Myanmar Family Planning Landscape Analysis

April 2017

Acknowledgements

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Contents

Acronyms

AFXB	Association Francois-Xavier Bagnoud
AMWs	Auxiliary Midwives
ANC	Antenatal Care
BCC	Behavioral Change Communication
BHS	Basic Health Staffs
BS	Birth Spacing
CHVs	Community Health Volunteers
CHW	Community Health Worker
CIP	Costed Implementation Plan
COCs	Combine Oral Contraceptives
CPI	Community Partners International
CPR	Contraceptive Prevalence Rate
CYP	Couple Years of Protection
DMPA	Depot Medroxy Progesterone Acetate
DoMS	Department of Medical Services
DoPH	Department of Public Health
FP	Family Planning
FP2020	Family Planning 2020
FRHS	Fertility Reproductive Health Survey
GBV	Gender Based Violence
GP	General Practitioner
HA	Health Assistant
HDI	Human Development Index
HFs	Health Facilities
HIV	Human Immunodeficiency Virus
HMIS	Health Management Information System
HPA	Health Poverty Action
ICT	Information and Communication Technology
IEC	Information Education Communication
INGOs	International Non-Governmental Organizations
IOM	International Organization for Migration
Ipas	International Pregnancy Advisory Services
IPPF	International Planned Parenthood Federation
IRC	International Rescue Committee
IUD	Intra-Uterine Device
Jhpiego	Jhpiego an affiliate of Johns Hopkins University
LAM	Lactational Amenorrhea Method
LARC	Long Acting Reversible Contraceptives
LMIS	Logistic Management and Information System
MCH	Maternal and Child Health
MEC	Medical Eligibility Criteria
MMA	Myanmar Medical Association
MMCWA	Myanmar Maternal and Child Welfare Association
MMR	Maternal Mortality Ratio
MOHS	Ministry Of Health and Sports
MRH	Maternal and Reproductive Health
MSI	Marie Stopes International
MVA	Manual Vacuum Aspiration

Ob/gyn	Obstetric and Gyencology
OC	Oral Contraceptive
OPD	Out-Patient Department
PHS	Public Health Supervisor
PM	Permanent Method
POP	Progestogen Only Pill
PPFP	Postpartum Family Planning
PPIUCD	Postpartum Intra-Uterine Contraceptive
PSI	Population Services International
RH	Reproductive Health
RHC	Rural Health Center
SARA	Service Availability and Readiness Assessment
SC	Sub-Center
SCI	Save the Children International
SDM	Standard Day Method
SH	Station Hospital
SRH	Sexual Reproductive Health
TFR	Total Fertility Rate
TH	Township Hospital
VBHW	Village-based health worker
VHV	Village Health Volunteer
VHW	Village Health Worker
UNFPA	United Nation Population Assistant Fund
WHO	World Health Organization
WRA	Women of Reproductive Age
YIC	Youth Information Corner

Introduction

This family planning landscape analysis in Myanmar was conducted as part of Family Planning 2020 (FP 2020) funded project activity. The activity was a collaborative effort between Government of Myanmar (Ministry Of Health and Sports (MOHS)) and Jhpiego with an overall goal to leverage best practices in family planning in order to accelerate family planning program implementation across the country and ultimately, to increase modern contraceptive use and decrease abortion rates.

Purpose of the assessment

This landscape analysis aims to:

1. Identify and document supportive policies and best practices in family planning program implementation
2. Assess the quality of family planning service provision
3. Propose recommendations for scaling up best family planning practices and new interventions to improve program effectiveness and increase utilization of contraception

Methodology

Desk Review Methodology

A desk review of current policies, strategies of the MOHS and existing available research/documents related to family planning was conducted. An observational study looking at the quality of service provision was also included in this landscape analysis.

Study design for observation

A cross-sectional descriptive study design was used to collect data on all States and Regions (administrative areas) which were categorized into 5 strata, then one State/Region from each stratum (Yangon, Magway, Ayeyarwaddy, Sagaing and Shan (North)) was selected. Three levels (tertiary, secondary and primary level) of public health facilities providing reproductive health services including family planning were included. In addition, general practitioner clinics and Myanmar Maternal and Child Welfare Association (MMCWA) clinics were included. Quality of family planning service provision in respective facilities was observed using a standardized checklist (Annex 3). Data collection activities were carried out from December 2016 to January 2017.

Sampling procedure for observation

The observational study considered the following broad categories of health facilities that provide modern methods of contraceptives and maternal/reproductive health (RH) services in the public sector as stratums:

A. Primary level Facilities/Hospitals (Sub-Centre, Rural Health Center, Maternal and Child Health Center (MCH) and Urban Health Center)
B. Secondary level Facilities/Hospitals (Station or Township Hospital without Obstetrics and Gynecology (ObGy) Specialist)
C. Tertiary level Hospitals (District/State/Region Hospitals and Hospitals with ObGy Specialist)

A list of all health facilities (providing family planning and maternal health services) in each of the administrative units of the country was taken from the Maternal and Reproductive Health Division, Department of Public Health (MRH/DoPH)[1]. This list served as a frame for the selection of samples[2]. Then, health facilities that could provide modern contraceptives were summarized by area and level.

[1] MOHS & UNFPA (2016): 2015 Facility Assessment for Reproductive Health Commodities and Services
[2] Annual hospital statistics report 2013, DHP, MOH

Three stage sampling was used; stratified sampling in the first stage, simple random sampling in the second stage, and simple random sampling in third stage, according to the following steps:

- Step 1: Grouped the 17 States/Regions into five stratums
- Step 2: Randomly selected the five States/Regions
- Step 3: Randomly selected the level of health facilities (HFs) in each state/region
- Step 4: A simple random sampling method was used to select the HFs based on the list (sampling frame) in each selected States/Regions. The list of sample HFs was described in the coordination meeting with stakeholders led by MRH, MOHS. A total of 15 public health facilities; one health facility from each level of HFs/sector in chosen State/Region was selected. A total of 11 public health facilities were included since some selected sites were left out due to conflict, security concerns by MRH, MOHS and Jhpiego. In addition, two general practitioner clinic and two MMCWA clinics were included in this observation study.
- Step 5: Finally, health care providers from the facility were randomly selected. The first and third clients of the chosen provider were then tracked after providing proper consent.

Data analysis

A desk review was conducted on family planning related documents such as strategy, policy, assessment, survey, and family planning and reproductive health reports. The information was analyzed using the outline and desk review report shown in annexes 4 and 5. Data collected from observing family planning service provisions was analyzed using descriptive analysis (number, percentage, by category of health facilities). Frequency tables, proportions and percentage were appropriately described in combination with graphical display. This information added to the desk review under the family planning landscape analysis.

Study limitation

Shan States (North) was selected but was not included in the assessed area as there was conflict in the area at the time of the data collection period. A substitution could not be made because of time limitations.

Expected outcomes and ethical consideration

The findings from this assessment are relevant to the Ministry of Health and Sports (MOHS) and FP partners as they present current challenges, best practices, and recommendations for future direction and areas for improvement for family planning services in Myanmar. The findings in this report will help to inform the review and finalization of national FP guidelines and training materials.

Prior permission from central authorities was received first because the assessment would disclose the situation of family planning service provisions in the country, and this information could be viewed as sensitive. Informed consent from local authorities of each study facility was also obtained before the assessment. The landscape analysis does not identify individual facility information and the quality of family planning service provision. Finally, permission was sought and granted from the MOHS for dissemination of the findings.

Country Context

Myanmar is located in South East Asia and has a population of 51.48 million people; about 30 percent living in urban areas, and 70 percent in rural areas. Close to 40 percent of the total population live in the Yangon, Ayeyarwaddy and Mandalay regions. Out of the total population, 26.66 million are female. The population density of Myanmar is 76 persons per square kilometer. Among the ASEAN member states, the population size of Myanmar ranks fifth in the region. The

annual population growth rate is estimated at 0.89 percent per annum between 2003 and 2014[3]. Annual rate of change in rate of urbanization is 2.49 percent (2010-2015 estimates).

Myanmar's Human Development Index (HDI) rating value for 2015 is 0.556, which is in the medium human development category, positioning the country at 145 out of 188 countries and territories. Myanmar's HDI is below the average of 0.631 for countries in the medium human development group, and below the average of 0.720 for countries in East Asia and the Pacific. Between 1990 and 2015, Myanmar's HDI value increased from 0.353 to 0.556, an increase of 57.4 percent (or) an average annual increase of about 2.2 percent, and life expectancy at birth increased by 7.4 years[4]. Life expectancy at birth for both sexes is 66.6 years whereas 64.6 years (male) and 68.5 years (female), respectively[5]. The percentage of the population living on less than $ 1/day decreased from 32 in 2005 to 26 in 2010[6]. Nearly 93 percent of the total population who are age 15 and over can read and write[7]. In all States/Regions, males generally have slightly higher literacy levels than females. However, Chin State has the largest difference in literacy rates between males and females, with a 16.6 percent difference[8].

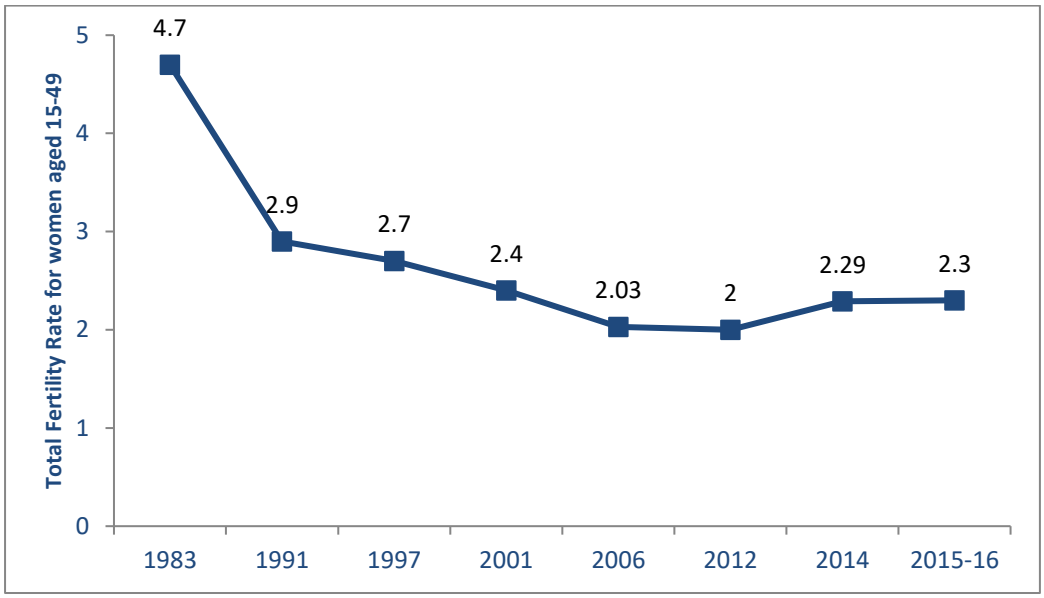
HIV prevalence declined from 0.94 percent in 2000 to an estimated 0.47 percent in 2013 among the general population aged 15 years and above[9]. Forty one percent of the 210,000 people living with HIV in 2014 were receiving antiretroviral therapy. The estimated number of new HIV infections in Myanmar decreased from 14,000 in 1990 to 8,700 in 2014[10]. Seventy seven percent of HIV-positive pregnant women received the WHO-recommended regimen for prevention of parent-to-child transmission[11].

Demographic trends

The total fertility rate (TFR) in Myanmar has decreased from 4.7 to 2.3 in the last 33 years (Figure 1)[12,13,14,15,16]. The TFR was 2.3 for all women in 2015[17] and 4.03 for ever-married women in 2014[18]. The TFR for all women ages 15 to 49 in Myanmar was slightly lower than the average TFR of other countries in the South East Asia region, at 2.5 children per woman[19]. The TFR differs according to population location; fertility is higher among rural women than among urban women at 2.4 and 1.9, respectively. The age specific fertility rate is higher in rural women ages 20 to 24 than the 25 to 29 age group[20].

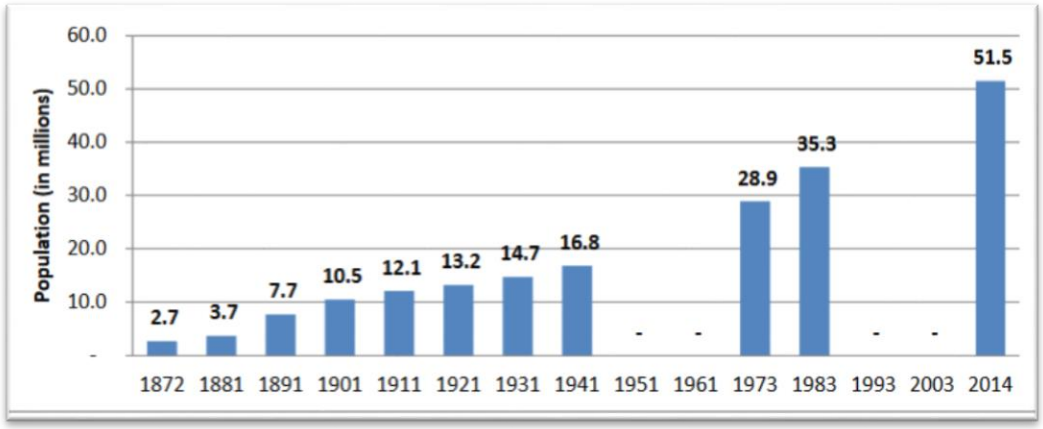
[3] MOIP/DOP, The 2014 Myanmar Population and Housing Census_2015
[4] UNDP, 2016. Human Development Report 2016 http://hdr.undp.org/sites/all/themes/hdr_theme/country-notes/MMR.pdf
[5] WHO, 2016. World Health Statistics 2016.
[6] ADB, 2014. Key Indicators for Asia and the Pacific 2014 retrieved from https://www.adb.org/sites/default/files/publication/43030/ki2014-mdg1.pdf
[7] Central Intelligence Agency (CIA) Factbook (2015)- Myanmar from https://www.cia.gov/library/publications/the-world-factbook/geos/print/country/countrypdf_bm.pdf
[8] MoIP (2015). 2014 Myanmar Population and Housing Census – Highlights of the main results
[9] UNAIDS, 2014. Retrieved from http://files.unaids.org/en/dataanalysis/knowyourresponse/countryprogressreports/2014countries/MMR_narrative_report_2014.pdf
[10] AIDS data hub. Retrieved from http://aidsdatahub.org/sites/default/files/country_review/Myanmar-country-poster-2015-final.pdf
[11] AIDS data hub. Retrieved from http://www.aidsdatahub.org/Country-Profiles/Myanmar
[12] Myanmar Fertility and Reproductive Health Survey 2001
[13] The status of birth spacing in Myanmar, UNFPA, 2010
[14] WHO, 2014. World Health Statistics 2014
[15] MOIP/DOP, The 2014 Myanmar Population and Housing Census_2015
[16] Myanmar Demographic and Health Survey 2015-2016 Key Indicators
[17] Myanmar Demographic and Health Survey 2015-2016 Key Indicators
[18] MOIP/DOP, The 2014 Myanmar Population and Housing Census_2015
[19] United Nations Demographic Yearbook 2013, Department of Economic and Social Affairs, New York
[20] Myanmar Demographic and Health Survey 2015-2016 Key Indicators

Figure 1: Trends in TFR for women (aged 15-49), 1983-2016



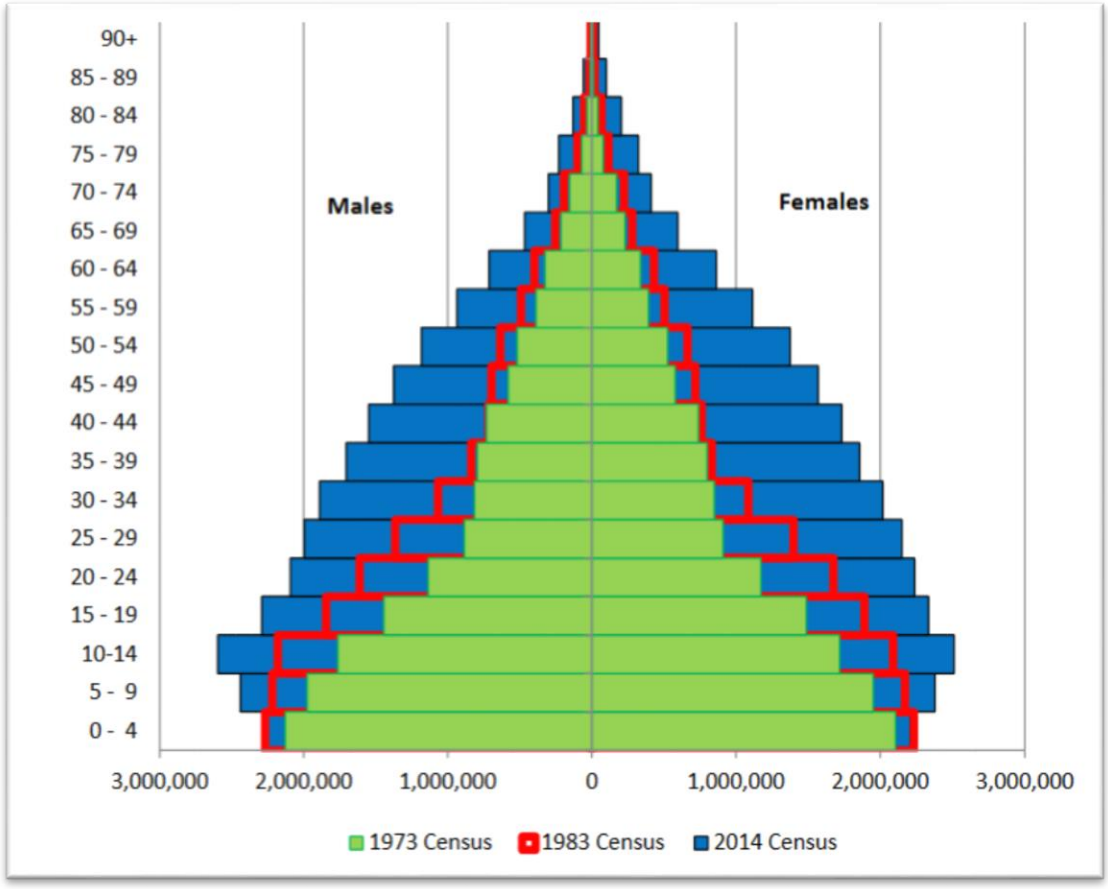
The population has increased from 2.7 to 51.5 million from 1872 to 2014 (Figure 2). The proportion of children has declined, while rapid growth of the population of young people is seen in pot-shaped population pyramid in 2014 (Figure 3)[21].

Figure 2: Population change from 1872 to 2014



[21] MOIP/DOP, The 2014 Myanmar Population and Housing Census_2015

Figure 3: Myanmar population pyramids: 1973, 1983, and 2014



Maternal and child health status

The maternal mortality ratio (MMR) in Myanmar is the second highest among ASEAN countries at 282 deaths per 100,000 live births, compared to 161 in Cambodia and 20 in Thailand. Every year, approximately 2,800 women die during pregnancy or child birth. The under-five mortality rate (U5MR) is 72 deaths per 1,000 live births, compared to 29 in Cambodia and 12 in Thailand. The infant mortality rate is 62 per 1,000 live births compared to 25 in Cambodia and 11 in Thailand[22]. The adolescent fertility rate is 36 births per thousand women aged 15-19 years[23].

