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Family Planning

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The Maternal and Child Health Integrated Program (MCHIP) is the USAID Bureau for Global Health flagship maternal and child health (MNCH) program. MCHIP supports programming in maternal, newborn and child health, immunization, family planning, malaria and HIV/AIDS, and strongly encourages opportunities for integration. Cross-cutting technical areas include water, sanitation, hygiene, urban health and health systems strengthening. Visit www.mchip.net to learn more.

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Abbreviations and Acronyms

CBFP	Community-Based Family Planning
CHW	Community Health Worker
COCs	Comprehensive Oral Contraceptives
CORE	Child Survival Collaborations and Resources Group
CSHGP	Child Survival and Health Grants Program
CYP	Couple-Years of Protection
DHS	Demographic and Health Survey
DMPA	Depo-Provera/Depot medroxyprogesterone acetate
ECP	Emergency Contraceptive Pills
FP	Family Planning
HTSP	Health Timing and Spacing of Pregnancies
IUD	Intrauterine Device
KPC	Knowledge Practices and Coverage Survey
LAM	Lactational Amenorrhea Method
LAPM	Long Acting and Permanent Methods
M&E	Monitoring and Evaluation
MCHIP	Mother and Child Health Integrated Project
MDGs	Millennium Development Goals
MIYCN	Maternal, Infant, and Young Child Nutrition
NGO	Nongovernmental Organization
PAC	Postabortion Care
PID	Pelvic Inflammatory Disease
PPFP	Postpartum Family Planning
POPs	Progestin-Only Pills
PVO	Private Voluntary Organization
SBCC	Social and Behavior Change Communication
SDM	Standard Days Method
STI	Sexually Transmitted Infection
TFR	Total Fertility Rate
TRM	Technical Reference Material
UNFPA	United Nations Population Fund
USAID	United States Agency for International Development
WHO	World Health Organization
WRA	Women of Reproductive Age

Introduction to the Technical Reference Materials

The Technical Reference Materials (TRMs) are a product of the Bureau for Global Health, Office of Health, Infectious Diseases and Nutrition Child Survival and Health Grants Program USAID/GH/HIDN/Child Survival and Health Grants Program (CSHGP). This document was co-produced by the Flexible Fund USAID/GH/PRH/Flexible Fund. It is a guide (not an authority) to help you think through your ability and needs in choosing to implement a family planning project or a family planning component of an integrated health project. An attempt has been made to keep the language simple to encourage translation for use as a field document.

The TRMs are organized into modules that correspond to the primary technical areas and key crosscutting areas that are central to the Child Survival and Health Grants Program. Each module is designed to reflect the essential elements to be considered when implementing the given intervention or strategy and important resources that grantees should consult when planning their interventions. Grantees are encouraged to download the modules that are most relevant to their proposed programs. The TRMs presently include the following modules:

Technical Areas

Family Planning
Maternal and Newborn Care
Nutrition
Immunization
Pneumonia
Diarrheal Disease Prevention and Control
Malaria

Crosscutting Areas

Behavior Change Communication
Quality Assurance
Monitoring and Evaluation
Health System Strengthening

The TRMs are periodically reviewed and updated with input from technical specialists in the USAID Collaborating Agency community, Child Survival Collaborations and Resources (CORE) Working Groups, and USAID technical staff. We ask that users of this document inform us of its usefulness, information that should be amended or changed, any suggested additions and subtractions, and general comments. This will help us keep the modules up to date and responsive to your needs. Please send comments related to this module and any (electronic) translated copies to the Maternal Child Health Integrated Program (MCHIP) at info@mchipngo.net.

MCHIP is grateful for the many contributions and reviews by staff of the different offices of the Bureau of Global Health, and many of their collaborating agencies, the CORE Working Groups, and most of all to our private voluntary organization (PVO)/nongovernmental organization (NGO) partners who continue to use these guides and provide valuable insight on how to improve them.

NEW ADDITIONS TO THE FAMILY PLANNING MODULE

The 2013 Family Planning module was revised as follows:

- The healthy timing and spacing of pregnancies messages were updated.
- The Family Planning Integration section was expanded to include immunization, nutrition, postabortion care, and primary health care programs.
- New sections were added on:
 - Postpartum family planning (PPFP)
 - Social and behavior change communication (SBCC)

- Training
- Monitoring and evaluation
- Advocacy
- Engaging faith-based organizations and faith leaders

Overview

Family planning (FP) is a key component of basic health services. It benefits the health and well-being of women, children, families, and their communities. Enabling couples to determine whether, when, and how often to have children is vital to safe motherhood and child health. To reduce the risk of adverse perinatal and under-five outcomes, a report of a 2005 Technical Consultation on Birth Spacing, organized by the World Health Organization (WHO), recommends¹ that couples should wait at least 24 months after the birth of their last baby before they try to conceive again.

More recently, a 2008 analysis of Demographic and Health Surveys (DHS) data from 52 countries found that birth-to-next conception intervals of 36 to 47 months have the lowest risk of neonatal, infant, and under-five mortality and stunting and underweight.² By limiting births and preventing closely spaced births or births to very young or old mothers, the risk of neonatal, infant, child, and maternal mortality can be significantly reduced.

- A 2012 analysis found that in one year, FP prevented more than 272,000 maternal deaths in 172 countries, a 44 percent reduction. If all needs for FP were met, an additional 104,000 maternal deaths per year could be prevented.³
- A 2010 study also found that the risk of maternal death increases as the number of children per woman rises from two to six or more. For 46 countries over 10 years, the study found that maternal deaths declined by 7–35 percent as the number of children per woman decreased.⁴

In addition to the health benefits, the social and economic benefits of FP are numerous, including the family's ability to better support their children economically and socially, increased equality between men and women, higher productivity and better incomes, and decreased burden on the public and environmental resources.

FP is a cost effective development investment that contributes to all eight of the Millennium Development Goals (MDGs):⁵ (For a full article detailing these contributions please see [Family planning: the essential link to achieving all eight Millennium Development Goals](#)⁶.)

¹ World Health Organization (WHO). 2007. Report of a WHO Technical Consultation on Birth Spacing, June 13–15, 2005. Geneva: WHO.

² Rutstein S.O. 2008. Further evidence of the effects of preceding birth intervals on neonatal, infant, and under-five-years mortality and nutritional status in developing countries: Evidence from the Demographic and Health Surveys. *DHS Working Paper*. Calverton, MD: Macro International Inc.

³ Ahmed S., Qingfeng L., Liu L., and Tsui, A. 2012. Maternal deaths averted by contraceptive use: An analysis of 172 countries. *The Lancet*, 380(9837), 111-125.

⁴ Stover, J., and Ross J. 2010. How increased contraceptive use has reduced maternal mortality. *Matern Child Health J*, 14, 687-695.

⁵ See UN Millennium Development Goals at <http://www.un.org/millenniumgoals/>.

⁶ Cates, Willard. 2010. Family planning: the essential link to achieving all eight Millennium Development Goals. *Contraception* 81 (2010) 460–461.

Essential Family Planning References and Resources

[Family Planning: a Global Handbook for Providers](#) (WHO, JHUCCP, USAID, 2011). Experts from around the world have contributed to the development of this handbook, and many major international organizations and professional organizations working in FP have endorsed and adopted this guidance. It is one of WHO's "Family Planning Cornerstones," a companion to the Medical Eligibility Criteria for Contraceptive Use, the Selected Practice Recommendations for Contraceptive Use, and the Decision-Making Tool for Family Planning Clients and Providers. (Available in many languages).

[Medical Eligibility Criteria for Contraceptive Use](#) (WHO, 2010). This document reviews the medical eligibility criteria for use of contraception, offering guidance on the safety of use of different methods for women and men with specific characteristics or known medical conditions. The recommendations are based on systematic reviews of available clinical and epidemiological research. It is available in English, French, and Spanish.

[Facts for Family Planning](#) (USAID, 2013). This publication contains 10 easy-to-read chapters on important FP topics such as delaying first pregnancy, spacing pregnancies, understanding fertility, and FP methods, with special chapters focused on unmarried youth and HIV/AIDS. Facts for Family Planning can be a useful tool for counselors, social workers, community health outreach workers, teachers, religious leaders, or others working in developing countries. Program directors and managers can use this information as a guide in the development of training materials, communication messages, and other program-related activities.

[K4Health Toolkits](#) provide quick and easy access to relevant and reliable health information in one convenient location. They are intended for health program managers, policy makers, and service providers. The resources in the toolkits are selected by experts and arranged for practical use. FP-specific toolkits include:

- [Family Planning Methods:](#)
 - [IUD Toolkit](#)
 - [Implants Toolkit](#)
 - [Injectables Toolkit](#)
 - [Oral Contraceptives](#)
 - [Condom Use Toolkit](#)
 - [Lactational Amenorrhea Method \(LAM\)](#)
 - [Standard Days Method Toolkit](#)
 - [TwoDay Method](#)
- [Family Planning/Reproductive Health Programs and Services:](#)
 - [A Forecasting Guide for New and Underused Methods of Family Planning](#)
 - [Community-Based Access to Injectable Contraceptives](#)
 - [Community-Based Family Planning Toolkit](#)
 - [Elements of Family Planning Success Toolkit](#)
 - [Family Planning and HIV Services Integration](#)
 - [Healthy Timing and Spacing of Pregnancy Toolkit](#)
 - [Maternal Infant Young Child Nutrition - Family Planning \(MIYCN-FP\) Integration Toolkit](#)
 - [Postpartum Family Planning \(PPFP\) Toolkit](#)
 - [Tips & Tools for Strengthening the Effectiveness and Sustainability of Contraceptive Security Committees](#)

FAMILY PLANNING TERMINOLOGY

Birth Limiting: Refers to when men or women have completed their family size and do not plan to have any more pregnancies.

Birth Spacing: Refers to when men or women have not yet completed their family size but desire to postpone their next birth.

Contraceptive Continuation Rates: The cumulative probability that acceptors of a contraceptive method will still be using any contraceptive method offered by the program after a specified period of time (e.g., one year).⁷

Contraceptive Prevalence: Percentage of couples currently using a contraceptive method.⁸

Couple-years of protection (CYP): The estimated protection provided by FP services during a one-year period, based upon the volume of all contraceptives sold or distributed free of charge to clients during that period.⁹

Family Planning: Family planning refers to use of modern contraceptives or natural techniques to limit or space pregnancies.¹⁰ Family planning allows individuals and couples to anticipate and attain their desired number of children and the spacing and timing of their births. It is achieved through use of contraceptive methods and the treatment of involuntary infertility. A woman's ability to space and limit her pregnancies has a direct impact on her health and well-being as well as on the outcome of each pregnancy.¹¹

Healthy Timing and Spacing of Pregnancies (HTSP): HTSP is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.¹²

Informed Choice: Decisions based on accurate information: "The best decisions about family planning are those that people make for themselves, based on accurate information and a range of contraceptive options. People who make informed choices are better able to use family planning safely and effectively."¹³ Programs should support the freedom of individuals to choose voluntarily the number and spacing of their children. Decisions regarding family planning should be based on free choice and not obtained by forms of coercion. Individuals should have access to information on a wide variety of family planning choices, including the benefits and health risks of particular methods.¹⁴

Method Mix: The percent distribution of contraceptive users (or alternatively, of acceptors) by method.¹⁵

Total Fertility Rate (TFR): The average number of children that would be born alive to a woman (or group of women) during her lifetime if she were to pass through her childbearing

⁷ http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/continuation-rates accessed on August 16, 2013

⁸ <http://www.prb.org/Educators/Resources/Glossary.aspx>

⁹ http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/cyp accessed on August 16, 2013

¹⁰ <http://measuredhs.com/topics/Family-Planning.cfm>

¹¹ http://www.who.int/topics/family_planning/en/

¹² Extending Service Delivery (ESD) Project. 2008. HTSP 101: Everything you wanted to know about healthy timing and spacing of pregnancy. http://www.esdproj.org/site/DocServer/HTSP_101_Brief_Final_corrected_4.9.08.pdf?docID=1761

¹³ <http://www.k4health.org/toolkits/info-publications/informed-choice-family-planning-helping-people-decide>

¹⁴ http://transition.usaid.gov/our_work/global_health/pop/voluntarism.html#

¹⁵ http://www.cpc.unc.edu/measure/prh/rh_indicators/specific/fp/method-mix accessed on August 16, 2013

years conforming to the age-specific fertility rates of a given year. This rate is sometimes stated as the number of children women are having today.¹⁶

Unmet Need: Unmet need for family planning is defined as the percentage of women who do not want to become pregnant but are not using contraception. Though the concept seems straightforward, the calculation can be somewhat complex and has changed over time. To address these issues, DHS revised the definition of unmet need in 2012.¹⁷ The history of unmet need and details of the definitions are explained in DHS Analytical Study No. 25 [Revising Unmet Need for Family Planning](#). You can also find a detailed description of this indicator in the [Key Family Planning Impact Indicators and Their Definitions](#) section below. It is also important to note that unmet need in a given country can vary from population to population (ethnic groups, urban/rural, age, parity, etc.).

