6

CHAPTER SIX

Family Planning

Contents:

- Preliminary Considerations
- Assessment of Needs
- Implementation of Family Planning Services
- Examples of Contraceptive Methods that May Be Provided in Refugee Settings
- Male Involvement in Family Planning Programmes
- Monitoring

Family planning helps save women's and children's lives and preserves their health by preventing untimely and unwanted pregnancies, reducing women's exposure to the health risks of childbirth and abortion and giving women, who are often the sole caregivers, more time to care for their children and themselves.

All couples and individuals have the right to decide freely and responsibly the number and spacing of their children and to have access to the information, education and means to do so.

Family Planning

Refugee women and men should be involved in all aspects of family planning programmes; and the programmes should be conducted with full respect for the various religious and ethical values and cultural backgrounds within the refugee community.

From the earliest stages of an operation, relief organisations should be able to respond to refugees' demand for contraceptives. As the situation stabilises, a range of safe and effective modern methods of family planning, approved by WHO, should be available. The provision of family planning services requires appropriately trained staff and a reliable supply of material and financial resources.

Preliminary Considerations

The situation in the refugees' country of origin will be an important factor influencing expectations, perceived needs and demand for family planning. Laws, infrastructure, religious and ethical values and cultural backgrounds and the training of health-care providers from the host country also have an important affect on the services that can be offered. Some women may want to continue using a contraceptive method that they used before displacement. These women's demands for continued family planning should be met as soon as possible.

Given the risk of pregnancy and exposure to sexually transmitted diseases (STDs), including HIV, that often prevails in refugee situations, condoms should be available as early as possible. (See Chapter Two – MISP.) Counselling services should also be available.

Providing a full range of family planning services will usually not be feasible until the situation has stabilised somewhat. A refugee situation is considered "stabilised" when the crude mortality rate falls below one in 10,000 per day, when there are no major epidemics, and when the "settled" refugee population is not expected to repatriate or relocate within six months.

Protocols used to manage family planning services in the country of origin may be different than those used in the host country. To the extent possible, host country protocols should be followed, although some negotiation may be necessary where differences exist.

Most family planning methods are used by women. Women have the right to confidentiality and privacy about their choice of methods. But frequently men are the decision-makers within the family unit. Where appropriate, men should be given appropriate information and encouraged to take an active role in the family planning decision-making process. This will help ensure that joint responsibility is taken for family planning decisions and will maximise acceptance of the programme within the community.

Assessment of Needs

Background information on reproductive health (RH) in the country of origin should be available from pre-existing data. Sources for this information include UNAIDS, UNFPA, WHO and other governmental and non-governmental agencies that work in reproductive health and family planning. Headquarters and regional offices should be able to provide this information to field operations.

A review of the national or other (UNFPA, NGO, bilateral, etc.) family planning programmes of the host country must be conducted to find ways and means for collaboration and to identify any differences in protocols which must be resolved. If services are made available to refugees, they should also be available to the surrounding local population on request.

The following activities will help assess the demand for family planning within a refugee population:

- Carry out an investigation of attitudes held by the refugee population concerning contraception.
- Assess attitudes and knowledge of providers from the refugee population,

including those involving traditional methods.

- Gather information on contraceptive prevalence by method in the country of origin.
- Verify in-country availability of supplies and continuity of supplies.
- Determine if refugees can use existing facilities in the host country.

The support of community, social and religious leaders should be sought before setting up family planning services. Without this support, only those willing to risk community censure may use the services. For example, in some traditional cultures, talk of women's reproductive rights may provoke opposition. But support may be given for an information, education and communication (IEC) campaign emphasising child spacing, safe motherhood and the health of women.

Discussions should be held with individual women (including leaders and traditional birth attendants [TBAs]) and women's organisations to obtain their advice on the location of service points, the timing of services at the health facilities and the level of privacy and confidentiality that will ensure maximum use.

Implementation of Family Planning Services

To ensure an appropriate and effective family planning programme, the following components must be integrated, according to the findings of the assessment:

High-Quality Family Planning Services

All RH services should be of the highest quality possible. High-quality contraceptive care involves providing women and men with safe and appropriate methods to meet individuals' and couples' needs at every stage of their reproductive lives. Accurate and complete information should be provided, allowing women and men to select freely a method that suits their needs.

