial assistance is necessary?

Evaluation

1. What is the overall evaluation strategy? for acceptance? for IE&C? for service delivery?
2. Who evaluates what and whom?
3. How are costs monitored? by whom?
4. How will management disseminate information on the program? to whom? for what purposes?

Source: Enterprise Program, 1986.

A SAMPLE WORK PLAN

The following work plan is from an Asian factory planning to establish company-based family planning services. The services are to be set up with assistance from an outside funder. The objectives of the program are:

1. To establish an on-site family planning clinic for employees and their spouses at the company.
2. To improve the family health status of employees through health education; information, education and communication (IE&C) and reproductive health services.
3. To reduce pregnancy-related employee illness and absenteeism and increase productivity and profitability.
4. To continue to serve the approximately 160 current family planning acceptors and to increase the number of acceptors by 250 (50%) of those married females currently not contracepting.
5. To promote the concept of company-based family planning services in order to replicate this model in other companies.
6. To promote economical private sector initiatives in health/benefit service packages for employees through the delivery of family planning services.

Services to be offered include:

- a. A clinic which will operate on a daily basis from 12 PM - 6 PM, five days per week and which will serve all of the 1300 workers and their spouses on the following schedule:

12:00 PM - 1:00 PM - employees
1:00 PM - 3:30 PM - spouses
3:30 PM - 6:00 PM - employees

A consultant physician will provide back-up services for a nurse-midwife, assume overall responsibility for the nurse-midwife's practice in the clinic, and manage all clients referred by the midwife. The consultant will be in the clinic two hours per week on a regular basis. Emergencies and clients that cannot be managed in the clinic due to lack of resources (for example, laboratory services) will be referred to the local hospital which is approximately fifteen minutes distance from the company by car.

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IE&C and health education talks to motivate workers to accept family planning services will be organized on a monthly basis. Family planning promotional activities such as luncheon meetings for supervisors and home visits by the nurse-midwife will be conducted. The nurse-midwife and consultant physician will attend contraceptive technology update seminars. Staff replacement for service delivery during this time will be provided. Two in-plant motivators will also attend a training course in IE&C. (One worker has already been trained in family planning motivation).

The work plan is set up in three phases:

PHASE I: PLANNING AND DEVELOPMENT OF CLINIC

1. Identify key management personnel who will be responsible for project activities.
2. Management renovates site for family planning clinic and provides basic furniture.
3. Interview and recruit nurse-midwife and consultant physician.
4. Train two in-plant motivators and develop an IE&C motivational program and strategies that are targeted towards supervisors, workers and their spouses. The IE&C program will be developed in conjunction with the nurse-midwife, consultant physician, in-plant motivators and management.
5. Develop and implement record keeping and reporting systems for clinic use, management needs and outside funder requirements as necessary.
6. Obtain equipment, supplies, commodities and health education materials.
7. Begin IE&C and motivational activities in the factory (to include distribution of IE&C materials).
8. Register clinic with appropriate health authorities.
9. Prepare plan for family planning promotional events.

PHASE II: IMPLEMENTATION OF CLINIC SERVICES AND IE&C

1. Provide family planning services to include pills, IUD's, spermicides, condoms, natural methods and counseling and health education; referrals for infertility and voluntary surgical contraception to local hospital.

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2. Conduct monthly health education and motivational talks in the factory.
3. Conduct home visits by nurse-midwife to spouses of workers and follow-up of drop-outs, as appropriate.
4. Maintain record keeping system, compile and submit quarterly reports to outside funder as necessary.
5. Maintain equipment, supplies and commodities.
6. Conduct evaluation of clinic services at end of first year of project; modify program to achieve service objectives as appropriate.
7. Perform technical assistance visits and monitoring of service activities by outside funders as necessary.
8. Develop plan for full assumption of clinic operations by enterprise management.
9. Implement family planning promotional events.

PHASE III: MANAGEMENT OF FP CLINIC BY THE COMPANY

1. Continue to provide FP services to employees and their spouses by the company.
2. Maintain FP commodities procurement and distribution by the company.
3. Conduct follow-up visit by Enterprise Program six months after transition.
4. Continue to report annual service statistics to Enterprise Program.

Source:
The Enterprise Program,
1986.