BENEFITS OF HEALTHY TIMING AND SPACING OF PREGNANCIES

As outlined above, HTSP is an intervention to help women and families delay or space their pregnancies to achieve the healthiest outcomes for women, newborns, infants, and children, within the context of free and informed choice, taking into account fertility intentions and desired family size.¹⁸ Individuals and couples should consider health risks and benefits along with other circumstances such as their age, fecundity, fertility aspirations, access to health services, child-rearing support, social and economic circumstances, and personal preferences in making choices for the timing of the next pregnancy.¹⁹

Recommendation for Spacing after a Live Birth

After a live birth, in order to reduce the risk of adverse maternal, perinatal, and infant outcomes, the recommended interval before attempting the next pregnancy is at least 24 months.²⁰

The basis for this recommendation is that, after a live birth, waiting 24 months before trying to become pregnant will help avoid the short birth-to-pregnancy intervals associated with the highest risk of poor maternal, perinatal, neonatal, and infant health outcomes. In addition, this recommended interval is considered consistent with the WHO/UNICEF recommendation of breastfeeding for at least two years, and is also considered easy to use in programs: “two years” may be clearer than 18 months or 27 months.²¹

HTSP Messages that Promote Healthy Outcomes

Healthier Children

Evidence indicates that birth-to-pregnancy intervals of at least two years (almost three years between births) are associated with:

- Decreased risk of neonatal and perinatal mortality, low birth weight, small for gestational age, and preterm delivery.
- Decreased stunting or underweight; allows children and mothers to experience the benefits of optimal breastfeeding for two years.

Healthier Mothers

The evidence indicates that:

¹⁶ <http://www.prb.org/Educators/Resources/Glossary.aspx>

¹⁷ <http://measuredhs.com/topics/Unmet-Need.cfm>

¹⁸ ESD. 2008. HTSP 101: Everything you wanted to know about healthy timing and spacing of pregnancy. http://www.esdproj.org/site/DocServer/HTSP_101_Brief_Final_corrected_4.9.08.pdf?docID=1761

¹⁹ WHO. 2005. Technical Consultation on Birth Spacing. http://whqlibdoc.who.int/hq/2007/WHO_RHR_07.1_eng.pdf

²⁰ Idem

²¹ Idem

- When birth-to-pregnancy intervals are more than six months or less than five years apart, there is a reduced risk of maternal mortality, pre-eclampsia, premature rupture of membranes, puerperal endometritis, third-trimester bleeding, anemia, high blood pressure, and induced and frequently unsafe abortion.
- Waiting until at least the age of 18 years before a first pregnancy helps young mothers reduce the risk of pregnancy-induced hypertension and associated complications.
- FP reduces abortions by preventing unintended pregnancies, for an added impact on maternal mortality.

Key Resources for HTSP:

- [Healthy Timing and Spacing of Pregnancies Toolkit](#) (K4Health, 2012)
- [Healthy Timing and Spacing of Pregnancies: A pocket guide for health practitioners, program managers and community leaders](#) (ESD). Available in English and French.
- [HTSP Counseling Pathways: A counseling tool for health care providers](#) (ESD)
- [HTSP: A Trainer's Reference Guide](#) (ESD, 2008)

Key Family Planning Messages

After a live birth:

- Couples should use an effective FP method of their choice continuously for at least two years before trying to become pregnant again.
- Couples should consider the potential risks of spacing pregnancies five years apart or more.

After a spontaneous or induced abortion:

- Although more research is needed, some studies indicate that after an abortion, couples should continuously use an effective FP method of their choice for at least six months before trying to become pregnant again.

For first pregnancies among youth:

- Youth should delay first pregnancy until they are at least 18 years old.
- To delay a first pregnancy, youth should use an effective FP method of their choice or practice abstinence.

For advanced maternal age pregnancies:

- Couples should be advised that the healthiest time for a pregnancy is between the ages of 18 and 34.

Key Resources for Developing FP Messages:

- [A Guide for Developing Messages for Women in the First Year Postpartum](#) (ACCESS-FP, 2010). Available in French and English.

Voluntary and Informed Choice

Ensuring that FP services are provided in a manner that fully respects the principles of voluntarism and informed choice is fundamental to all FP programs. This includes respecting an individual's right to make decisions about whether to obtain or decline treatment or services, what treatment or services to select, whether to seek and follow up on a referral, and whether to continue to consider the options available. The informed choice process can occur alone or in consultation with health care providers, family, or friends. Informed choice occurs when people know about FP, have access to a broad range of methods, and have support for individual choice.²²

- Clients who make voluntary and informed choices are more likely to be satisfied and follow through with the method or course of treatment they have chosen.
- Women who receive their method of first choice from a range of options are more likely to continue with that method.

Services should support individual decision-making by supplying information the individual wants, by facilitating an evaluation of all information and options, and by offering the means to implement the decision made, while recognizing the different needs and circumstances of different clients. The following are required to ensure informed choice regardless of the specific situation:

- Good interpersonal communication between the client(s) and providers
- Respect for individual choice and autonomy
- Information about a broad range of relevant methods and services
- Counseling tailored to the client's choice of method
- Sufficient time to consider options and the right to reconsider at any time
- Informed consent, especially for sterilization, implants, and intrauterine device (IUD) insertions

USAID SUPPORT TO VOLUNTARY FAMILY PLANNING

Through its FP and reproductive health funds, USAID supports FP programs that promote and provide voluntary and informed FP and that reduce unintended pregnancies. It also supports the integration of other reproductive health components into FP programs. For example, USAID supports the integration of HIV/sexually transmitted infection (STI) prevention, postabortion care, basic education on reproductive health and FP for adolescents, and prevention of harmful practices, such as female genital cutting, into traditional FP programming.

Programs receiving USAID funds are required to meet certain criteria as summarized below:

Tiahrt Amendment:

- Service providers and referral agents may not implement or be subject to numerical targets or quotas for total number of births, number of FP acceptors, or acceptors of a specific method, although quantitative estimates or indicators can be used for budgeting or planning purposes.

²² *Studies in Family Planning*; Nov./Dec. 1991.

- No incentives can be given to individuals in exchange for accepting FP or to program personnel for achievement of targets or quotas for total number of births, number of FP acceptors, or acceptors of a specific method.
- Individuals cannot be denied rights or benefits such as food or medical care based on their decision not to accept FP services.
- FP acceptors must be provided comprehensible information on the health benefits and risks of the method chosen.
- Experimental contraceptive drugs and devices and medical procedures may only be provided in the context of a scientific study in which participants are advised of potential risks and benefits.

The Foreign Assistance Act of 1961 (22 U.S.C. 2151b(f)(1)) prohibits the use of foreign assistance funds “to pay for the performance of abortions as a method of FP, or to motivate or coerce any person to practice abortions.” The August 1984 announcement by President Reagan of what has become known as the “Mexico City Policy” directed USAID to expand this limitation and withhold USAID funds from NGOs that use non-USAID funds to engage in a wide range of activities, including providing advice, counseling, or information regarding abortion, or lobbying a foreign government to legalize or make abortion available. The Mexico City Policy was rescinded under President Obama in 2009.

Key Voluntary and Informed Choice Resources:

- [Guidance on the Definition and Use of the Global Health Programs Account: A Mandatory Reference for ADS Chapter 200](#) (USAID, 2013). For more information regarding USAID policies, refer to Chapter 9 “Family Planning and Reproductive Health.”
- [Statutory Requirements & Policies Governing U.S. Global Family Planning and Reproductive Health Efforts](#) (Kaiser Family Foundation, 2012).

FAMILY PLANNING METHODS

FP programs should offer as many different modern FP methods as programmatically feasible and refer clients to service providers offering other services. The FP methods that are offered by a program will depend upon:

- The availability of different FP methods in the country
- Policies governing how these methods can be distributed
- The level of commitment to expanding method choice, including the availability of both short- and long-term methods, and to making non-hormonal methods available
- The resources needed to deliver the services: the level and training of staff, the availability of essential equipment, and the practice of minimum infection prevention activities required to support the delivery of some methods (e.g., injectables, implants, IUDs, and voluntary sterilization)

Familiarity, at least with the methods available in a program area, is fundamental for working on a FP intervention in order to maximize uptake and continuation. In some situations, it may be necessary to improve counseling of clients on side effects and misconceptions of specific methods.

For more summary information on FP methods, refer to the chart found in [Annex A](#). In addition, [Annex B](#) includes information on FP methods that may be safely used at different stages post-partum, which is presented in a chart developed by the ACCESS FP project.

Key FP Method Resources:

- [Family Planning: A Global Handbook for Providers](#) (WHO, JHUCCP, USAID, 2011) offers the latest guidance on providing contraceptive methods.
- [Contraceptive Technology](#) (Hatcher et al., 2011)

LONG-ACTING AND PERMANENT METHODS

Women and couples who want safe and effective protection against pregnancy would benefit from access to more contraceptive choices, including long-acting and permanent methods (LAPMs). LAPMs are convenient for users and effective in preventing pregnancy. They are also cost effective for programs over time, can result in substantial cost savings for governments, and contribute directly to reaching national and international health goals. Despite these advantages, LAPMs remain a relatively small, and sometimes missing, component of many national reproductive health and FP programs.²³

LAPMs offer individuals and couples advantages that other methods of FP do not, and their provision gives women who want to space or limit their pregnancies more choices. For women and couples who want to delay or space their pregnancies, implants and IUDs offer long-term effectiveness and reversibility. These reversible LAPMs are effective for three to 12 years, depending on which method is chosen. Once either device is removed, a woman's fertility returns almost immediately. Implants and IUDs are also options for individuals and couples who do not want any more children.

For women and couples who want to limit their pregnancies, female sterilization and vasectomy effectively prevent pregnancies throughout the reproductive years.²⁴ Mature family planning programs should ensure access to LAPMs for women and couples who wish to stop childbearing. In a study of 14 countries in sub-Saharan Africa, only 17 percent of contraceptive users who stated that they wanted to stop childbearing were using LAPMs.²⁵

Key LAPM Resources:

- [Long-Acting and Permanent Methods: Addressing Unmet Need for Family Planning in Africa](#) (FHI, 2007). Package of eight briefs present the benefits of LAPMs and the rationale for introducing or revitalizing them within national FP programs.
- [LA/PM Toolkit Series](#) (K4Health). Includes [Implants Toolkit](#), [IUD Toolkit](#), [Permanent Methods](#).

EMERGENCY CONTRACEPTION

Improved education on the availability, use, and function of emergency contraception can be an important complement to other FP options. The term “emergency contraception” refers to several contraceptive methods that can be used to prevent pregnancy after sex. These methods

²³ Family Health International. 2007. Addressing unmet need for family planning in Africa.

http://www.k4health.org/sites/default/files/LAPM_addressing%20unmet%20need%20in%20africa.pdf

²⁴ Family Health International (FHI). 2007. The Benefits of Long-Acting and Permanent Methods for Individuals.

<http://www.k4health.org/sites/default/files/LAPM%20brief%20%20Benefits.pdf>

²⁵ Pile J.M. et al. 2007. “Investing in the Future—The Case for Long-acting and Permanent Contraception in Sub-Saharan Africa” (secondary analysis of DHS data), paper presented at the Union for African Population Conference, Arusha, Tanzania, Dec. 10-14, 2007.

include several kinds of Emergency Contraceptive Pills (ECPs) as well as insertion of an IUD. They offer women an important second chance to prevent pregnancy when a regular method fails, no method was used, or sex was forced.²⁶

Research over the past 30 years has shown that these methods are safe and effective. Emergency contraception is endorsed by WHO and many other international and national organizations. Depending on the method used, emergency contraception can reduce a woman's risk of becoming pregnant from a single act of intercourse by between 75 and 99 percent.²⁷

Be aware of the national policies in the country where you are working. Some countries do not support the use of emergency contraception as a FP method. This may be because of the misconception that emergency contraception works by aborting a fertilized egg. In reality, emergency contraception actually *prevents* pregnancy after unprotected intercourse by preventing the sperm from reaching the egg by changing the vaginal/uterine environment and thickening the mucus.

Key Emergency Contraception Resources:

- [Emergency Contraceptive Pill: Guidelines and Factsheets](#) (The International Consortium on Emergency Contraception, 2012). Available in multiple languages.
- [Status & Availability Database](#) (The International Consortium for Emergency Contraception). Provides emergency contraception information across countries.

Family Planning Program Design

The below methodologies and tools support program design while developing a new, or expanding a current, FP program. The *Key FP Program Design Resources* box on page 18 lists recommended tools associated with each methodology.