High quality means that:

- the needs of clients are assessed;
- an appropriate range of methods is provided;
- complete and accurate information about all methods is offered, thus ensuring informed choice;
- a mix of methods matches the needs of all potential clients;
- providers have the necessary technical skills to offer the methods safely (i.e., providers screen women for medical contraindications, assess STD/HIV risks, and can medically manage side effects);
- providers are trained in technically accurate and culturally appropriate counselling techniques and use them effectively;
- services are convenient, accessible and acceptable to clients;
- follow-up care to ensure continuity of services is provided; and
- an adequate logistics system ensures a continuity of supplies.

Procurement of Contraceptives and Logistics of Distribution

It is not possible to provide quality services unless an uninterrupted supply of contraceptives is ensured and staff are appropriately trained. Local supply channels should be investigated. If these are inadequate, supplies should be obtained through reliable suppliers or with support from UNFPA, UNHCR or WHO. These agencies can facilitate the purchase of bulk quantities of good-quality contraceptives at low cost.

The following are the basic steps required to manage stocks of contraceptives:

- **Select contraceptives.** Selection should be based on past use within the refugee

community, the providers' skills, and consideration for the laws, procedures and practices of the host country. Negotiation maybe necessary to resolve any differences.

- **Estimate quantities to be procured.** Estimates should initially be based on data from the country of origin and, later, on data generated within the refugee situation.
- **Set up a system for record keeping.** See section below on monitoring.
- **Set up procedures for efficiently managing the procurement, distribution and inventory of contraceptives.** Under- or over-supply may be avoided by careful organisation, primarily by appointing an individual who will assume this specific responsibility.

Planning Outlets and Opportunities for Family Planning Services

Family planning delivery sites should be accessible and convenient. Ideally, family planning services should be available at health centres, outreach health posts and through community-based distribution channels, when appropriate. Some groups, such as adolescents, unmarried women and men, may need special consideration so they feel comfortable using the services and so they can avoid the risk of stigmatisation by the community. Contraceptives should be available at the consultation point; the client should not be referred to a central pharmacy to obtain the selected method.

Counselling and family planning methods should be systematically offered to refugees after providing services related to post-abortion care, STDs or after childbirth.

Human Resource Needs

Family planning programmes should be organised and supervised by an experienced nurse, midwife or doctor and maximum use should be made of qualified or experienced refugees or local staff. If lay workers are used for community-based distribution, they must be trained in appropriate skills and attitudes and must be supervised.

Those involved in providing family planning services must show respect for the client's opinion and for the need for confidentiality. To increase use, the provider may need to be of the same sex and cultural background as the user and have strong communication skills.

To ensure administrative, technical and referral support, there must be coordination and cooperation with the host country's family planning programme and with NGOs or UN agencies, such as UNFPA. Such cooperation will also increase the chances of sustainability of the refugee family planning programme.

Preparation of the information, education and communication (IEC) component

Counselling should always be an integral part of family planning services. Appropriate, culturally acceptable IEC materials help individuals and couples make free contraceptive choices. Information must include the benefits and constraints of different methods, and how to use them. (See Appendix One–The Essentials of IEC Programmes.)

Preparation of an adequate training programme for service providers

In many situations, there will be trained providers among the refugee population. These people should be employed to the fullest extent possible. All staff involved in providing family planning services must have adequate training on contraceptive methods and counselling, as indicated in the list below. This training should be supplemented by periodic refresher courses. On-the-job training and supervised practice are essential to ensure adequate performance and must be integral components of the supervisory programme.

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

- **Technical Competence**
  - description of methods (including advantages and effectiveness)
  - mode of action, side-effects, complications, danger signs
  - appropriate groups of users and instructions for use or administration
  - contraindications and drug interactions
  - technical skills relating to the provision of each method (e.g., insertion of IUD or hormonal implant)
  - follow-up and re-supply requirements, including ordering supplies
  - record keeping

  For methods that require specific technical skills–such as implants, IUDs, voluntary sterilisation and the diaphragm–providers need hands-on training in method provision and close supervision.

- **Interpersonal Skills**
  - communication and counselling skills
  - appropriate attitudes towards users and non-users and respect for their choices
  - appropriate responses to rumours and misconceptions
  - respect for dignity, privacy, confidentiality
  - understanding of the needs of specific groups, such as adolescents, single women and men

- **Communication Skills**

  It is important for providers to be trained in culturally sensitive, unbiased communication techniques that encourage open, interactive relationships with clients. Skills necessary for this kind of communication include listening, clarifying, encouraging clients to speak, acknowledging client feelings, and summarising what has been said. In addition, providers should be taught strategies for effective counselling of clients about method choices in a limited time period. Providers should also be trained to use visual and other support materials and to identify clients with special needs, such as those with a high risk of STDs, post-abortion clients, breastfeeding women, adolescents, etc.