Contraceptive use and focus of the national family planning (FP) program

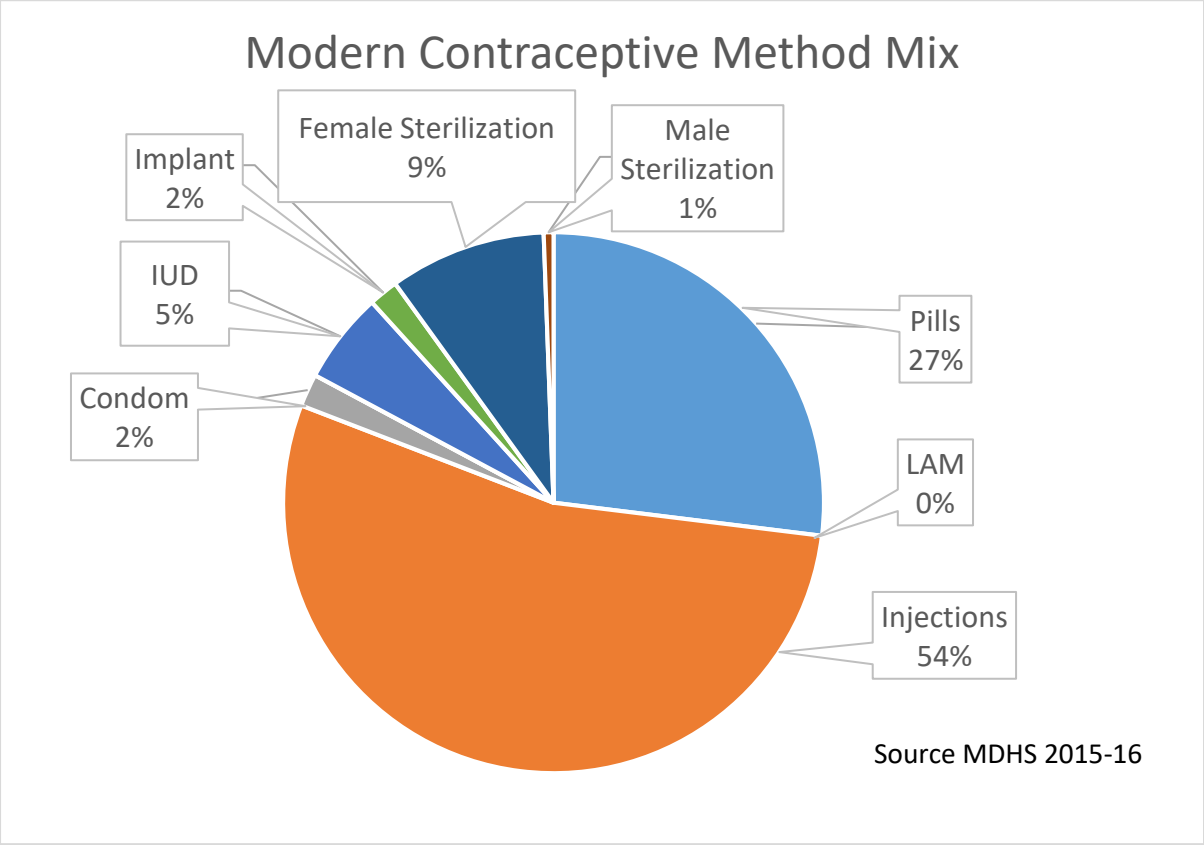
The Government of Myanmar views family planning as critical to save lives, by protecting mothers and children from death, ill health, disability and under development. It views access to family planning information, commodities, and services as a fundamental right for every woman and community if they are to develop to their full potential. In order to improve the life of women and girls through access to quality birth spacing services without any social and regional disparities, Myanmar has committed to Family Planning 2020 with the aim to (1) Increase Contraceptive Prevalence Rate (CPR) from 41 percent to above 60 percent by 2020, (2) Reduce unmet need to less than 10 percent, (3) Increase demand satisfaction from 67 percent to 80

[22] Ministry of Health and Sports (MOHS), Myanmar, 2016. National Health Plan 2017-2021 (draft)
[23] Myanmar Demographic and Health Survey 2015-2016 Key Indicators

percent, and (4) Improve method mix with increased use of long acting methods and decentralization to districts[24,25]. Myanmar's commitment includes policy, financial and service delivery perspectives that are critical to increasing access for more women and girls.

Overall, 52 percent of currently married women use a method of family planning, with 51 percent using a modern method and 1 percent using a traditional method. Contraceptive use is highest among women in urban areas, those with secondary or higher education, and among the richest women. Ever-married women with two children have the highest usage rate of contraceptives[26]. Injectable contraceptives account for 54 percent in modern contraceptive method mix followed by 27 percent of oral contraceptive pills, with less than 8 percent using long acting reversible contraceptives (LARC) (Figure 4)[27].

Figure 4: Modern Contraceptive Method Mix

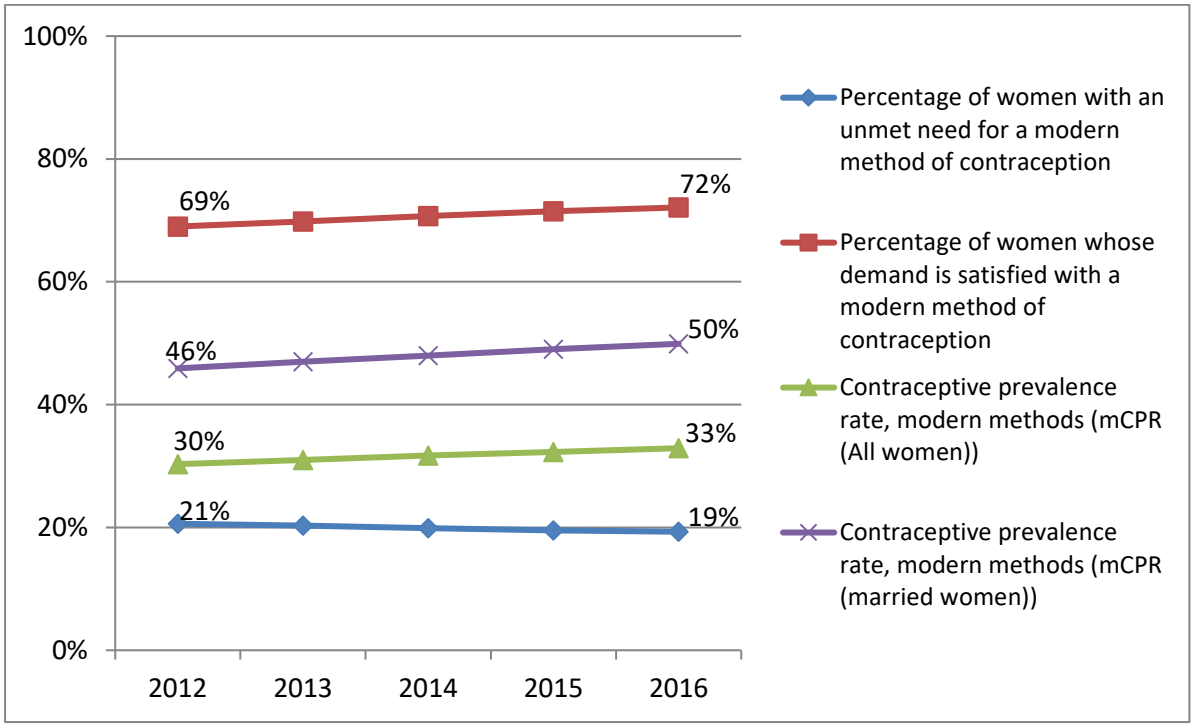


Increasing trends in demand satisfaction, the contraceptive prevalence rate for modern method of contraception, and decreasing trend of unmet need from 2012-2016 can be seen in figure 5[28]. Trends are consistent with the data from recent Myanmar demographic health survey; 16 percent of currently married women have an unmet need (5 percent for spacing, 11 percent for limiting) for family planning services and 52 percent of married women are currently using a

[24] http://ec2-54-210-230-186.compute-1.amazonaws.com/wp-content/uploads/2013/11/2013_11-14_New_Country_Commitments_to_FP 2020_Benin_DRC_Guinea_Mauritania_Myanmar_V2.pdf
[25] FP 2020: Commitments and Progress in Myanmar presentation by Dr. Hla Mya Thway Einda, Director (Maternal & Reproductive Health), Department of Public Health, Ministry of Health and Sports in High level meeting on FP 2020 in Naypyitaw on 31st May 2016
[26] Myanmar Demographic and Health Survey 2015-2016 Key Indicators
[27] Unicef, 2010. Myanmar Multiple Indicator Cluster Survey (MICS) 2009-2010.
[28] FP 2020, Myanmar 2016: General information and Core indicator, 2016 http://www.familyplanning2020.org/entities/82

contraceptive method. Sixty nine percent of currently married women have a demand for family planning and 76 percent of the potential demand for family planning is being met. Unmet need is highest among women who reside in rural areas, those with no education and those belonging to lowest wealth quantile[29]. There is high unintended pregnancy among young people, but low seeking of support at public facilities due to social stigma. There is high proportion of never married women of reproductive age (52 percent)[30].

Figure 5: Unmet need, demand satisfied, CPR on modern method of contraception 2012-2016



Disparities in percentage of adolescent women who have begun childbearing, by wealth, education, rural/urban residence

The adolescent fertility rate is 36 births per thousand women aged 15-19 years. The rate does not vary substantially between urban and rural areas (36 and 37 per thousand, respectively). The proportion of teenagers who began childbearing rises rapidly with age, from 1 percent at age 15 to 18 percent at age 19. Teenagers residing in rural areas with no education tend to start childbearing earlier than other teenagers. Eleven percent of the teenagers in Kachin, Chin, and Shan began childbearing compared with four percent of those in Yangon and two percent in Mandalay. Teenagers in the highest wealth quintile tend to start childbearing later than those in other quintiles[31].

Findings

This section will describe the findings from a desk review and observation at 15 health facilities for family planning service provision (Table 1) looking at supply, enabling environment and demand.

[29] Myanmar Demographic and Health Survey 2015-2016 Key Indicators
[30] Myanmar FP 2020 country action
[31] Myanmar Demographic and Health Survey 2015-2016 Key Indicators

Table 1: Health Facilities included in observation

		Number	Percentage
Tertiary	District/State/Region Hospitals and Hospitals with Ob/Gy	3	20%
Secondary	Township Hospital (TH)	2	13%
	Station Hospital (SH)	1	7%
Primary	MCH Center (MCH)	1	7%
	Rural Health Center (RHC)	3	20%
	Sub-Center (SC)	1	7%
	General Practitioner Clinic (GP)	2	13%
	Myanmar Maternal and Child Welfare Association's clinic (MMCWA)	2	13%
Total		15	100%

Supply

1) Health system structure and range of service delivery modalities offering FP

The Government of Myanmar implemented a policy which has made contraceptives available in the public sector since 1991. Birth spacing activities have taken place in townships; since 1996, combined oral contraceptive (COCs) pills, depomedroxyprogesterone acetate (DMPA) injection and condoms have been available at primary level HFs. Woman have access to intrauterine devices (IUD) at township hospitals, maternal and child health centers and some rural health centers. Previously, contraceptive users needed to pay a user charge as part of a cost recovery scheme, however currently there is no charge. Female sterilization can be done in most township hospitals only after prior official approval has been obtained. Male sterilization is legally available only to those whose wives cannot undergo female sterilization due to possible adverse health consequences. Male sterilization is restricted by law to those men whose wives have been approved for, but are not able to undergo sterilization[32]. Injectable contraceptives can be purchased at most drug stores by health staff as well as clients without any prescription.

United Nation Population Assistant Fund (UNFPA) provides family planning commodities (oral contraceptive (OC) pills, injectables, condoms, and implants) to the Maternal and Reproductive Health Division, Department of Public Health (DoPH) and family planning implementing partners (INGOs, NGOs). Marie Stopes International (MSI)/Myanmar's clinics, mobile outreach activities, and Sun Quality Health Network, franchise network of Population Services International (PSI)/Myanmar, provide a broad range of FP services (OC pills, injectables, condoms, implants, IUD). MSI and PSI distribute FP commodities in a social marketing approach to pharmacies and clinics. Local non-governmental organization such as maternity clinics of the MMCWA, provide family planning services as well.

2) Equipment and staffing of health facilities

During the cross-sectional observational study, the team found that health staff or service providers in health facilities included in the observation were assigned to conduct FP counseling/education. However, more than 50 percent of the health facilities did not have job aids or visual aids, for counselling (Figure 6) during family planning service provision. All of the

[32] WHO, Myanmar and Birth Spacing: An overview
http://www.searo.who.int/entity/maternal_reproductive_health/documents/mmr-fp.pdf?ua=1

tertiary level hospitals included in the observation have a high load of clients for antenatal care and postnatal care in the out-patient department (OPD). OPD space is very limited for OPD day of Ob/gyn ward admittance in all tertiary level hospitals; nursing station, examination bed for clients/patients, and doctor station were in the trolley way in one of the health facilities. In total, 97 healthcare providers (18 midwives, 47 nurses and 32 doctors) were available at the 15 observed health facilities and provided FP service with 37 supporting staff (Nurse Aid, Public Health Supervisor (PHS) II, Health Assistant (HA), cleaner).

Figure 6: Available facilities and staff for conducting counseling

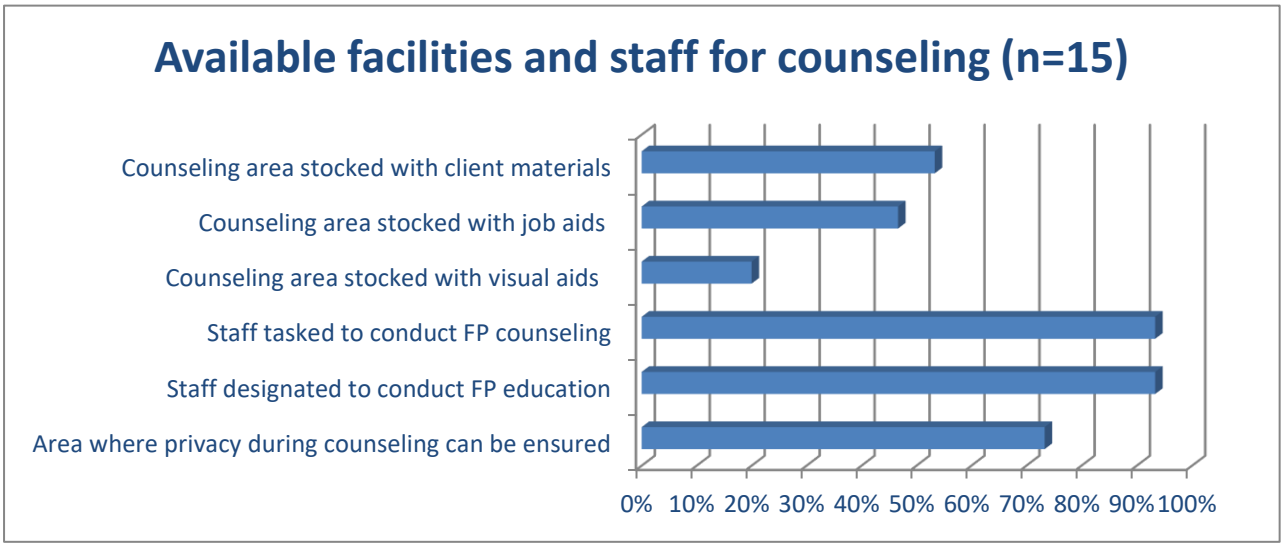


Figure 7: Instruments and materials for Implant service provision

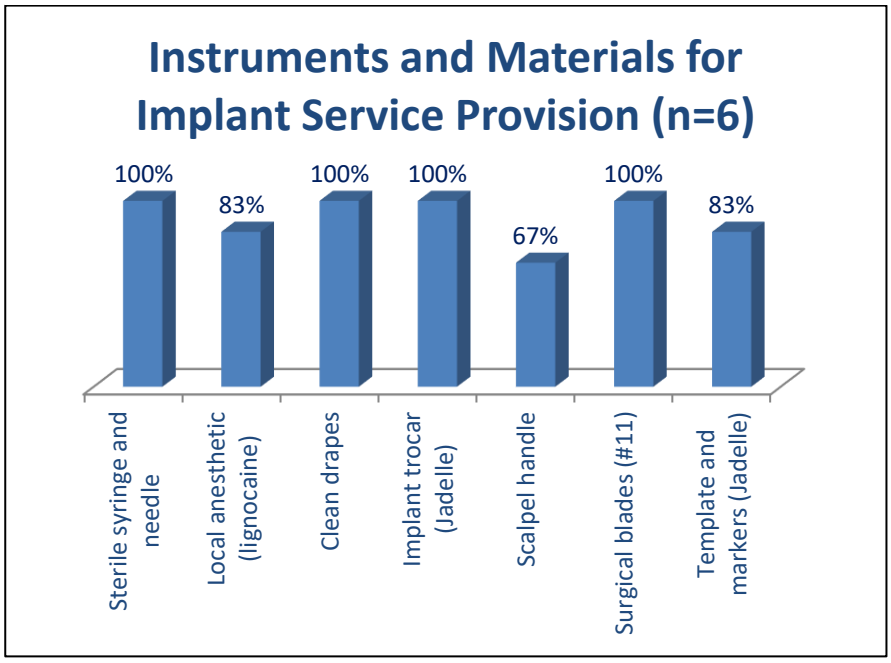
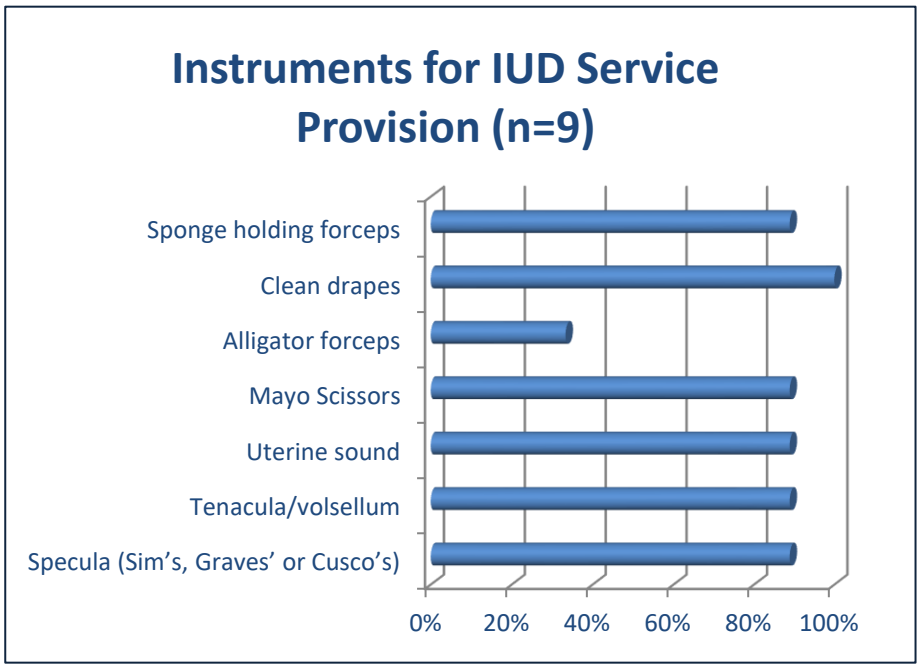


Figure 8: Instruments for IUD service provision



More than 80 percent of health facilities have the necessary facilities, instruments/kits and materials needed to support the provision of FP service (listed in Q 226 - Q241 of section 1). More than 80 percent of health facilities which provide IUD services have almost all of instruments except alligator forceps, 33 percent of health facilities have alligator forceps. More than 80 percent of health facilities providing contraceptive implants have all necessary instruments and materials, except scalpel since most of providers use the disposable trocar for implant (Jadelle) insertion (Jadelle implants and disposable trocars were supplied by UNFPA through the Maternal Reproductive Health Division, Department of Public Health, Ministry of Health and Sports).