- Conducting a **landscape analysis** is key before starting new FP programs in order to map out who the various “players” are and what services are already available. “The situation analysis is a methodology invented by Population Council researchers to pinpoint problems in family planning service delivery.... Family planning professionals can use the methodology to assess the quality of care; evaluate the extent to which other reproductive health services are available to family planning program clients; estimate staff training needs; examine the availability of information, education, and communication materials; highlight equipment requirements; guide plans for facility renovation; quantify contraceptive supply levels; and provide data for policy formulation.”²⁸
- A **baseline household survey** can be a key resource for information on the preferences and customs of the target population. USAID's CSHGP program, in collaboration with MCHIP, has just released a 2013 [Family Planning & Pregnancy Spacing Knowledge Practices and Coverage Survey](#) (KPC).
- When projects are designing and monitoring **sustainability of community-based family planning services**, a useful assessment tool is [The Family Planning Sustainability Checklist](#). The goal of the checklist is to provide a tool that enables family planning project designers, implementers, and evaluators to think through all of the elements that need to be

²⁶The International Consortium for Emergency Contraception (ICEC) <http://www.cecinfo.org/what-is-ec/general-information/>

²⁷ICEC. <http://www.cecinfo.org/what-is-ec/general-information/>

²⁸ Population Council. <http://www.popcouncil.org/what/technicalservices/SA.asp> Accessed on 6-11-13. Additional Population Council situation analysis resources can be accessed here: <http://www.popcouncil.org/what/technicalservices/SA.asp#/Resources>

in place to sustain community-based family planning services over the long term. The checklist can be used at multiple points during a project cycle—from the initial design phase through regular staff meetings, annual reviews, to midterm and final evaluations.

- Programs may find it useful to conduct a **barrier analysis**, a rapid assessment tool for identifying behavioral determinants.
- Programs may find it useful to consult recent **Demographic and Health Surveys (DHS)** that present country-wide information on many reproductive issues, including family planning.

Health programs in general, and FP programs in particular, need to consider four program elements to ensure effectiveness:

1. Increasing knowledge and demand,
2. Improving access,
3. Ensuring quality services, and
4. Developing a supportive policy and social environment.

It is not essential that a single program address all these elements. However, if the situation analysis indicates that there are significant barriers to FP use in any of these areas, it is important for the program to consider how the barriers might best be addressed to ensure the success of the program. If the program itself does not have the resources to address the identified barriers, it might look for options to leverage other resources and/or to work with collaborators to address the gaps.

Key FP Program Design Resources:

- [The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook](#) (Population Council, 1997). This book is a tool to help implement situation analysis studies.
- [Family Planning & Pregnancy Spacing Knowledge Practices and Coverage Survey](#) (MCHIP, 2013). The KPC is a small population-based survey tool, which consists of a questionnaire, tab plan, and indicator list.
- [Family Planning Sustainability Checklist](#) (USAID, 2012). This is a project assessment tool for designing and monitoring sustainability of community-based family planning services.
- [Barrier Analysis Facilitator's Guide](#) (Food for the Hungry, 2010). A rapid assessment tool for identifying behavioral determinants.
- [Demographic and Health Surveys](#) (DHS). DHS are nationally-representative household surveys that provide data for a wide range of monitoring and impact evaluation indicators in the areas of population, health, and nutrition.

POSTPARTUM FAMILY PLANNING

Postpartum family planning (PPFP) is the prevention of unintended and closely spaced pregnancies through the first 12 months following childbirth. Not only do pregnancies during this period hold the greatest risk for mother and infants, the first 12 months after childbirth also present the greatest opportunities for women and their infants to come in contact with a health worker and receive PPFP services. Postpartum women are among those with the greatest unmet need for FP, yet they do not receive the attention or FP services they need and desire to support longer birth intervals and reduce unintended pregnancy and its consequences.

- According to an analysis of DHS data from 27 countries, 65% of women who are 0–12 months postpartum want to avoid a pregnancy in the next 12 months but are not using contraception.²⁹
- FP can avert more than 30% of maternal deaths and 10% of child mortality if couples spaced their pregnancies more than two years apart.³⁰ Closely spaced pregnancies within the first year postpartum are the riskiest for mother and baby, resulting in increased risks for adverse outcomes such as preterm, low birth weight, and small for gestational age. Pregnancy occurring within six months of the last delivery holds a 7.5-fold increased risk for induced abortion and a 1.6-fold increased risk of stillbirth.³¹
- Risk of mortality in children is highest for very short birth-to-pregnancy intervals (<12 months). If all couples waited 24 months to conceive again, under five mortality would decrease by 13%. If couples waited 36 months, the decrease would be 25%.³²
 - Postpartum women (and their health care providers) may not realize that they are at risk of pregnancy even if they are breastfeeding. A study in Egypt found that 15% of breastfeeding women, who were not using lactational amenorrhea method (LAM), conceived prior to resumption of menses.³³

Given recent calls in the international community to invest in FP as a key life-saving and development intervention, PFPF has an important role to play in strategies to reduce unmet need. WHO recommends that health systems miss no opportunities to make FP an essential component of health care that is provided during the antenatal period, immediately after delivery, and during the first year postpartum.³⁴ Antenatal care, labor and delivery care, postpartum care, and well-child/immunization care provide appropriate settings for the integration of PFPF care.

As shown in the graphic in [Annex B](#), the immediate postpartum period (immediately following the delivery of the placenta or prior to discharge from the facility) is an appropriate time for such methods as IUD, tubal ligation, or LAM. Providing a contraceptive method prior to discharge from a facility is more convenient for the woman and her family, is less expensive, and reduces loss to follow-up. Other methods can be provided throughout the postpartum period in the community and home, as well as in the facility.

Key PFPF Resources:

- [Postpartum Family Planning \(PFPF\) Toolkit](#) (K4Health, 2012)
- [Postpartum Family Planning: New Research Findings and Program Implications](#) (FHI 360/PROGRESS, 2012)

FAMILY PLANNING INTEGRATION

Program integration is when two or more services are provided through a single platform. Some integrated programs offer two services as one coordinated and combined service. An example is

²⁹ Ross J. and Winfrey W. 2001. Contraceptive use, intention to use and unmet need during the extended postpartum period. *International Family Planning Perspectives*. 27(1): 20–27.

³⁰ Cleland J. et al. 2006. Family planning: The unfinished agenda. *The Lancet*. 368(9549): 1810–1827.

³¹ DaVanzo J. et al. 2007. Effects of interpregnancy interval and outcome of the preceding pregnancy on pregnancy outcomes in Matlab, Bangladesh. *BJOG*. 114(9): 1079–1087.

³² Rutstein S.O. 2008. Further Evidence of the Effects of Preceding Birth Intervals on Neonatal, Infant, and Under-Five-Years Mortality and Nutritional Status in Developing Countries: Evidence from the Demographic and Health Surveys. *DHS Working Papers*. Calverton, MD: Macro International, Demographic and Health Research Division.

³³ Shaaban O.M. and Glasierr A. 2008. Pregnancy during breastfeeding in rural Egypt. *Contraception*. 77(5):350–354

³⁴ WHO. 2012. From Evidence to Policy: Expanding Access to Family Planning. WHO Policy Brief. Geneva, Switzerland.

the addition of FP to an existing health program as a way to improve quality of services, increase the method mix, expand access to FP services, or make services affordable or convenient to clients. Alternatively, FP can be integrated into non-health program such as environmental protection, water and sanitation, or micro-enterprise. FP integration with health and non-health sector programs offers an opportunity to enhance the work of other activities and interventions. It also capitalizes on existing programs and expands service delivery into underserved geographical areas.

When considering whether to integrate FP into a program you should:

- Identify a service entry point that will reach the appropriate target audience with a minimum of effort and will benefit both interventions, not just one.
- Identify training, management support, and commodities that are needed at all levels to ensure quality service delivery
- Calculate the costs and determine all resources needed to provide the additional service.
- Determine the impact of the new intervention on the existing program.

Developing linkages and partnerships is another way to strengthen quality programming, access to services, and demand for FP services. If one of these program areas is weak, the overall FP program will be incomplete and ineffective. In this situation, the program should identify a local partner or collaborators with the capacity and willingness to fill the gap and round out the program. Examples of potential partners for FP include local NGOs, the ministry of health, the ministry of education, United Nations agencies such as the United Nations Population Fund (UNFPA), other donors, international PVO/NGOs, and community organizations. By developing and nurturing these partnerships, not only are services improved, but there are also opportunities for increasing the scale, increasing ownership, attracting additional resources, ensuring that all elements are more fully addressed, and improving sustainability.

Key FP Integration Resources:

- [Better Together: Linking Family Planning and Community Health for Health Equity and Impact](#) (Core Group, 2012)

In alphabetical order, here are some options for integrating FP with other programs:

Environmental Programs

Integration emphasizes FP as a way to reduce rapid population growth and its burden on the environment. Behavior change programs can be integrated into program activities designed to prevent environmental decline and protect biodiversity. Programs maintain the same target audience and geographic focus, giving them opportunities to integrate appropriate messages and either provide or partner with others to ensure service provision.

Key FP–Environment Integration Resources:

- [Family Planning + Environment](#) section of the [Population Health & Environment Toolkit](#) (K4Health, 2012)

HIV/AIDS

Integration of FP into HIV/AIDS programs, such as voluntary counseling and testing, helps prevent mother to child transmission and increases access to FP services. Both HIV/AIDS and FP share a common client base who need access to protection from STIs and pregnancy prevention.

Dual Protection

Dual protection is a strategy to protect against unwanted pregnancies **and** STI/HIV infection. This can be done through:

- Consistent use of condoms alone (male or female) for both purposes
- Use of condoms plus another FP method or emergency contraception, referred to as dual method use
- Avoidance of sex at risk for STI/HIV infection through mutual monogamy between uninfected partners combined with a FP method
- Avoidance of sex at risk for both STI/HIV infection and unintended pregnancy through avoiding all penetrative sex and (for youth) delaying sexual debut

Key FP–HIV Integration Resources:

- [Family Planning and HIV Services Integration](#) Toolkit on K4Health

Immunization

Immunization is one of the most effective and well utilized child-health promotion strategies globally. The recommended vaccination schedule for children allows for multiple health care contacts with infants and their mothers during the first year of life. These postpartum women are the same target group that many FP programs are trying to reach. Although evidence is limited, providing FP information and/or services to postpartum women during their infants' immunization visits may be an effective way to reach women with high unmet need for FP.³⁵

Key FP-Immunization Integration Resources:

- [Integration of Family Planning with Immunization Services: A Promising Approach to Improving Maternal and Child Health](#) (FHI, MCHIP, 2010)

Maternal, Newborn, and Child Health

Introducing FP for the mother during antenatal care, immediately postpartum, and through the extended postpartum period, inclusive of infant immunizations and maternal and infant, young child nutrition visits, provides timely promotion of messages on healthy spacing of pregnancy. Both maternal, newborn, and child health care and FP share a common client base and timing of services.

Key MNCH-FP Integration Resources:

- [FP-MNCH-NUTRITION Integration Technical Consultation: Conference Report](#) (USAID, 2011)

³⁵ FHI and MCHIP. 2010. *Integration of Family Planning with Immunization Services: A Promising Approach to Improving Maternal and Child Health*. Accessed at http://www.k4health.org/sites/default/files/FP_immunization_brief%20FINAL_061410.pdf

Nutrition

Maternal, infant, and young child nutrition (MIYCN) and FP programs and services are often perceived as distinct, yet integration of these interventions can be mutually beneficial for mothers and their children. For example, exclusive breastfeeding in the first six months after birth not only protects the infant from becoming malnourished but also meets the mother's contraceptive needs if she practices LAM.

Recent research demonstrates that short birth-to- pregnancy intervals increase the risk of neonatal, child, and maternal mortality; stunting in children (the most prevalent form of under-nutrition); and poor pregnancy outcomes, such as small for gestational age, preterm delivery, and delivery of a low-birth weight baby.

Key FP-Nutrition Integration Resources:

- [Maternal Infant Young Child Nutrition - Family Planning \(MIYCN-FP\) Integration Toolkit](#) (K4Health, 2012)
- [Maximizing synergies between maternal, infant, and young child nutrition and family planning](#) (MIYCN-FP Working Group, 2012). A 4-page summary of key global evidence.

Postabortion Care

Postabortion care (PAC) clients are women and girls with a need for FP. Even if a woman wants to have a child immediately, WHO guidelines recommend she wait at least six months after a spontaneous or induced abortion before getting pregnant again. Postabortion care includes three components:

1. Emergency treatment for complications of abortion.
2. FP counseling and service provision and, where financial and human resources are available, evaluation and treatment for STIs as well as HIV counseling and/or referral for testing of postabortion women.
3. Community empowerment through community awareness and mobilization.