- **Administrative Skills**

  Many family planning providers must also perform routine administrative and managerial tasks, such as record keeping, referrals and inventory control, and should therefore be trained in these activities. Training should emphasise not only the specific skills necessary to carry out these functions, but also why they are important.

Plan protocols to be used during the family planning consultation

First contact involves:

- registration and taking an individual RH history;
- physical, gynaecological and pelvic examination when indicated (for example, to ascertain whether a woman is pregnant, to investigate unexplained vaginal bleeding, to determine the presence of an STD);
- counselling regarding available methods and the user's preferred choice according to her/his STD/HIV risk;
- provision of the contraceptive method supply, as indicated;
- counselling on when and how to use the contraceptives;
- counselling on possible side effects and reassurance that she/he can return to the health facility at any time and change methods;
- scheduling a follow-up visit.

See Annex 2 for an example of the decision-making process during a first visit. Annex 3

shows an example of a checklist used at a first visit to screen female refugees for contra-indications against the use of various methods. Host-country checklists may exist for each method and should be used where appropriate.

For a new user, frequent follow-up (at one month, three months and six months) gives the client opportunities to ask questions about use and any side-effects which she/he may have experienced. As the user becomes familiar with a method, he/she no longer needs frequent follow-up visits. With some methods, such as pills, condoms, and injectables, clients must make regular visits to obtain the contraceptives, so follow-up is more automatic. Whatever the frequency of follow-up visits, the user should be assured of immediate access if she/he experiences any difficulties. When arranging follow-up visits, providers must be sensitive to the literacy and numeracy of the client.

Examples of Methods That May Be Provided in Refugee Settings

Providers and users must be aware of the particularities of each method, its effectiveness, safety, side effects. They should also know its effect on the risk of STD transmission, its appropriateness for breastfeeding women and the usual length of time between discontinuation of the method and return to normal fertility. Information on the common methods is presented here. “In no cases should abortion be promoted as a method of family planning” (ICPD para 8.25).

Barrier Methods

In most refugee situations, the most important barrier method will be male latex condoms. Consistent and correct use of condoms can play the dual role of protection against STD and HIV infection and prevention of conception. They can be used alone or in combination with another method to increase effectiveness. Only water-based lubricants should be used with condoms. Other barrier methods, such as spermicides and female condoms, may be requested by refugees who are familiar with these methods from their country of origin. If requested, every effort should be made to supply these methods.

Hormonal Contraceptives

Oral Contraceptive Pills should include at least:

- one combined oral contraceptive (COC): ethinyl oestradiol < 0.035 mg and levonorgestrel 0.15 mg;
- one progestogen-only oral contraceptive (POP): levonorgestrel 0.03 mg or norethisterone 0.35 mg.

Injectable Contraceptives could include depot-medroxyprogesterone acetate (DMPA, Depo-provera), one injection every three months, norethisterone enatharem (NET-EN) one injection every 2 months, or Cyclofem, one injection per month. Trained health professionals should administer injectables. It is recommended that only one injectable method should be used to avoid confusion and misunderstanding over the schedule for reinjection.

Supportive counselling and continued reassurance during follow-up visits will help clients tolerate common side effects, such as changed patterns of menstrual bleeding.

See Chapter Four for details about the provision of Emergency Contraceptive Pills (ECPs). National policies and the demands of well-informed users should guide the use of ECPs in refugee situations.

Copper IUDs (Intra-Uterine Devices)

IUD insertion, like sterilisation and implants, requires special training, facilities and equipment that must be in place before these methods are provided.

Women known to be infected or at high risk for an STD, including HIV, should not have an IUD inserted. For nulliparous women, an IUD is not the method of first choice.

Natural Family Planning (NFP) Methods

Natural Family Planning methods include the basal body temperature method, the cervical mucus or ovulation method, the calendar method and the sympto-thermal method. NFP is particularly appropriate for people who do not wish to use other methods for medical reasons or because of religious or personal beliefs. Counselling must be provided to both partners when choosing these methods and when practising them. The methods require initial training and regular follow-up until confidence is achieved in detecting fertility signs. Teaching these methods to potential users is relatively time consuming, and requires separate sessions for those refugees who wish to use them.