3) Provider training and skills

Ninety seven staffs were available for family planning service provision during observation and they were also delivering other healthcare services. Among them, 16.5 percent (11 midwives, five doctors) received training or refresher training on general family planning within last five years. Among the doctors who received family planning related training in last five years, 60 percent received training on IUD and 80 percent on implant insertion and removal.

The number and percentage of standards achieved by following family planning service provision guidelines (especially FP counseling, three month injection, and contraceptive pills) were low on the day of observation. Standards achieved on implant insertion (which was observed) and postpartum IUCD insertion, managing follow up/return clients of PPIUCD, and IUD removal (which were reported) were 100 percent (Figure 9, Figure 10).

Standards achieved on the months injection was high in secondary facilities (87 percent) compared to primary (56 percent) and tertiary (40 percent). However, performance on contraceptive pills provision was lowest in secondary (57 percent) compared to primary (71 percent) and tertiary (64 percent). Family planning counseling performance was low in all levels of health facilities (Table 2).

Figure 9: Percentage of Standard Achieved on FP service provision by FP methods

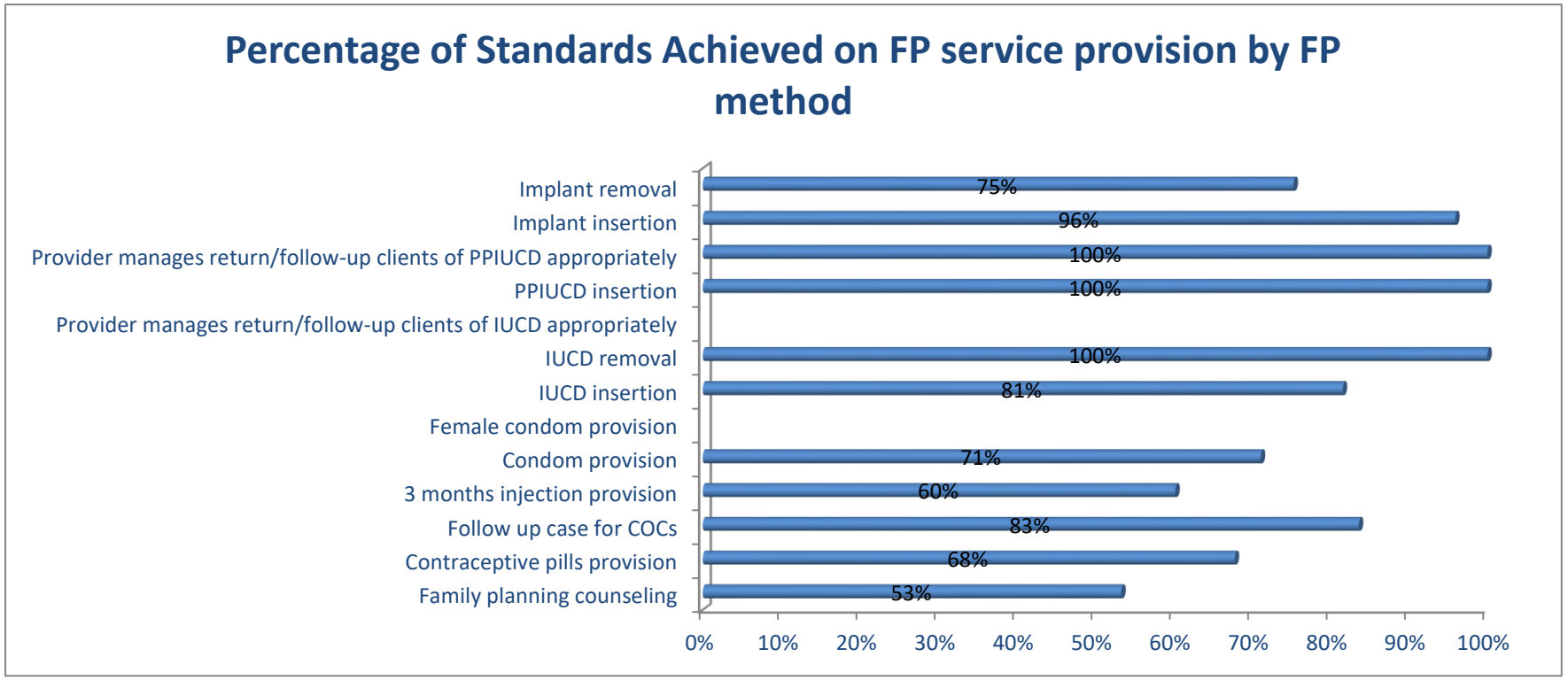
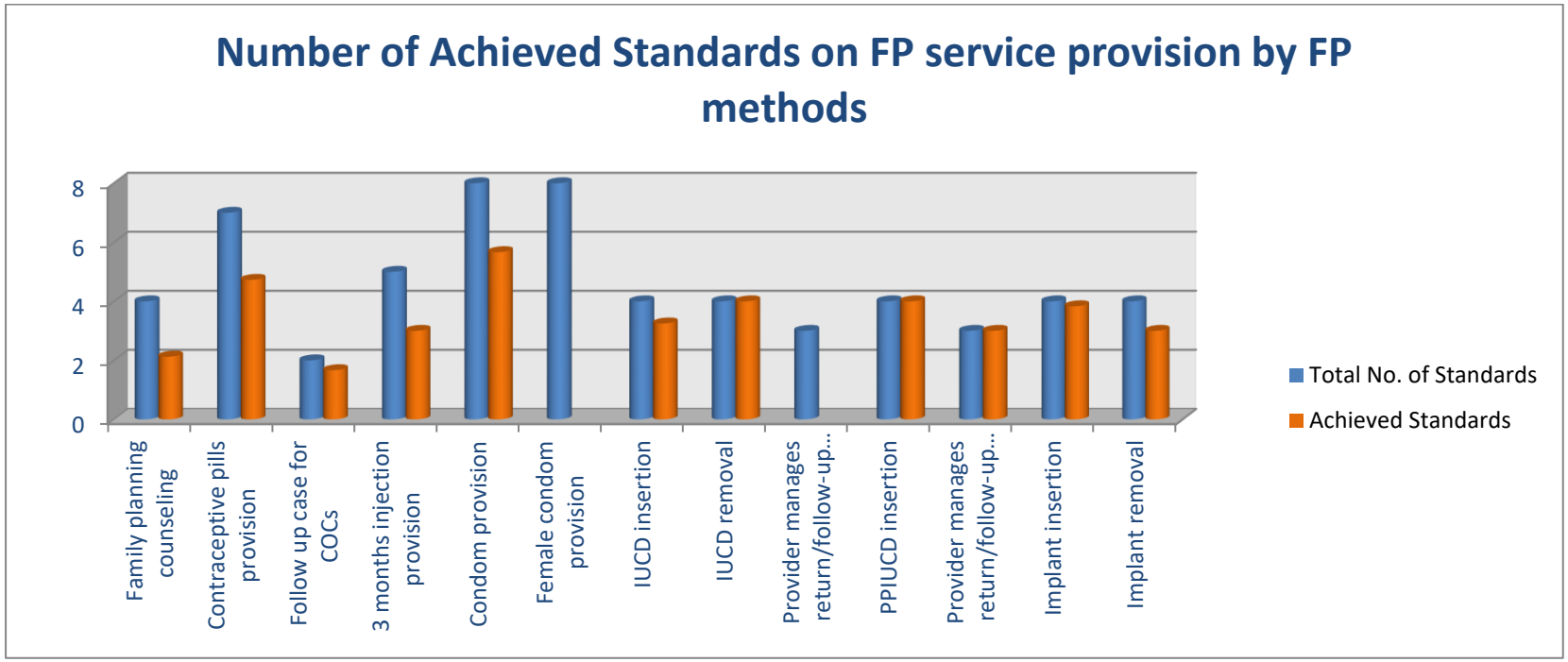


Table 2: Percentage of Standard achieved on FP service provision by different level of health facilities

	Primary HFs (n=9)	Secondary HFs (n=3)	Tertiary HFs (n=3)
Family planning counseling	52% (n=13)	50% (n=4)	46% (n=7)
Contraceptive pills provision	71% (n=7)	57% (n=2)	64% (n=2)
Follow up case for COCs	83% (n=3)	-	-
3 months injection provision	56% (n=10)	87% (n=3)	40% (n=2)
Condom provision	71% (n=3)	-	-
Female condom provision	-*	-*	-*
IUCD insertion	75% (n=1)**	75% (n=2)**	100% (n=1)**
IUCD removal	100% (n=1)**	100% (n=1)**	-
Provider manages return/follow-up clients of IUCD appropriately	-	-	-
PPIUCD insertion	-	-	100% (n=1)**
Provider manages return/follow-up clients of PPIUCD appropriately	-	-	100% (n=1)**
Implant insertion	100% (n=2)	88% (n=2)**	100% (n=2)
Implant removal	-	75% (n=1)**	-

Note (Table 2): Primary level includes sub-center, rural health center, urban health center/maternal child health, maternity clinic, general practitioner clinic. Secondary level health facilities consist of Station or Township Hospital without Ob/Gyn Specialist, and Tertiary level health facilities include District/State/Region Hospitals and Hospitals with Ob/Gyn Specialist. (Total N=15). ** reported, -* commodity for this method is not available at the health facilities.

Figure 10: Number of Achieved Standards on FP service provision by FP methods



According to the 2016 health facility assessment for reproductive commodities and services, the percentage of facilities with trained staff for birth spacing was lowest in the secondary level (40.65) compared to tertiary and primary levels (61 percent and 69 percent, respectively). The difference was statistically significant (P<0.001). In all health facility levels, the percentage was less than that of the previous year. Fifty two percent of tertiary level health facilities had trained staff for implant insertion and removal, which was highest among the three levels of health facilities. Nearly six percent of primary level health facilities trained staff for implant insertion and removal. The private sector also had low levels of trained staff for both birth spacing and implant (48 percent and 52 percent, respectively).

4) Management, supervision, quality assurance and improvement systems

Capacity building of national level monitoring and evaluation officers was carried out with the support of the Track 20 team to improve the monitoring system for family planning. Moreover, consensus building workshops for FP 2020 indicators have been conducted since 2016 to get agreement among stakeholders while discussing data utilization, data monitoring, private sector involvement, and other monitoring issues. The reproductive health logistic management and information system (LMIS) was implemented in selected project townships starting in 2014 to ensure reproductive health commodity security (12 townships in 2014, 55 townships under Shan (South) and Mandalay regions in 2016)[33].

5) Mix of available FP methods

More than 80 percent of the health facilities in the observation offered at least three modern contraceptives; oral contraceptives, injectables, male condom/emergency contraceptives. There was no difference between urban and rural or among levels of health facilities on the availability of at least three modern contraceptives. However, IUD insertion and removal services were available in 60 percent of health facilities, followed by 33 percent for implants and permanent methods. None of the health facilities were able to offer female condoms as a method of choice in FP service provision due to a lack of commodity/supply and lack of awareness. In the last 12 months at the health facilities, 68 percent of clients received injectables and 20 percent combined oral contraceptive pills, out of 13,054 FP clients. Ten percent received male condoms and just one percent were IUD clients. There is low client load on oral contraceptives and male condom in all of health facilities since those can be purchased at drug stores without any prescription.

According to the 2016 health facility assessment for reproductive commodities and services, 81.4 percent of primary level health facilities were providing at least three modern contraceptives, differences between urban and rural (83.1 percent vs. 75 percent) were not significant. However, 49.5 percent of secondary, tertiary and private health facilities were offering at least five modern contraceptive methods (Table 3). Urban and rural difference (61.3 percent vs 33.33 percent) for service delivery points offering at least five modern contraceptive methods was substantial[34].

[33] http://www.familyplanning2020.org/entities/82
[34] DMR, DoPH and UNFPA, 2016. 2016 Health Facility Assessment for Reproductive Health Commodities and Services

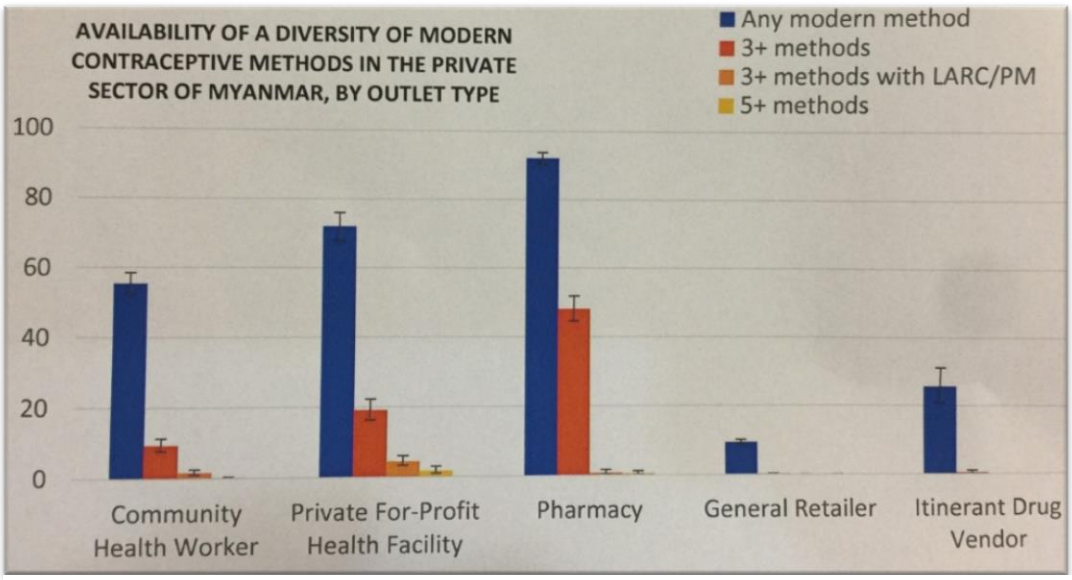
Table 3: Percentage distribution of secondary, tertiary and private service delivery points offering at least five modern contraceptive methods by type of facility

			Doing minimum birth spacing services		Total
			Not doing	Doing	
Level of Health Facility	Tertiary	Frequency	2	21	23
		Percentage	8.7%	91.3%	100%
	Secondary	Frequency	97	63	160
		Percentage	60.6%	39.4%	100%
	Private	Frequency	5	18	23
		Percentage	21.7%	78.3%	100%
Total		Frequency	104	102	206
		Percentage	50.5%	49.5%	100%

Source: 2016 Health Facility Assessment for Reproductive Health Commodities and Services

According to a 2016 FPwatch survey, 48 percent of pharmacies had three or more modern family planning methods available compared to 19 percent of private health facilities and 9 percent of community health workers. Less than 5 percent of private facilities screened in FPwatch had three or more methods including at least one LARC/PM (Long acting reversible contraception/ permanent method) available and only one percent had five or more methods available (Figure 11)[35].

Figure 11: Availability of modern contraceptive methods in the private sector, by outlet type



Source: Myanmar 2016 FPwatch survey

[35] FP watch, PSI/Myanmar, 2017. Myanmar 2016 FPwatch survey: findings from a contraceptive commodity and service assessment among private sector outlets. Dissemination meeting on 8th Feb, 2017

6) Integration of services

Most health facilities in the observation offered family planning (FP) services during out-patient department (OPD) day for antenatal care, postnatal care, general diseases, and the gynecology clinic, thus providing and integrated approach to care. One primary health care facility had a separate FP clinic day in addition to OPD day on which the facility offered FP services.

7) Referral systems

Nearly all of the primary health care facilities included in the observation for family planning service provision reported that they refer clients to a higher level health facilities in the public sector that offers LARC (implant, IUD) and female sterilization services. Similarly, many referrals go to INGO affiliated clinics (SUN clinics) or INGOs clinics (MSI clinics) which offer LARC (implant, IUD) per the client's request. Among the primary level health care facilities, only maternal and child health clinics with trained medical doctors provided LARCs to clients. In primary, secondary and tertiary level health facilities, no formal mechanism existed for reporting of side effects or adverse events related to contraceptives service provision for both short term and long term methods. The same was true in the MMCWA maternity clinics and general practitioner clinics. Village Health Volunteers and Auxiliary Midwives provide information to the community on contraceptives and where supplies can be obtained[36].

8) Private-sector involvement

The majority of the private sector contraceptive market is comprised of general retailers (42 percent). Outside of general retailers, the private outlets stocking modern contraceptives (excluding condoms only outlets) are made up of 25 percent pharmacies, 15 percent private facilities, 16 percent private community health providers (village health volunteers, midwives, nurses, retired health workers), and 2 percent itinerant drug vendors[37].

The pharmacy contribution to contraceptive market share of total couple years of protection in the private sector was 54 percent, followed by 21 percent from private facilities, and 12 percent from community health workers and health providers in the community. General retailers and non-profits accounted for about 10 percent and 4 percent of the total private market share, respectively. Less than 1 percent was from itinerant drug vendors[38].

Injectables account for about 60 percent of the private sector market share; ranging from 48 percent in metro areas to 62 percent in urban areas and the highest in rural areas, at 71 percent. Oral contraceptives account for 29 percent of the private sector market share; ranging from 27 percent each in urban and rural areas and highest in the metro areas, at 36 percent. Long acting reversible contraceptive (LARC)/permanent methods account for only 6 percent of the private market share, primarily from distribution of intrauterine contraceptive devices (IUDs). Emergency contraceptive pills and male condoms accounted for less than 3 percent of the market each (Figure 12)[39].

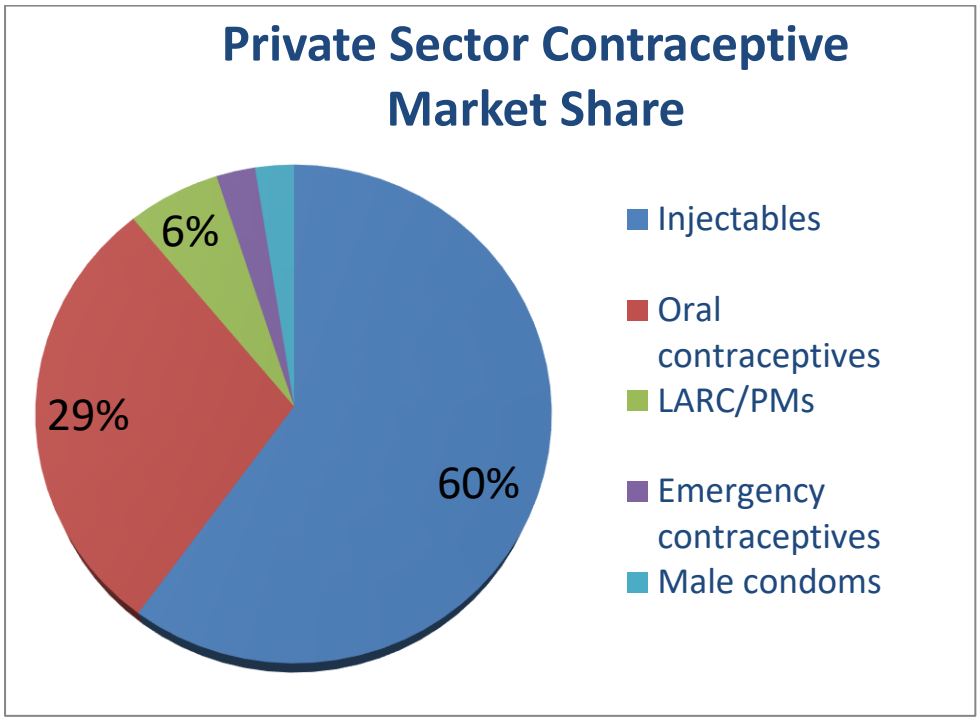
[36] Government of Myanmar (2014). Myanmar Official Report on policy & political progress from http://www.familyplanning2020.org/entities/82/commitments

[37] FP watch, PSI/Myanmar, 2017. Myanmar 2016 FPwatch survey: findings from a contraceptive commodity and service assessment among private sector outlets. Dissemination meeting on 8th Feb, 2017

[38] FP watch, PSI/Myanmar, 2017. Myanmar 2016 FPwatch survey: findings from a contraceptive commodity and service assessment among private sector outlets. Dissemination meeting on 8th Feb, 2017

[39] FP watch, PSI/Myanmar, 2017. Myanmar 2016 FP watch survey: findings from a contraceptive commodity and service assessment among private sector outlets. Dissemination meeting on 8th Feb, 2017

Figure 12: Private Sector Contraceptive Market Share



Source: Myanmar 2016 FPwatch survey

PSI conducted eight trainings of Implanon insertion for 64 SUN providers from 51 townships in 2016[40].