Unmet need for FP is high among postabortion clients. A review of PAC research from 10 studies found that, on average, nearly 20% of postabortion clients reported having had a previous induced abortion. Among five studies with data, more than a quarter (27%) of PAC clients wanted to wait more than two years to have additional children. Furthermore, more than half of PAC clients expressed an interest in using contraception (10 studies), yet only about one-quarter (27%) left the facility with a contraceptive method (six studies).³⁶

Women are at risk of pregnancy almost immediately after abortion. Fertility returns as soon as one week after an abortion.³⁷ Timely FP services can prevent a subsequent unplanned pregnancy.

Key Postabortion Care Resources:

- [Postabortion Family Planning: Strengthening the family planning component of postabortion care](#) (USAID, 2012).
- [The PAC Global Resource Site](#) (USAID). This site provides comprehensive, standardized, scientifically accurate, and evidence-based information on postabortion care.
- [The Postabortion Care \(PAC\) Consortium](#). The PAC Consortium website has essential elements of PAC, including in resource-poor settings or in the community.

³⁶ Kidder E., Sonneveldt E., and Hardee K. 2004. Who receives PAC services? Evidence from 14 countries. Washington, D.C.: The Futures Group, POLICY Project. Available from: http://www.usaid.gov/our_work/global_health/pop/techareas/pac/kidder_hardee.pdf.

³⁷ Wilcox A.J., Dunson D., and Baird D.D. 2000. The timing of the "fertility window" in the menstrual cycle: Day specific estimates from a prospective study. *British Medical Journal*, 321(7271), 1259-62.

Primary Health Care Programs

Integration of FP into primary health care programs involves including FP as part of an overall primary health care program that is designed to reduce child and maternal mortality. Health care providers can provide counseling and services in tandem with other services. These programs attract women and children and provide a logical opportunity for reaching women of reproductive age. Health care providers must be trained and work to ensure a consistent supply of FP commodities.

COMMUNITY-BASED FAMILY PLANNING

Community-based family planning (CBFP) brings FP information and services to women and men in the communities where they live, rather than requiring them to travel to health facilities. CBFP can effectively increase access to, interest in, and demand for FP in underserved rural and urban areas in the following cases:

- When demand for FP is high but access to services is low
- When demand for, access to, and use of FP is low
- When demand for and of FP services is low, but access to services is high, and there is an interest in increasing demand
- Where the health infrastructure is weak

CBFP programs utilize a variety of community-based channels, including community health workers, community depots, drug shops, mobile services, and the private sector. CBFP services involve a significant level of community ownership. Key steps to encourage community ownership include working with leaders, stakeholders, and community members to identify challenges and priorities for improving FP, and subsequently involving them in identifying and implementing strategies and activities to address any concerns. These groups include women of reproductive age, partners, in-laws, traditional and religious leaders, politicians, health representatives, community health workers, representatives of special interest groups, community organizations, and local NGOs. Because this involvement creates a program that is responsive to the community's needs, community members will be more likely to recognize and accept the benefits of the program. This participation also fosters community ownership and responsibility for the program's success and contributes both to behavior change and to sustainability.

CBFP programs should be linked to the government's health system so as to not duplicate, replace, or ignore the system. A CBFP program must carefully choose the types of FP methods to be offered based on the ministry of health's policy, community needs, and availability of methods via health facilities. If there is a gap between community needs and what is available, the CBFP program should consider how to fill this gap. CBFP programs need to ensure that quality FP services are available at the referral health facilities and address identified health facility strengthening needs in their project plan or through partners' plans.

CBFP Strategies

Community health workers (CHWs) are an effective means to bring FP information and services to women and men in the communities where they live. CHWs have an affinity and understanding of the clients they serve because CHWs are known in their community and come from the same or a similar cultural background. Historically, CHWs have been trained to safely provide pills, condoms, and spermicides. More recently, global technical experts agree that CHWs can safely offer injectable contraceptives and educate women and couples to use fertility

awareness methods, such as LAM and the Standard Days Method (SDM). CHWs are discussed in more detail in the [CBFP Challenges](#) section below.

Traditional Birth Attendants (TBAs) can be trained to work as CHWs or otherwise brought formally into health systems/programs to provide and promote FP methods.

Community depots are useful for resupplying existing FP users with their method of choice. The depot strategy is a convenient solution for following up with a client when the only other option is a distant health facility, thereby helping to prevent method discontinuation.

Drug shops (e.g., privately accredited drug dispensing outlets) are an effective means to expand the FP method mix, including Depo-Provera/Depot medroxyprogesterone acetate (DMPA), in underserved communities, thereby increasing access to FP.

Mobile services are a way to link clinical, provider-dependent methods to communities whose access to a full range of FP methods, especially LAPMs, is limited. This strategy can greatly improve method choice at the community level.

Private sector actors can provide access to resources and techniques that increase FP uptake through media outlets, development of job aids and communication materials, and transportation. Social marketing of FP commodities is an example of engaging the private sector to increase contraceptive use.

CBFP Challenges

- Maintaining a cadre of motivated and well-trained CHWs that will remain in place after a program ends requires creativity and planning.
- Supervising, mentoring, and supporting CHWs and geographically scattered community depots and drug shops can be complex and costly, yet these components are essential for maintaining the quality of the program.
- Establishing and maintaining links to health facilities that provide other methods is an ongoing task.
- CHWs, community depots, and drug shops have limits in the range of methods they can distribute, and thus clients may still need to travel to a health facility for their method of choice.

CBFP is a less appropriate and less cost-effective choice when FP awareness and knowledge are high, contraceptive prevalence is relatively high, and a sufficient number of fixed health facilities are accessible and offer a range of methods. There are examples where the need for CBFP services has naturally decreased as the demand for FP and the quality and access to the health services and facilities increased. In this case, CBFP, and CHW provision of FP in particular, can be seen as an interim strategy to raise demand and access, recognizing that once this is accomplished, the expense for services at the community level may no longer be necessary.

CBFP programs (especially those working with CHWs) should take into account the following:³⁸

- **Logistics and supplies:** A CBFP program depends on having a reliable source of commodities and supplies. This is often through the local health center, although it may also be through the local social marketing distribution system. Products are typically procured with money obtained through cost recovery, and/or may be subsidized by the government or

³⁸ USAID/Global Health e-Learning Center. *Community Based Family Planning eLearning Course*. Washington, D.C: USAID. <http://www.globalhealthlearning.org/>. Accessed September 2012.

donor. CHWs must know the procedures for replenishing their FP commodities and other supplies, know who is responsible for resupplying, and have a system to maintain good communication with their supplier.

- **Training and supervision:** A CBFP program should develop criteria to identify and select women and men to serve as effective CHWs. This should be done in consultation with community members. Upon selection, training for CHWs takes place, usually lasting at least two weeks. Programs should also include a plan for regular refresher training of CHWs and on-the-job training as part of regular supervision. For supervision and support, CHWs should be linked to the local health center and a government health worker. A supervisor's task is to help CHWs do their work correctly and effectively by: (1) reviewing reports and record keeping; (2) observing the CHW's counseling skills for client and group education sessions; (3) giving immediate, tactful feedback to correct errors in information or approach, to praise what the agent did well, and to suggest areas where the agent can improve; and (4) mentoring the CHW, by carrying out activities with her or him and demonstrating the desired practice.
- **Referral system:** A CBFP program will need to create or strengthen the referral systems for the health facility to increase client access to LAPMs. Facility workers can also refer clients back to CHWs, who can monitor FP clients for side effects and answer clients' questions about methods they obtained at the facility.
- **Volunteer management and motivation:** CBFP programs exist with both paid and volunteer CHWs. Volunteer CHWs typically receive modest incentives, such as supplies and increased status in the community. Retaining volunteer CHWs can sometimes be addressed by expanding the "portfolio" of the CBFP program to include other socially marketed products such as insecticide-treated bednets, and/or expanded health roles, which increase their credibility, status, and access to training allowances.
- **Scale and sustainability plan:** CHW programs may be implemented on a relatively small scale due to the level of training and support required. Ownership at the ministry of health is essential for finding long-term support for supervision and refresher training to sustain CHW programs.

Key Resources for Community-Based Family Planning:

- [Community-based Family Planning Toolkit](#) (K4Health, 2012)
- [Basics of Community Based Family Planning Curriculum](#) (USAID, 2009). Available in English and French.
- [Community-based Access to Injectable Contraceptives Toolkit](#) (K4Health, 2012)
- [Community-Based Access to Injectables: An Advocacy Guide](#) (USAID, 2010). The guide describes six steps that advocates can take to support policy change to permit CHWs to provide injectables.
- [Conclusions from a Technical Consultation: Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives](#) (FHI, 2009)
- [Expanding Contraceptive Choice to the Underserved Through Delivery of Mobile Outreach Services: A Handbook for Program Planners](#) (USAID)

SOCIAL AND BEHAVIOR CHANGE COMMUNICATION

Using modern FP requires practicing new behaviors—whether they are going to the health facility for FP services, using pills consistently, or practicing exclusive breastfeeding (for LAM). Decisions about whether to access FP services and select a contraceptive method are often deeply influenced by social factors, such as social norms around sexual activity and use of FP services, religious beliefs, social support, cultural traditions, myths and rumors, local or national policies, and the role of women in reproductive health decision-making. Social and behavior change communication (SBCC) uses communications to promote and support

recommended FP practices among women, their partners and family members, and health providers; addresses changes in related socio-cultural norms; and builds a supportive environment for recommended FP practices.

SBCC activities may include providing families with information about available FP services and benefits of using FP, holding group-based discussions to address myths and misconceptions about FP, and engaging community leaders to build support for FP. SBCC activities should be designed strategically to address key barriers and enablers for recommended FP practices identified during formative assessment. Development of an SBCC strategy (or communication strategy) can help ensure that all messages and materials are designed strategically for the appropriate target audiences.

Efforts to increase the use of FP are much more likely to be successful and sustainable if they promote broader social change in addition to individual behavior change.

Key Resources for Behavior Change Communication:

- [A Guide for Developing Messages for Women in the First Year Postpartum](#) (ACCESS-FP, 2010). Available in English and French.
- [Clear Communication: A Family Planning Provider's Guide for Developing Easy-to-Read Materials](#) (JSI, 2008)
- [Designing for Behavior Change Curriculum](#) (Core Group, 2008)
- [A Field Guide for Designing a Health Communication Strategy: A Resource for Health Communication Professionals](#) (JHUCCP, 2003)

SOCIAL MARKETING

Social marketing applies commercial marketing principles to create behavior change among a target audience, which in turn will benefit society at large. Effective social marketing includes strong branding, robust distribution networks, and appropriate pricing strategies, ranging from commercially profitable, to subsidized, to free. Social marketing reaches people with quality products and services they need at prices they can afford. A variety of communication channels, including mass media, community mobilization, and interpersonal communication create demand for products and services, and promote correct use.

Social marketing is used to promote products such as condoms and oral contraceptive pills, as well as to increase demand for services. Social marketing programs are informed by market and consumer research and are measured to ensure equity, efficiency, and effectiveness.

Key Resources for FP Social Marketing:

- [Social Marketing: A Practical Resource for Social Change Professionals](#) (AED, 2009)
- [Social Marketing Guides](#) page in the Community-Based Family Planning Toolkit (K4Health)

Elements of Family Planning Service Delivery

COUNSELING

Counseling is “a special type of client-provider interaction. It is a two-way communication between a health care worker and a client, for the purpose of confirming or facilitating a decision

by the client, or helping the client address problems or concerns.”³⁹ It addresses two of the essential elements of quality for FP: interpersonal communication and accurate, complete information for informed, voluntary choice. Research suggests that clients who understand the nature of their needs and treatment, and who believe the provider respects them and is concerned about their well-being, show greater satisfaction with the care they receive and are more likely to continue using FP. In addition, clients who get the method they thought they wanted are also more likely to be satisfied and continue using that method—making it imperative for the provider to listen carefully and work with clients on their decision. Fears and concerns regarding side effects are a common reason for discontinuation of FP methods. Ensuring that health care workers are trained to counsel clients on potential side effects, as well as to address clients concerns on side effects when they arise, are a key component of quality FP counseling. Good counseling also depends upon good interpersonal skills, maintaining confidentiality and privacy, tailoring the interaction to the client’s needs, and providing enough information while avoiding overload. Ultimately, counseling needs to help clients assess their own needs, make their own voluntary and informed decisions, and ensure their ability to follow through with those decisions. As mentioned in the introduction to this TRM, the principle of informed choice is central to an effective FP program, and counseling is the primary tool for achieving this.

Key FP Counseling Resources:

- [Postpartum Family Planning for Community Health Workers](#) (ACCESS-FP, 2010). Provides all of the tools and materials needed to conduct a three-day workshop to prepare CHWs to counsel mothers, families and communities on PFP.
- [Counseling for Effective Use of Family Planning: Trainer’s Manual](#) (EngenderHealth/The ACQUIRE project, 2008)
- [The Balanced Counseling Strategy: A Toolkit for Family Planning Service Providers](#) (Population Council)
- [Introducing Systematic Screening to Reduce Unmet Health Needs: A Manager’s Manual](#) (Population Council, 2008)

TRAINING

Quality FP services require competent and well-prepared staff and volunteers who can safely provide FP methods and help clients make informed choices. Training needs to be interactive where learners/participants are engaged in activities such as role plays, small group work, learning games, and opportunities to demonstrate what they have learned in field.

