Family Planning Training for Drug Shop Operators

Reference Manual for Trainers and Course Participants

ADAPTED FROM MINISTRY OF HEALTH UGANDA
June 2018
This curricula was adapted from the Accredited Drug Sellers curriculum (Uganda/MOH, 2010) and the VHT Family Planning Training curriculum (Uganda/MOH, 2012).

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June 2018

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### Abbreviations

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<th>Abbreviation</th>
<th>Description</th>
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<tbody>
<tr>
<td>ADS</td>
<td>Accredited drug shop</td>
</tr>
<tr>
<td>AIDS</td>
<td>Acquired Immune Deficiency Syndrome</td>
</tr>
<tr>
<td>ASRH</td>
<td>Adolescent Sexual and Reproductive Health</td>
</tr>
<tr>
<td>CHW</td>
<td>Community Health Worker</td>
</tr>
<tr>
<td>DADI</td>
<td>District assistant drug inspector</td>
</tr>
<tr>
<td>DMPA</td>
<td>Depot medroxyprogesterone acetate</td>
</tr>
<tr>
<td>DSO</td>
<td>Drug Shop Operator</td>
</tr>
<tr>
<td>ECP</td>
<td>Emergency Contraceptive Pills</td>
</tr>
<tr>
<td>FP</td>
<td>Family Planning</td>
</tr>
<tr>
<td>HC</td>
<td>Health Centre</td>
</tr>
<tr>
<td>HIV</td>
<td>Human Immunodeficiency Virus</td>
</tr>
<tr>
<td>ICCM</td>
<td>Integrated Community Case Management</td>
</tr>
<tr>
<td>IEC</td>
<td>Information, Education, and Communication</td>
</tr>
<tr>
<td>IM</td>
<td>Intramuscular</td>
</tr>
<tr>
<td>MoH</td>
<td>Ministry of Health</td>
</tr>
<tr>
<td>NDA</td>
<td>National Drug Authority</td>
</tr>
<tr>
<td>RH</td>
<td>Reproductive Health</td>
</tr>
<tr>
<td>SC</td>
<td>subcutaneous</td>
</tr>
<tr>
<td>SP</td>
<td>Sayana Press</td>
</tr>
<tr>
<td>STI</td>
<td>Sexually Transmitted Infection</td>
</tr>
<tr>
<td>VHT</td>
<td>Village Health Team</td>
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Introduction to the Course and Reference Manual

Purpose of Training
To prepare drug shop operators (DSOs) to provide short-term FP services, including oral contraceptives, emergency contraceptives, condoms, and DMPA injectable contraceptives in their communities.

Purpose of Reference Manual
This manual is for trainers and course participants. This manual along with the job aids booklet provides important information that DSOs need to know. This manual also includes materials that are used during the course activities. Each participant should receive a copy at the beginning of the training to use during the course.

Learning Objectives
By the end of the training drug shop operators will be able to:
1. Perform all activities according to the standards stipulated in the laws pertaining to operation of an accredited drug shop (ADS).
2. Purchase the appropriate medicines in the right quantities.
3. Appropriately store and dispense the medicines in a rational manner.
4. Define family planning (FP), describe the benefits it provides, and help clients meet their FP needs.
5. Describe the function of the male and female reproductive organs and their relationship to FP.
6. Explain the menstrual cycle and its relationship to FP and pregnancy; and use a pregnancy checklist to determine whether a client may be pregnant.
7. Describe the FP methods available in Uganda, identify those that are provided by drug shop operators and those that require referral.
8. Use communication skills and apply a streamlined counseling approach to ensure that clients make informed FP choices.
9. Using the job aids provided, screen clients to ensure that they are medically eligible and understand how to use their method of choice.
10. Provide DMPA injectable contraceptives (DMPA IM and SC) to new and continuing clients as an integral part to other FP services within their scope.
11. Identify and refer clients who have needs that drug shop operators cannot meet.
12. Maintain accurate records at the drug shop and submit reports to appropriate authorities.
13. Identify steps/strategies to include in their Application Plan describing how they will implement at their drug shop what they have learned during the course.
Curriculum Modules/Sessions
The curriculum is divided into ten modules. Each module is divided into discreet sessions. The modules/sessions are as follows:

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<th>FAMILY PLANNING TRAINING FOR DRUG SHOP OPERATORS</th>
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<td>Session Two: The Menstrual Cycle and Its Application to FP Methods</td>
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<td><strong>Module 7: Quality Control</strong></td>
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<td>Session One: Referrals, Linkages, and Supervision system</td>
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<td>Session Two: Post-training Knowledge Assessment and Course Evaluation</td>
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Practicum/Clinical Objectives

During the clinic practicum, each participant will perform the following minimum number of FP procedures according to established standards:

- Conduct individual counselling for informed choice - 3
- Use screening checklist to assess client’s suitability (medical eligibility) for DMPA IM/SC Injections - 3
- Administer DMPA IM injection - 1
- Administer DMPA /SC injection - 2
- Follow the steps for safe handling and disposal of sharps - 3
- Correctly fill the FP Client Card, Return Appointment Card, FP Register and HMIS Forms - 3

During the practicum, the Checklist for Evaluating DSO Counselling and Method Provision (see Annex of this Reference Manual) will be used to observe and document the DSO’s compliance with established standards for the clinical procedures. Facilitators will provide details regarding the logistics of the practicum.

In some situations, it may be necessary for trainees to complete the clinical procedures required for certification outside of the formal practicum. In these cases, arrangements will be made with the trainee’s supervisor or an in-charge (mentor) at a local health care facility who is able to observe the trainee and certify that the trainee has met the performance standards for the required procedures.
Module 1: Overview of RH/FP and Rationale for FP Services
Module 1, Session 1: General Overview of RH/FP Situation in Uganda

Meaning of Family Planning
It is a basic human right for an individual/couple to exercise control over their fertility, make an informed decision on the number of children they want to have, when to have a first and last pregnancy and the space between pregnancies.

Uganda’s total population is 34.6 million (National Population Census, 2014). The population growth rate is 3% making Uganda one of the fastest growing nations of the world (National Population Census, 2014). One of the most important contributing factors is the high fertility rate at 5.4 (Uganda Demographic and Health Survey (UDHS), 2016) from 6.2 (UDHS, 2011).

Population problems particularly the population characteristics such as population size, growth, distribution by age (dependency ratio), sex ratio, literacy, occupation, marital status, religion and tribe affect the socio-economic development of a country. Family planning plays a key role in addressing these problems.