9) Youth-friendly services

There is no particular day scheduled/appointed for youth in health facilities (this was also found in the observation of family planning service provision), as health providers in those facilities provide family planning services regardless of the client's characteristics.

10) Client-provider interaction/counseling on FP

The percentage of standards achieved for client-provider FP counseling was low compared to other FP services provision (Figure 9). Most of the clients did not enquire for more information and very few of the providers encouraged the clients to ask questions/queries.

Enabling Environment

11) Leadership and management

Available data collection tools are not consistent in the health facilities for keeping records of family planning services. Even more, there are more demand generation activities at the primary and secondary level of health facilities compared to tertiary levels. The staff from primary level health care facilities is managing the available family planning stock effectively, although they need to record the data in various forms and in different formats, which takes time.

[40] PSI, 2017. Data from Management Information System of PSI.

12) Supportive laws, policies, and guidelines

There is some progress in the policy environment for providing clinical contraceptive methods by trained and skilled nurses and volunteers, such as the commitment for task shifting to Auxiliary Midwives (AMW) for family planning services. Oral contraceptive pills and condom can be provided by the AMW since Myanmar aims to strengthen the policy of providing clinical contraceptive methods by trained/skilled nurses, midwives and volunteers through better collaboration among multi-stakeholders[41]. Myanmar pledges to increase the health budget to cover nearly 30 million couples by 2020. The MOHS commits to working toward increasing the resources allocated to family planning in State budgets[42]. A costed national implementation plan was developed to meet the commitments to FP 2020, which will complement the strategic plan for reproductive health[43].

A very low percentage of related guidelines regarding family planning were found on the day of the observation at all facility types. This finding is also consistent with the findings from a nation-wide service availability and readiness assessment (SARA) in Myanmar for reproductive health conducted in 2015.

13) Human and financial resources for FP

The 2015 SARA showed that the percentage of health facilities with at least one trained staff in the past two years was low at primary and secondary level and lowest in private hospitals. According to the health facility survey of 2016, 55.3 percent of health facilities had trained staff for birth spacing in 2016, while only 15.6 percent of health facilities had trained staff for implant removal/insertion. Trained staff for birth spacing was lowest in the secondary level (40.6 percent) compared to tertiary and primary levels (87 percent and 75 percent). Nationwide implant trainings were offered to health care providers, with a focus on secondary level providers, in 2016 through a public-private partnership. Five trainings on LARC (1 master mentor, 1 training of trainers, and 3 multiplier trainings) were conducted by Jhpiego, in collaboration with the MOHS. Sixty five service providers in Yangon, Magway, Minbu, Pakokku and Thayet were trained. Nationwide LARC trainings were also conducted through a 2016 partnership between UNFPA, PSI, Pathfinder, IRC and Jhpiego. (Table-4)

Table 4: Nationwide LARC trainings conducted in 2016

No	Type of Training	Level	Area	No. of session	Training Team/Funding agencies
1.	Master Mentor	Central	Yangon	1	JHPIEGO
2.	Training of Trainers	State/ Region	Yangon Mandalay Magwe	2 2 1	PSI/UNFPA PSI/UNFPA Jhpiego
3.	Multiplier Training	District	Magwe Yangon Mandalay Ayeyarwaddy Shan (South) Kayin	5 6 7 1 4 3	JHPIEGO PSI/UNFPA PSI/UNFPA PSI/UNFPA PSI/Pathfinder PSI/IRC

Source: Presentation of MRH 2016

[41] http://www.familyplanning2020.org/entities/82/commitments
[42] Government of Myanmar (2014). Myanmar Official Report on financial progress from http://www.familyplanning2020.org/entities/82
[43] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014

Myanmar committed USD $1.29 million during the 2012-2013 financial period and USD $3.27 million during the 2013-2014 financial period for the purchase of contraceptives. With an increasing government health budget, the resource allocation for family planning increased in state budgets. The Government of Myanmar increased its health budget from 368.66 billion kyats (local currency) in 2012-2013 to 528.57 billion kyats in 2013-2014, to 652.74 billion kyats in 2014-2015. There was increased purchasing of contraceptive commodities with government health budget every fiscal year to reduce unmet need for family planning[44].

14) Evidence-based decision making

High level advocacy on FP and technical working group meetings have been held quarterly along with frequent coordination meetings among FP partners, under the guidance of the MRH Division of the MOHS, to implement FP2020 together with FP goals and indicators through a systematic and transparent approach. A one page standard reporting format was developed to collect FP data from implementing partners monthly. Reporting mechanism for the FP2020 global indicators was also established. Data review meetings were conducted in 2016 with the MOHS to share finding and lessons learned from different studies conducted by implanting organizations to formulate policy level recommendations.[45]

Health facility assessments for reproductive health commodities and services were conducted in 2014, 2015 and 2016. Integrated procurement planning and spot checks were done on reproductive health commodities through the health commodity logistic supply system, and an automated system to capture facility-level reproductive health commodities was initiated.

To improve the monitoring system of family planning, a national level capacity building training was held for the M&E officers from the Track 20 team. Moreover, consensus building workshops have been held consistently since 2015 to discuss and reach agreement among stakeholders around data utilization, data monitoring, private sector involvement, and other monitoring issues.

The introduction of the Sayana Press in Myanmar is still ongoing in collaboration with UNFPA and other INGOs under the guidance of the MRH Division of the MOHS. Central trainers from respective FP stakeholders (MRH Division, Myanmar Medical Association, MSI, PSI, Community Partners International, Myanmar Nurse and Midwife Association) will conduct township level trainings and develop detailed implementation plans using a community participatory approach at every pilot township for Sayana Press introduction. Approximately 3,000 midwives at the township level and MCH staff from Ethnic Health Organizations will be reached these trainings. Seventy seven to 83 townships will be covered with supplies from UNFPA; 11 townships in Shan (East) State by MMA, 21 townships in Shan (South) State by MMCWA, 19 townships in Shan (North) State by PSI, seven townships in Kayin State by MSI, ten to 16 townships in Rakhine State by Myanmar Nurse and Midwife Association, and nine townships in Chin State by Community Partners International. For this Sayana Press Initiation, UNFPA will support 0.8 million doses of Sayana Press. This will increase additional users of modern method of contraception[46].

15) Contraceptive security

The 2015 SARA report showed that commodities of female condom, implants and emergency contraceptives is low (<35%). In 2016, contraceptives supplies in the secondary level is low (39.4

[44] Government of Myanmar (2014). Myanmar Official Report on financial progress from http://www.familyplanning2020.org/entities/82
[45] MOH, Data Review Meeting on Studies done for Health System Strengthening on Reproductive Health Commodities Security and Services, June 2016
[46] UNFPA & MOHS, March 2017. Initiation of Sayana Press in Myanmar

percent) compared with the primary (82.4 percent) and tertiary level facilities (91.3 percent). Approximately 26 percent of health facilities were able to provide a choice of modern contraceptive method during the last six month. The availability was least in the tertiary level of health facilities compared to other facility levels. Although "no stock-out" for oral contraceptive pills and injectable were high (70 percent) for all levels of health facilities, stock of female condoms and implant were very low (<5 percent) for all levels.

16) Advocacy efforts

The MRH Division, Department of Public Health, in cooperation with national and international partners conducted evidence-based advocacy for birth spacing at the national and sub-national levels in 2014, emphasizing the benefits and cost-effectiveness of healthy timing and spacing of pregnancies. As a result, interest within communities in birth spacing increased. The MRH Division and partners identified activities, audiences and venues to engage with different audiences to conduct social mobilization and advocacy through organizing meetings and other events for national, state/regional, township and village authorities/leaders, non-state actors and NGOs. The Department of Public Health has conducted advocacy efforts on reproductive health in seven states/regions and 160 townships.[47]

17) Community engagement

The 2015 SARA showed there were not many user friendly reproductive health and FP services at the peripheral level (mainly sub center level) or at private hospitals. Most necessary items for the specific services on reproductive health were not available and/or not functioning on the day of assessment. Facilities which had relevant family planning guidelines were also low[48]. Trainings for township medical officers, lady health volunteers, health assistants, midwives and community volunteers were conducted to improve interpersonal communication skills and counseling along with training on the benefits of healthy timing and spacing of pregnancies and modern contraceptive methods. Development of guidelines and trainings for dedicated birth spacing promoters from villages were included in the birth spacing strategy to generate demand. Targeted audiences were informed through outreach community dialogue sessions and household visits about birth spacing services which are provided by community health volunteers (CHVs), auxiliary midwives (AMWs) and village health workers (VHWs)[49]. Since 1980, CHWs and AMWs have been trained as voluntary health workers (VHW) selected from the villages, given training for one month for CHW and six months for AMW, mainly with the support from WHO, USAID and UNICEF[50].

To improve young people's access to high-quality and equitable services in the areas of sexual and reproductive health, the first edition of the Adolescent and Youth Friendly Health Services Manual for Basic Health Staff was developed in 2015. UNFPA supported training for basic health staff using this manual. The manual is based on WHO's adolescent job aid, which was adapted to the Myanmar context through stakeholder consultations. The manual is an accessible desk reference for health workers who provide primary health care services.

18) Efforts to foster positive social norms and transform gender roles

Promotion of gender equity and male engagement are integral parts of family planning program

[47] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014
[48] WHO, DMR & DOPH (2015). Nation-wide service availability and readiness assessment (SARA) in Myanmar
[49] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014
[50] WHO (2014), Health Systems in Transition Vol. 4 No. 3 2014

planning and implementation[51]. Increasing accessibility to contraception is also a key enabler of gender equality and empowerment. When women have the opportunity to decide whether and when they have children, they have greater freedom to plan and achieve goals and take advantage of opportunities and resources which are generally available to men. Contraceptive use among married women in Myanmar has more than tripled over the past 20 years[52]. In 1991, only 13 percent of married women were using a contraceptive methods compared to 52 percent in 2016[53].

However, updated trainings and information, education and communication (IEC) materials based on current international standards on gender and sexual and reproductive health issues are still required in youth information centers. Seventy nine percent of youth information centers have included gender issues in their trainings, together with information on the services which they are providing. The issues addressed in integrating gender through youth information corner outreach activities are listed in the table below[54].

YIC Activities	Rank
Gender balance in activities	39%
Male Involvement in contraception	36%
GBV	25%
BCC for gender equality	25%

Demand

19) Strategies to reduce FP costs to increase demand

A principle outlined in the national reproductive health strategy plan is cost-effective and high impact interventions to increase equitable access to quality and integrated health services. Long-acting methods, IUDs and implants are more effective in terms of cost and quality as they provide contraceptive protection for a year or more and can also be used without resupply for several years. Although short-acting methods are the most prevalent contraceptives in the current method mix, pills and condoms require high levels of user adherence and motivation and with inconsistent and incorrect use can lead to both method failures and high rates of discontinuation[55].

The 2007 Fertility Reproductive Health Survey (FRHS) showed that most women would prefer to have long birth intervals and use of long-term methods (IUD or implants)[56]. New approaches to meet the needs of population groups such as migrants, the urban poor and key affected populations are essential. Provision of LARC (implants) at district and township hospitals and IUDs at township hospitals and health centers have been initiated[57].

In Myanmar, one in four women of reproductive age cannot access modern contraceptives when they need to in order to prevent or delay pregnancy. Contraceptive implant services were

[51]MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014
[52] MRH presentation, FP 2020 target and indicators, Data Review Meeting June 2016
[53] Myanmar Demographic and Health Survey 2015-2016 Key Indicators
[54] UNFPA Presentation, Situation Analysis on Youth Information Corners, Data Review Meeting June 2016
[55] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014
[56] DOP & UNFPA (2009). Fertility and Reproductive Health Survey 2007
[57] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014

launched through a partnership approach, with commodities supplied by UNFPA, implant training for quality service provision led by Jhpiego, PSI, PathFinder, the International Rescue Committee (IRC), Myanmar Medical Association, and the Ministry of Health and Sports. Worldwide studies have shown that long-lasting implants are particularly popular among younger women. Protecting them from unwanted pregnancy gives them the freedom to develop their lives and careers in the way they want and allows them to reach their full potential[58].

20) The FP program's social and behavior change communication (SBCC) strategy

A social and behavior change communication strategy for family planning is implemented through activities such as workshops to develop standard messages for postpartum family planning (PPFP) and approaches to be used at different levels for priority target audiences. Furthermore, the health and social benefits of birth spacing and modern methods (including LARC) to address FP myths and misconceptions were developed, tested, printed and disseminated, targeting diverse populations (women, men and adolescents) in different dialects. IEC materials were translated into the Chin and Shan indigenous languages and UNFPA supported IEC/SBCC activities in 132 townships in Chin, Kachin, Kayin, Mon, Rakhine and Shan States. Production of family planning method posters and pamphlets on implants for all public health facilities was also supported by UNFPA. Related IEC materials (WHO medical eligibility criteria wheels, implants pamphlets and posters on FP methods) have been distributed after LARC trainings conducted for secondary level health care providers.

21) Commercial and social marketing

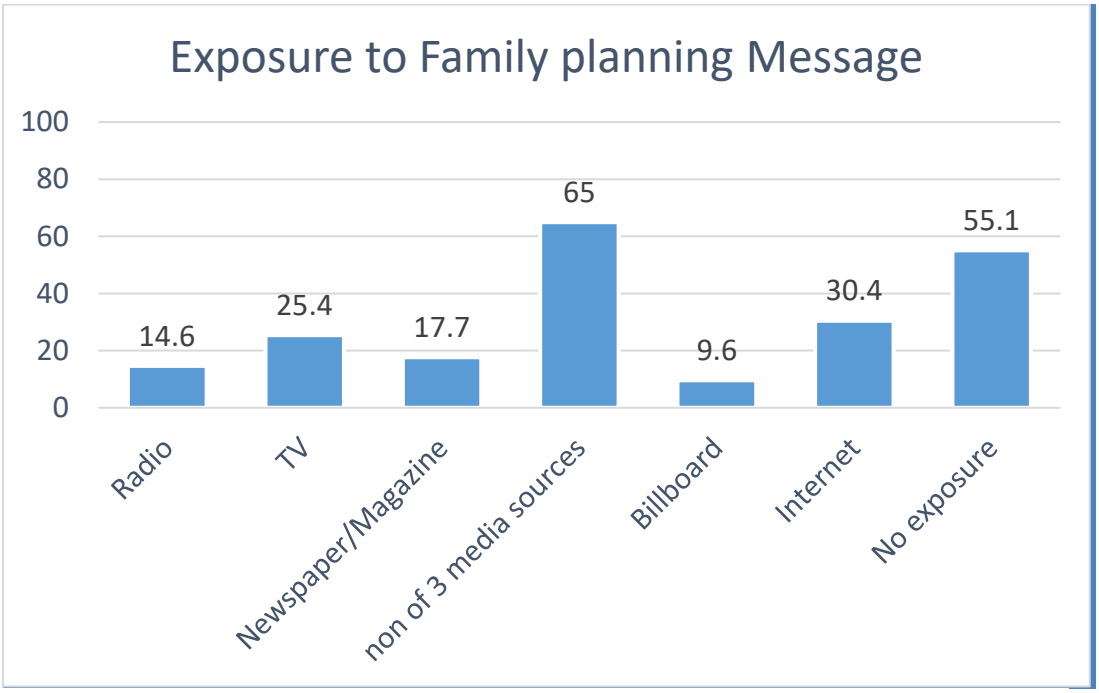
Social marketing of contraceptive commodities has been expanded to cover populations in difficult-to-reach areas in certain states/regions. INGOs are using social marketing to connect existing commercial and noncommercial distribution networks, and retail shops have made subsidized commodities from donor agencies available to the target population. To increase demand for subsidized commercial commodities, information on family planning services is being transferred to the community through various methods of social marketing activities: materials development and translation and printing fliers, posters, billboards, radio and other media communications. A total market approach for FP was conducted by PATH in collaboration with MOHS and UNFPA.

22) Mass media

Mass media campaigns on reproductive health and birth spacing have been conducted through national media and local radio stations to raise awareness and create demand. Telephone hotlines have been established for youth in Yangon and Mandalay to disseminate information and address misinformation. The new channels, mobile apps and social media, could be instrumental in driving behavior change[59].

[58] UNFPA, Myanmar (2015). Annual Report 2015
[59] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014

Figure 13: Exposure to Family Planning Message through media



Source: MDHS (2015-16). Myanmar Demographic and Health Survey 2016

More than 50 percent of reproductive age women had not heard or seen a family planning message on radio, on television, in a newspaper or magazine, or on the internet or a billboard, according to the 2015-16 Demographic and Health Survey (Figure-13)[60].

PSI has launched two digital interventions- a Facebook page and mobile app to make reproductive health and maternal and child health information more readily available to women of reproductive age. The Facebook page reached over 120,000 members, 88 percent of whom were women of reproductive age[61]. The Adolescence Sexual and Reproductive Health and Rights app, introduced in 2016 by UNFPA, contained information on sexual and reproductive health and rights, and is being developed for young people by young people, including those in conflict-affected areas. A key feature of the application approach is that it allows young people to access sensitive information without violating their privacy.

23) Engaging communities and champions in Social and Behavior Change Communication (SBCC)

Efforts to engage communities in family planning focus on trainings to improve the communication skills of community volunteers on the benefits of healthy timing and spacing of pregnancies and modern contraceptive methods; BCC/outreach activities to increase awareness on healthy timing and spacing of pregnancy; information on modern contraceptive methods and dual protection, follow up for correct and consistent use; dispelling myths and misperceptions and initiation for greater involvement of men in birth spacing.

Youth information centers, where young people can access information on sexual and reproductive health, were initiated by UNFPA in partnership with the MOHS through the Health

[60] MDHS (2015-16). Myanmar Demographic and Health Survey 2016
[61] http://www.psi.org/country/myanmar/#about

Education Division. These centers are not only meant to provide information on sexual and reproductive health, but also to provide information on sexual and reproductive health services that can be accessed directly in the centers as they are attached to rural health centers. In the survey of YICs, 70 percent of young people had previous experience as peer educators. Out of those who had experience, 77 percent and 48 percent had experience as a peer educator for RH and BCC issues, respectively. These numbers demonstrate a high interest in peer education on sexual and reproductive health related issues[62].

24) Peer education

Delivery of youth friendly services within the service delivery system has been enhanced through expanding the network of youth-friendly health centers and ensuring that information materials and contraceptive commodities are available. The drop-in-centers of some NGOs are providing reproductive health and birth spacing information and services to key affected populations by peer educators[63].

Youth information centers engage adolescents and young people through interactive activities, and train them as peer educators who then reach out in their local communities, often in rural areas of the country. The Myanmar Medical Association, MSI and the Association François-Xavier Bagnoud (AFXB) built the capacity of young people, including marginalized and vulnerable youth, through peer education, training, and a telephone hotline, providing access to services and information on sexual and reproductive health, including birth spacing. The peer educators went on to help with information dissemination and linking young people to service delivery points if and when they need the services[64].