Key Resources for FP Training:

- [The Training Resource Package for Family Planning \(TRP\)](#) (WHO, 2012). The TRP is a comprehensive set of materials designed to support up-to-date training on family planning and reproductive health. The TRP was developed using evidence-based technical information from WHO. The development of the TRP has been led by USAID, WHO, and UNFPA.
- [Postpartum Family Planning for Community Health Workers](#) (ACCESS FP, 2010). This package provides all of the tools and materials needed to conduct a three-day workshop to help community health workers learn how to counsel mothers, families, and communities about PFP.
- [PFP Toolkit: Capacity Building/Training](#) (K4Health, 2012). Includes links to training materials for both facility and community-based interventions.
- [Basics of Community-Based Family Planning Training Curriculum: Facilitators Guide](#) (USAID, 2009)

³⁹ Engender Health, 2003. *Comprehensive Counseling for RH: A Participants’ Handbook*. Page 26. http://www.engenderhealth.org/files/pubs/counseling-informed-choice/ccrh_ph.pdf (Accessed March, 26, 2013)

CONTRACEPTIVE LOGISTICS

Effective and efficient contraceptive logistics are essential for assuring the continuous availability of a range of quality contraceptive methods so that contraceptive security can be achieved. An effective logistics system must get the RIGHT goods in the RIGHT quantity in the RIGHT condition to the RIGHT place at the RIGHT time and for the RIGHT cost.⁴⁰ In order to achieve this, the following steps are needed:

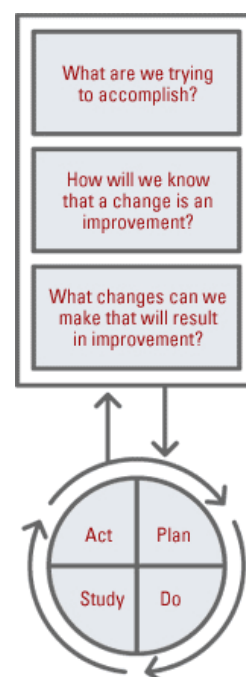
- Select the right product based on customer demand and with the goal of offering the widest variety of choices while keeping management systems simple.
- Conduct regular quantification exercises. This includes forecasting the amount needed using population data, service statistics, logistics monitoring data, and supply planning to specify the quantities and costs of contraceptives needed.
- Maximize the quality of the product by maximizing the quality of the storage. This includes storing enough to meet projected needs while carefully monitoring expiration dates and available space.

The ultimate goal of a logistics management system is to minimize losses due to overstock, waste, expiry, damage, pilferage, and inefficiency while avoiding stock outs. In order to do this, there are three essential data items:

- Stock on hand,
- Losses and adjustments
- Rate of consumption

This requires recording consumption/utilization data, recording the movement of supplies, and maintaining an inventory of stocked supplies. From this information, a program defines a maximum stock level, a minimum stock level, and an emergency order point; and maintains a safety stock. When deciding upon these variables, one keeps in mind seasonality, the reliability of supply at higher levels, and preparing for unknown events.

Regular monitoring and evaluation provides feedback to gauge system performance, to report results, and helps determine where resources and assistance is needed. To ensure contraceptives reach the intended client or destination, adequate funding for purchasing contraceptives and the operation of the supply chain is essential.



Key Contraceptive Logistics Resources:

- [Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs](#) (USAID DELIVER, 2009). Includes information on developing and managing logistics systems. Available in English, Spanish and French.
- [K4Health Contraceptive Security Toolkit](#) (K4Health, 2011)
- [e-Learning Courses on Supply Chain Management](#) (JSI). To help logisticians gain the skills they need, the USAID | DELIVER PROJECT developed a series of computer-based training courses in supply chain management. The courses are free of charge.

⁴⁰ USAID | DELIVER PROJECT, Task Order 1. 2011. *The Logistics Handbook: A Practical Guide for the Supply Chain Management of Health Commodities*. Arlington, Va.: USAID | DELIVER PROJECT, Task Order 1.

PERFORMANCE AND QUALITY IMPROVEMENT

The wide range of initiatives aimed at improving quality in health care build on models and tools first used in industry. One of the most widely used approaches promoted by the Institute for Health Care Improvement⁴¹ is based on Langley's Model for Improvement,⁴² which asks three questions:

1. What are we trying to accomplish?
2. How will we know that a change is an improvement?
3. What changes can we make that will result in improvement?⁴³

A good quality improvement intervention:

- Meets expectations and needs of community, clients, and providers, and internationally accepted technical standards
- Focuses on systems and processes
- Uses data to analyze the service delivery process, such as through a health facilities assessment, or other tools
- Encourages a team approach to ongoing problem solving and quality improvement

Elements of Quality for Family Planning

Initially, six elements of quality were identified that needed to be in place if FP services are to address client rights. These are⁴⁴:

4. A choice of methods continuously available from FP service providers
5. Interpersonal skills of FP service providers
6. Accuracy and completeness of information given to clients
7. Technical competence of providers
8. Appropriate constellation of services
9. Continuity of care and follow up

Based on further development of client rights and work in quality improvement, the following elements have been added for consideration:

1. Adequate infrastructure and equipment
2. Efficiency and effectiveness of services

41 <http://www.ihc.org/knowledge/Pages/HowtoImprove/default.aspx>

42 Langley, G.L., K.M. Nolan, T.W. Nolan, C.L. Norman, and L.P. Provost. 2009. *The Improvement Guide: A Practical Approach to Enhancing Organizational Performance* (2nd Edition). San Francisco: Jossey-Bass Publishers.

43 <http://www.hciproject.org/publications/applying-quality-improvement-integrate-family-planning-maternal-health-and-hiv-services>

44 Bruce, J. 1990. Fundamental Elements of the Quality of Care: A Simple Framework. *Studies in Family Planning*. Vol. 21, No. 2 (Mar – Apr 1990) pages 61-91.

Key Quality Improvement Resources:

- [Partnership Defined Quality: A Tool Book for Community and Health Provider Collaboration for Quality Improvement](#) (Save the Children, 2003)
- [Screening Checklists for Family Planning Services: Tools for Service Providers](#) (FHI, 2008)
- [Applying Quality Improvement to Integrate Family Planning in Maternal Health and HIV Services](#) (USAID, 2012)

INFECTION PREVENTION

The importance of infection prevention has been increasingly recognized as an essential component of quality health service delivery and technical competence. Clients, service providers, and the community at large are all at risk if standard precautions for infection prevention are not practiced. Infection prevention for FP is of most concern for injections, IUD and implant insertions, and sterilization operations.

Standard precautions are designed to help minimize client, staff, and community risk of exposure to infectious materials and to help prevent disease transmission. These include:

- Washing your hands—This is the most important infection prevention strategy.
- Protective barriers—Wear gloves, eyewear, and gowns and maintain a sterile field where needed.
- Instrument processing—Correctly process instruments and other items through decontamination, cleaning, and high-level disinfection or sterilization.
- Housekeeping—Keep the facility clean.
- Waste disposal—Properly dispose waste through burial or incineration.
- Linen processing—Handle, transport, and process linen correctly.
- Use and disposal of sharps⁴⁵—Prevent injuries with sharps.

Key Infection Prevention Resources:

- [Infection Prevention: A Reference Booklet for Health Care Providers](#) (EngenderHealth, 2001)
- [Infection Prevention Guidelines for Healthcare Facilities with Limited Resources Learning Package](#) (Jhpiego, 2004)

Monitoring and Evaluation

Monitoring and evaluation (M&E) are key aspects of any project and together they serve to support informed decisions, the best use of resources, and an objective assessment of the extent to which an organization's services and other activities have led to a desired result.⁴⁶

To make informed decisions, health care managers need an M&E system that yields reliable and timely information about such factors as:⁴⁷

⁴⁵ Sharps refer to needles, scalpel blades, razors, etc.

⁴⁶ <http://www.k4health.org/toolkits/m-and-e>

⁴⁷ Idem

- The health needs of the people in their catchment area—the area from which clients are drawn to receive health services
- The health priorities of the country, province, district, and communities the program serves
- The quality and coverage of the health services the program offers
- The resources the program has used and resources still available
- Progress in the implementation of program activities and progress toward desired outputs and outcomes⁴⁸

What is different about M&E of FP programs compared with M&E of other programs? The answer in many ways is “not much.” The fundamental M&E principles (i.e., frameworks, indicators, data sources) apply to FP programs. However, FP programs have a few specific features. First, the outcomes are relatively well-defined, focused, and measurable, unlike in some other health program areas, including wider reproductive health. There is also a long history of data collection on FP outcomes through global survey programs such as the World Fertility Survey and the DHS, among others. This means that data collection methods and indicators have been well-tested and are fairly standard now and that we have extensive documentation of global trends in these indicators going back to the 1970s and 1980s in many countries. Also, given historical population debates, there have also been several attempts to demonstrate that FP programs work, giving rise to a relatively rich literature on FP program impact evaluation and associated methods.⁴⁹

- **Outputs for FP programs** cover the different functional areas and are also similar to other programs. For example:
 - Functional area of training include people trained in FP activities, their performance, and the cost per person trained.
 - Service outputs for FP program M&E include things like service delivery points providing FP services, the quality of FP services, and the cost of increasing access and quality of FP services.
 - Service utilization outputs are closer to the population outcomes and impact and include measures of the volume and cost of services provided, such as new FP acceptors, couple-years of protection (which accounts for the length of protection from pregnancy provided by different methods), returning clients, and the cost of increasing these various service utilization outputs.
 - **Intermediate outcomes and long-term outcomes and impacts** for FP programs typically include the contraceptive prevalence rate, unmet need (detailed below), and fertility rates, particularly unintended fertility rates.⁵⁰

⁴⁸ Idem

⁴⁹ Monitoring and Evaluation: Family Planning Programs. PowerPoint. USAID and MEASURE Evaluation. <http://www.cpc.unc.edu/measure/training/materials/m-e-of-family-planning-programs>

⁵⁰ Idem

Key M&E Resources:

- [Monitoring and Evaluation Toolkit](#) (K4Health, 2011). The M&E Toolkit is a collection of resources intended for use by project managers and M&E practitioners working in public health in low- and middle-income countries. The toolkit is categorized according to the basic M&E project cycle, which many organizations use and follow.
- [Monitoring and Evaluation \(M&E\) Fundamentals](#) (USAID, 2011). Course on the USAID Global Health e-Learning Center.
- [M&E TRM](#) (USAID/CSHGP, 2007). This module of the Technical Reference Materials describes basic M&E concepts and a six-step process for developing an M&E plan linked to the project design.
- [M&E of Family Planning Programs—1 Day Module](#) (MEASURE Evaluation). This module is designed and intended to be used as a three-hour training session that is delivered as part of a larger M&E workshop on population, health, and nutrition topics, including HIV. This training module includes a PowerPoint presentation, readings, and class exercises.

KEY FAMILY PLANNING IMPACT INDICATORS AND THEIR DEFINITIONS

Contraceptive Prevalence Rate (CPR): Measures the proportion of women of reproductive age (WRA) who are using (or whose partner is using) a modern method of FP at a particular point in time. Calculation depends on a population-based household survey: number of women age 15–49 who are using a modern method of FP/total number of WRA.

Couple-Years of Protection (CYP): Estimates the amount of protection distributed over 12 months based on the total number of contraceptives distributed. It uses a formula based on an assumed number of each kind of contraceptive method that would protect one couple for one year. Data are collected from FP distribution points.

Number of Acceptors New to Modern Contraception: Identifies the number of people who accept **for the first time in their lives** any contraceptive method during a 12-month period. It is collected from the health information system and/or consultation registers. In spite of not offering a true denominator, tracking this indicator over time offers a way to track whether change is occurring in the adoption of FP.

Unmet Need for Family Planning: WRA (15–49) currently married or in union who are fecund (not pregnant or unsure if they are pregnant and not sterilized) who desire to have no more children or postpone childbearing, and who are not currently using a method of FP. Calculation depends on a population-based household survey.

Knowledge of Benefits of Adequate Birth Spacing: Number/percent of target population who can state at least one health benefit of waiting at least two years after last live birth before attempting the next pregnancy.

Key FP Indicator Resources:

- [Family Planning and Reproductive Health Indicators Database](#) (MEASURE Evaluation). Provides a comprehensive listing of the most widely used indicators for evaluating FP and reproductive health programs in developing countries. The database contains definitions, data requirements, data sources, purposes, and issues for core indicators along with links to other websites and documents containing additional family planning and reproductive health indicators.
- [Postpartum Family Planning Indicators](#) (ACCESS-FP, 2010). A set of indicators developed to measure PFP programs.