Health Indicators Related to RH/FP
The following are important indicators:
- Infant mortality rate
- Total fertility rate
- Maternal mortality ratio
- Population growth rate
- Contraceptive prevalence rate
- Couple years of protection (CYP)
- Unmet need/unmet demand for Family Planning

To measure mortality the following are used;
*Infant mortality rate (IMR):* Number of deaths of infants in a year per 1,000 live births in the same year. In Uganda, it is estimated at 54. (UDHS, 2016).

*Maternal mortality ratio (MMR):* Number of deaths of women due to complications of pregnancy, child birth and puerperium per 100,000 live births. The 2016 UDHS estimated it to be about 336/100,000.
To measure fertility the following are used:

i. Total fertility rate (TFR): Average number of children a woman is expected to produce under the prevailing circumstances if she lives through the reproductive span (15 -49 years). Currently in Uganda TFR is 5.4 (UDHS, 2016).

ii. Growth Rate: The rate at which the population is increasing due to natural increase and net migration expressed as percentage of the base population. Uganda and indeed Africa as a whole has a high population growth rate. In the 2014 population census Uganda has an annual population growth rate of 3% with this rate population will double by 2025.

iii. Contraceptive prevalence rate (CPR)
The percentage of all women of reproductive age or married women of reproductive typically aged 15-49 years, who are using a method of contraception. Contraceptive prevalence usually refers to the use of all methods, but may be given separately for modern methods. It is calculated by dividing the number of Women of Reproductive Age (WRA) or Married Women of Reproductive Age (MWRA) who are using a method by the total number of WRA or MWRA respectively.

According to UDHS 2016, CPR is 39% (Urban (57.5%) and Rural (46.8%) and by region; North Central (47.4%), West Nile (21.8%), Eastern – Busoga (31%) Western – Bunyoro (31%) and Tooro (43.3%), East Central (32%), South-western- Kigezi (46.5 %) and Ankole (43.1), Kampala (48.7%) and Karamoja (7.3 %).

iv. Unmet need for Family planning:
This is a term used to describe the number of people or the percentage of the population who desire to use contraceptives to space or limit births but for a variety of reasons including lack of access to information or services, are not currently using contraceptives. Currently in Uganda the unmet need for Family planning has lowered to 28 % (UDHS 2016) while the total demand is 83%.

The above categories of indicators are among the core for population planning. Although mortality is high, the high fertility rate overshadows the impact of mortality, resulting in a high population growth rate. Family planning most times addresses fertility but the integrated approach aims at both reducing mortality and fertility.
Consequences of Rapid Population Growth

1. Increased demand for education which puts lots of pressure on the available facilities. Uganda has a large proportion of young people less than 24 years (make up about 69% of total population) (National Population Census 2014).
2. Increased pool of under-employed or unemployed labor force whose absorption into gainful employment is difficult. These youth are relatively under-trained, unskilled and inexperienced.
3. Increased demand for housing/shelter especially in urban areas.
4. Increased demand for food resulting in a shortage of food.
5. Increased demand for health care; including a shortage of health workers and inadequate health facilities.
6. Shortage of land which results in deforestation and encroaching of wetlands. This disrupts the normal ecosystem in many districts turning them into deserts. There is disruption of water bodies and contamination.
7. Rapid, uncontrolled, rural urban migration which presents negative consequences (e.g., slums, high crime rates, high levels of unemployment).

Factors that Affect Acceptance/Non-acceptance of FP in Uganda

a). Factors that enhance FP acceptance such as:
   - Availability of FP/RH services including an adequate method mix
   - Awareness about and access to FP/RH services
   - Good couple communication
   - Good interpersonal relations between providers and clients
   - Quality of FP/RH care provided at service delivery site.

b). Factors that negatively affect acceptance of FP:
   - Inaccurate information about FP as well as myths and misconceptions
   - Negative provider attitude
   - Inadequate provider skills
   - Insufficient FP knowledge amongst providers
   - Socio-cultural, political and religious beliefs (e.g., community value for big families)
   - Non-availability and accessibility of FP/RH services.
   - Inadequate method mix (e.g., limited choices of FP methods)
Adopting positive family planning practices provides benefits to the mother, child, father and community. Family planning helps an individual or couple to live a healthy and useful life that contributes to the development of the family, community and nation.

It is important to stress both health and socio-economic benefits of Family Planning when educating or counselling clients. Examples of these benefits include:

<table>
<thead>
<tr>
<th>Health benefits</th>
<th>Socio-economic benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Mother</strong></td>
<td><strong>Offers time to engage in self or family improvement activities such as income generation</strong></td>
</tr>
<tr>
<td>Spacing pregnancies gives the mother enough time to recover from the effects of pregnancy, labour and delivery</td>
<td>Able to provide improved nutrition to the child and rest of the family</td>
</tr>
<tr>
<td>Provides protection from anaemia</td>
<td></td>
</tr>
<tr>
<td>Reduces risks of pregnancy, labour (e.g., closely spaced pregnancies, bleeding after delivery partum haemorrhage, maternal depletion syndrome)</td>
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<table>
<thead>
<tr>
<th><strong>Child</strong></th>
<th><strong>Improved parental and child-to-child relationships</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td>Prolonged breastfeeding protects babies from childhood diseases such as diarrhoea</td>
<td>Opportunities for better education</td>
</tr>
<tr>
<td>Promotes proper growth and development</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Father</strong></th>
<th><strong>Able to plan together with their partners the size of family they want and can afford.</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Enhances communication among spouses and joint decision-making</td>
</tr>
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</table>

<table>
<thead>
<tr>
<th><strong>Community</strong></th>
<th><strong>Improved quality of life of the people as food, education and other opportunities are more readily available.</strong></th>
</tr>
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Voluntary Informed Choice

Client is given correct and complete information about FP methods, and explores her/his reproductive goals, FP needs, ability to use a method, and makes her/his own choice of method upon receiving all information without being coerced/forced.

Concept of High-Risk in FP/RH Service Delivery

A high-risk client in FP/RH is one whose life and that of her baby/baby-to-come are threatened by pregnancy. For example:

- Young mothers below 20-years old: Children born to young mothers and those born after a short birth interval are subject to much higher mortality rates than those born to older mothers and after longer birth intervals.
- All sexually active males and females are at risk of contracting STIs/HIV. Behaviours that put the individual/couple at risk include engaging in unprotected sex, having more than one sexual partner or having sex with an infected person without protection.