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A SAMPLE WORK PLAN

The following work plan is from an Asian factory planning to establish company-based family planning services. The services are to be set up with assistance from an outside funder. The objectives of the program are:

1. To establish an on-site family planning clinic for employees and their spouses at the company.
2. To improve the family health status of employees through health education; information, education and communication (IE&C) and reproductive health services.
3. To reduce pregnancy-related employee illness and absenteeism and increase productivity and profitability.
4. To continue to serve the approximately 160 current family planning acceptors and to increase the number of acceptors by 250 (50%) of those married females currently not contracepting.
5. To promote the concept of company-based family planning services in order to replicate this model in other companies.
6. To promote economical private sector initiatives in health/benefit service packages for employees through the delivery of family planning services.

Services to be offered include:

- a. A clinic which will operate on a daily basis from 12 PM - 6 PM, five days per week and which will serve all of the 1300 workers and their spouses on the following schedule:

12:00 PM - 1:00 PM - employees
1:00 PM - 3:30 PM - spouses
3:30 PM - 6:00 PM - employees

A consultant physician will provide back-up services for a nurse-midwife, assume overall responsibility for the nurse-midwife's practice in the clinic, and manage all clients referred by the midwife. The consultant will be in the clinic two hours per week on a regular basis. Emergencies and clients that cannot be managed in the clinic due to lack of resources (for example, laboratory services) will be referred to the local hospital which is approximately fifteen minutes distance from the company by car.

IE&C and health education talks to motivate workers to accept family planning services will be organized on a monthly basis. Family planning promotional activities such as luncheon meetings for supervisors and home visits by the nurse-midwife will be conducted. The nurse-midwife and consultant physician will attend contraceptive technology update seminars. Staff replacement for service delivery during this time will be provided. Two in-plant motivators will also attend a training course in IE&C. (One worker has already been trained in family planning motivation).

The work plan is set up in three phases:

PHASE I: PLANNING AND DEVELOPMENT OF CLINIC

1. Identify key management personnel who will be responsible for project activities.
2. Management renovates site for family planning clinic and provides basic furniture.
3. Interview and recruit nurse-midwife and consultant physician.
4. Train two in-plant motivators and develop an IE&C motivational program and strategies that are targeted towards supervisors, workers and their spouses. The IE&C program will be developed in conjunction with the nurse-midwife, consultant physician, in-plant motivators and management.
5. Develop and implement record keeping and reporting systems for clinic use, management needs and outside funder requirements as necessary.
6. Obtain equipment, supplies, commodities and health education materials.
7. Begin IE&C and motivational activities in the factory (to include distribution of IE&C materials).
8. Register clinic with appropriate health authorities.
9. Prepare plan for family planning promotional events.

PHASE II: IMPLEMENTATION OF CLINIC SERVICES AND IE&C

1. Provide family planning services to include pills, IUD's, spermicides, condoms, natural methods and counseling and health education; referrals for infertility and voluntary surgical contraception to local hospital.

2. Conduct monthly health education and motivational talks in the factory.
3. Conduct home visits by nurse-midwife to spouses of workers and follow-up of drop-outs, as appropriate.
4. Maintain record keeping system, compile and submit quarterly reports to outside funder as necessary.
5. Maintain equipment, supplies and commodities.
6. Conduct evaluation of clinic services at end of first year of project; modify program to achieve service objectives as appropriate.
7. Perform technical assistance visits and monitoring of service activities by outside funders as necessary.
8. Develop plan for full assumption of clinic operations by enterprise management.
9. Implement family planning promotional events.

PHASE III: MANAGEMENT OF FP CLINIC BY THE COMPANY

1. Continue to provide FP services to employees and their spouses by the company.
2. Maintain FP commodities procurement and distribution by the company.
3. Conduct follow-up visit by Enterprise Program six months after transition.
4. Continue to report annual service statistics to Enterprise Program.

Source:
The Enterprise Program,
1986.

MODULE EVALUATION

This section contains two evaluation forms-- one for trainers and one for participants. The goal of the trainer's evaluation form is to help the Enterprise Program improve this module. The same is true of the participant's form. In addition, the participant's evaluation form will be helpful to the trainer in improving the delivery of training. The trainer is requested to send the completed forms to:

Ms. Kulmindar Johal
The Enterprise Program
Ninth Floor
1100 Wilson Boulevard
Arlington, VA 22209
USA.

TRAINER EVALUATION FORM

Please complete this form and mail it, along with the completed participant evaluation forms, to:

Ms. Kulmindar Johal
The Enterprise Program
Ninth Floor
1100 Wilson Boulevard
Arlington, VA 22209
USA

For the following questions, please circle the number that best represents your opinion, either strongly no (1), strongly yes (6) or somewhere in between (2,3,4 or 5). Please do not circle "yes" or "no."