25) Technical organizations working on FP

Technical working group meetings were conducted both quarterly and annually with family planning implementing partners for coordination and collaboration on evidence based decision making. The following is a list of the organizations which participated in the coordination meetings regarding family planning and reproductive health[65].

- Burnet Institute
- Community Partners International/Myanmar (CPI)
- Health Poverty Action (HPA)
- International organization for Migration (IOM)
- International Planned Parenthood Federation (IPPF)-MMCWA
- International Pregnancy Advisory Services (Ipas)
- Jhpiego an affiliate of Johns Hopkins University
- John Snow International/Myanmar (JSI)
- Marie Stopes International/Myanmar (MSI)
- Myanmar Medical Association (MMA)
- Pathfinder
- Population Services International/Myanmar (PSI)
- Save the Children (SCI)
- United Nations Population Fund (UNFPA)
- World Health Organization (WHO)

[62] UNFPA Myanmar, Annual report, 2015
[63] MOH & UNFPA (2014). Costed Implementation Plan to meet FP 2020 commitments Myanmar 2014
[64] UNFPA Myanmar, Annual report, 2015
[65] MOHS, 2017. Implant training implementation in public sector in 2016 on March, 2017

Recommendations

Based on the desk review and findings from the observational study, this section will propose recommendations in supply, enabling environment, demand for investment in family services in Myanmar, both at the policy and leadership level by the MOHS and potential donor programming.

Supply

- Build up and upgrade the infrastructure of health facilities within available budgets to ensure the privacy of a client during family planning counseling and service provision, and to accommodate the high client load in out-patient department day.
- Strengthen support to all levels of health facilities with job aids and visual aids for service providers; family planning information education and communication materials for clients such as posters, flip charts, brochures, information sheet, counseling cards, and family planning regulatory submission posters.
- Provide competency based general family planning trainings and refresher trainings as a low percentage of trained providers have been trained in last five years and a low percentage of standards have been achieved on FP service provision; contraceptive pills, and three month injectables.
- Provide competency based IUD trainings and to expand the competency based implant trainings to all states/regions which will not only enable health facilities to provide the LARC methods as a method of choice for the client during her visit but also facilitate the performance of providers (quality of service delivery).
- Strategy should be tailored towards unmet need and youth although there is an integrated approach for family planning services in out-patient department (OPD) day.
- Strengthen data sharing mechanism for a total market approach on family planning commodities in order to track the progress of FP 2020 as Myanmar aims for universal access to family planning.
- Develop a formal mechanism for reporting side effects and adverse events related to contraceptive service provision for both short term and long term methods in all levels of health facilities.

Enabling Environment

- Standardized data collection tools in all level of health facilities for keeping records of family planning services and managing family planning commodities.
- Translation of costed implementation plans for family planning service provision to the state and regional levels (there is a national costed implementation plan for FP2020).
- Standardized guidelines for family planning services to provide quality care by each health facility of private and public sectors.
- Case studies and dissemination of those case studies of innovative programs developed by the MOHS or NGOs.
- Develop a resource pool and sharing culture for different kinds of information communication and technology interventions related to family planning by different organizations.

Demand

- Review behavior change and communication plans and tools to be in line with international standards and technology in reproductive health and gender.
- Family planning information, education and communication materials available in all main local languages in order to increase local ethnic populations' knowledge of family planning.
- Encourage publicity for the champions of family planning by using mass media and popular social networks (e.g. Facebook)

Annexes

Annex 1: Contributors

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13. Dr. Thida Moe
14. Daw Nan Nan Aung
15. Dr. Khine Haymar Myint
16. Dr. Hayman Nyo Oo

Annex 2: Consent form for family planning observation

ကျန်းမာရေးဌာနများ၏ မျိုးဆက်ပွား ကျန်းမာရေးစောင့်ရှောက်မှုလုပ်ငန်းများဆန်းစစ်လေ့လာခြင်း

သဘောတူညီချက်ပုံစံ

<u>၁။ ရှင်းလင်းပြောကြားချက်</u>

ယခုဆန်းစစ်လေ့လာခြင်းသည် ကျွန်ုပ်တို့ဌာနနှင့် ကျန်းမာရေးဦးစီးဌာန (မိခင်နှင့်မျိုးဆက်ပွားကျန်းမာရေးဌာနခွဲ) တို့ ပူးပေါင်းလျက် မြန်မာနိုင်ငံအတွင်းရှိ ကျန်မာရေး အလွှာအသီးသီး၏ သားဆက်ခြားလုပ်ငန်းနှင့် မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများ ဆောင်ရွက်နေမှု အပေါ်တွင် လေ့လာဆန်းစစ်ရန် ဖြစ်ပါသည်။ ရရှိသောအချက်အလက်များအရ လက်ရှိလုပ်ငန်းများအနေဖြင့် အနာဂတ်တွင် ဆက်လက်ဆောင်ရွက်ရန် လိုအပ်ချက်များကို တိကျစွာဖော်ထုတ်သိရှိရမည်ဖြစ်ပြီး ဝန်ဆောင်မှုလုပ်ငန်းများ အဆက်မပြတ်ရေးနှင့် တိုးတက်ဖွံ့ဖြိုးရေးအတွက် အထောက်အပံ့ဖြစ်စေမည် ဖြစ်ပါသည်။ ယခုဆန်းစစ်လေ့လာခြင်းတွင် ပါဝင်ရန် သင်၏ခွင့်ပြုချက်ကို ကျွန်ုပ်တို့ ရလိုပါသည်။

ကျွန်ုပ်တို့၏ အလွှာအလိုက် ကျပန်းရွေးချယ်မှုစနစ်အရ ဤဆေးရုံ/ဆေးခန်းကို ရွေးချယ်ရခြင်း ဖြစ်ပါသည်။ သင့်ကို မျိုးဆက်ပွားကျန်းမာရေးနှင့် ပစ္စည်းများအကြောင်း၊ ဝန်ဆောင်မှုများအကြောင်း မေးမြန်းမည်ဖြစ်ပါသည်။ မေးမြန်းရရှိသော အချက်များကို ကျန်းမာရေးနှင့်အားကစားဝန်ကြီးဌာနနှင့် အခြားဆက်စပ်အဖွဲ့အစည်းများအတွက် စီမံခန့်ခွဲမှုနှင့်ဝန်ဆောင်မှုများ ပိုမိုတိုးတက်ကောင်းမွန်စေရန် အသုံးပြုပါမည်။

ဤသုတေသနတွင် အပိုင်း ၂ပိုင်း ရှိပါသည်။ ပထမပိုင်းတွင် ဝန်ထမ်းများက ဖြေဆိုရန်ဖြစ်ပြီး ဒုတိယပိုင်းကိုမူ ဆေးခန်းသို့ သားဆက်ခြားနိုင်ရေးအတွက် လာရောက်ပြသသောသူများထဲမှ လေးဦးကို ဝန်ဆောင်မှုပေးသူ နှစ်ဦး၏ ဆောင်ရွက်နေမှုအား လေ့လာကြည့်ရှုရန်ဖြစ်ပါသည်။ ယင်းအတွက်လည်း သင်၏ခွင့်ပြုချက်ကို ကျွန်ုပ်တို့ ရလိုပါသည်။ သင်၏ အမည်ကိုသော်၎င်း၊ သင်ကတာဝန်ပေးဖြေဆိုခိုင်းသူ၏ အမည်ကိုသော်၎င်း၊ ကျန်းမာရေးဝန်ဆောင်မှုပေးသူ၏ အမည်ကိုသော်၎င်း၊ ဆေးခန်းပြသူ၏အမည်ကိုသော်၎င်း ကျွန်ုပ်တို့၏ အချက်အလက် သိမ်းဆည်းမှုစနစ်နှင့် အစီရင်ခံစာတွင်လုံးဝဖော်ပြမည်မဟုတ်ပါ။

သင့်အနေဖြင့် မည်သည့်မေးခွန်းကိုမဆို မဖြေဆိုလိုက ငြင်းဆိုနိုင်ခွင့်ရှိပါသည်။ မေးနေစဉ် မည်သည့်အချိန်တွင် မဆို မဖြေဆိုလိုတော့ပါက ရပ်ဆိုင်းနိုင်သည်။ သို့သော်သင်၏ဖြေဆိုချက်များက နိုင်ငံ၏မျိုးဆက်ပွားကျန်းမာရေး စောင့်ရှောက်မှုလုပ်ငန်း ဖွံ့ဖြိုးတိုးတက်လာစေရန် အထောက်အပံ့ ဖြစ်စေနိုင်သဖြင့် ပြည့်စုံစွာဖြေဆိုလိမ့်မည်ဟု မျှော်လင့်ပါသည်။ တချို့မေးခွန်းများကို သင့်ထက်ပိုမိုပြည့်စုံမှန်ကန်စွာ ဖြေဆိုနိုင်မည့်သူရှိသည်ဆိုလျှင် ထိုသူနှင့် ကျွန်ုပ်တို့အား မိတ်ဆက်ပေးလိုပါသည်။ ကျွန်ုပ်ယခုပြောပြသမျှအပေါ်တွင် မရှင်းလင်းသည်များ ရှိပါသလား။ ရှိပါလျှင် ယခုပြန်လည် မေးမြန်းနိုင်ပါသည်။ ယခုကျွန်ုပ်တို့ ဆက်လက်ဆောင်ရွက်ရန် သင်၏ခွင့်ပြုချက်ကို ရရှိလိုပါသည်။

၂။ သဘောတူခွင့်ပြုချက်ပုံစံ

ကျွန်တော်/ကျွန်မသည် ယခုဆန်းစစ်လေ့လာခြင်းသည် ကျန်းမာရေးဌာနအလွှာအသီးသီး၏ သားဆက်ခြား လုပ်ငန်းနှင့် မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများ ဆောင်ရွက်နေမှုအပေါ်တွင် ဝန်ဆောင်မှုအရည်အသွေး စံနှုန်းများကို လေ့လာဆန်းစစ်ရန်ဖြစ်ပြီး ရရှိသောအချက်အလက်များဖြင့် ဝန်ဆောင်မှု လုပ်ငန်းများအဆက်မပြတ်ရေး နှင့် တိုးတတ်ဖွံ့ဖြိုးရေးအတွက် အထောက်အပံ့ဖြစ်စေမည်ဖြစ်ကြောင်း သိရှိပါသည်။ ကျပန်းရွေးချယ်မှုစနစ်အရ ဤဆေးရုံ/ဆေးခန်းကို ရွေးချယ်ရခြင်းဖြစ်ကြောင်း သိရှိရပါသည်။ ပထမပိုင်းတွင် ဝန်ထမ်းများက ဖြေဆိုရန်ဖြစ်ပြီး ဒုတိယပိုင်းကိုမူ ဆေးခန်းသို့ သားဆက်ခြားနိုင်ရေးအတွက် လာရောက်ပြသသောသူများထဲမှ လေးဦးကို ဝန်ဆောင်မှုပေးသူ နှစ်ဦး၏ ဆောင်ရွက်နေမှုအား လေ့လာကြည့်ရှုရန်ဖြစ်ကြောင်း သိရှိရပါသည်။ မည်သည့်မေးခွန်းကို မဆို မဖြေဆိုလိုက ငြင်းဆိုနိုင်ခွင့်ရှိကြောင်း သိရှိပါသည်။ မရှင်းလင်းသည်များရှိပါလျှင် ယခုပြန်လည်မေးမြန်းနိုင်ကြောင်းနှင့် ကျေနပ်သည်အထိ ပြန်လည်ဖြေကြားပေးမည်ကို သိရှိပါသည်။ ကျွန်ုပ်က ယခုဆန်းစစ်လေ့လာခြင်းတွင် ပါဝင်ရန်နှင့် မျိုးဆက်ပွားကျန်းမာရေးဝန်ဆောင်မှုများ ဆောင်ရွက်နေမှုအား ဆွေးနွေးမေးမြန်းခြင်းနှင့် လေ့လာကြည့်ရှုရန် ကိစ္စအား သဘောတူခွင့်ပြုပါသည်။

လက်မှတ်	_____	မေးမြန်းသူလက်မှတ်	_____
အမည်	_____	အမည်	_____
ရက်စွဲ	_____	ရက်စွဲ	_____

Annex 3: Data collection tool

Facility ID Number		

Section 1: (TOOL 1) Facility Background Information

Job title/position of respondent_____

Name of Facility_____

Name of State/Region_____

Name(s) of evaluator conducting assessment:

_____

Date(s) of assessment _____

Type of facility

Sector	☐ Public		☐ Private
Health Facilities (HFs) Level	☐ Tertiary level	☐ Secondary level	☐ Primary level
Type of HFs	☐ District/State/Region Hospitals and Hospitals with Ob/Gy ☐ Township Hospital (TH) ☐ Station Hospital (SH) ☐ MCH Center (MCH) ☐ Urban Health Clinic (UHC) ☐ Rural Health Center (RHC) ☐ Sub-Center (SC) ☐ General Practitioner Clinic (GP) ☐ Myanmar Maternal and Child Welfare Association's clinic (MMCWA)		
Presence of separate FP clinic & schedule.		☐ Yes (if Yes, Skip Next Question)	☐ No (continue Next Question)
FP service provision in integrated approach (e.g., FP service provision in Gyne clinic)		☐ Yes (if Yes, please Specify……)	☐ No
If GP clinic	☐ NGOs/INGOs affiliated (e.g., SUN)		☐ Not affiliated with NGOs/INGOs

Section 1: Facility Staffing on Family Planning Service Provision

Please complete the section below of staffing in the family planning service provision of the health facility. Insert NA if a cadre is not applicable for the facility. For cadres that are applicable, state the number as well as number trained in FP service provision. Please fill "Total # in FP Unit" if applicable.

CADRE		MALES					FEMALES				
		TOTAL # IN FP UNIT (IF APPLICABLE)	TOTAL# TRAINED IN FP	# TRAINED IN LAST 5 YEARS			TOTAL # IN FP UNIT (IF APPLICABLE)	TOTAL# TRAINED IN FP	# TRAINED IN LAST 5 YEARS		
				GENERAL FP	IUD	IMPLANTS (SPECIFY TYPE)			GENERAL FP	IUD	IMPLANTS (SPECIFY TYPE)
101.	Midwives										
102.	Nurse-Midwives										
103.	Doctors (i.e., General Medical Officers, Obstetrician)										
104.	Other Support Staff										
105.	TOTAL										

Section 2: Family Planning Services

DOES THIS FACILITY OFFER THE FOLLOWING SERVICES?		YES	NO	COMMENTS
Family Planning				
201.	Family planning counseling in the antenatal clinic			
202.	Family planning counseling in the postpartum ward and/or clinic			
203.	Family planning counseling for the non-pregnant woman (FP clinic)			
204.	Postabortion FP counseling			
205.	Provision of LAM (Lactational Amenorrhea Method)			
206.	Provision of Fertility Awareness Based Methods			Specific (SDM)
207.	Provision of Combined pills			
208.	Provision of Progestin only pills			
209.	Injectables (DMPA or Noristerat)			
210.	Implants (Jadelle, NXT Implanon) insertion/removal	□ Insertion □ Removal	□ Insertion □ Removal	Specify type of implants:
211.	Interval IUD insertion/removal	□ Insertion □ Removal	□ Insertion □ Removal	Specify:
212.	Postpartum IUD insertion			
213.	Postabortion IUD insertion			
214.	Postpartum Implant insertion	□ Jadelle □ NXT Implanon	□ Jadelle □ NXT Implanon	Specify type of implants:
215.	Postabortion Implant insertion	□ Jadelle □ NXT Implanon	□ Jadelle □ NXT Implanon	Specify type of implants:

216.	Condoms (Male/Female)	□ Male □ Female	□ Male □ Female	
217.	tubal ligation			
218.	Vasectomy			
219.	Other methods (Specify):			
Facility and Staff for conducting counseling				
220.	Area where privacy during counseling can be ensured			
221.	Staff designated to conduct FP education			
222.	Staff tasked to conduct FP counseling			
223.	Counseling area stocked with visual aids			
224.	Counseling area stocked with job aids			
225.	Counseling area stocked with client materials			
Facility, Instruments/Kits and materials needed to support the provision of FP services				
226.	Designated room for FP procedure			
227.	Water closet or toilet for clients			
228.	Hand washing facility (sink, running water, soap or equivalent)			
229.	Examination table			
230.	Stool			
231.	Flashlight/lamp			
232.	Adult weighing scale			

233.	Blood pressure machine and BP cuff			
234.	Arm rest suitable for implant insertion			
235.	Antiseptic (Povidone or equivalent)			
236.	Clean examination gloves			
237.	Sterile surgical gloves			
238.	Sharps container/boxes			
239.	Covered bucket with Decontamination solution (0.5% Chlorine)			
240.	Bucket for non-hazardous materials			
241.	Bucket for bio-hazards			
Implant Service				
242.	Sterile syringe and needle			
243.	Local anesthetic (lignocaine)			
244.	Clean drapes			
245.	Implant trocar (Jadelle)			
246.	Scalpel handle			
247.	Surgical blades (#11)			
248.	Template and markers (Jadelle)			
IUD Service				
249.	Specula (Sim's, Graves' or Cusco's)			
250.	Tenacula/volsellum			
251.	Uterine sound			
252.	Mayo Scissors			

253.	Alligator forceps			
254.	Clean drapes			
255.	Sponge holding forceps			
Other essential FP/RH Items				
256.	Current National Family Planning Guidelines (***Specify title:)***			
257.	FP Regulatory Compliance poster			
258.	Family planning IEC materials (***Specify types***, e.g., posters, flip charts, brochures, information sheet, job aids, counseling cards, etc.):			
Contraceptive Commodities/Supplies				
259.	COC stock	□ Ward □ OPD	□ Ward □ OPD	Qty and expiry
260.	POP stock	□ Ward □ OPD	□ Ward □ OPD	Qty and expiry
261.	Injectables stock	□ Ward □ OPD	□ Ward □ OPD	Qty and expiry
262.	Implants	□ Ward □ OPD	□ Ward □ OPD	Qty and expiry
263.	IUD	□ Ward □ OPD	□ Ward □ OPD	Qty and expiry
264.	SDM Beads			

Section 3: Instrument Processing Area/ Room

DOES THIS AREA HAVE THE FOLLOWING?		YES	NO	COMMENTS
301.	Separate area for processing of soiled instruments			
302.	Running water and sink at processing area			
303.	Instrument containers			
304.	Bucket with soapy water for dirty instruments			
305.	Bucket with clean water			
306.	Chlorine solution			
307.	Brush for cleaning instruments			
308.	Utility gloves and rubber apron			
309.	Water boiler (“sterilizer”)			
310.	Wall clock or timer			
311.	Autoclave machine with functional temperature and pressure gauges			
312.	Supply of indicator paper			
313.	Reliable and safe electric connection or gas/fuel			
314.	Counter top for sorting/preparing instruments for final processing			
315.	Storage receptacle for processed instruments			
316.	Closet or storage bin for processed instrument kits			

Comments: _____

Section 4: Demand Generation Activities

	Activity	Venue	Frequency	Person in Charge	Comments
401	On-site group education				
402	Community outreach by Facility Staff				
403	Community outreach through CHV				

Section 5: Health Management Information System (HMIS) and Recordkeeping

1. **What reports do you submit routinely to the State/Regional departments of Ministry of Health and Sports (MOHS)?**

	Name of Report	Data Source	Frequency of Preparation?	Who prepares the report?	To whom is the report sent/given to?
5_101	Number of New FP Acceptors				
5_102	Number of Continued FP Users				
5_103	Complications/Adverse Events				
5_104	Other (Specify)				