Special Considerations

ADVOCACY

Advocacy can play a key role in FP programming. While the June 2012 London Summit on Family Planning began the process of reinvigorating FP and engaging high-level country officials, transforming that energy into a sustained, visible movement calls for concerted advocacy efforts among donors, partners, and global leaders. At the national level, strengthening FP programs will mean finding ways to increase political commitment and creative leadership on the part of government officials and public administrators.

Convincing policymakers to take action requires evidence-based information, strategic thinking, strong advocacy skills, and persistence. Together, these factors lay the foundation for successful advocacy campaigns. In addition to policy audiences, increased advocacy efforts are needed among all of those audiences that have the potential to influence leaders and society (NGOs, religious and traditional leaders, the media, women's groups, and youth) as well as the general public.

Looking at the benefits of FP through a broader development lens, advocacy efforts need to encompass a range of activities that will help maintain high visibility and ensure that FP is a central development intervention. Potential activities to achieve this goal include the following:

- **Incorporate FP into national strategies and budgets.** FP advocates need to take a multi-sectoral approach and persuade decision-makers to include FP as a key component of all relevant development programs, including poverty-reduction strategies and action plans, debt-relief and sector-wide approaches, country strategic plans, and national health budgets.
- **Build the evidence base—document proof of success.** FP yields considerable returns on investments in the health, education, and economic sectors. These benefits need to be documented and quantified to better justify the importance of strengthening FP services. Showing the number of lives that could be saved and the links between smaller family size and poverty reduction are powerful arguments. Demonstrating how FP investments help achieve the Millennium Development Goals is another compelling advocacy message for high-level officials.
- **Maximize advocacy opportunities.** High-level meetings such as the International Conference on Family Planning, which was held in Dakar in November 2011, can help keep FP on government and donor agendas. These meetings provide excellent opportunities to strengthen FP commitment among authorities and technical and financial partners, and to give more visibility to the movement.
- **Create and maintain coalitions of FP champions.** Building and reinforcing leadership is essential for advancing FP. A coalition of champions can better mobilize political support. Champions must be provided with the training and tools to effectively advocate for and advance the FP agenda.
- **Mobilize the media.** To keep FP high on national and international agendas, advocates need to work closely with print and broadcast media to expand the quality and quantity of coverage on FP. Increased efforts through the press to hold governments responsible for policy implementation and the equitable distribution of FP program resources can influence policymakers to take action.

Key FP Advocacy Resources:

- [Repositioning Family Planning: Guidelines for Advocacy Action](#) (WHO, 2008). This toolkit aims to help those working in family planning across Africa to effectively advocate for renewed emphasis on family planning.
- [Engaging Innovative Advocates as Public Health Champions](#) (FHI, 2010). A 2007 Cochrane review concluded that the use of opinion leaders can successfully promote evidence-based practices.
- [Family Planning: West Africa on the Move – A Call to Action](#) (Ouagadougou Partnership 2012). This report presents targeted areas of investments in family planning to spur progress in the region and provides advocacy ideas for mobilizing political commitment and resources.
- [ENGAGE Snapshots](#) (PRB, 2010-2012). These mini-presentations offer key data on concise topics as tools for advocacy. These one- to three-minute videos with English narration are the perfect way to launch a conversation about a critical family planning or reproductive health issue with policy audiences. Like the [full-length PRB ENGAGE presentations](#), ENGAGE Snapshots are downloadable and easily embedded into PowerPoint.

ENGAGING MEN

Traditional FP programs focused almost exclusively on women, failing to recognize that men play a significant role in reproductive health decision-making. In 1994, the Program of Action from the International Conference on Population and Development in Cairo highlighted the importance of involving men in reproductive health, recognizing that “male responsibilities and participation are critical aspects for improving reproductive health outcomes, and achieving gender equality, equity, and empowering women.”⁵¹

Research has shown that men ARE willing to change their attitudes, beliefs, and behaviors relating to reproductive health when they are given the information and support to do so.⁵² Involving men in FP can happen in their roles as clients, as supportive partners, or as agents of change around community norms. The appropriate information and education on the benefits of FP can encourage a man to support his partner in achieving FP success and allow him to be an active participant in planning the number and spacing of his children.

Men’s roles as clients themselves can contribute to FP by encouraging the use of male methods, such as vasectomy and condoms. While vasectomy is currently poorly accepted due largely to misconceptions, it is the simplest, safest, and least expensive of the permanent methods.

Key Resources for Engaging Men in FP:

- [Engaging Men and Boys in Gender Equality and Health: A global toolkit for action](#) (UNFPA, 2010)
- [Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations](#) (PRB, 2010)
- [Involving Men in Sexual and Reproductive Health: An Orientation Guide](#) (Interagency Gender Working Group)
- [Report on the Qualitative Assessment of Community Based Approaches to Promote Smaller Families and Family Planning Among Men in Uganda](#) (JHU-CCP, 2008)
- [Men As Partners: A Program for Supplementing the Training of Life Skills Educators](#) (EngenderHealth, 2001)

⁵¹ Program of Action, adopted at ICPD, Cairo, September, 1994.

⁵² Barker G., Ricardo C., and Nascimento M. 2007. *Engaging Men and Boys in Changing Gender-Based Inequity in Health: Evidence From Programme Interventions*. Geneva, Switzerland: World Health Organization.

YOUTH

More than 1 billion young people are entering their reproductive years, with another 2 billion to follow, yet many young people lack basic information about and access to services for reproductive and sexual health.

The majority of adolescent pregnancies actually occurs within marriage. Girls under 18 who become pregnant are twice as likely to die of pregnancy-related complications than young women aged 20–24, and girls under age 15 may be five times as likely to die. Age is not a contraindication for any method of contraception, although methods such as sterilization are in most cases inappropriate. However, adolescents often have high rates of discontinuation of FP methods, in part due to concerns about side effects or lack of understanding of how to use the method correctly. Judgmental attitudes, locations of health centers, and inconvenient hours of services often make it difficult for youth to get the health services they need.

Delaying the onset of sexual activity and first pregnancy, and increasing positive health behaviors, including abstinence, partner reduction, and use of contraceptives such as condoms, will help protect young people's health and quality of life. "Youth-friendly" FP as well as the prevention and management of STIs/HIV are central components of health services for youth. These services should also include age-appropriate education and counseling on responsible sexual behavior, FP, STI/HIV prevention, and pregnancy care, as well as counseling on and referral for gender-based violence and sexual abuse, for both young men and women.

The active involvement of youth as partners in the planning and implementation programs can help ensure that the program is relevant to their needs, increases ownership, and takes advantage of young people's expertise and energy in developing strategies and messages for effectively reaching their peers.

Key Resources for Youth FP:

- [Integrating Reproductive Health into Youth Development Programs Toolkit](#) (K4Health)
- [A Framework for Integrating Reproductive Health and Family Planning into Youth Development Programs](#) (IYF, 2008)
- [Family Planning And Young People: Their Choices Create The Future](#) (UNFPA, 2006)

ENGAGING FAITH LEADERS

The role of faith in FP is critical in achieving successful outcomes related to maternal and child health. Faith communities, organizations, and leaders can be important facilitators to educate communities, create demand for FP services, act as agents of change, and create synergies with organizations and institutions that provide the elements needed to carry out robust programs.

Religious leaders are often important gatekeepers in disseminating reproductive health messages and influencing positive behavior change within communities. Research has shown that not only is FP accepted by many religious leaders and faith communities around the world, they are already engaged in FP activities within their communities.⁵³ Religious leaders have the potential to actively influence shifts in gender norms and attitudes about FP and optimal child-spacing. An important entry-point into these discussions can be HTSP and fertility awareness-based FP methods because they are directly linked to fertility concepts, which are strong cultural forces in many societies.

⁵³ Huber D., Yang E., Brown J., and Brown R. 2009. *International Family Planning: Christian Actions and Attitudes*. Christian Connections for International Health.

[Faith-Based Organizations as Partners in Family Planning: Working Together to Improve Family Well-being](#). Institute for Reproductive Health, Georgetown University. 2011.

FP Resources on Engaging Faith Leaders:

- [Working with Faith Based Organizations on Family Planning and Reproductive Health](#) (CCIH). The Christian Connections for International Health website has a list of resources.
- [Advancing Reproductive Health and Family Planning through Religious Leaders and Faith-Based Organizations](#) (Pathfinder, 2006).
- [Project Best Practices: Mobilizing Religious Leaders](#) (ESD)

Family Planning References and Resources

Throughout this document, text boxes listing key resources for each topic were included with hyperlinks. Below you will find the complete list of all the resources listed with URLs for the links. They are organized in the same order as they are found in the document itself.

The lists in this document are by no means exhaustive, but rather provide a couple of key resources per subject area. This is a dynamic list, as are the TRMs in general. We ask that throughout the year you provide us with information on the availability and usefulness of these resources, as well as additional resources that you think should be added to this list, as appropriate, so that we can continue to update it.

Please send comments and recommendations info@mchipngo.net.

ESSENTIAL FAMILY PLANNING REFERENCES AND RESOURCES (P. 3)

- **Family planning: a global handbook for providers** (WHO, JHUCCP, USAID, 2011). <http://www.fphandbook.org/>
- **Medical Eligibility Criteria for Contraceptive Use** (WHO, 2010). http://www.who.int/reproductivehealth/publications/family_planning/9789241563888/en/index.html
- **Facts for Family Planning** (USAID, 2013). <http://www.fphandbook.org/factsforfamilyplanning/>
- **K4Health Toolkits** (<http://www.k4health.org/toolkits#1>) FP-specific toolkits include:
 - **Family Planning Methods:** <http://www.k4health.org/toolkits/topics/847>
 - **Family Planning/Reproductive Health Programs and Services:** <http://www.k4health.org/toolkits/topics/848>

KEY RESOURCES FOR HTSP (p. 6)

- **Healthy Timing and Spacing of Pregnancies Toolkit** (K4Health, 2012): <http://www.k4health.org/toolkits/htsp>
- **Healthy Timing and Spacing of Pregnancies: A pocket guide for health practitioners, program managers and community leaders** (ESD). http://www.esdproj.org/site/DocServer/HTSP_pocket_guide_8-2-06.pdf?docID=141
- **HTSP Counseling Pathways: A counseling tool for health care providers** (ESD): http://www.esdproj.org/site/DocServer/HTSP_Counseling_Pathways_-_FINAL_-_Aug_10.pdf?docID=3681
- **HTSP: A Trainer's Reference Guide** (ESD, 2008): http://www.esdproj.org/site/DocServer/HTSP_TRG_COMPLETE_FINAL.pdf?docID=3241

KEY RESOURCES FOR DEVELOPING FP MESSAGES (p. 6)

- **A Guide for Developing Messages for Women in the First Year Postpartum** (ACCESS-FP, 2010).. <http://www.k4health.org/toolkits/ppfp/guide-developing-messages-women-first-year-postpartum>

KEY VOLUNTARY AND INFORMED CHOICE RESOURCES (p. 8)

- **Guidance on the Definition and Use of the Global Health Programs Account: A Mandatory Reference for ADS Chapter 200** (USAID, 2013).
<http://transition.usaid.gov/policy/ads/200/200mab.pdf>
- **Statutory Requirements & Policies Governing U.S. Global Family Planning and Reproductive Health Efforts** (Kaiser Family Foundation, 2012).
<http://transition.usaid.gov/policy/ads/200/200mab.pdf>

KEY FP METHOD RESOURCES (p. 8)

- **Family Planning: A Global Handbook for Providers** (WHO, JHUCCP, USAID, 2011)
<http://transition.usaid.gov/policy/ads/200/200mab.pdf>
- **Contraceptive Technology** (Hatcher et al, 2011):
<http://transition.usaid.gov/policy/ads/200/200mab.pdf>

KEY LAPM RESOURCES (p. 9)

- **Long-Acting and Permanent Methods: Addressing Unmet Need for Family Planning in Africa** (FHI, 2007).
<http://www.k4health.org/toolkits/communitybasedfp/long-acting-and-permanent-methods-addressing-unmet-need-family-planning>
- **Family Planning Methods Toolkit Topics** (K4Health).
<http://www.k4health.org/toolkits/topics/847>.