The ‘4 Toos’ Concept

Certain women and/or their unborn babies are likely to have problems during pregnancy, child birth and after delivery. The service provider needs to pay special attention to them. For example:

<table>
<thead>
<tr>
<th>Concept</th>
<th>Effects on mother</th>
<th>Effects on the baby</th>
</tr>
</thead>
</table>
| Too early:       | • The birth passage is immature and therefore a very young woman is more likely to have difficulties during delivery.  
                   • They have also been found to be more likely to develop pregnancy-induced hypertension. This creates risks for mother and baby; e.g., assisted deliveries which may result in birth injuries.  
                   • In some cases, teenage pregnancies are not wanted; the young girl may resort to abortion, resulting in post-abortion complications.  
                   • The babies of these young girls are more likely to be born premature. | • Because the baby may not be wanted, it may be poorly looked after, leading to suffering from diseases and neglect.  
                   • The baby could be abandoned or thrown away.  
                   • The baby is more likely to be born prematurely or small and therefore it has decreased chances of survival. |
<table>
<thead>
<tr>
<th>Phenomenon</th>
<th>Description</th>
<th>Implications</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Too soon:</strong> Having a pregnancy within an interval of less than 2 years</td>
<td>When the mother has closely spaced pregnancies, she is likely not to rest, replace the lost blood and therefore she may be weak or anaemic. She might experience maternal depletion syndrome.</td>
<td>Likely to be born small. May not get enough breast milk because the mother may have to wean it early and there is a risk of lowered immunity and diarrhoea. May lack the care and love that could be given under better circumstances.</td>
</tr>
<tr>
<td><strong>Too many:</strong> Having more than four (4) pregnancies</td>
<td>Repeated childbirth may lead to:  - Antepartum or postpartum haemorrhage (APH/PPH) in the successive pregnancies  - Mal-positions requiring assisted deliveries</td>
<td>Premature deliveries; small for age  Potential challenges distributing scarce resources</td>
</tr>
<tr>
<td><strong>Too late:</strong> Having a pregnancy after 35 years of age</td>
<td>Women over the age of 35 years are more likely to have pre-existing health problems (e.g., high blood pressure, diabetes) that increase the risk of pregnancy and delivery</td>
<td>Baby may be born with problems such as congenital handicaps or prematurely or small for age.</td>
</tr>
</tbody>
</table>

**Clients’ Rights in Relation to FP**

*Information*: To receive clear, accurate, and complete information to learn about the availability and benefits of all maternal/child health (MCH)/FP services.

*Access*: To obtain MCH/FP services regardless of the client’s age, marital status, socio-economic class, and HIV status.

*Choice*: To decide whether to use MCH/FP services, and what FP method to use that best meets their needs, goals, and lifestyles.

*Safety*: To receive all FP information and MCH/FP services that will prevent unwanted pregnancies without harm.

*Privacy*: To have both a visual and auditory private environment during counselling and service delivery.
Confidentiality: To be assured that any personal information will not be shared in public or with any member of the client’s family or other members of the staff without her/his consent.

Dignity: To be treated with courtesy, enthusiasm, attentiveness, and respect, regardless of their socio-economic status.

Comfort: To feel comfortable while receiving MCH/FP services.

Continuity: To receive appropriate MCH/FP services, drugs, and FP commodities as needed.

Opinion: To express an opinion about the services being offered without fear and with confidence that the opinion will be considered and respected.

What Providers Need to Ensure Clients’ Rights

- *Information, training and development*: need to be informed and trained/updated.
- *Infrastructure*: pleasant working environment.
- *Management and supervision*: supportive working environment.
- *Supplies*: right tools to do their jobs, ample amount of high-quality commodities.
Module 2: Anatomy and Physiology of Male and Female Reproductive Organs and the Menstrual Cycle

Module 2, Session 1: Anatomy and Physiology of Human Reproductive Organs

Male Reproductive System

Penis: The part of man's body that deposits the man's sperm into the vagina and serves as the organ for urination. The condom is worn over the penis.

Urethra: This is a single tube approximately 15 cm running from the bladder through the penis and is a passage for urine and for seminal fluid.

Vas Deferens: Two tubes that carry sperm from the testicles to the penis. This is the site for vasectomy; these tubes are tied and cut so that they can no longer carry the man's sperm from the testicles to the penis. Vasectomy does not affect sperm production; they continue to be produced by the testis but after maturing, they degenerate and are absorbed into the body.

Seminal vesicles: These two accessory glands lie posterior to and at the base of the urinary bladder that secret the liquid portion of the semen, which contributes to the viability of the sperm. Mature sperm are stored here until they are ejaculated during sexual intercourse or passed out during wet dreams. The seminal vesicle continues to produce semen even after vasectomy. This information helps to dispel the myth that a man will continue to ejaculate but the ejaculation will have no sperm.

Testis: Two balls inside the scrotum; they produce sperm and sex hormones. They store sperm. The mature sperm can live to about 3-5 days in a woman's
genitals after ejaculation. The average male will produce roughly 500 billion sperm cells over a lifetime and shed at least one billion of them per month. Hundreds of millions of sperm can be released during each ejaculation.

**Epididymis:** These are two comma-shaped coiled tubes about 5-6 meters (20 feet) long coiled on top of each of the testis. It stores sperm (for about 10 days) until they mature. But after 4 weeks, if sperm are not passed to the vas deferens, they are absorbed into the body.

**Prostate gland:** One of the accessory glands that secretes a fluid that helps sperm move and neutralizes the acidity in the penile urethra and the vagina. Cowper’s glands are two accessory glands about the size of peas, lying beneath the prostate; they produce semen and an alkaline secretion, which protects sperm against the acid secretions of the male urethra and vagina. After removal of the prostate gland, the Cowper’s glands continue to secrete alkaline.

**Scrotum:** It is a sac that contains and protects the testes. It regulates the temperature of the testes, which is critical for normal function of the testes.

### Female Reproductive System

**Vagina:** This is the passage from outside the female body to the uterus. It is outlet for menstrual flow, entry for the penis during sexual intercourse, and passage for a baby at birth. This is where the female condom is applied and can be found here if it slips off during intercourse. Threads for the IUD can be felt in the vagina.