2. **Data collection tools**

Number	Question	Response
5_201	Which data collection tools are available in this facility for keeping records of family planning services? (CIRCLE ALL THAT APPLY)	Antenatal register……A Labor and delivery register……..B National family planning register…..…...C OPD register……D Post Abortion Care register……..E Gynae emergency register……F National HMIS……G Exercise book…….....H No record keeping format…….I Other (Identify)_____

3. Maternity services provided in the last 12 months:

	ACTIVITY	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
5_301	Normal deliveries													
5_302	Caesarean Sections													
5_303	**Total Deliveries**													
5_304	Evacuation of retained products/MVA													
5_305	Maternal deaths													

4. Family planning services provided to clients in the facility in the last 12 months:

	FP SERVICE	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
5_401	Clients receiving FP counseling													
5_402	New Clients receiving FP Methods													
5_403	Re-visit Clients receiving FP Methods													
5_404	Total Clients receiving FP Methods													

5. **Types of family planning methods used by NEW and Continuing clients or their partners in the last 12 months:**

FP METHODS	**Jan**		**Feb**		**Mar**		**Apr**		**May**		**Jun**		**Jul**		**Aug**		**Sep**		**Oct**		**Nov**		**Dec**		**Total**	
	N	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**	**N**	**R**
Combined pills																										
Progestin only pills																										
Injectables (Depo)																										
Injectables (Noristerat)																										
Implants – J																										
Implants – N																										
IUDs – Cu 380																										
IUDs – Cu 375																										
Condoms (Male)																										
Condoms (Female)																										
Female sterilization																										
Vasectomy																										
Others (Specify):																										
Total																										

6. **Types of family planning methods received specifically by <u>Postpartum[66] clients *</u> or their partners in the last 12 months:**

FP METHODS FOR PPC	Jan	Feb	Mar	Apr	May	Jun	Jul	Aug	Sep	Oct	Nov	Dec	Total
LAM													
Combined pills													
Progestin only pills													
Injectables													
Implants													
IUDs													
Condoms													
Female sterilization													
Vasectomy													
Others (Specify):													
Total													

[66]For the purpose of this assessment, postpartum here is defined as the 1st 6 months. A woman in the 1st 6 months after her delivery will be counted

Section 2: Tools for Observation

Tool 2.1: Provider Observation Tool for General Family Planning Counseling[67]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
1	The Service provider provides **general family planning counseling**.	**Observe the service provider:**				
		• Greets woman respectfully and with kindness				
		• Introduces herself/himself and explains role				
		• Ensures privacy and confidentiality				
		• Obtains biographic information (name, address, etc.)				
		• Informs the client (and partner, if present) that there will be opportunities to address both health needs and family planning needs during this consultation				
		• Asks client about her family size, age of last child, and current family planning practices and experience				
		• If last pregnancy less was than 2 years ago, tells client about the health benefits of FP to space birth to next pregnancy of at least 24-36 months, both for mother and the baby				
		• Uses/refers pregnancy checklist to rule out pregnancy				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider provides **counseling for all method** to the woman.	**Observe that the service provider:**				
		• Use the counseling flip chart (or) Lays out the Balanced Counseling Strategy Plus (BCS+) counseling cards by effectiveness tiers; uses this to eliminate inappropriate methods, and asks				
		- Does the client want more children in the future?				
		- Is she breastfeeding a baby less than 6 months old?				
		- Does her partner support her in family planning?				
		- Does she have any medical conditions, or is she taking any medication?				
		- Are there any methods she does not want to use or has not tolerated in the past?				
		• Starts showing the methods (or) cards that have not been				

[67] Adapted from Family Planning Counseling Checklist adapted for the interval period in MCSP program

		eliminated, beginning with the most effective				
		• Reads the back of the flip chart/counseling cards (or) specific information related to particular method with the picture side up				
		• Displays all the methods/cards, and asks the client if she is interested in using any of these methods				
		• If the client expresses an interest in using one of the Long Acting Reversible Contraceptive (LARC) methods, continues with the next steps				
		• Discusses the benefits & risks of long-acting methods: - Can be inserted anytime during the menstrual cycle after ruling out pregnancy - Are greater than 99% effective in preventing pregnancy - Have no impact on breastfeeding - Can be removed when she and her partner are ready to become pregnant again - (Uncommon health risks of IUD) May contribute to anemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding - (Rare health risk of IUD) Pelvic inflammatory disease (PID) may occur if the woman h as chlamydia or gonorrhea at the time of insertion				
		• If the client expresses an interest in using the IUD, describes the interval copper IUD (Cu IUD) insertion and timing of insertion: - Can be inserted anytime during the menstrual cycle (after ruling out pregnancy) - Is effective for up to 12 years - The IUD contains no hormones - The IUS contains low doses of hormones and is safe for breastfeeding women - Some minor changes in the bleeding pattern may happen initially				
		• If the client expresses an interest in using the contraceptive implant, describes implant insertion and timing of insertion: - Can be inserted anytime during the menstrual cycle after ruling out pregnancy - The implant is effective for up to 3–5 years (depending on the type) - The implant contains low doses of hormones and is safe for breastfeeding women - Some minor changes in the bleeding pattern are expected initially				
		• Asks the client if she wants the provider to explain the method/card over again				
		• Confirms the client's understanding by asking open-ended questions				
		• Allows the client to make a final decision by herself (informed choice) without any coercion				
		Score: All "Yes"=1 point; Any "No"=0 points				
3	The provider uses job aids appropriately.	**Observe the provider:**				
		• Consults Job Aids: National guideline/checklists (or) World Health Organization (WHO) Medical Eligibility Criteria (MEC) Wheel for Contraceptive Use (or) 2015 Quick Reference Chart for the WHO MEC for Contraceptive Use to check whether there is any contraindication. If any contraindication is present, goes back to choose another method.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider performs	**Observe the provider:**				

	the post counseling tasks.	• Documents the family planning method chosen in the client's record card				
		• Tells the client that she can change her decision at any time and inform the provider about it				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

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Scoring: Family Planning Counseling	
Total standards	**4**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.2: Provider Observation Tool for Oral Contraceptive Pills Provision[68]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
Combined Oral Contraceptive (COCs) method of choice						
1	Specific information on COCs is given to the woman.	**Observe the service provider:**				
		• Asks the woman what she already knows about COCs and corrects any misinformation.				
		• Briefly, giving only the most important information, tells the woman about COCs that she has chosen:				
		- How it works				
		- Effectiveness				
		- Explains it does not prevent both pregnancy and Sexually Transmitted Infections (STIs)				
		• Asks if client has any questions and responds to them				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider provides very specific instruction on how to correctly use and when to take COCs.	**Observe the service provider:**				
		• Gives client her pill packet to hold and look at				
		• Shows her how to follow the arrows on the pack.				
		• If the client uses a 28-pill pack: instructs her to start a new pack the day after she finishes all of the pills in the packet				
		• If the client uses a 21 day pack, instructs her to wait 7 days before starting a new pack.				
		• Instructs the client to start the pill on first day of her next menstrual period (or on fifth day of her menstrual period, or use local guidelines for this instruction). If the client starts the pill after day five of her cycle she should use a back-up method for the first 7 days.				
		Score: All "Yes"=1 point; Any "No"=0 points				
3	The provider provides the instructions about missed pills to client.	**Observe the service provider:**				
		• Explain to the client that if she forgets to take her pills, she may become pregnant. If she forgets to take her pills, she should do the following:				

[68] Training Resource Package for Family Planning- Combined Oral Contraceptives (COCs) from https://www.fptraining.org/content/evaluation-tools-cocs

		- If she misses one pill, the client should take it as soon as she remembers. Take the next one at the regular time. - If she misses two pills, the client should take two pills as soon as she remembers. She should take two pills the next day, and use a backup method for the next week. The client should finish the packet normally. - If she misses more than two pills, or starts a pack 3 or more days late the client should take a pill as soon as possible, continue taking 1 pill each day, and use condoms or avoid sex for next 7 days. If these pills missed in week 3, the client should ALSO skip the inactive pills in a 28-pill pack and immediately start a new pack. If inactive pills are missed, the client should throw away the missed pills and continue taking pills, 1 each day.				
		• Cautions client that she may feel queasy or nauseated if she takes two pills in one day, but taking two pills reduces her chances of becoming pregnant.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider discusses the precautions.	**Observe the provider:**				
		• Explains other situations in which a back-up method is needed: - *Diarrhea/vomiting*: Start using a back-up method on the first day of diarrhea or vomiting, and use it for at least 7 days after the diarrhea/vomiting is over. Meanwhile, continue to take your pills as usual. - If taking certain medications used in the treatment of tuberculosis and seizures (rifampin, phenytoin, carbamazepine).				
		• Stresses the importance of informing other doctors/health workers who may care for her, that she is using the COC.				
		Score: All "Yes"=1 point; Any "No"=0 points				
5	The provider asks client to repeat back the instructions.	**Observe the provider:**				
		• Asks client to repeat back in her own words instructions for when to start the Pill, which pill she will begin with, how she will take the second and subsequent pills, and what she will do if she misses a pill or pills				
		Score: All "Yes"=1 point; Any "No"=0 points				
6	The provider explains early pill warning signs.	**Observe the provider:**				
		• Explains in a non-alarming way the early pill warning signs, stressing the rarity of these: - Severe, constant pain in belly, chest or legs or very bad headaches that start or become worse after she begins to take COCs - Brief loss of vision, seeing flashing lights or zigzag lines (with or without bad headaches) - Jaundice (skin and eyes look yellow)				
		Score: All "Yes"=1 point; Any "No"=0 points				
7	The provider performs tasks after counseling	**Observe the provider:**				
		• Asks client a few questions to ensure that she understands and				

	on COCs.	remembers key instructions.				
		• Prescribes or provides client with at least three- month supply of COCs.				
		• Reassures client she should return at any time for advice, more COCs or when she wants to use another method.				
		• Plans for a return visit and gives client a definite return date. - Asks client to bring her pill packets with her on the return visit.				
		• Documents/records the visit according to local clinic guidelines.				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

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Scoring: Oral Contraceptive Pills	
Total standards	**7**
Total standards met	
Percent achievement	%

Management on oral contraceptive pills follow-up case[69]

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
8	The provider asks client on current method.	**Observe the provider on management of COC follow-up case:**				
		• Asks client if she is satisfied with COC				
		• Asks if she is having any problems or experiencing any side effects. If yes, manage these as appropriate according to government guidelines.				
		• Asks client how she is taking the COCs and to demonstrate with the package she is using.				
		Score: All "Yes"=1 point; Any "No"=0 points				
9	The provider conducts history taking, examination and notes down the follow-up findings in follow-up register.	**Observe the provider on management of COC follow-up case:**				
		• Repeats the history checklist. If history suggests client has developed a precaution, does an appropriate physical examination to rule out or verify.				
		• Checks client's blood pressure.				
		• If the client is satisfied with the COC, is tolerating the COC well, is not experiencing any serious side effects, and no precautions exist: - Prescribes/provides at least another three cycles of COCs.				

[69] Training Resource Package for Family Planning- Combined Oral Contraceptives (COCs) from https://www.fptraining.org/content/evaluation-tools-cocs

		(She may be provided with 13-18 cycles.) -Provides her with a sufficient supply of condoms, if at risk of an STD.				
		• If client wants to discontinue the COC, helps her make an informed choice of another method.				
		• Encourages client to see her/him at any time if she has questions or problems.				
		• Fills up the follow-up register correctly.				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

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Scoring: Oral Contraceptive Pills (Return client)	
Total standards	**2**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.3: Provider Observation Tool for 3 months Injection Provision[70]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3months Injection method of choice						
1	Specific information on 3 months injection is given to the woman.	**Observe the service provider:**				
		• Asks the woman what she already knows about 3 months injection and corrects any misinformation				
		• Briefly, giving only the most important information, tells the woman about 3 months injection that she has chosen:				
		- How it works				
		- Effectiveness				
		- Advantages and non-contraceptive benefits				
		- Disadvantages				
		- Precaution				
		- Common side effects and warning signs				
		- Lack of protection against STIs, HIV/AIDS				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider prepares equipment and supplies to provide 3 months	**Observe that the service provider:**				
		• Ensures that woman has given consent for 3 months injection				
		• Assures necessary privacy during the procedure				
		• Assemble the supplies and materials needed in advance:				

[70] INFO project Center for Communication Programs, Johns Hopkins Bloomberg School of Public Health https://www.k4health.org/sites/default/files/InjectableContraceptivesProviders.pdf

	injection to the woman.	- Single-dose vial - Sterile needle and syringe (If auto-disable (AD) or conventional disposable syringes and needle are not available, use sterile equipment designed for steam sterilization. Do not reuse disposable equipment.) - Cotton wool				
		• Wash hands with soap and water before giving the injection, if possible. Gloves are not needed unless there is a chance of direct contact with blood or other body fluids.				
		• Inspect the vial and check expiry date. Discard any with visible cracks or leaks.				
		• With injectable containing DMPA, roll the vial back and forth or gently shake to mix contents. If the vial of NET-EN is cold, warm to skin temperature before giving the injection.				
		Score: All "Yes"=1 point; Any "No"=0 points				

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3	The service provider gives the injection safely.	**Observe if the provider:**				
		• Washes hands thoroughly and dries (either air dries or uses a hygienic personal towel) them and puts on sterile gloves.				
		• Explain the injection procedure to the client and point out that the syringe and needle are sterile.				
		• Ask the client her preferred site for injection: upper arm (deltoid muscle) or buttocks (gluteal muscle). To decrease discomfort, position her so that her muscles are relaxed.				
		• Wash the injection site with soap and water if it is visibly dirty. Swabbing clean skin or wiping the skin with antiseptic before giving an injection is not necessary.				
		• Pierce the top of the vial with the sterile needle and fill syringe with the proper dose.				
		• With a smooth, steady motion, insert the needle deep into the muscle at a right angle (90°) and inject the contents of the syringe.				
		• After the injection ask the client to hold cotton wool on the injection site. Instruct the client not to massage the injection site.				
		• Wash hands with soap and water after giving the injection, if possible.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider disposes of waste appropriately.	**Observe if the provider:**				
		• Do not recap, bend, cut, or break needles after use.				
		• Discard the used disposable needle and syringe immediately in an enclosed sharps container.				
		• If reusable syringes and needles are used, they must be sterilized again after each use.				
		• Seal and dispose of sharps containers when they are three-fourths full. Follow program or clinic guidelines for proper waste management.				
		Score: All "Yes"=1 point; Any "No"=0 points				
5	The woman receives post- injection counseling.	**Observe if the provider:**				
		• Discusses what to do if the client experiences any side effects or problems (e.g. pain, swelling, changes in menstrual cycle)				
		• Explains about the need for follow up				

		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

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Scoring: 3 months injection provision	
Total standards	**5**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.4: Provider Observation Tool for Male Condom Provision[71]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
Male condom method of choice						
1	Specific information on male condom is given to the woman and/or her partner.	**Observe the service provider:**				
		• Asks the woman and/or partner what she and/or he already knows about male condom and corrects any misinformation.				
		• Briefly, giving only the most important information, tells the woman and/or her partner about male condom that she and/or he has chosen:				
		- How it works				
		- Effectiveness				
		- Stresses that consistent and correct use with every act of intercourse is the key to effectiveness				
		- Explains it ability to prevent both pregnancy and Sexually Transmitted Infections (STIs)				
		- Asks if client/partner has any allergies to latex				
		- Tell where to obtain them and the cost				
		• Asks if client/partner has any questions and responds to them				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider provides very specific instruction on how to correctly use and when to use male condoms.	**Observe that the service provider provides the instructions:**				
		• Package must be torn open carefully				
		• Use during every act of intercourse				
		• Use with spermicide whenever possible				
		• Do not "test" condoms by blowing up or unrolling				
		• Put on when penis is erect				
		• Put on before penis is near/introduced into vagina				
		Score: All "Yes"=1 point; Any "No"=0 points				
3	The provider demonstrates how to correctly put on condom by using a model, banana, or two	**Observe that the service provider provides the instructions:**				
		• Cautions client not to unroll condom before putting it on				
		• Shows how to place rim of condom on penis and how to unroll up to the base of penis				
		• Instructs how to leave 1/2 inch space at tip of condom for semen, which must not be filled with air or the condom may				

[71] Training Resource Package for Family Planning-Male Condom Module from https://www.fptraining.org/resources/competency-based-skills-assessment-checklist-male-condom

	fingers.	burst				
		• Shows how to expel air by pinching tip of condom as it is put on				
		• Cautions about tearing accidentally with fingernails/rings				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider counsels client on how to remove penis from vagina with condom intact and with no spillage of semen.	**Observe the provider counsels client on how to remove:**				
		• Hold on to rim of condom when withdrawing				
		• Be careful not to let semen spill into vagina when penis is flaccid				
		Score: All "Yes"=1 point; Any "No"=0 points				
5	The provider discusses the precautions	**Observe the provider:**				
		• Counsels client what to do if condom breaks or slips off during intercourse: - See doctor/clinic where woman can be assessed for emergency contraception - Request emergency contraceptive pills within 72 hours (the earlier the better) of unprotected intercourse or condom breakage				
		• Discusses use of lubricants and what not to use: - Do NOT use: petroleum-based products (Vaseline) - Do NOT use: mineral, vegetable, or cooking oil - Do NOT use: baby-oil - Do NOT use: margarine or butter - Use a water-based lubricant if one is needed				
		Score: All "Yes"=1 point; Any "No"=0 points				
6	The provider allows client to practice.	**Observe the provider:**				
		• Allow client to demonstrate and practice putting on condom using the model/banana/fingers. Corrects any technique errors.				
		Score: All "Yes"=1 point; Any "No"=0 points				
7	The provider provides information on safe disposal of male condom.	**Observe the provider:**				
		• Advises client to dispose of condoms by burning, burying, or throwing in the latrine and to not flush down the toilet				
		Score: All "Yes"=1 point; Any "No"=0 points				
8	The provider provides post demonstration tasks	**Observe the provider:**				
		• Provider repeats major condom messages to client:: - Be sure to have a condom before you need one - Use a condom with every act of intercourse - Do not use a condom more than once - Do not rely on condom if package is damaged, torn, outdated, dry, brittle, or sticky				
		• Provides client with at least a three-month supply (about 30–40 condoms) or according to the needs.				
		• Reassures client s/he should return at any time for advice, more condoms or when s/he wants to use another method.				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

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Scoring: Condom provision	
Total standards	**8**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.5: Provider Observation Tool for female Condom Provision[72]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
Female condom method of choice						
1	Specific information on female condom is given to the woman and/or her partner.	**Observe the service provider:**				
		• Asks the woman and/or partner what she and/or he already knows about female condom and corrects any misinformation				
		• Briefly, giving only the most important information, tells the woman and/or her partner about female condom that she and/or he has chosen:				
		- How it works				
		- Effectiveness				
		- Stresses that consistent and correct use with every act of intercourse is the key to effectiveness				
		- Explains it ability to prevent both pregnancy and Sexually Transmitted Infections (STIs)				
		- Provides that woman can initiate use				
		- Tell where to obtain them and the cost				
		• Asks if client/partner has any questions and responds to them				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider provides very specific instruction on how to correctly use and when to use female condoms (FC).	**Observe that the service provider provides the instructions:**				
		• The FC can be inserted anytime from 8 hours before to immediately before intercourse				
		• Neither insertion nor removal requires an erect penis				
		• Cautions that the outer ring may move from side to side or the sheath may slip up and down inside the vagina during intercourse, but this does not reduce protection				
		• Explains that there is little protection if the outer ring is pushed into the vagina, or the penis is underneath or beside the sheath, rather than inside the sheath				
		• Explains that any kind of lubricant can be used with the female condom				
		• Tells not to use the male condom with the female condom as it may cause too much friction and result in one or the other slipping or tearing				
		Score: All "Yes"=1 point; Any "No"=0 points				
3	The provider provides instructions on how to	**Observe that the service provider provides the instructions:**				
		• The packet must be carefully torn open				

[72] Training Resource Package for Family Planning- Female Condom Module from https://www.fptraining.org/resources/competency-based-skills-assessment-checklist-female-condom

	insert the female condom.	• Find the inner ring, which is at the closed end of the condom				
		• Squeeze together the inner ring with your fingers and put it in your vagina				
		• Put the inner ring in the vagina				
		• Push the inner ring up into your vagina with your finger. The outer ring stays outside the vagina.				
		• When you have intercourse, guide the penis through the outer ring, making sure it goes inside the sheath.				
		• Another way to insert the FC is to put it over the erect penis so that the end of the penis is touching the inner ring, and insert the penis with the sheath into the vagina.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider counsels client on how to remove female condom with no spillage of semen.	**Observe the provider counsels client on how to remove:**				
		• Remove the female condom immediately after sex, before you stand up.				
		• Squeeze and twist the outer ring to keep the man's sperm inside the pouch.				
		• Pull the pouch out gently				
		Score: All "Yes"=1 point; Any "No"=0 points				
5	The provider discusses the precautions.	**Observe the provider:**				
		• Counsels client what to do if female condom breaks or slips off during intercourse: - See doctor/clinic where woman can be assessed for emergency contraception - Request emergency contraceptive pills within 72 hours (the earlier the better) of unprotected intercourse or condom breakage				
		Score: All "Yes"=1 point; Any "No"=0 points				
6	The provider allows client to practice.	**Observe the provider:**				
		• Asks client to repeat back instructions and practice with a FC. Corrects any errors in technique.				
		Score: All "Yes"=1 point; Any "No"=0 points				
7	The provider provides information on safe disposal of female condom	**Observe the provider:**				
		• Advises client to dispose of female condoms by burning or burying it. Do not flush down the toilet				
		Score: All "Yes"=1 point; Any "No"=0 points				
8	The provider provides post demonstration tasks	**Observe the provider:**				
		• Provider repeats major condom messages to client:: - Be sure to have a condom before you need one - Use a condom with every act of intercourse - Do not use a condom more than once - Do not rely on condom if package is damaged, torn, outdated, dry, brittle, or sticky				
		• Provides client with at least a three-month supply (about 30–40 condoms) or according to needs.				
		• Reassures client she should return at any time for advice, more condoms or when she wants to use another method.				