Breastfeeding

Breastfeeding is effective as a contraceptive method if a woman is exclusively breastfeeding on demand her infant (no other food being given to the baby), she is not menstruating and her infant is less than six months old. If any one this these three criteria are not met, then an additional method of contraception is advised.

Family planning methods recommended for breastfeeding mothers are:

- from delivery up to six weeks postpartum: barrier methods, postpartum IUD insertion and sterilisation;
- from six weeks to six months postpartum: barrier methods, progestin-only methods (pills, injectables, implants), IUDs, and sterilisation;
- after six months postpartum: COCs and combined injectables, and natural family planning methods.

Hormonal Implants

An implant is a long-lasting progestogen-only contraceptive. The most widely used types (Norplant and Norplant 2) consist, respectively, of six or two silastic capsules containing the progestogen levonorgestrel. The capsules, inserted under the skin of the arm, slowly release the progestogen. These implants are effective for five years. They should only be inserted or removed by properly trained personnel.

Before using any long-term contraceptive within a refugee situation, service providers must be sure that the necessary facilities and skilled personnel exist in the country of origin to reverse or remove the method, since refugees may return home at any time. If such facilities do not exist in the country of origin, the method should not be used.

Voluntary Surgical Contraception

Both male (vasectomy) and female sterilisation are desirable methods of contraception for some clients. As a surgical method, sterilisation should only be performed in safe conditions, with the formal consent of the user and by trained personnel with the necessary equipment. Sterilisation should not be excluded especially if it is familiar to the refugees from their country of origin and is allowed within the host country.

Male Involvement in Family Planning Programmes

Men must be involved in family planning programmes to increase recognition of other RH issues, such as the prevention of STDs/HIV/AIDS, and to increase acceptance within the community. Activities might include couples counselling, condom promotion, special health facility times for men, peer-group sessions and social groups. Consideration of men's perspectives and motivation must be integral to programme activities. Contraceptive use by men enables them to share the responsibility of family planning with their female partners. Some services may need to be specifically tailored to meet the needs of male users.

Monitoring

Providers should maintain a daily activity register and individual forms to help them record information and offer effective follow-up. The following information should be recorded:

- date
- user name–or, if required for confidentiality, only a number
- user information (age, parity, address)
- method selected (and brand name)
- side effects experienced
- type of user (new, repeat, etc.)
- reason for discontinuation–dropout or changed to other method
- date of next visit (for follow-up).

Record-keeping forms should be simple and appropriate to the information gathered and to staff literacy levels. All staff should receive training in how to maintain appropriate records and be informed of how the information being collected will be useful to users and providers.

Family Planning Indicators

✔ **Indicators to be collected at the health-facility level**

Contraceptive Prevalence Rate (CPR). CPR is the percentage of women who are using (or whose partner is using) a method of contraception at a given point in time.

✔ **Indicators to be collected at the community level**

Community-based surveys could be carried out to assess the knowledge, attitudes and practices of refugees concerning family planning services.

✔ **Indicators concerning training and quality of care**

Regular skills training and assessments. Health personnel implementing family planning programmes should be trained and their skills assessed regularly. An indicator of this competency should be monitored at least once a year. A possible indicator to assess the skills of family planning workers is the proportion of health workers appropriately implementing family planning services.

(Refer to Chapter Nine–Monitoring and Surveillance.)

Checklist for Establishing Family Planning Services

- ✔ Assessment of attitudes of different groups undertaken
- ✔ Contraceptive prevalence in country of origin known
- ✔ Family planning services sites established with participation of refugees
- ✔ Contraceptives procured and logistics system in place
- ✔ Health and community workers trained in family planning service delivery
- ✔ Family planning record keeping system in place
- ✔ Involvement of male community undertaken

Further Readings

"Pocket Guide for Family Planning Service Providers", Blumenthal, P. et al. JHPIEGO, Baltimore, MD, 1995.

"Contraceptive Logistic Guidelines for Refugee Settings", Family Planning Logistics Management Project, John Snow, Inc., Arlington, VA, 1996.

Hatcher, R. and W. Rinehart, R. Blackburn, and J. Geller. "The Essentials of Contraceptive Technology", a joint WHO/USAID publication, Population Information Program, Centre for Communication Programs, The Johns Hopkins School of Public Health, Baltimore, MD, 1997.