**Cervix:** This is the mouth of the uterus (womb). It allows menstrual blood to come out from the uterus and sperm to enter the uterus from the vagina. It dilates and permits the birth of a baby from the uterus.

**Uterus:** A muscular, pear-shaped organ where the baby grows and is
nourished until ready to be born. Every month, the womb prepares itself for a baby by making a thick lining. If there is no baby, the womb throws away the lining, that is, monthly bleeding comes from here. The baby grows in the womb during pregnancy.

**Fallopian tubes**: Two tubes connecting the ovaries to the womb. One egg travels along the tube from the ovary to the womb every month and if it meets the man’s sperm, then they join to start making a baby. In the surgical methods performed on a woman, the Fallopian tubes are tied and cut so that the passage is blocked and the woman’s egg and male sperm cannot meet to make a baby.

**Ovaries**: Two sacks on each side of the womb. Contain 300,000–500,000 egg cells at birth. One egg (ovum) matures and is released into the Fallopian tube every month. Ovaries secrete female hormones, oestrogen and progesterone, which change a girl into a woman at puberty and continue to secrete female hormones after puberty. When a woman is using a hormonal FP method, the eggs do not mature and are not released from the ovary. Therefore, there is no union of the female egg and the male sperm to make a baby.

**Relationships of Male and Female Anatomy to FP and Reproduction**

Clients may be interested in how family planning methods prevent pregnancy. FP methods work in different parts of the male and female anatomy to keep the sperm from meeting the egg as described below:

- **Vasectomy** closes off the vas deferens to keep sperm out of semen.
- **Female sterilization** blocks or cuts the Fallopian tubes to prevent eggs/sperm from meeting.
- **Copper IUD** inserted in the uterus creates a chemical change that damages sperm and egg before they can meet.
- **Male condoms** are worn over the penis to prevent sperm from entering the vagina.
- **Female condoms** inserted in the vagina collect semen from the penis so that it doesn’t enter the vagina.
- **Hormonal methods** prevent release of eggs from the ovaries and/or thicken the cervical mucus to prevent sperm from passing.
Activity Sheet—Male Reproductive Anatomy

Instructions: Label the body parts.
Activity Sheet—Female Reproductive Anatomy 1

Instructions: Label the body parts.
Activity Sheet—Female Reproductive Anatomy 2

Instructions: Label the body parts.
Activity Sheet—Female Reproductive Anatomy 3

Instructions: Label the body parts.
Module 2, Session 2: The Menstrual Cycle

The term menstrual cycle refers to the recurring natural changes that occur in the ovaries and uterus of a woman of childbearing age in preparation for possible pregnancy. The normal menstrual cycle is 21–35 days. For most women, the cycle is about 28 days. The day the woman first sees menstrual blood is taken as day one of the cycle.

Family Planning Methods and the Menstrual Cycle

Knowledge of the menstrual phases helps health workers to instruct their clients about when to start and how to use family planning methods. Most natural methods are based on knowledge of the menstrual cycle. Knowledge of the menstrual cycle helps one to know when pregnancy is likely to occur.

Knowledge of the cycle helps when counselling adolescents who are anxious about their menstrual cycles, especially just after menarche; and adult women approaching menopause. During these times, menstrual cycles tend to be irregular. Irregular cycles make it difficult for adolescents and women approaching menopause to determine the “safe days” when they cannot get pregnant.

As a drug shop operator, being able to decide whether a woman might be pregnant is also important because women who are already pregnant do not need contraception. The Pregnancy Checklist (included in the DSO Job Aids Booklet) uses a set of questions to help with this task.

Common Terms Used

- **Menstruation** (menses/period) is shedding of the inner lining of the womb which occurs for 2-7 days at the beginning of every cycle starting at puberty and going up to menopause.
- **Ovulation** is the release of the mature egg from the ovary ready for fertilization. It normally occurs 14 days before the next menstruation. A woman is most likely to become pregnant during ovulation. When a girl is born, she has all the eggs her body will ever use, and many more -- as many as 500,000.
- **Fertilization** occurs when the egg and sperm join to make a baby.
- **Implantation** occurs when the fertilized egg imbeds in the uterine lining.
- **Menarche** is the onset of first menstruation in life.
- **Menopause** is the normal termination of menstrual cycles that usually occurs between 45-55 years of age.
Phases of the Menstrual Cycle

- **Menstrual or flow phase**: This is when blood passes from the uterus through the vagina. Usually takes 2-7 days.
- **Preparation or growth phase**: Lining of uterus grows and is fully supplied with blood in preparation for the reception of the possible fertilized egg/pregnancy. During this phase, the egg(s) develop to maturity.
- **Secretory phase**: Lining of the uterus grows more and becomes spongy in preparation for the possible fertilized egg/pregnancy. Ovulation (release of a mature egg) takes place at the beginning of this phase.

**Body Changes that Occur during the Menstrual Cycle**

- Increased vaginal secretion and a slight rise in body temperature indicates release of an egg (ovulation). Some women feel heaviness in the legs and breasts due to retained fluids.
- Some women get contractions of the womb during menstruation which cause cramps (abdominal pain).
How Pregnancy Occurs

- When an egg is released from the ovary (ovulation), it enters the fallopian tube and remains there for about a day.
- During the same time, the woman’s cervix (entrance into the womb) starts producing a large amount of clear mucus.
- The mucus makes it easy for sperm to enter the womb and swim upward to reach the egg; it also provides nourishment to enable sperm to survive for several days.
- During sex the man ejaculates releasing semen that contains millions of sperm (but only one will be successful in causing pregnancy).
- The sperm enter the cervix within seconds after ejaculation and reach the Fallopian tube within five minutes.
- The Fallopian tube is where sperm unite with the egg (a process called fertilization). A sperm that unites with the egg, creates a chemical barrier to other sperm.
- Sperm can survive in a woman’s reproductive tract up for 5 days and wait for an egg to be released.
- After the egg is released from the ovary, fertilization must take place within 24 hours because the egg can survive for only that long.
- The fertilized egg continues down the tube toward the uterus; at the same time, it divides and grows.
- The journey to the uterine wall takes about five days. Within two days of reaching the wall, the egg attaches itself to it – a process called implantation.
- Implantation is the beginning of pregnancy.