Comments:

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Scoring: Female condom provision	
Total standards	**8**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.6: Provider Observation Tool for Intra-uterine contraceptive device (IUCD) Provision[73,74]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

IUCD insertion

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
IUCD method of choice						
1	Specific information on IUCD is given to the woman	**Observe the service provider:**				
		• Asks the woman what she already knows about IUCD and corrects any misinformation				
		• Briefly, giving only the most important information, tells the woman about IUCD that she has chosen:				
		- How it works				
		- Effectiveness				
		- Advantages and non-contraceptive benefits				
		- Disadvantages				
		- Precaution				
		- Common side effects and warning signs				
		- Lack of protection against STIs, HIV/AIDS				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider performs pre-insertion tasks to provide IUCD to the woman.	**Observe that the service provider:**				
		• Ensures that woman has given consent for IUCD				
		• Assures necessary privacy during the procedure				
		• Checks the instrument kit and supplies are available: - Ring forceps/sponge holding forceps - Volsellum/Tenaculum - Uterine Sound - Scissors - Cusco/bi-valve speculum - Cotton swabs/gauze pieces - Betadine - Cu T 380 A or Cu 375 (whichever client has chosen)				
		• Ensures that instruments are processed following the recommended 3 steps (decontamination after use, cleaning with soap and water and then HLD or sterilization)				
		• Checks that there is contraindication for insertion of IUCD - Current purulent cervicitis or chlamydial infection or gonorrhoea - Current Pelvic Inflammatory Disease (PID) - Unresolved vaginal bleeding - Immediate post-septic abortion - Pregnancy				

[73] Jhpiego (2015): Providing Long Acting Reversible Contraception (LARC)- Course Notebook for Trainers
[74] WHO (2011): A Global Handbook for providers- Family Planning 2011 update

		- Distortion of uterine cavity (anatomical abnormalities) If contraindication/s present, Do Not insert IUCD.				
		Score: All "Yes"=1 point; Any "No"=0 points				
S. No	**PERFORMANCE STANDARDS**	**DEFINITION (VERIFICATION CRITERIA)**	**Observation**			
			1	**2**	**3**	**4**
3	The provider correctly inserts IUCD (interval IUCD insertion).	**Observe if the provider:**				
		• Performs hand hygiene. (Washes hand if needed and puts on HLD or sterile gloves)				
		• Inspects the perineum, labia and vaginal walls for infection/lacerations.				
		• Performs speculum examination with Cusco's speculum to visualize the cervix.(Note: If cervix is not visible after placing the Cusco's speculum and depressing the posterior wall of vagina, adjust the speculum to make the cervix descend and visible)				
		• Cleans cervix with Betadine – 2 times				
		• Grasps the anterior lip of the cervix with volsellum/tenaculum				
		• Insert the uterine sound using no-touch technique to fundus to determine uterine measurement.				
		• Opens 1/3rd of sterile IUCD packet and load the IUCD in its sterile package.				
		• Set the blue depth gauge to the measurement of the uterus.				
		• If IUCD is Cu T 380 A, - Carefully insert the loaded IUCD, and release the arms of the IUCD into the uterus using the withdrawal technique. - Gently push the insertion tube upward again until you feel a slight resistance (to ensure arms of IUD are in fundus). (OR) • If IUCD is Cu 375, - Carefully insert the loaded IUCD until you feel a slight resistance (to ensure IUCD is in correct placement)				
		• If IUCD is Cu T 380 A, withdraw the rod, and partially withdraw the insertion tube until the IUCD strings can be seen. (OR) • If IUCD is Cu 375, partially withdraw the insertion tube until the IUCD strings can be seen.				
		• Examines the cervix to ensure that: - Strings of CuT 380A are visible at the os of the cervix or use Mayo scissors to cut the IUCD strings to 4 cm length if needed. (or) - Use Mayo scissors to cut the IUCD strings to 2 or 4 cm of strings of Cu 375 are visible at the os of the cervix.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider performs	**Observe if the provider:**				

	post-insertion tasks including record-keeping and advice for Follow Up.	• Removes all instruments and immerses them in 0.5% chlorine solution, disposes of waste materials in proper containers, immerse both gloved hands in 0.5% chlorine solution and removes gloves by turning them inside out and disposing of them. Performs hand hygiene.				
		• Fills up the record of IUCD insertion in IUCD register correctly.				
		• Tells key messages for IUD users - Basic facts about her IUCD (e.g., type, how long effective, when to replace/remove) - No protection against STIs; need for condoms if at risk - Possible side effects - Warning signs - How to check for possible IUCD expulsion - When to return to clinic				
		• Encourages client to return any time she has questions or concerns or warnings signs.				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments: _____
_____
_____

Tool: IUCD Insertion	
Total standards	**4**
Total standards observed	
Total standards achieved	
Percent achievement	%

IUCD removal

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
1	The woman receives IUCD pre-removal counseling and examination.	**Observe if the provider:**				
		• Greets the client respectfully				
		• Asks the client for her reason for removal				
		• Confirms her name, address and other required information and completes IUCD card and records all relevant details on woman's record.				
		• Evaluates her reason for removal				
		• Answers any questions she asks				
		• Reviews the client's reproductive goals and needs				
		• Examines insertion area for any sign of infection or abnormality				
		• If client has complained about abnormal vaginal bleeding				
		- Prepares equipment and supplies for pelvic examination (including a light source)				
		- Asks the woman to wash and rinse her genital area. Ensures that the woman has emptied her bladder				
		- Helps the woman onto examination table, ensures her comfort and makes sure that she is draped/covered appropriately throughout the procedure.				
		- Washes hands thoroughly and puts on sterile gloves.				
		- Without contaminating them, arranges instruments and supplies in HLD container or sterile tray.				
		- Performs pelvic examination.				

		- Based on findings, determines whether woman needs removal of IUCD and/or referral for appropriate services.				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	A service provider prepares for IUCD removal.	**Observe if the provider:**				
		• Prepares necessary instruments for the removal				
		• Helps the client to position herself on procedure bed comfortably				
		• Interacts with client to make her feel at ease all the time				
		• Explains the removal procedure and answers any questions				
		• Washes hands thoroughly and puts on sterile gloves				
		Score: All "Yes"=1 point; Any "No"=0 points				

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3	The woman receives IUCD removal services.	**Observe if the provider:**				
		• Uses proper infection prevention practices such as proper hand washing, use of sterile gloves, disposal syringes, use of appropriate disposal waste containers (sharp and leak proof containers) etc.				
		• Gently insert the HLD (or sterile) speculum to visualize the strings, and cleanse the cervical os and vaginal wall with antiseptic.				
		• Alert the client immediately before you remove the IUCD.				
		• Grasp the IUCD strings close to the cervix with an HLD (or sterile) hemostat or other narrow forceps.				
		• Apply steady but gentle traction, pulling the strings toward you to remove the IUCD. **Do not use excessive force.**				
		• Shows removed IUCD to the woman.				
		• Immerses instruments gently into 0.5% chlorine solution for 10 minutes for decontamination.				
		• Disposes of wastes materials in a leak proof container before removing the gloves.				
		• Rinses gloves in 0.5% chlorine solution, removes and disposes appropriately				
		• Washes hands properly with water and dries with clean towel or in absence of clean towel air-dries the hands.				
		• Completes record in woman's card/register.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The woman receives IUCD post removal counseling.	**Observe if the provider:**				
		• Counsels the client about new family planning method if desired				
		• Helps the client to receive a temporary method for the time being i.e. condom until the client will start another method of choice (if she could not use another method on the same day/time)				
		• Encourages a client to return whenever she has any questions or concerns				
		• Explains about the return of fertility				
		• Provides her information about ANC if she wants another child.				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:_____
_____

Tool: IUCD Removal	
Total standards	**4**
Total standards observed	
Total standards achieved	
Percent achievement	%

Management of IUCD follow-up case

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
1	The provider rules out pregnancy.	**Observe the provider:**				
		• Asks client how she is feeling with the IUCD				
		• Checks if the client is amenorrheic (asks questions related to symptoms of pregnancy to rule out pregnancy)				
		• If client has complained about abnormal vaginal bleeding				
		- Performs a pelvic examination if client evokes symptoms of pregnancy or performs pregnancy test				
		- If pregnant with IUCD inside the uterus, counsel and manage/refer accordingly				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider conducts pelvic examination (per speculum) to check the strings, condition of cervix and notes down the follow-up findings in follow-up register.	**Observe the provider:**				
		• Performs pelvic examination and documents presence of strings				
		• If string problems:				
		- Too long—confirms that it is not partial expulsion, trim strings;				
		- Not found—assess for expulsion. Consider ultrasound to check location of IUCD				
		• If suspected expulsion: if IUCD is partially expelled, remove and replace; if IUCD not found ask woman if IUCD expelled (offer replacement or another method); if IUCD not found and woman unaware of expulsion, consider X-Ray or ultrasound.				
		• Fills up the follow-up register correctly.				
		Score: All "Yes"=1 point; Any "No"=0 points				

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3	The provider identifies and manages side effects or problems with IUCD.	**Observe if the provider:**				
		• Asks if she is experiencing any side effect or problem with the contraceptive method				
		• If side effects and/or problems are identified, conducts brief assessment and provides initial management (noted here): and either manages accordingly or refers for additional treatment - **Heavy vaginal bleeding**: provides explanation and reassurance, assesses for anemia, performs pelvic exam, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), and provides iron tablets - **Irregular bleeding:** provides explanation and reassurance, provides NSAIDs (ibuprofen 400mg twice daily for 5 days),and provides iron tablets - **Low abdominal pain or cramping**: assesses for signs of infection by palpating abdomen for tenderness and observing vaginal discharge, provides explanation and reassurance and provides NSAIDs (ibuprofen 400mg twice daily for 5 days). Treat infection and reassess for insertion - **Severe lower abdominal pain**: Rules out ectopic pregnancy or pelvic infection - **Fever and purulent vaginal discharge**: performs pelvic exam, assesses for pelvic infection. (Note: it is not necessary to remove IUCD during treatment)				
		• If initial management approaches are not effective, refers woman for additional evaluation and management, as necessary				
		• Offers to remove the IUCD for any woman who wants to have it removed and offers other methods to choose.				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

_____

_____

Tool: THE PROVIDER MANAGES RETURN/FOLLOW-UP CLIENTS OF IUCD APPROPRIATELY	
Total standards	**3**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.7: Provider Observation Tool for Post-partum Intra-uterine contraceptive device (PPIUCD) Provision[75]

Name of health facility (Name and Place):	Name: ……. Place: ……
Date of visit:	Date…….Month…….Year…….
Name of observer:	1…… 2…….

Scoring Key: Y=Yes, N=No, NA=Not Applicable

PPIUCD insertion

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
PPIUCD method of choice						
1	Specific information on PPIUD is given to the woman.	**Observe the service provider:**				
		• Asks the woman what she already knows about PPIUD and corrects any misinformation				
		• Briefly, giving only the most important information, tells the woman about PPIUD that she has chosen:				
		- How it works				
		- Effectiveness				
		- Advantages and non-contraceptive benefits				
		- Disadvantages				
		- Precaution				
		- Common side effects and warning signs				
		- Lack of protection against STIs, HIV/AIDS				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider performs pre-insertion tasks to provide PPIUD to the woman.	**Observe that the service provider:**				
		• Ensures that woman has given consent for PPIUCD				
		• Assures necessary privacy during the procedure				
		• Checks the instrument kit and supplies are available: - PPIUCD insertion forceps - Ring forceps/sponge holding forceps - Sims speculum - Cotton swabs/gauze pieces - Betadine - Cu T 380 A or Cu 375 (whichever client has chosen)				
		• Ensures that instruments are processed following the recommended 3 steps (decontamination after use, cleaning with soap and water and then HLD or sterilization)				
		• Checks that there is no contraindication for insertion of PPIUCD - Client is within 10 minutes of expulsion of placenta or within 48 hours of delivery - No history of prolonged rupture of membranes > 18 hours - No sign of infection/puerperal sepsis - No unresolved postpartum hemorrhage				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments: _____

S.	PERFORMANCE	DEFINITION (VERIFICATION CRITERIA)	Observation

[75] Adapted from Standards for Postpartum family planning (PPFP) and Postpartum IUCD (PPIUCD) training sites March, 2014

No	STANDARDS		1	2	3	4
3a	For post placental insertion and within 48 hours of insertion: The provider correctly inserts PPIUCD.	**Observe if the provider:**				
		• Performs hand hygiene. (Washes hand if needed and puts on HLD or sterile gloves)				
		• Inspects the perineum, labia and vaginal walls for lacerations. If lacerations not bleeding heavily, repair, if needed, after inserting PPIUCD				
		• Performs speculum examination with Sim's speculum to visualize the cervix.(Note: If cervix is not visible after placing the Sim's speculum and depressing the posterior wall of vagina, applies gentle undal pressure to make the cervix descend and visible)				
		• Cleans cervix with Betadine – 2 times				
		• Grasps the anterior lip of the cervix with ring forceps/sponge holder				
		• Opens 1/3rd of sterile IUCD packet and grasps IUCD within the sterile packet with the PPIUCD insertion forceps				
		• Inserts the PPIUCD insertion forceps with IUCD into lower uterine cavity				
		• Releases the ring forceps/sponge holder and pushes the uterus upwards with left hand on the abdomen to straighten the angle between the cervix and uterus				
		• Moves the PPIUCD insertion forceps with IUCD upward toward the fundus while keeping the forceps closed				
		• When forceps reaches the fundus, releases IUCD by opening the forceps and slightly tilting the forceps inwards and then sweeps the open forceps towards the side wall of the uterus				
		• Moves the placental forceps downwards in a slightly open position while stabilizing the uterus and removes the forceps from the uterine cavity				
		• Examines the cervix to ensure that: strings of CuT 380A are not visible at the os of the cervix (or) Only 1 or 2 cm of strings of Cu 375 are visible at the os of the cervix (in all post placental insertions and most insertions within 48 hours depending on the height of uterus)				
		Score: All "Yes"=1 point; Any "No"=0 points				
3b	For intracesarean insertion: The provider correctly inserts PPIUCD	**Observe if the provider:**				
		• Ensures that woman has received uterotonic drug after baby is out and uterus is not malformed which limit the successful use of IUCD				
		• Grasps the uterus at the fundus to stabilize the uterus				
		• Inserts the IUCD (manually or with ring forceps/sponge holder) through the uterine incision to the fundus				
		• Removes the hand/ring forceps/sponge holder carefully without dislodging the uterus and places the IUCD strings directed towards the lower uterine segment (Note: Does not pass the strings though the cervix)				

		• Takes care not to include strings in repair of uterine incision				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The provider performs post-insertion tasks including record-keeping and advice for Follow Up.	**Observe if the provider:**				
		• Removes all instruments and immerses them in 0.5% chlorine solution, disposes of waste materials in proper containers, immerse both gloved hands in 0.5% chlorine solution and removes gloves by turning them inside out and disposing of them. Performs hand hygiene.				
		• Fills up the record of PPIUCD insertion in PPIUCD register correctly				
		• Tells the client to return at 6 weeks for PPIUCD routine follow-up, postnatal care and immunization of child and encourages client to return any time she has questions or concerns or warnings signs				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments: _____
_____

Tool: PPIUCD Insertion	
Total standards	**4**
Total standards observed	
Total standards achieved	
Percent achievement	%

Management of PPIUCD follow-up case[76]

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
1	The provider rules out pregnancy.	**Observe the provider:**				
		• Asks client how she is feeling with the PPIUCD				
		• Checks if the client is completely or partially breastfeeding the child (asks questions related to symptoms of pregnancy to rule out pregnancy)				
		• If client has complained about abnormal vaginal bleeding				
		- Performs a pelvic examination if client evokes symptoms of pregnancy or performs pregnancy test				
		- If pregnant with IUCD inside the uterus, counsel and manage/refer accordingly				
		• Asks client how she is feeling with the PPIUCD				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider conducts pelvic examination (per speculum) to check the strings, condition of cervix and notes down the follow-up findings in follow-up register.	**Observe the provider on management of PPIUCD follow-up case:**				
		• Performs pelvic examination and documents presence of strings				
		• If string problems:				
		- Too long—confirms that it is not partial expulsion, trim strings;				
		- Not found—assess for expulsion. Consider ultrasound to check location of IUCD				
		• If suspected expulsion: if IUCD is partially expelled, remove and replace; if IUCD not found ask woman if IUCD expelled (offer replacement or another method); if IUCD not found and woman unaware of expulsion, consider X-Ray or ultrasound				
		• Fills up the follow-up register correctly				
		Score: All "Yes"=1 point; Any "No"=0 points				

[76] Adapted from Standards for Postpartum family planning (PPFP) and Postpartum IUCD (PPIUCD) training sites March, 2014