"Improving Access to Quality Care in Family Planning: Medical Eligibility Criteria for Contraceptive Use", WHO, Geneva, 1996.

"Medical and Service Delivery Guidelines for Family Planning", WHO, IPPF, AVSC, Second Edition, 1997.

Technical and Managerial Guidelines on Family Planning, WHO, Geneva

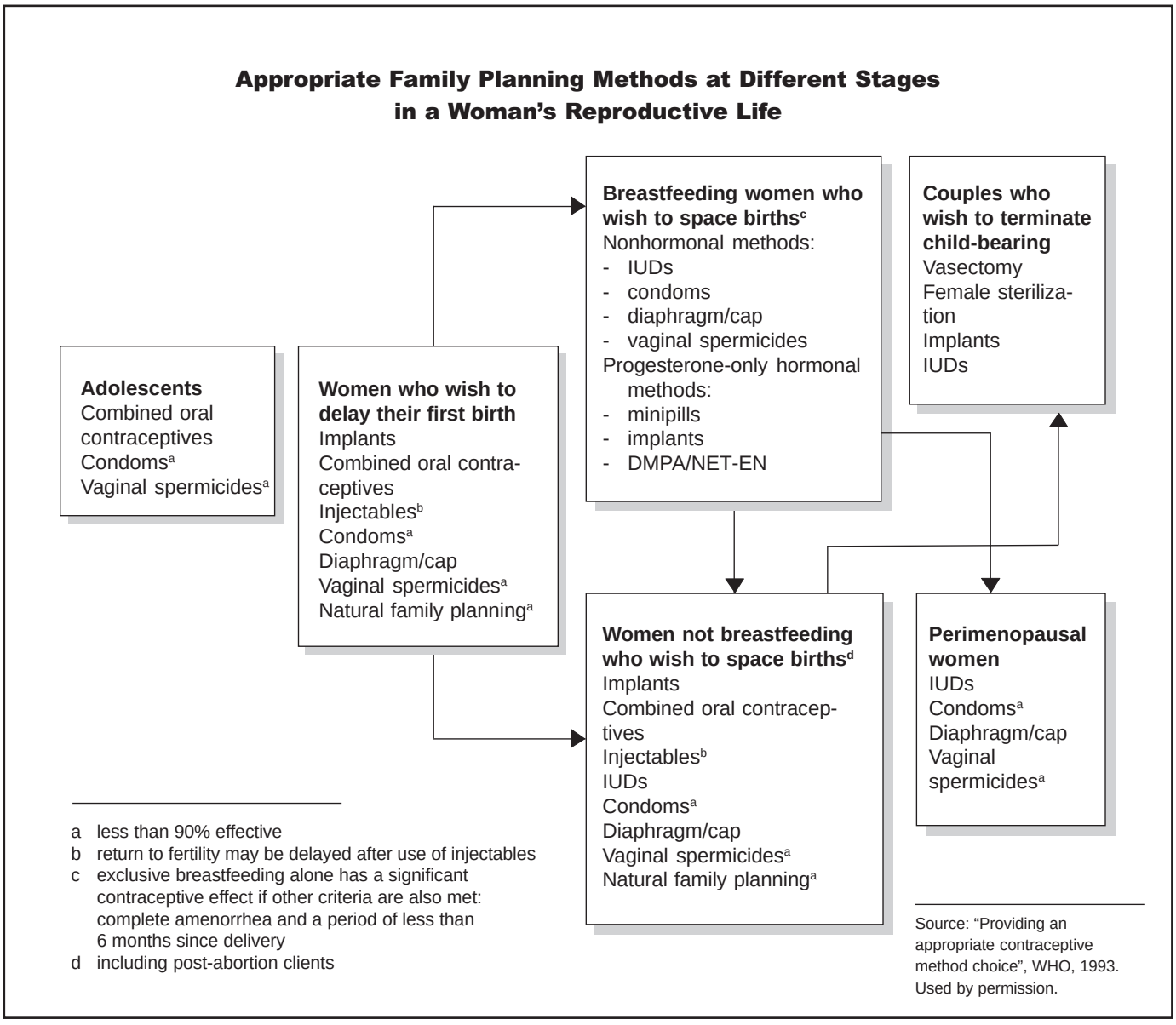
- Barrier Methods and Spermicides: Their Role in Family Planning Care, 1987.
- Natural Family Planning - A Guide for Provision of Services, 1988.
- Norplant Contraceptive Implants: Managerial and Technical Guidelines, 1990.
- Injectable Contraceptives: Their Role in Family Planning Care, 1991.
- Guidelines for Community-based Distribution of Contraceptives, 1994.
- Emergency Contraception: A Guide Service Delivery, 1998.
- Female Sterilisation: A Guide to the Provision of Services, 1992.
- Technical and Managerial Guidelines for Vasectomy Services, 1988.
- Intrauterine Devices: Technical and Managerial Guidelines for Services, 1997.