KEY EMERGENCY CONTRACEPTION RESOURCES (p. 10)

- **Emergency Contraceptive Pill: Guidelines and Factsheets** (The International Consortium on Emergency Contraception, 2012). <http://www.cecinfo.org/publications-and-resources/icec-publications/#pub1>
- **Status & Availability Database** (The International Consortium for Emergency Contraception). <http://www.cecinfo.org/country-by-country-information/status-availability-database/>

KEY FP PROGRAM DESIGN RESOURCES (p. 11)

- **The Situation Analysis Approach to Assessing Family Planning and Reproductive Health Services: A Handbook** (Population Council, 1997).
http://www.popcouncil.org/pdfs/1997_SituationAnalysisHandbook.pdf
- **Family Planning & Pregnancy Spacing Knowledge Practices and Coverage Survey** (MCHIP, 2013). http://www.mchipngo.net/controllers/link.cfc?method=tools_mande
- **Family Planning Sustainability Checklist** (USAID, 2012).
<http://www.k4health.org/toolkits/communitybasedfp/family-planning-sustainability-checklist-project-assessment-tool-designing>
- **Barrier Analysis Facilitator's Guide** (Food for the Hungry, 2010).
http://www.coregroup.org/storage/Tools/Barrier_Analysis_2010.pdf
- **Program Design and Monitoring and Evaluation of Reproductive Health Programs** (USAID, 2006). <http://www.k4health.org/toolkits/oral-contraceptives/program-design-monitoring-and-evaluation-pdme-family-planning-programs>

KEY PFPF RESOURCES (p. 12)

- **Postpartum Family Planning (PFPF) Toolkit** (K4Health, 2012)
<http://www.k4health.org/toolkits/PFPF>
- **Postpartum Family Planning: New Research Findings and Program Implications** (FHI 360/PROGRESS, 2012): <http://www.fhi360.org/resource/postpartum-family-planning-new-research-findings-and-program-implications>

KEY FP-INTEGRATION RESOURCES (p. 13)

- **Better Together: Linking Family Planning and Community Health for Health Equity and Impact** (Core Group, 2012):
<http://www.coregroup.org/storage/SMRH/FamilyPlanningReport/FPIreportRevised-online.pdf>

KEY FP-ENVIRONMENT INTEGRATION RESOURCES (p. 13)

- **Family Planning + Environment** section of the **Population Health & Environment Toolkit** (K4Health, 2012): <http://www.k4health.org/toolkits/phe/family-planning-environment>; <http://www.k4health.org/toolkits/phe/family-planning-environment>

KEY FP-HIV INTEGRATION RESOURCES (p. 14)

- **Family Planning and HIV Services Integration Toolkit** on K4Health.
<http://www.k4health.org/toolkits/fphivintegration>

KEY FP-IMMUNIZATION INTEGRATION RESOURCES (p. 14)

- **Integration of Family Planning with Immunization Services: A Promising Approach to Improving Maternal and Child Health** (FHI, MCHIP, 2010):
<http://www.mchip.net/sites/default/files/Integration%20of%20FP%20and%20Imm%20Services-%20A%20Promising%20Approach%20to%20Improving%20Maternal%20and%20Child%20Health.pdf>

KEY MNCH-FP INTEGRATION RESOURCES (p. 14)

- **FP-MNCH-NUTRITION Integration Technical Consultation: Conference Report** (USAID, 2011): http://www.esdproj.org/site/DocServer/FP-MNCH-Nutrition_Integration_Conference_Report_7.12.11_.pdf?docID=4161

KEY FP-NUTRITION INTEGRATION RESOURCES (p. 15)

- **Maternal Infant Young Child Nutrition - Family Planning (MIYCN-FP) Integration Toolkit** (K4Health, 2012). <http://www.k4health.org/toolkits/miycn-fp>
- **Maximizing synergies between maternal, infant, and young child nutrition and family planning** (MIYCN-FP Working Group, 2012). A 4-page summary of key global evidence. http://www.k4health.org/sites/default/files/MIYCNTechBrief_Final.pdf

KEY POSTABORTION CARE RESOURCES (p. 15)

- **Postabortion Family Planning: Strengthening the family planning component of postabortion care** (USAID, 2012).
http://www.fphighimpactpractices.org/sites/fphighimpactpractices.org/files/HIP_PAC_Brief.pdf
- **The PAC Global Resource Site** (USAID). <http://www.postabortioncare.org/>

- **The Postabortion Care (PAC) Consortium.** <http://www.pac-consortium.org/index.php/community>

KEY RESOURCES FOR COMMUNITY-BASED FAMILY PLANNING (p. 18)

- **Community-Based Family Planning Toolkit** (K4Health, 2012): <http://www.k4health.org/toolkits/communitybasedfp>
- **Basics of Community Based Family Planning Curriculum** (USAID, 2009). <http://www.advancingpartners.org/>
- **Community-Based Access to Injectable Contraceptives Toolkit** (K4Health, 2012): <http://www.k4health.org/toolkits/cba2i>
- **Community-Based Access to Injectables: An Advocacy Guide** (USAID, 2010). The guide describes six steps that advocates can take to support policy change to permit CHWs to provide injectables. [http://www.k4health.org/sites/default/files/HPI%20Advocacy Guide CBD Final FINAL .pdf](http://www.k4health.org/sites/default/files/HPI%20Advocacy%20Guide%20CBD%20Final%20FINAL.pdf)
- **Conclusions from a Technical Consultation: Community-Based Health Workers Can Safely and Effectively Administer Injectable Contraceptives** (FHI, 2009): http://www.who.int/reproductivehealth/publications/family_planning/WHO_CBD_brief/en/index.html
- **Expanding Contraceptive Choice to the Underserved Through Delivery of Mobile Outreach Services: A Handbook for Program Planners** (USAID): <http://www.k4health.org/sites/default/files/expanding%20contraceptive%20choice.pdf>

KEY RESOURCES FOR BEHAVIOR CHANGE COMMUNICATION (p. 19)

- **A Guide for Developing Messages for Women in the First Year Postpartum** (ACCESS-FP, 2010). <http://www.k4health.org/toolkits/ppfp/guide-developing-messages-women-first-year-postpartum>
- **Clear Communication: A Family Planning Provider's Guide for Developing Easy-to-Read Materials** (JSI, 2008): <http://www.k4health.org/sites/default/files/clear%20comm.pdf>
- **Designing for Behavior Change Curriculum** (Core Group, 2008): [http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008 .pdf](http://www.coregroup.org/storage/documents/Workingpapers/dbc_curriculum_final_2008.pdf)
- **A Field Guide for Designing a Health Communication Strategy: A Resource for Health Communication Professionals** (JHUCCP, 2003): <http://www.jhuccp.org/sites/all/files/A%20Field%20Guide%20to%20Designing%20Health%20Comm%20Strategy.pdf>

KEY RESOURCES FOR FP SOCIAL MARKETING (p. 19):

- **Social Marketing: A Practical Resource for Social Change Professionals** (AED, 2009): <http://www.drexel.edu/~media/Files/greatworks/WI12/Social-Marketing-Behavior-Book.ashx>
- **Social Marketing Guides** page in the *Community-Based Family Planning Toolkit* (K4Health): <http://www.k4health.org/toolkits/communitybasedfp/social-marketing-guides>

KEY FP COUNSELING RESOURCES (p. 20)

- **Postpartum Family Planning for Community Health Workers** (ACCESS-FP, 2010). <http://www.k4health.org/toolkits/ppfp/postpartum-family-planning-community-health-workers>
- **Counseling for Effective Use of Family Planning: Trainer’s Manual** (EngenderHealth/The ACQUIRE project, 2008): http://www.engenderhealth.org/files/pubs/acquire-digital-archive/10.0_training_curricula_and_materials/10.2_resources/fp_curric_tm_part_1.pdf
- **The Balanced Counseling Strategy: A Toolkit for Family Planning Service Providers** (Population Council): http://www.popcouncil.org/publications/books/2008_BalancedCounselingStrategy.asp
- **Introducing Systematic Screening to Reduce Unmet Health Needs: A Manager’s Manual** (Population Council, 2008): <http://www.popcouncil.org/pdfs/frontiers/Manuals/SystematicScreening.pdf>

KEY RESOURCES FOR FP TRAINING (p. 20)

- **The Training Resource Package for Family Planning (TRP)** (WHO, 2012). <http://www.fptraining.org/>
- **Postpartum Family Planning for Community Health Workers** (ACCESS FP, 2010). <http://www.k4health.org/toolkits/miyen-fp/postpartum-family-planning-community-health-workers>
- **PPFP Toolkit: Capacity Building/Training** (K4Health, 2012). <http://www.k4health.org/toolkits/ppfp/capacity-buildingtraining>
- **Basics of Community-Based Family Planning Training Curriculum: Facilitators Guide** (USAID, 2009): http://www.advancingpartners.org/sites/default/files/Basics_Family_Planning-Facilitators.pdf

KEY CONTRACEPTIVE LOGISTICS RESOURCES (p. 21)

- **Logistics Handbook: A Practical Guide for Supply Chain Managers in Family Planning and Health Programs** (USAID DELIVER, 2009). <http://www.who.int/rhem/supplychain/logihand/en/index.html>
- **K4Health Contraceptive Security Toolkit** (K4Health, 2011): <http://www.k4health.org/toolkits/fpsuccess/contraceptive-security>
- **e-Learning Courses on Supply Chain Management** (JSI). <http://elearning.jsi.com/>

KEY QUALITY IMPROVEMENT RESOURCES (p. 22)

- **Partnership Defined Quality: A Tool Book for Community and Health Provider Collaboration for Quality Improvement** (Save the Children, 2003): <http://www.healthynewbornnetwork.org/resource/partnership-defined-quality-tool-book-community-and-health-provider-collaboration-quality-i>
- **Screening Checklists for Family Planning Services: Tools for Service Providers** (FHI, 2008)
- **Applying Quality Improvement to Integrate Family Planning in Maternal Health and HIV Services** (USAID, 2012):

<http://www.hciproject.org/publications/applying-quality-improvement-integrate-family-planning-maternal-health-and-hiv-services>

KEY INFECTION PREVENTION RESOURCES (p. 23)

- **Infection Prevention: A Reference Booklet for Health Care Providers** (EngenderHealth, 2001): <http://www.k4health.org/sites/default/files/infection%20prevention.pdf>
- **Infection Prevention Guidelines for Healthcare Facilities with Limited Resources Learning Package** (Jhpiego, 2004): <http://reprolineplus.org/resources/infection-prevention-guidelines-healthcare-facilities-limited-resources-learning-package>

KEY M&E RESOURCES (p. 24)

- **Monitoring and Evaluation Toolkit** (K4Health, 2011). <http://www.k4health.org/toolkits/m-and-e>
- **Monitoring and Evaluation (M&E) Fundamentals** (USAID, 2011). Course on the USAID Global Health eLearning Center (registration required). <http://globalhealthlearning.org/>
- **M&E TRM** (USAID/CSHGP, 2007). http://www.mchipngo.net/controllers/link.cfc?method=tools_cross
- **M&E of Family Planning Programs—1 Day Module** (MEASURE Evaluation). <http://www.cpc.unc.edu/measure/training/materials/m-e-of-family-planning-programs>

KEY FP INDICATOR RESOURCES (p. 25)

- **Family Planning and Reproductive Health Indicators Database** (MEASURE Evaluation). http://www.cpc.unc.edu/measure/prh/rh_indicators
- **Postpartum Family Planning Indicators** (ACCESS-FP, 2010).. <http://www.k4health.org/sites/default/files/PPFP%20Indicators%2015Dec2010%20%282%29.pdf>

KEY FP ADVOCACY RESOURCES (p. 26)

- **Repositioning Family Planning: Guidelines for Advocacy Action** (WHO, 2008). <http://www.k4health.org/sites/default/files/repositioning%20fp.pdf>
- **Engaging Innovative Advocates as Public Health Champions** (FHI, 2010). http://www.k4health.org/sites/default/files/RUchampions_0.pdf
- **Family Planning: West Africa on the Move – A Call to Action** (Ouagadougou Partnership 2012). http://www.prb.org/pdf12/ouagadougou-partnership_en.pdf
- **ENGAGE Snapshots** (PRB, 2010-2012). <http://www.prb.org/Journalists/ENGAGEPresentations/ENGAGEMinis.aspx>
- **Full-length PRB ENGAGE presentations**. <http://www.prb.org/Journalists/ENGAGEPresentations.aspx>

KEY RESOURCES FOR ENGAGING MEN IN FP (p. 27)

- **Engaging Men and Boys in Gender Equality and Health: A global toolkit for action** (UNFPA, 2010): <http://www.unfpa.org/public/home/publications/pid/6815>

- **Synchronizing Gender Strategies: A Cooperative Model for Improving Reproductive Health and Transforming Gender Relations** (PRB, 2010): http://www.prb.org/igwg_media/synchronizing-gender-strategies.pdf
- **Involving Men in Sexual and Reproductive Health: An Orientation Guide** (Interagency Gender Working Group): <http://www.igwg.org/Publications/InvolvingMenGuide.aspx>
- **Report on the Qualitative Assessment of Community Based Approaches to Promote Smaller Families and Family Planning Among Men in Uganda** (JHU-CCP, 2008): <http://www.k4health.org/toolkits/hcp/promoting-family-planning-among-men>
- **Men As Partners: A Program for Supplementing the Training of Life Skills Educators** (EngenderHealth, 2001): <http://www.engenderhealth.org/files/pubs/gender/ppasamanual.pdf>

KEY RESOURCES FOR YOUTH FP (p. 28)

- **Integrating Reproductive Health into Youth Development Programs Toolkit** (K4Health): <http://www.k4health.org/toolkits/rh-youth>
- **A Framework for Integrating Reproductive Health and Family Planning into Youth Development Programs** (IYF, 2008): http://www.iyfnet.org/sites/default/files/P4L_Framework_RHFP.pdf
- **Family Planning And Young People: Their Choices Create The Future** (UNFPA, 2006): http://www.unfpa.org/rh/planning/mediakit/docs/new_docs/sheet5-english.pdf

FP RESOURCES ON ENGAGING FAITH LEADERS (p. 28)

- **Working with Faith Based Organizations on Family Planning and Reproductive Health** (CCIH). <http://www.ccih.org/family-planning-a-reproductive-health/154-working-with-faith-based-organizations-on-family-planning-and-reproductive-health.html>
- **Advancing Reproductive Health and Family Planning through Religious Leaders and Faith-Based Organizations** (Pathfinder, 2006). <http://www.pathfinder.org/publications-tools/Advancing-Reproductive-Health-and-Family-Planning-through-Faith-Based-Organizations.html>
- **Project Best Practices: Mobilizing Religious Leaders** (ESD): http://www.esdproj.org/site/PageNavigator/Best_Practices_Religious_Leaders

Annex A: Family Planning Methods

The following table provides a brief summary of the different FP methods with some of their characteristics and considerations; it is not exhaustive and should be used to identify where further information is needed. The publication *Contraceptive Technology, 2007*⁵⁴ provides complete detailed information on FP methods.