Early Signs of Pregnancy

- Missed period
- Tender or swollen breasts; sensitive nipples
- Frequent urination
- Nausea and vomiting
- Unusual fatigue
- Cramps; feeling bloated
- Changes in appetite
- Feeling unusually emotional
Sexually Transmitted Infections (STIs) including HIV

What are STIs?
These are infections acquired during unprotected sex with an infected partner. Examples of STIs include Gonorrhoea, syphilis, candida, HIV, and chancroid. STIs are the major cause of infertility if not properly treated. Male and female condoms, if used consistently and correctly, are the only FP methods that can prevent STIs.

Common signs and symptoms of STIs:*
- Urethral discharge
- Pain when passing urine
- Vaginal discharge
- Lower abdominal pain
- Genital ulcers

* Sometimes people infected with an STI have no symptoms at all.

Some contraceptive users with untreated STIs may blame the family planning method for their symptoms. DSOs/CHWs should counsel clients to be screened for STIs, go for treatment early, complete the treatment and notify their partners so that they are also treated. They should also discourage self-medication.
Module 3: Family Planning Methods

Module 3, Session 1: FP Methods Available in Uganda

Short-Acting Methods

Condoms

What are condoms?
A condom is a thin rubber sheath worn on an erect penis by a man (male condom) or inserted into the vagina by a woman (female condom) to prevent the male fluids from mixing with the female vaginal fluids. Condoms serve a dual purpose—preventing pregnancy and preventing sexually transmitted infections including HIV.

Condoms are the only family planning methods that also prevent STIs/HIV.

How do condoms work to prevent pregnancy and sexually transmitted infections (STIs)?
Both male and female condoms stop sperms from entering the vagina. They also keep infectious organisms in semen, on the penis, or in the vagina from infecting the other partner.

Who can use condoms?
Condoms can be used by any man or woman regardless of his or her health status. People who may want to consider condom use include:

- Men who want to participate more actively in family planning.
- Couples who do not have sex regularly but can agree on using condoms when they do.
- Those who have more than one sexual partner, or whose partners have other sexual partners, and are at increased risk of STIs.
- People in a casual sexual relationship where pregnancy is not desired.
- Couples who need a back-up method while waiting for another contraceptive method to become effective or when the woman has forgotten to take her pills.
- Couples who need a temporary method while waiting to receive another FP method.
- Couples where one or both partners are HIV-positive.
Who should NOT use condoms?
- Men or women who are allergic to rubber.
- Couples who are unwilling to use condoms consistently and correctly.
- Men who cannot maintain an erection when using a condom.

Male condoms

How effective are male condoms?
- As commonly used, 87 of every 100 women whose partners use male condoms will not get pregnant.
- When used correctly with every act of sex, about 2 pregnancies will occur among 100 women whose partners use male condoms over the first year.

What is good about male condoms?
- Prevents pregnancy immediately.
- Prevents sexually transmitted infections including HIV.
- Can be used soon after childbirth.
- Safe, no hormonal side effects.
- Can be stopped any time.
- Easy to keep on hand in case sex occurs unexpectedly.
- Can be used by men of any age.
- Can be used without seeing a health care provider first.
- Usually easy to obtain and sold in many places.
- Provides lubrication during sex especially for women with dry vagina.
- Enables men to take responsibility for preventing pregnancy and STIs.
- Increases sexual enjoyment because there is no need to worry about pregnancy and STIs.
- Can help prevent premature ejaculation (help the man last longer during sex).

What may not be good about male condoms?
- Latex condoms may cause itching for a few people who are allergic to latex.
- Couple must take the time to put the condom on the erect penis before sex.
- Small possibility that condom will slip off or break during sex.
- A man’s cooperation is needed for a woman to protect herself from pregnancy and STIs.
• May embarrass some people to buy condoms, ask partner to use, put on, take off, or dispose of.

How to use a Male Condom
• Use a new condom for each act of sex. Check package for damage and check the expiration date. Tear open the package carefully without using any sharp objects.
• Before any physical contact, put condom on the tip of the erect penis with the rolled side out.
• Unroll condom all the way to the base of the erect penis.
• Immediately after ejaculation, hold rim in place and withdraw penis while it is erect. Slide the condom off, avoiding spilling semen.
• Dispose of the used condom safely; throw it in a pit latrine, burn it, or bury it.

Avoid the following:
• Reusing condoms.
• Unrolling the condom in advance.
• Using oil-based lubricants.
• Using condoms that may be old or damaged (dried out, brittle, sticky).
• Practicing dry sex.
• Using the same towel for cleaning the penis and vagina respectively.

Female condoms

How effective are female condoms?
• As commonly used, 79 of every 100 women using female condoms will not become pregnant.
• When used correctly with every act of sex, about 5 pregnancies will occur per 100 women using female condoms over the first year.

What is good about female condoms?
• Controlled by the woman.
• Designed to prevent both pregnancy and STIs, including HIV.
• No medical condition appears to limit its use.
• No apparent side effects.
What is NOT good about female condoms?
- Expensive.
- Usually need partner’s consent.

How to use a Female Condom
- Use a new female condom for each act of sex.
  - Check package for the date and damage.
  - If possible, wash hands with mild soap and clean water.
- Insert condom before any physical contact.
  - Can insert up to 8 hours before sex.
  - Find a comfortable position for insertion—squat; raise one leg, sit, or lie down.
  - Grasp the ring at the closed end, and squeeze it so it becomes long and narrow.
  - With the other hand, separate the outer lips and locate the opening of the vagina.
  - Gently insert the inner ring into the vagina as far up as it will go.
- Insert a finger inside the condom to push it into place. (The inner ring should be pushed up just past the pubic bone.)
- Ensure that penis enters inside of condom and stays inside it.
- After the man withdraws his penis, hold outer ring, twist to seal in fluids, and gently pull condom out.
  - The female condom does not need to be removed immediately after sex.
- Remove the condom before standing up, to avoid spilling semen.
- Dispose of the used condom safely; throw it in a pit latrine, burn it, or bury it.

Avoid the following:
- Reusing condoms.
- Using a male and female condom at the same time.
- Using condoms that may be old or damaged (dried out, brittle, sticky).
- Using the same towel for cleaning the penis and vagina respectively.
Oral Pills

Combined Oral Contraceptive Pills (COCs)

What are COCs?
Combined oral contraceptive pills contain two hormones similar to the natural hormones in a woman’s body—an estrogen and progestin. Also called combined pills, COCs are taken orally and daily at the same time of the day to prevent pregnancy.