WHO Brochures: What Health Workers Need to Know

- Natural Family Planning
- Providing an Appropriate Contraceptive Method Choice
- Female Sterilisation
- Vasectomy
- Breastfeeding and Child Spacing
- IUDs
- Injectable Contraceptives

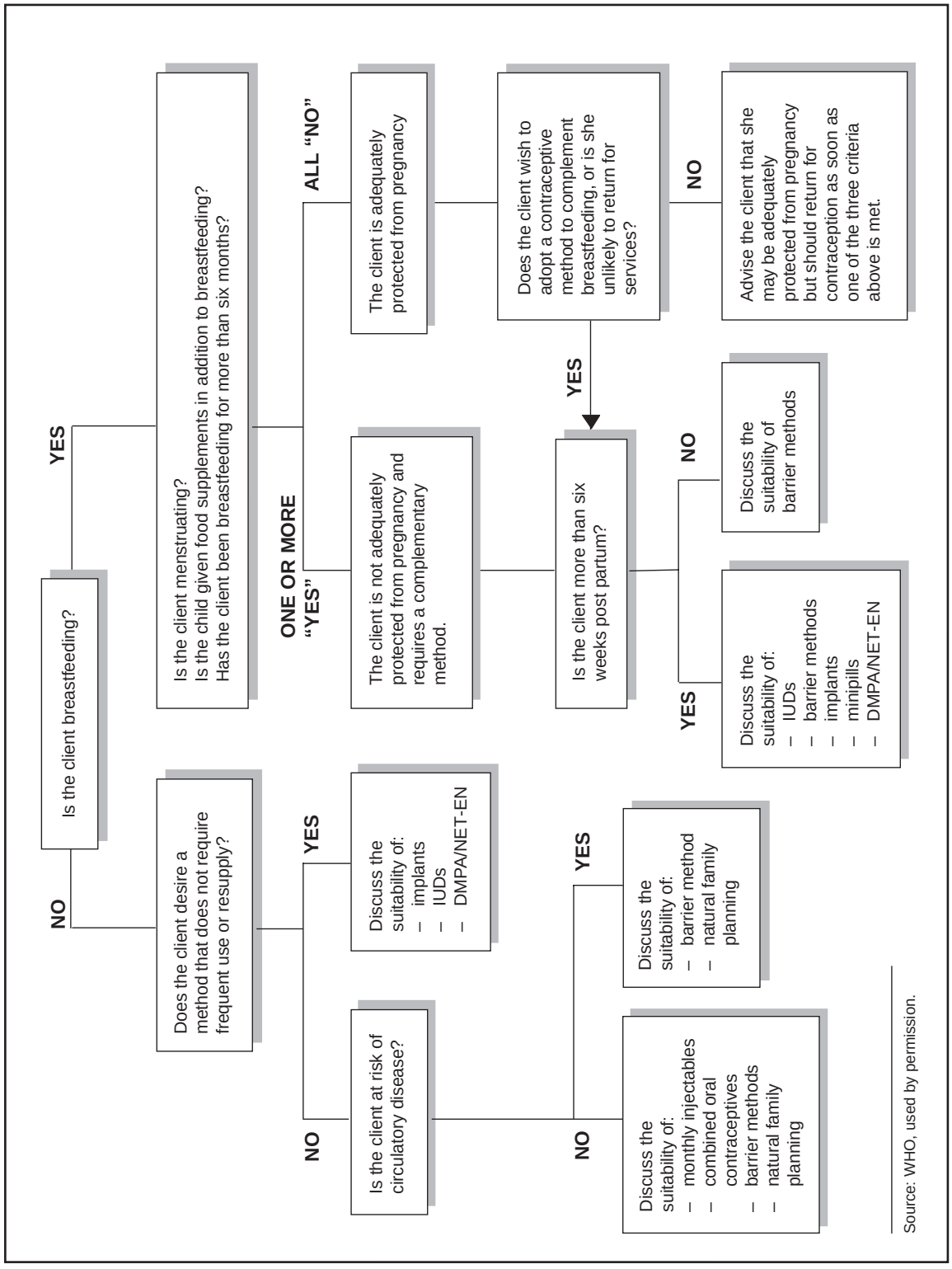
ANNEX 1

Appropriate Family Planning Methods at Different Stages in a Woman's Reproductive Life



ANNEX 2

Contraceptive Choice Decision Tree for Refugees Who Desire More Children



Source: WHO, used by permission.