1. Overall, was the manual useful?

No 1 2 3 4 5 6 Yes

2. Was the material logically sequenced?

No 1 2 3 4 5 6 Yes

For each section of the manual, please rate the appropriateness of both the content material provided and the procedures suggested for delivering the content in workshop settings.

3. Section I: Content Material

No 1 2 3 4 5 6 Yes

Section I: Suggested Procedures

No 1 2 3 4 5 6 Yes

4. Section II: Content Material

No 1 2 3 4 5 6 Yes

Section II: Suggested Procedures

No 1 2 3 4 5 6 Yes

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5. Section III: Content Material

No	1	2	3	4	5	6	Yes
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Section III: Suggested Procedures

No	1	2	3	4	5	6	Yes
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6. Section IV: Content Material

No	1	2	3	4	5	6	Yes
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Section IV: Suggested Procedures

No	1	2	3	4	5	6	Yes
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7. Section V: Content Material

No	1	2	3	4	5	6	Yes
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Section V: Suggested Procedures

No	1	2	3	4	5	6	Yes
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8. Section VI: Content Material

No	1	2	3	4	5	6	Yes
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Section VI: Suggested Procedures

No	1	2	3	4	5	6	Yes
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9. Section VII: Content Material

No	1	2	3	4	5	6	Yes
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Section VII: Suggested Procedures

No	1	2	3	4	5	6	Yes
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Please answer the following questions in writing.

10. Can you suggest additional content that should be added in a revised version of the manual? Please be as specific as possible.

11. On the basis of your experience in using the manual in a workshop setting, what content do you think should be removed? Please give us your reasons.

12. What suggestions could you offer for improving the format of the manual?

13. How could the process suggested in the manual be improved?

14. Was the time suggested for the various sections of the module sufficient? If not, which sections took less time than estimated? Which sections took more time?

15. What other comments do you have for improving the manual?

PARTICIPANT EVALUATION FORM

Please complete this and turn it in at the end of the workshop. For the first fifteen questions, please circle the number that best represents your opinion, either strongly no (1) strongly yes (6) or somewhere in between (2,3,4 or 5). Please do not circle either "yes" or "no."

1. Do you now understand the role of the for-profit private sector in promoting and providing company-based family planning services?

No 1 2 3 4 5 6 Yes

2. Are you now more aware of the successes and failures of others who have set up company-based services?

No 1 2 3 4 5 6 Yes

3. Are you now more aware of the benefits derived from providing company-based family planning services?

No 1 2 3 4 5 6 Yes

4. Are you now more aware of the various contraceptive options that could be made available through company-based family planning services?

No 1 2 3 4 5 6 Yes

5. Do you now understand IE&C efforts better and are you more aware of how they could be used in a factory context?

No 1 2 3 4 5 6 Yes

6. Are you now better able to identify decision points in planning, implementing and evaluating company-based family planning services?

No 1 2 3 4 5 6 Yes

7. Were you able to prepare a work plan for setting up family planning services?

No 1 2 3 4 5 6 Yes

8. Were the trainers dynamic, interesting and versatile presenters?

No 1 2 3 4 5 6 Yes

9. Were the trainers confident and knowledgeable in regards to the workshop topic?

No 1 2 3 4 5 6 Yes

10. Was there sufficient time for group discussion, questions and answers?

No 1 2 3 4 5 6 Yes

11. Will this workshop help you start-up family planning services?

No 1 2 3 4 5 6 Yes

12. Did you learn a lot from other participants at this workshop?

No 1 2 3 4 5 6 Yes

13. Would you highly recommend this workshop to others?

No 1 2 3 4 5 6 Yes

14. Will you share the course information with other staff at your place of employment?

No 1 2 3 4 5 6 Yes

15. Overall, I would rate the workshop as:

1 2 3 4 5 6

Poor Below Average Above Average Very Excellent Average
Good

Please answer the following questions in writing:

16. Refer to the statement you wrote the first day. Now that the workshop is over, how do you see the role of your enterprise in the promotion and provision of family planning services?

17. Which aspects of the workshop will be most useful to you?

18. Which aspects of the workshop will be the least useful to you?

19. How would you advise the trainer on changes or improvements needed in the workshop?

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20. Please list other related topic areas that you feel should be included in the workshop.

21. Do you have any comments to make on the workshop location or facilities?

22. Additional comments or suggestions?

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