How do COCs work?
- Stop the release of the female egg from the egg sack (ovulation).
  Thicken the mucous at the mouth of the womb to prevent the sperm passing to the womb.
- They do not work by disrupting an existing pregnancy.

How effective are COCs?
- As commonly used, 93 out of every 100 women using COCs will not become pregnant.
- When used correctly and consistently, 99 out of every 100 women using COCs will not become pregnant.

What is good about COCs?
- A woman will know when to expect her period.
- Can reduce menstrual blood loss which prevents lack of blood (anaemia).
- Can help to reduce painful periods where pain is not caused by infection.
- Can be used as emergency contraception.
- Are very effective if they are used correctly.
- Women can become pregnant very quickly when they stop using them.
- Are safe for most women.
- Do not affect sexual intercourse.

What is NOT good about COCs?
- Must be taken daily at the same time of the day.
- Require regular and sure source of supply.
- Women may experience minor side effects which are common in the first three months such as spotting, amenorrhea, nausea, painful breasts, headaches, weight change, depression, and/or acne.
- Does not protect against other STIs including HIV.
Who can use COCs?
- Any women of reproductive age who desire to use COCs.
- Women with:
  - Anaemia (the cause of the anaemia needs to be evaluated and treated)
  - Painful periods which are not caused by infection
  - Irregular cycles
  - STIs including HIV/AIDS (unless taking the drug ritonavir for ARV therapy)

Who should NOT use COCs?
- Women who are:
  - Already pregnant (COCs are not dangerous if accidentally used)
  - Breastfeeding mothers with infants less than six months old
- Women with:
  - Heart disease
  - High blood pressure
  - Diabetes
  - Headaches with blurred vision
  - Yellow colouring of the eyes
  - Breast cancer
  - Women who smoke cigarettes if older than 35 years
  - Women taking certain drugs for treating conditions like TB, epilepsy, and HIV (DSOs/CHWs should refer these clients to health care facilities)

How to screen clients using a checklist to determine eligibility for COCs
Clients who make a choice to use COCs must be screened to determine whether they have any conditions that make using COCs unsafe. By asking the questions and following the instructions on the checklist DSOs can decide if: a woman can safely use the method or requires evaluation by a clinician, is not pregnant, and whether she needs to use a back-up method. If a client should not use the method, the DSO can counsel the client on other methods or refer the client to the clinic for assessment.

How to use COCs:
- Start taking pills at any time during the menstrual cycle.
- Follow the arrows on the packet.
• Take one pill at the usual/same time everyday preferably after a meal or before going to bed.
• If you start taking pills after day 5 of your cycle, you need to use another method such as condoms or abstain from sex for seven days.
• Use condoms in addition to the pill if you think there is any chance that you or your partners are at risk of exposure to STIs, including HIV.
• You will have your period when you are taking the brown pills. Do not stop taking the pills. Continue swallowing them until the pack is gone.
• When you finish one packet, start on a new packet the next day.
• Store the pills in a dry place and out of reach of children.
• Return for more pills before you have finished your last pack of pills.

What to tell a client who misses taking Pills:
• If you miss one or two white pills, take a pill as soon as you remember, then continue to take one each day at the usual time until you finish that packet.
• If you miss white pills three days or more in a row, or start a pack three days or more late, take a pill as soon as you remember and continue taking one pill each day. In addition, you must abstain from sexual intercourse for a full week or use condoms.
• If you miss the three pills during week three (the third row pill in the pack), abstain or use condoms for seven days, skip the brown pills, and start a new pack immediately.
• If you miss taking a brown pill, do not worry. Skip the missed pill and continue to take a brown pill until the end of the packet.
• If you keep forgetting to take pills you may need to use another method.

What to do if a client has diarrhoea and vomiting:
If a client has severe diarrhoea or vomiting for any reason, her pill may not work as well as it is supposed to. Counsel the client to use condoms or abstain from sexual intercourse until she is well and she has taken white pills for seven days after diarrhoea and vomiting has stopped.

What clients should do in the case of side effects:
• Feeling like vomiting—continue taking the pill; this feeling will generally disappear after 3 months. Consider taking the pill with food or at night before going to sleep.
• Mild headache—advise to take a pain killer; if it persists, refer.
• Severe headache—refer.
Signs that require a client to seek urgent medical attention:
- Severe headache with vision problems
- Severe constant pain in the chest with difficulty in breathing
- Acute abdominal pain
- Sharp pain in the leg muscles
- Eyes or skin become unusually yellowish

Progestin-Only Pills (POPs)

What are POPs?
- Progestin-only pills contain a hormone similar to the natural hormone, progesterone in a woman’s body.

How do POPs work?
- Mainly in two ways:
  o Thickening the mucus at the mouth of the womb within the first 48 hours of initiation of the pill to make it difficult for the sperm to enter the womb.
  o Suppressing the ripening of the woman’s egg.

How effective are POPs?
- In typical use, 93 out of every 100 women using POPs will not become pregnant over the first year.
- POPs are most effective when taken at the same time every day.
- Delaying taking the pills for three hours may result in pregnancy, if a woman has unprotected sexual intercourse.
- For breastfeeding women, POPs are very effective when taken correctly because breastfeeding itself provides much protection against pregnancy.
- POPs can also be very effective when used correctly and consistently by non-breastfeeding women; their effectiveness is comparable to that of COCs.

What is good about POPs?
- Very effective if taken correctly.
- Can be very effective during breastfeeding, starting six weeks after delivery.
- Do not suppress breast milk.
• Can be used as emergency contraception.
• Suitable for those with high blood pressure, heart conditions, or sickle cell disease.

What is NOT good about POPs?
• Women who are not breastfeeding may have:
  o Spotting or bleeding between periods.
  o No menstrual bleeding.
  o Mild headaches.
  o Pain in the breasts.
• Delay in the taking the pill may result in a pregnancy.
• Does not protect against other STIs including HIV.

Who can use POPs?
• Any women of reproductive age who desires to use POPs.
• After having an abortion (post-abortion, any time).
• Breastfeeding mothers (beginning six weeks after delivery).
• Women with:
  o Sickle-cell disease
  o Diabetes without having high blood pressure
  o STIs including HIV/AIDS (unless taking the drug, ritonavir, for ARV therapy)
  o Having suffered heart attack
  o Smokers

Who should NOT use POPs?
• Women with the following conditions:
  o Breastfeeding less than six weeks after delivery.
  o Pregnant (POPs are not dangerous if accidentally used).
  o Has breast cancer or has suffered breast cancer previously.
  o Blood clot in the vein.
  o Liver disease.
  o Women taking certain drugs for treating conditions like TB, epilepsy, and HIV (DSOs/CHWs should refer these clients to health care facilities).