METHOD	CATEGORY	ADVANTAGES/DISADVANTAGES	USAGE	LIMITATIONS	SIDE EFFECTS	OK TO USE DURING LACTATION	THE TRUTH ABOUT MISCONCEPTIONS
Lactation Amenorrhea Method (LAM) 98% effective*	<ul style="list-style-type: none"> ▪ Fertility awareness ▪ Short term 	<ul style="list-style-type: none"> ▪ Free and easy for women who are exclusively breastfeeding. ▪ Universally available and very effective. ▪ Improves breastfeeding and weaning patterns. 	Three conditions: <ul style="list-style-type: none"> ▪ Give <i>only</i> breast milk to the baby whenever baby is hungry, at least 10 times during 24 hours with at least one feed during the night, feeds are not further apart than six hours. ▪ Monthly bleeding not returned. ▪ Baby is less than six months old. 	<ul style="list-style-type: none"> ▪ If mother is living with HIV, encourage that she or her baby take antiretrovirals per country protocol. ▪ EXCLUSIVE breastfeeding is safer than mixed feeding during first six months. 	None	☺	<ul style="list-style-type: none"> ▪ LAM is very effective ▪ Breastfeeding women are NOT practicing LAM unless: <ul style="list-style-type: none"> – Give only breast milk – No monthly bleeding – Infant less than six months
Condoms (male or female) 79–98% effective*	Barrier	<ul style="list-style-type: none"> ▪ Protects against pregnancy AND STIs, including HIV/AIDS. ▪ Effective when used correctly. ▪ Must be used correctly every time to be highly effective. 	<ul style="list-style-type: none"> ▪ Must be used every time ejaculation occurs near or in the vagina. 	<ul style="list-style-type: none"> ▪ Don't use condoms with nonoxynl-9. This can increase micro-abrasions and increase risk for HIV transmission. 	<ul style="list-style-type: none"> ▪ Occasionally causes skin rash. 	☺	<ul style="list-style-type: none"> ▪ Married couples do use condoms as well as smart couples who want to prevent pregnancy and infections.

⁵⁴ <http://www.contraceptivetechnology.com/>

METHOD	CATEGORY	ADVANTAGES/DISADVANTAGES	USAGE	LIMITATIONS	SIDE EFFECTS	OK TO USE DURING LACTATION	THE TRUTH ABOUT MISCONCEPTIONS
Intrauterine Device IUD 99.2–99.4% effective*	<ul style="list-style-type: none"> ▪ Medium- to long-term method 	<ul style="list-style-type: none"> ▪ Highly effective without doing anything. ▪ Available at health center level but requires sterile technique. ▪ Good option for HIV-positive women. ▪ Return to fertility after removal. 	<ul style="list-style-type: none"> ▪ Insert in health center, good for 12–13 years with copper T ▪ May insert during first 48 hours postpartum by trained providers. 	<ul style="list-style-type: none"> ▪ Women at very high risk for STIs. ▪ Should not be inserted, but may be continued with purulent cervicitis, chlamydia, gonorrhea, or pelvic inflammatory disease (PID). ▪ Follow up 	<ul style="list-style-type: none"> ▪ NOT associated with higher PID or infertility rates. ▪ May cause heavier monthly bleeding. 	☺	<ul style="list-style-type: none"> ▪ IUDs do NOT cause infertility, travel inside the body, and they do NOT cause abortions.
Progestin-only pill (POP) oral contraceptive 92–99.3% effective*	<ul style="list-style-type: none"> ▪ Hormonal ▪ Short term 	<ul style="list-style-type: none"> ▪ Used while breastfeeding after six weeks postpartum, or by women who should not use estrogen. ▪ Can distribute at community level. ▪ Can be used with most medical conditions. ▪ Take at the same time every day to prevent irregular bleeding. 	<ul style="list-style-type: none"> ▪ Take daily – <u>must</u> be taken <i>at the same time every day</i> or will not protect as effectively. 	<ul style="list-style-type: none"> ▪ Breast cancer, liver tumors. ▪ Less effective if on certain drugs (Rimfampin). 	<ul style="list-style-type: none"> ▪ Irregular monthly bleeding. ▪ Vaginal spotting. ▪ Amenorrhea 	☺	<ul style="list-style-type: none"> ▪ POPs are very effective

METHOD	CATEGORY	ADVANTAGES/DISADVANTAGES	USAGE	LIMITATIONS	SIDE EFFECTS	OK TO USE DURING LACTATION	THE TRUTH ABOUT MISCONCEPTIONS
Progestin-only injectables (DMPA, Noristerate) 97–99.7% effective*	<ul style="list-style-type: none"> ▪ Hormonal ▪ Medium- or long-term method 	<ul style="list-style-type: none"> ▪ Effective. ▪ Doesn't need to be remembered daily. ▪ Discreet. ▪ Usually only available in facilities. 	<ul style="list-style-type: none"> ▪ Injection every three months for DMPA. ▪ Every two months for Noristerate. ▪ Can start after 6 weeks postpartum. ▪ Available subcutaneous with lower dose and same effect in DMPA. 	<ul style="list-style-type: none"> ▪ Can cause a delay in return to fertility. 	<ul style="list-style-type: none"> ▪ Include changes in monthly bleeding, spotting or prolonged monthly bleeding then changes and amenorrhea, weight gain, headaches, and dizziness – but symptoms decrease within 4-6 months so counseling essential. ▪ Temporary loss of bone density. 	☺	<ul style="list-style-type: none"> ▪ Will NOT have negative effects on breastfeeding or (if pregnant) the development of baby. ▪ Do not give to a woman if early pregnancy cannot be ruled out. “The effects of DMPA use and its effects on the fetus remain unclear” (WHO MEC 2004).
Implants (Jadelle, Implanon) 99.95%	<ul style="list-style-type: none"> ▪ Hormonal ▪ Long-term method 	<ul style="list-style-type: none"> ▪ Highly effective. ▪ Can be withdrawn early with return to fertility. ▪ Safe during breastfeeding. ▪ Nursing mothers can start implants six weeks after childbirth. ▪ Can be difficult insert or remove. 	<ul style="list-style-type: none"> ▪ Jadelle: 2 rods/5yrs. ▪ Implanon:1 rod/3yrs. ▪ Implanon is easier to insert and remove. 	<ul style="list-style-type: none"> ▪ 	<ul style="list-style-type: none"> ▪ Irregular monthly bleeding, vaginal spotting, or amenorrhea. 	☺	

METHOD	CATEGORY	ADVANTAGES/DISADVANTAGES	USAGE	LIMITATIONS	SIDE EFFECTS	OK TO USE DURING LACTATION	THE TRUTH ABOUT MISCONCEPTIONS
Combined oral contraceptives 92–99.3% effective	<ul style="list-style-type: none"> ▪ Hormonal ▪ Short term 	<ul style="list-style-type: none"> ▪ Reliable. ▪ Can distribute at community level. ▪ Protects against certain cancers, anemia and other conditions. ▪ Quick return to fertility. 	<ul style="list-style-type: none"> ▪ One pill taken daily. ▪ Can start any time assuming woman is not pregnant. ▪ No known adverse outcome reported when taken inadvertently during pregnancy. 	<ul style="list-style-type: none"> ▪ Breast feeding baby less than six months. ▪ Smoking. ▪ History of venous thrombosis. ▪ Hypertension systolic >160 or diastolic >100. 	<ul style="list-style-type: none"> ▪ Estrogen-related side effects. 	<ul style="list-style-type: none"> ▪ After six months. 	<ul style="list-style-type: none"> ▪ These are NOT contraindications: varicose veins, previous depression, benign ovarian tumors, STIs, HIV positive, thyroid disorders, simple migraines headaches, and iron deficiency.
Combined injectable contraceptives 97–99.3%	Hormonal	<ul style="list-style-type: none"> ▪ Doesn't need to be remembered daily. ▪ Discreet. ▪ More regular bleeding cycles. 	<ul style="list-style-type: none"> ▪ Monthly injection. 				
Vasectomy/Tubal ligation >99% effective	<ul style="list-style-type: none"> ▪ Surgical ▪ Permanent 	<ul style="list-style-type: none"> ▪ Very safe, effective, and cost-effective. ▪ People often lack adequate information to overcome rumors. 	<ul style="list-style-type: none"> ▪ Surgery one time for permanent protection. ▪ Tubal ligation can be done with C-Section. ▪ Not difficult, but often not taught in medical school. 	Vasectomy does not provide immediate sterility, must use another method for three months after procedure.	<ul style="list-style-type: none"> ▪ No-scalpel technique (male) with less pain and bleeding. 	☺	<ul style="list-style-type: none"> ▪ Vasectomy does NOT affect sexual function, nor is it associated with prostate cancer, heart disease, or testicular cancer. ▪ Women still get their monthly bleeding after a tubal ligation.
Spermicides	<ul style="list-style-type: none"> ▪ Barrier ▪ Short term 	<ul style="list-style-type: none"> ▪ Easily available. 	<ul style="list-style-type: none"> ▪ Must be used every time. 	<ul style="list-style-type: none"> ▪ Not very effective by themselves. ▪ If nonoxynl-9 is in spermicide can increase risk of HIV transmission. 	<ul style="list-style-type: none"> ▪ Can cause vaginal itching. 	☺	<ul style="list-style-type: none"> ▪ Current spermicides do NOT protect from HIV or any STI. ▪ May enhance transmission of HIV.

METHOD	CATEGORY	ADVANTAGES/DISADVANTAGES	USAGE	LIMITATIONS	SIDE EFFECTS	OK TO USE DURING LACTATION	THE TRUTH ABOUT MISCONCEPTIONS
Natural methods – withdrawal, calendar-based and observation-based (basal body temperature, Cervical mucous (Billings) Standard Days method, rhythm, sympto-thermal)	Fertility awareness	<ul style="list-style-type: none"> ▪ Acceptable, free and no side effects. ▪ Depend on couple negotiation, commitment. ▪ Depends on couple’s ability to identify fertile days and abstain or use other protection. ▪ High failure rates. ▪ Difficult to practice in lactating women. 	<ul style="list-style-type: none"> ▪ Requires daily monitoring of fertility status. ▪ Depends on cycles. 	<ul style="list-style-type: none"> ▪ If both members of the couple are not committed. 	None	<ul style="list-style-type: none"> ▪ Breastfeeding women need to wait until they have resumed normal monthly bleeding. 	None
Emergency contraception	Hormonal	<ul style="list-style-type: none"> ▪ Can prevent pregnancy after unprotected intercourse has occurred. 	<ul style="list-style-type: none"> ▪ Use 1.5mg of progestin-only (levonorgestrel) up to 120 hours after unprotected sex or ▪ Use comprehensive oral contraceptives (COC) of 100 of estrogen and 0.50 of progestin within 120 hours of unprotected sex followed by the same dose 12 hours later. 	<ul style="list-style-type: none"> ▪ No medical contraindications except do not use during pregnancy. ▪ Emergency contraception pills (ECPs) are not thought to be harmful but they are not as effective as routine contraception. ▪ They are not effective for ongoing family planning protection. 	<ul style="list-style-type: none"> ▪ May have nausea and vomiting, especially with COCs due to higher dosage. 	Breastfeeding women need to remove all breast milk and throw it away for eight hours after taking emergency contraception.	The ECPs do NOT interrupt an established pregnancy (they act before implantation).

Annex B: Postpartum Contraceptive Options