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3	The provider identifies and manages side effects or problems with IUCD.	**Observe if the provider:**				
		• Asks if she is experiencing any side effect or problem with the contraceptive method				
		• If side effects and/or problems are identified, conducts brief assessment and provides initial management (noted here): and either manages accordingly or refers for additional treatment - **Heavy vaginal bleeding**: provides explanation and reassurance, assesses for anemia, performs pelvic exam, provides NSAIDs (ibuprofen 400 mg twice daily for 5 days), and provides iron tablets - **Irregular bleeding:** provides explanation and reassurance, provides NSAIDs (ibuprofen 400mg twice daily for 5 days), and provides iron tablets - **Low abdominal pain or cramping**: assesses for signs of infection by palpating abdomen for tenderness and observing vaginal discharge, provides explanation and reassurance and provides NSAIDs (ibuprofen 400mg twice daily for 5 days). Treat infection and reassess for insertion - **Severe lower abdominal pain**: Rules out ectopic pregnancy or pelvic infection - **Fever and purulent vaginal discharge**: performs pelvic exam, assesses for pelvic infection. (Note: it is not necessary to remove IUCD during treatment)				
		• If initial management approaches are not effective, refers woman for additional evaluation and management, as necessary				
		• Offers to remove the IUCD for any woman who wants to have it removed and offers other methods to choose				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

_____

_____

Tool: THE PROVIDER MANAGES RETURN/FOLLOW-UP CLIENTS OF PPIUCD APPROPRIATELY	
Total standards	**3**
Total standards observed	
Total standards achieved	
Percent achievement	%

Tool 2.8: Provider Observation Tool for Implant Provision[77]

Name of health facility (Name and Place):	Name:……. Place:……
Date of visit:	Date…….Month…….Year……
Name of observer:	1…… 2……

Scoring Key: Y=Yes, N=No, NA=Not Applicable

[77] Adapted from Jhpiego Gates ASI (2013): Provider observation tool for implant provision

Implant Insertion

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
Implant method of choice						
1	Specific information on Implant is given to the woman.	**Observe the service provider:**				
		• Asks the woman what she already knows about Implant and corrects any misinformation				
		• Briefly, giving only the most important information, tells the woman about Implant that she has chosen:				
		- How it works				
		- Effectiveness				
		- Advantages and non-contraceptive benefits				
		- Disadvantages				
		- Precaution				
		- Common side effects and warning signs				
		- Lack of protection against STIs, HIV/AIDS				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	The provider prepares to provide an implant to the woman.	**Observe that the service provider:**				
		• Tells woman what is going to be done (step by step), listens to her and responds attentively to her questions and concerns.				
		• Determines that required sterile (Implant) insertion set is ready.				
		• The Implant service room has curtains in the doors and windows				
		• Helps client to position herself on the examination bed comfortably.				
		• Provides continual emotional support and reassurance to make the client comfortable				
		Score: All "Yes"=1 point; Any "No"=0 points				

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3	The service provider inserts implant properly	**Observe if the provider:**				
		• Washes hands thoroughly and dries (either air dries or uses a hygienic personal towel) them and puts on sterile gloves.				
		• Prepares instruments and other necessary supplies on HLD/sterile tray				
		• Uses proper infection prevention procedures such as use of hand gloves, disposable syringes, etc.				
		• Applies antiseptic solution to the insertion area two times				
		• Gives an injection of local anesthesia under the skin (sub-dermal) of the arm (in "V" shape (for Jadelle)).				
		• Makes small incision in the skin on the inside of the upper arm if needed.				
		• Inserts the implants just under the skin (while doing this client may feel some pressure or tugging)				
		• Closes the incision with an adhesive bandage after implants are inserted.				
		• Covers and wraps the incision with sterile gauze and bandage				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The woman receives post- insertion counseling	**Observe if the provider:**				
		• Explains to the client when to remove the adhesive tape and how to keep the incision area dry				
		• Discusses what to do if the client experiences any side effects or problems (e.g. pain, swelling, expulsion of rods)				
		• Explains about the need for follow up				

		Score: All "Yes"=1 point; Any "No"=0 points				

Comments:

_____
_____
_____
_____
_____
_____

Scoring: Implants Insertion	
Total standards	**4**
Total standards met	
Percent achievement	%

Implant Removal

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
1	The woman receives implant pre-removal counseling and examination	**Observe if the provider:**				
		• Greets the client respectfully				
		• Asks the client for her reason for removal				
		• Confirms her name, address and other required information and completes Implant card and records all relevant details on woman's record.				
		• Evaluates her reason for removal				
		• Answers any questions she asks				
		• Reviews the client's reproductive goals and needs				
		• Examines insertion area for any sign of infection or abnormality				
		• If client has complained about abnormal vaginal bleeding				
		- Prepares equipment and supplies for pelvic examination (including a light source)				
		- Asks the woman to wash and rinse her genital area. Ensures that the woman has emptied her bladder				
		- Helps the woman onto examination table, ensures her comfort and makes sure that she is draped/covered appropriately throughout the procedure.				
		- Washes hands thoroughly and puts on sterile gloves.				
		- Without contaminating them, arranges instruments and supplies in HLD container or sterile tray.				
		- Performs pelvic examination.				
		- Based on findings, determines whether woman needs removal of implant and/or referral for appropriate services.				
		Score: All "Yes"=1 point; Any "No"=0 points				
2	A service provider prepares for implant removal	**Observe if the provider:**				
		• Prepares necessary instruments for the removal				
		• Helps the client to position herself on procedure bed comfortably				
		• Interacts with client to make her feel at ease all the time				
		• Explains the removal procedure and answers any questions				
		• Washes hands thoroughly and puts on sterile gloves				
		Score: All "Yes"=1 point; Any "No"=0 points				

S. No	PERFORMANCE STANDARDS	DEFINITION (VERIFICATION CRITERIA)	Observation			
			1	2	3	4
3	The woman receives Implant removal services	**Observe if the provider:**				
		• Uses proper infection prevention practices such as proper hand washing, use of sterile gloves, disposal syringes, use of appropriate disposal waste containers (sharp and leak proof containers) etc.				
		• Gives injection of local anesthesia (1% Xylocaine without adrenaline) under the implants rods.				
		• Makes a small incision (4mm) in the skin vertically between rods.				
		• Pulls out each implant one by one using the "U" technique.				
		• Closes incision with medicated adhesive tape and applies firm dressing.				

		• Shows removed implants to the woman				
		• Immerses instruments gently into 0.5% chlorine solution for 10 minutes for decontamination				
		• Disposes of wastes materials in a leak proof container before removing the gloves				
		• Rinses gloves in 0.5% chlorine solution, removes and disposes appropriately				
		• Washes hands properly with water and dries with clean towel or in absence of clean towel air-dries the hands				
		• Completes record in woman's card/register.				
		Score: All "Yes"=1 point; Any "No"=0 points				
4	The woman receives implant post removal counseling	**Observe if the provider:**				
		• Counsels the client about new family planning method if desired				
		• Helps the client to receive a temporary method for the time being i.e. condom until the client will start another method of choice (if she could not use another method on the same day/time)				
		• Encourages a client to return whenever she has any questions or concerns				
		• Explains about the return of fertility				
		• Provides her information about ANC if she wants another child				
		Score: All "Yes"=1 point; Any "No"=0 points				

Comments: _____
_____

Tool: Implants Removal	
Total standards	**4**
Total standards met	
Percent achievement	%

Tool 2.9: Summary on clinical observation

AREA	TOTAL NUMBER OF STANDARDS	NUMBER OBSERVED	NUMBER ACHIEVED	PERCENTAGE
Area 1: Family planning counseling	**4**			
Area 2: Contraceptive pills provision	**7**			
Area 2.1: Follow up case for COCs	**2**			
Area 3: 3 months injection provision	**5**			
Area 4: Condom provision				
Area 4.1: Condom provision	**8**			
Area 4.2: Female condom provision	**8**			
Area 5: Intra-uterine contraceptive device (IUCD) provision				
Area 5.1: IUCD insertion	**4**			
Area 5.2: IUCD removal	**4**			
Area 5.3: Provider manages return/follow-up clients of IUCD appropriately	**3**			
Area 6: Postpartum Intra-uterine contraceptive device (PPIUCD) provision				
Area 6.1: PPIUCD insertion	**4**			
Area: 6.2: Provider manages return/follow-up clients of PPIUCD appropriately	**3**			
Area 7: Implant provision				
Area 7.1: Implant insertion	**4**			
Area 7.2: Implant removal	**4**			
OVERALL	**60**			

Annex 4: Outline for Desk review

Desk Review Sample Outline[78]

Family Planning and Reproductive Health in [*insert country name*]

1) Introduction
   a. Population data/trends (e.g., population growth, youth population, urban/rural population)
   b. General health status of women (e.g., maternal mortality rate, unwanted fertility)
   c. National family planning (FP) program status
   d. Political/policy support for FP
   e. Contraceptive prevalence rate (CPR) from the most recent Demographic and Health Survey (DHS)

   Resource examples: DHS; national policy documents on FP and sexual and reproductive health (SRH), United Nations Population Fund (UNFPA), Population Reference Bureau (PRB)

2) Country Context
   a. United Nations Development Programme (UNDP) Human Development Index rating, life expectancy
   b. Economic status(e.g., per capita income, gross domestic product, percentage of population living on less than $1/day)
   c. Rate of urbanization
   d. Literacy rate

   Resource examples: UNDP Human Development Index, Central Intelligence Agency (CIA) Fact book, UNFPA, World Population Data Sheets (PRB), U.S. Agency for International Development (USAID)

3) National Family Planning Program
   a. History (e.g., structure, past successes/failures)
   b. Current status(e.g., implementation plan, political/policy support, budget support)
   c. Focus of current program (e.g., lowering maternal mortality, decreasing the total fertility rate [TFR], women's empowerment, male engagement, economic growth)

   Resource examples: Ministry of Health (MOH), national FP/SRH program/policy documents, international/national NGO program documents

4) Population Growth
   a. TFRs, past and present
   b. Annual growth rate
   c. Projected population growth

   Suggested table: Trends in TFR, wanted fertility rate, and met and unmet need for modern contraception, by DHS date (covering the past 20years)

[78]https://www.engenderhealth.org/files/pubs/family-planning/seed-model/seed-appendixes/adobe-acrobat-pdf/SEED-Appendix-A---All.pdf

Resource examples: DHS, MOH, international/national NGO program documents

5) Adolescent Sexual Health
   a. Growing youth population cohort
   b. Average age at first marriage/first intercourse
   c. Rates of adolescent child bearing
   d. Knowledge and use of contraception among adolescents

   Resource examples: DHS, MOH, World Population Data Sheets (PRB), World Health Organization (WHO) Core Health Indicators, international/national NGO program documents

6) Total Fertility Rates
   a. Country's TFR; how it compares regionally/worldwide
   b. Historical change in TFR
   c. Total wanted fertility rates
   d. Modern CPR (past and present)
   e. Internal disparities in TFR (by geographic location, income level, educational level, etc.)

   Suggested table: Internal disparities in certain key health indicators (e.g., TFR, infant mortality rate, average age at which adolescent women begin child bearing, deliveries attended by skilled personnel, modern CPR, percentage of women who attend at least one antenatal visit)

   Suggested graph: Wanted fertility rates (women/men), compared with actual fertility rates

   Resource examples: DHS, MOH, national FP/SRHprogram/policy documents.

7) Demand for FP
   a. Data on the demand to space versus limit child bearing
   b. Internal disparities in demand (by geographic location, income, education, etc.) Suggested graph: Met and unmet demand for FP

   Resource examples: DHS, MOH, national FP/SRH program/policy documents

8) Contraceptive Knowledge and Use
   a. Percentage of women/men who know of at least one modern FP method
   b. Knowledge of short-acting versus long-acting methods
   c. Growth in knowledge and use rates historically
   d. Modern method CPR
   e. Government's current CPR goal; achievability

   Suggested graph: TFR and CPR trends over the past 20 years; contraceptive use among currently married women over the past 20 years

   Resource examples: DHS, MOH, national FP/SRH program/policy documents

9) Method Preference
   a. FP preference by method, among currently married women
   b. Discussion as to why some methods have increased/decreased in popularity/use overtime

   Suggested graph: Percentage of married women using a contraceptive, by method use (comparing current DHS data with DHS data from 10-20 years ago)

Resource examples: DHS

10) Source of Modern Contraception
    a. Data on the most common sources of FP services

    Suggested graph: Percentage distribution of contraceptives, by sector (comparing current DHS data with DHS data from 10-20 years ago)

    Resource examples: DHS, national FP/SRH program/policy documents, international/national NGO program documents.

11) Attitudes Toward FP
    a. Percentage of married women who approve of FP
    b. Percentage of husbands/partners who approve of FP
    c. Opposition to FP

    Resource examples: DHS, national FP/SRH program documents, international/national NGO program documents

12) Factors Affecting Fertility Patterns
    a. Sociocultural and economic determinants of contraceptive use (e.g., urban/rural, married/unmarried, female/male, educated/uneducated)

    Resource examples: DHS, national FP/SRH program/policy documents, international/national NGO program documents

13) Maternal Mortality and Morbidity
    a. Maternal mortality ratio
    b. Percentage of deliveries attended by a skilled provider
    c. Percentage of women who receive at least one antenatal care (ANC) visit Resource examples: DHS, MOH, national FP/SRH program/policy documents, international/national NGO program documents

14) HIV/AIDS
    a. HIV/AIDS rate compared regionally and globally
    b. Change in HIV rates over time(increase/decrease)
    c. HIV rates among adolescents
    d. Mother-to-child transmission rates
    e. Impact of HIV rates on socioeconomic development factors

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For the purpose of these Desk Review and Final Report outlines, data for *currently married women* are suggested only because they are often the easiest for which to obtain FP information. However, it is highly recommended to use data for *all women* if the data exist locally.

f. National HIV/AIDS policy
g. Donor support for HIV/AIDS

Resource examples: DHS, MOH, WHO, USAID, national FP/SRH program/policy documents, international/national NGO program documents

15) Health Sector Reform
   a. History
   b. Decentralization
   c. Sector-wide approaches (SWAps)
   d. Poverty-Reduction Strategy Program (PRSP)

   Resource examples: MOH, World Bank, International Monetary Fund (IMF), USAID, national FP/SRH program/policy documents, international/national NGO program documents

16) Health System Structure
   a. Health system structure (e.g., pyramid structure, where a referral hospital is at the top and community/village health services are at the bottom; number of facilities)
   b. Public-sector versus private-sector health facilities

   Resource examples: MOH, WHO, USAID, national FP/SRH program/policy documents, international/national NGO program documents

17) Service Delivery
   a. Modes of service delivery offered in the country (e.g., static clinics, mobile services, community-based distribution, faith-based organizations, private providers)
   b. Rural/urban distribution of service delivery options

   Resource examples: MOH, USAID, national FP/SRH program/policy documents, international/national NGO program documents

18) Access to Services
   a. Percentage of population with access to health care services
   b. Barriers to access

   Resource examples: MOH, international/national NGO program documents

19) Human Resources for Health
   a. Number of various cadres of healthcare providers
   b. Geographic distribution of health workers

   Suggested graph: Distribution of health workforce, by cadre

   Resource examples: USAID, WHO, MOH, international/national NGO program documents

20) Financial Resources for FP
   a. Total national expenditure on health per capita
   b. Total national expenditure on reproductive health
   c. Is there a line item for contraception/FP in the national budget?
   d. Are allocated funds released appropriately?

e. Is there a national costed implementation plan for FP/SRH?
f. Level of donor funding
g. Level of private expenditure on health/FP
h. Is FP/SRH part of the national development plan?
i. Government's current strategy with respect to sustainable health financing
j. Are national vouchers or national insurance schemes available?

Resource examples: USAID, WHO, MOH, World Population Data Sheet (PRB), international/national NGO program documents

21) Contraceptive Security
   a. Health system's logistics management information system
   b. Source of contraceptive funding and its impact on commodity procurement
   c. Stock-out rates (method-specific stock-outs?) and potential causes

   Suggested graph: Funding for FP commodities by source (comparing current data with data from 10-20 years ago)

   Resource examples: USAID, MOH, national FP/SRH program/policy documents, international/national NGO program documents

22) National policy documents
   a. National reproductive health laws
   b. FP/SRH policy documents
   c. National development strategies

   Resource examples: MOH, national FP/SRH program/policy documents

23) Exposure to FP Messages
   a. Percentage of women/men who receive FP messaged via various modes of communication (e.g., radio, television, newspapers, billboards)
   b. Disparities in exposure to FP messages via the media (e.g., urban/rural, educated/uneducated, women/men)
   c. Demand-creation strategies and approaches.

   Resource examples: DHS, MOH, international/national NGO program documents

24) Technical organizations working on FP
   a. A paragraph or chart outlining the work of international/national NGOs, research organizations, or other groups working on FP in the county

   Resource examples: international/national NGO program documents, donor information on grantees

25) Bibliography

Annex 5: Final Report Outline

Final Report Sample Outline[79]

Family Planning in [*insert country name*]

Introduction

Country context (e.g., United Nations Development Programme [UNDP] Human Development Index ranking, percentage of population living onlessthan$1/day, literacy rate, life expectancy, HIV prevalence[if it is high])

Demographic trends (e.g., population growth, youth population, urban/rural population, total fertility rate [TFR], with comparisons to other countries)

- Population pyramid

Maternal and child health-national goals, trends, and status (e.g., maternal mortality rate, child mortality rate, infant mortality rate, birth intervals, early marriage, adolescent childbearing)
Contraceptive use and focus of the national family planning (FP) program (e.g., national goals and trends in contraceptive prevalence rate [CPR], method mix, internal disparities in CPR)

- Table showing disparities in TFR, CPR, unmet need, and percentage of adolescent women who have begun child bearing, by wealth, education, rural/urban residence
- Graph showing trends in TFR and CPR
- Graph showing changes in the modern method mix

Contraceptive knowledge and preferences (e.g., demand for spacing and limiting, desired fertility rate, unmet need for FP, percentage of demand met, intention to use, method preferences, women's and men's approval of FP, other sociocultural factors affecting demand)

- Table showing unmet need, met need (actual use), potential demand (unmet plus met need), and percentage of demand met for spacing and limiting.

Resource examples: United Nations Development Programme (UNDP) Human

Development Index, UN data, United Nations Economic, Scientific, and Cultural Organization (UNESCO), Central Intelligence Agency (CIA) Fact book, United Nations Population Fund(UNFPA),Population Reference Bureau(PRB), U.S. Census Bureau, U.S. Agency for International Development(USAID), Demographic and Health Survey (DHS), national Policy documents on FP and sexual and reproductive health(SRH)

Methodology

Purpose of the assessment
Desk review methodology In-country assessment methodology

Findings

Supply

1) Health system structure and range of service delivery modalities offering FP
2) Equipment and staffing of health facilities
3) Provider training and skills
4) Management, supervision, and quality assurance and improvement systems

[79]https://www.engenderhealth.org/files/pubs/family-planning/seed-model/seed-appendixes/adobe-acrobat-pdf/SEED-Appendix-A---All.pdf

5) Mix of available FP methods
6) Integration of services
7) Referral systems
8) Private-sector involvement
    - Graph showing trends in the source (e.g., private, public) of contraception
9) Youth-friendly services
10) Client-provider interaction/counseling on FP

Enabling Environment

11) Leadership and management
12) Supportive laws, policies, and guidelines
13) Human and financial resources for FP
14) Evidence-based decision making
15) Contraceptive security
16) Advocacy efforts
17) Champions for FP
18) Community engagement
19) Efforts to foster positive social norms and transform gender roles

Demand

20) Strategies to reduce FP costs to increase demand
21) The FP program's social and behavior change communication (SBCC) strategy
22) Commercial and social marketing
23) Mass media
    - Table showing exposure to FP methods via various modes of communication
24) Engaging communities and champions in SBCC
25) Peer education

Recommendations

Supply
Enabling Environment
Demand

References

Appendix List of tools used in observation