How to screen clients using a checklist to determine eligibility for POPs: Clients who make a choice to use POPs must be screened to determine whether they have any conditions that make using POPs unsafe. By asking the
questions and following the instructions on the checklist DSOs can decide if:

- a woman can safely use the method or requires evaluation by a clinician
- is not pregnant
- whether she needs to use a back-up method.

If a client should not use the method, the drug shop operator can counsel the client on other methods or refer the client to the clinic for assessment.

**How to use POPs:**

- Start taking pills at any time as long as you are reasonably sure you are not pregnant.
- Take one pill at the same time every day.
- If you start taking pills after day 5 of your cycle, you need to use another method such as condoms or abstain from sex for two days.
- Continue taking pills, one every day until the pack is empty. Start a new pack the next day. Unlike COCs, all the pills in a pack of POPs are active pills.
- When you finish one packet, start on a new packet immediately.
- Use condoms in addition to the pill if you think there is any chance that you or your partner is at risk of exposure to STIs, including HIV.
- Store the pills in a dry place and out of reach of children.
- Return for more pills before you have finished your last pack of pills.

**What to tell a client who misses taking pills:**

- If you are late taking a pill by more than three hours, or if you miss taking a pill completely, you should take the missed pill as soon as you remember.
- Keep taking pills as usual, one each day. This may mean taking two pills at the same time or on the same day.
- If you vomit within two hours of taking your pill, take another pill as soon as possible, and keep taking pills as usual. If the vomiting or severe diarrhoea continues, also follow the instructions below.
- In addition, all POP users (except breastfeeding women who have not resumed menses) who miss a pill should:
  - Use a back-up method for the next two days.
  - If you have had sex in the past five days, consider using emergency contraceptive pills.
  - If you keep forgetting to take pills you may need to use another method.
What clients should do in the case of side effects:

- Irregular or no monthly bleeding—reassure and refer if problematic for client.
- Heavy or prolonged bleeding—reassure, advise to take NSAIDs, or refer.
- Mild headaches—reassure and advise to take a pain killer, if it persists refer.

Signs that require a client to seek urgent medical attention:

- Repeated severe headaches which start or become worse while client is on the method.
- Missed or delayed menses after several months of regular menses.
- Severe lower abdominal pain (which may be the sign of pregnancy outside of the womb).
- Unexplained vaginal bleeding.
Injectable Contraceptives DMPA IM and SC

Note: DMPA IM and SC injections may only be offered by drug shop operators who have been trained to provide this method.

What is DMPA IM?
This is a family planning method given by intramuscular injection every three months.

What is DMPA SC?
DMPA SC is a low-dose form of depot medroxyprogesterone acetate (DMPA) prefilled for subcutaneous injection in a Uniject, an easy-to-use injection device. DMPA SC has the same effectiveness and the same side effects as DMPA IM.

What is Uniject?
An injection system that is:
- Single-dose
- Prefilled
- Easy to use
- Not reusable
- Small in size

Parts of the Uniject

- Reservoir: Will be 3/4 full. Large air bubble is normal.
- Valve: Prevents re-use.
- Port: Hold Uniject here to prepare and inject.
- Needle: 9.5 mm for Sayana Press.
Expected Benefits of Uniject
  • Allows more women to receive injectable contraceptives:
    o Community-based providers can reach women in the community.
    o Easier and quicker to use.
    o Less waste to dispose of.
  • Helps the injection to be safe:
    o Prefilled with correct dose.
    o Assures sterile injection.
    o Clients may prefer the smaller needle.
    o There is some discomfort after the procedure.

Similarities
Both DMPA-IM and SC contain a hormone similar to the natural hormone, progesterone in a woman’s body.
  • Are injectable contraceptives.
  • Are made with the same hormone, progestin.
  • Are administered every 3 months (13 weeks).
  • Have a similar reinjection grace period.
  • Are equally effective.
  • Have the same side effects, except that DMPA SC might cause temporary irritation at the injection site.

Differences
How are DMPA-IM and SC different?

<table>
<thead>
<tr>
<th>FEATURE</th>
<th>DMPA IM</th>
<th>DMPA SC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mg/dose</td>
<td>150mg</td>
<td>104mg</td>
</tr>
<tr>
<td>Package</td>
<td>Vial and syringe</td>
<td>Prefilled Uniject syringe</td>
</tr>
<tr>
<td>Product names</td>
<td>Depo-Provera, Depo, Injectaplan</td>
<td>Sayana Press, Easy Plan, Lydia Easy Plan</td>
</tr>
<tr>
<td>Type of injection</td>
<td>Intramuscular (deep into the muscle)</td>
<td>Subcutaneous (in the fatty tissue under the skin)</td>
</tr>
<tr>
<td>Where to inject</td>
<td>Arm (Deltoid muscle), hip and buttocks</td>
<td>Anterior thigh (front of thigh), abdomen and back of arm</td>
</tr>
<tr>
<td>Skin irritation</td>
<td>Skin irritation at the injection site is not likely.</td>
<td>Skin may be a little irritated at injection site.</td>
</tr>
</tbody>
</table>
Additional information:

DMPA SC is only available in a small injection system called Uniject. Uniject has a shorter needle and looks very different from DMPA IM which is in a standard syringe.

DMPA SC is the same drug, but the dose is one-third less than DMPA IM. However it is just as effective as DMPA IM. DMPA SC must be given into the fatty tissue under the skin—not into muscle. Subcutaneous injections are taken up more slowly in the body than IM injections. This is why DMPA SC can be a lower dose but equally effective to DMPA IM.

How do DMPA injections work?

- They prevent ovulation (the release of eggs from the ovaries)
- They prevent implantation of an egg by keeping the walls of the womb thin.
- They prevent sperm from entering the womb by thickening the mucus at the opening of the womb.

How effective are the injections?
- When used correctly and consistently more than 99 of every 100 women using the injections will not become pregnant.
- As typically used, 96 of every 100 women using these injections will not become pregnant.