ANNEX 3

Family Planning Consultation Card

Camp:						**Number:**	
Name:			Age:	Education:			
Address:							
Pregnancies:	Births:		Living Children:			Desired:	
Age of youngest living child:	Wishes to SPACE: duration:			Wishes to LIMIT:			
Last menstrual period:	Date __ /__ /__		Duration:		Affluence:		

Method(s) already used: / Method desired:		NO	YES	Available methods IUD	COC	POP	INJ*
A. ANAMNESIS	**1. Nullipara**	o	o	(–)	+	+	–
	2. Post partum < 6 weeks	o	o	(–)	-	+	+
	3. Post abortum < 6 weeks	o	o	(–)	+	+	+
	4. Caesarean section < 6 months	o	o	(–)	+	+	+
	5. Diabetes not under surveillance	o	o	(–)	+	+	+
	6. Two of the following: age > 35 years o						
	heavy smoker o	o	o	+	–	+	+
	obesity o						
	7. Hypermenorrhea/dysmenorrhea	o	o	(–)	+	+	+
	8. Metrorrhagia	o	o	–	–	–	–
	9. Medicinal treatment which could interfere with efficiency of oral contraceptives	o	o	+	(–)	(–)	+
B. HISTORY	**1. Phlebitis, arterial thrombosis, embolism**	o	o	+	–	+	(–)
	2. Extra-uterine pregnancy	o	o	(–)	+	+	+
	3. Upper genital infection	o	o	(–)	+	+	+
	4. Recent liver disease (< 6 months)	o	o	+	–	–	–
C. GENERAL AND GYNAECOLOGICAL EXAMINATION	**1. Yellow conjunctiva (liver malfunction)**	o	o	+	–	–	–
	2. Cardiac valvular pathology	o	o	–	+	+	+
	3. Blood pressure above 14/9	o	o	+	–	+	(–)
	4. Mammary tumour	o	o	+	–	–	–
	5. Phlebitis, important varicose veins	o	o	+	–	+	+
	6. Pregnancy	o	o	–	–	–	–
	7. Upper or lower genital infection	o	o	–	+	+	+

Possible complementary exams:

CONCLUSION:	RECOMMENDED METHOD(S)				
	METHOD RETAINED				

Date: __ / __ / __ NAME _____ QUALIFICATION_____ Signature_____

*IUD
(intra-uterine device)

COC
(combined oral contraceptive pill)

POP
(progesterone-only pill)

INJ
(injectable)

ANNEX 4

Calculating Contraceptive Requirements

Example of needs for one year in Two Camps: A and B

Items	Population Camp A 100 000	Population Camp B 50 000	Total (both camps)	Unit costs ($) average	Total costs ($) per year
CONDOMS					
Target group (males): 20% of population	20 000	10 000			
Users: 20% of the target group	4 000	2 000			
12 condoms per user per month	576 000	288 000	864 000 (+20% wastage)	$5.40 per 144 pieces	39 000
CONTRACEPTIVES					
Target group (women 15-44 yrs): 20% of population	20 000	10 000			
Contraceptive Prevalence Rate: 15%	3 000 women	1 500 women			
65% of the users prefer depoprovera (4 per year)	1 950 women or 7 800 doses	975 women or 3 900 doses	11 700 doses (+10% wastage)	$1.5 per vial	19 300
30% of the users prefer pills (13 cycles per year)	900 women or 11 700 cycles	450 women or 5 850 cycles	19 300 cycles (+10% wastage)	$60 per 100 cycles	11 600
5% of the users prefer IUD	150 women or 150 IUDs	75 women or 75 IUDs	225 IUDs	$1.2 per IUD	270
					$70 170

When ordering contraceptives, always keep in mind the time it will take between the date of your order and actual receipt of the contraceptives (usually 2 to 3 months).