What is good about the injections?
- Does not require daily action; must get injection only once every three months. Does not interfere with sex.
- It is private. No one else can tell that the woman is using contraception.
- Reduces menstrual flow, thus reducing chances of anaemia.
- Causes no monthly bleeding (for many women).
- May help women to gain weight.
- Helps protect against cancer of the lining of the uterus.
What is NOT good about the injection?
- Many women experience changes in their menstrual bleeding pattern including irregular or prolonged bleeding in the first three months and infrequent or no bleeding after one year.
- Some women may experience minor side effects such as weight gain, headaches, dizziness, mood changes, and abdominal bloating and discomfort.
- Implants do not protect against STIs including HIV.

Who can use the injection?
- Any women of reproductive age, including adolescents and women over 40-years old, who desire to use an injectable contraceptive, including women who have or have not had children and are not married.
- Women who smoke cigarettes, regardless of the woman’s age or number of cigarettes smoked.
- Women who have just had an abortion or miscarriage.
- Women who are breastfeeding (starting as soon as 6 weeks after childbirth).
- Women who are infected with HIV, whether or not on antiretroviral therapy (ART).

Who should NOT use the injection?
- Women who are/or have:
  - Already pregnant (injectable contraceptive is not dangerous if accidently used)
  - Breastfeeding mothers with infants less than six-weeks old
  - History of a stroke, blood clots in legs or lungs, heart attack, or serious heart problems
  - Very high blood pressure (160/100 or higher)
  - Diabetes for more than 20 years with damage to arteries, vision, kidneys, or nervous system caused by diabetes
  - Yellow colouring of the eyes (liver disease)
  - Breast cancer
  - Unexplained vaginal bleeding

When and where should DSOs/CHWs refer clients interested in injectable contraceptives, if they are not trained to provide injections?
- When the client chooses the method.
- Refer client to the nearest health facility or DSO/CHW that provides the service.
Emergency Contraceptive Pills (ECPs)

What are ECPs?
Emergency contraceptive pills help prevent pregnancy when swallowed within 5 days (120 hours) after unprotected sexual intercourse, but the sooner, the more effective. After 5 days (120 hours) EC cannot protect against pregnancy.

How effective are ECPs?
- It is estimated that Postinor-2 will prevent 85% of expected pregnancies. 95% of expected pregnancies will be prevented if taken within the first 24 hours, declining to 58% if taken between 48 hours and 72 hours after unprotected intercourse.
- COCs are the least effective form of emergency contraception but should be considered when other options are not available.
- The FP Global Handbook shares this explanation of ECP efficacy:
  - If 100 women each had sex once during the second or third week of the menstrual cycle without using contraception, 8 would likely become pregnant.
  - If all 100 women used progestin-only ECPs, one would likely become pregnant.
  - If all 100 women used estrogen and progestin ECPs, 2 would likely become pregnant.

How do ECPs work?
- They work primarily by preventing or delaying the release of eggs from the ovaries. They will not work if a woman is already pregnant as they will not disrupt an existing pregnancy.

When should a woman consider taking emergency contraception?
- She has unprotected sex and wants to avoid pregnancy.
- A condom breaks or slips off during sex.
- She has been raped or defiled.

What is good about ECPs?
- Offer a second chance at preventing pregnancy.
- Are controlled by the woman.
- Couples can have on hand in case an emergency arises.
- They are safe and suitable for all women including women who cannot use hormonal methods on an ongoing basis.

What is NOT good about ECPs?
- Do not protect a woman from sex acts that occur after she takes ECPs.
Women should start an FP method immediately to avoid unintended pregnancy.

- Some users report side effects (similar to other hormonal methods).

Who can use ECPs?

- Any woman of reproductive age who has had unprotected sex in the past five days. There are no women who are not eligible.

How to use ECPs:

- Take the pills within five days of having unprotected sex; the sooner the pills are taken, the better.
- Follow the instructions provided for each type.

<table>
<thead>
<tr>
<th>Type</th>
<th>Common brand name</th>
<th>No pills per dose</th>
<th>Doses required</th>
<th>Timing of administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>Combined Oral Contraceptives</td>
<td>Microgynon</td>
<td>4</td>
<td>2</td>
<td>First dose within 120 hrs of unprotected sex but the sooner the better. Second dose: 12 hrs later</td>
</tr>
<tr>
<td></td>
<td>Lofeminal</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Pill plan</td>
<td>4</td>
<td>2</td>
<td></td>
</tr>
<tr>
<td>Progestin Only Contraceptives</td>
<td>Ovrette: each pill contains 0.37mg</td>
<td>20</td>
<td>2</td>
<td>First dose within 120 hrs of unprotected sex but the sooner the better. Second dose: 12 hrs later</td>
</tr>
<tr>
<td></td>
<td>Postinor LNG 750mcg</td>
<td>2</td>
<td>1</td>
<td>As soon as possible after unprotected sex but not later than 120 hours</td>
</tr>
<tr>
<td></td>
<td>Revoke LNG 1.5mg</td>
<td>1</td>
<td>1</td>
<td>As soon as possible after unprotected sex but not later than 120 hours</td>
</tr>
</tbody>
</table>

What clients should do in the case of side effects:

- Vomiting (within two hours of taking the pills)—repeat the dose.
- Nausea—take anti-nausea medication.
Natural Methods

Lactational Amenorrhea Method (LAM)

What does lactation mean?
• Lactation means breastfeeding

What does amenorrhoea mean?
• Absence of menstruation (monthly bleeding)

What is LAM?
• The Lactational Amenorrhea Method (LAM) is a family planning method based on breastfeeding. In order to use LAM, the following must be observed:
  o A woman’s menses have not returned since delivery.
  o A woman is exclusively breastfeeding her baby day and night without any other feeds including water.
  o Baby is less than 6 months old.
• If any one of the 3 above changes, a more effective family planning method must be started immediately.

How does LAM work?
• LAM works by preventing the release of eggs from the ovaries. Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

How effective is LAM?
• Commonly used, 98 out of every 100 women using LAM will not become pregnant.
• When used correctly, 99 out of every 100 women using LAM will not become pregnant.

Who can use LAM?
• Women who have delivered less than six months ago and whose menses have not returned.
• Woman who is exclusively breastfeeding (not giving any additional food or liquid) whenever the baby wants to feed.

Who can NOT use LAM?
• A woman whose menses have returned.
• A woman who cannot breastfeed her baby all the time whenever the baby wants.
• A woman whose baby has reached six months of age.
What is good about LAM?

- Very effective contraceptive method during the first 6 months after delivery for women who are only giving breast milk to their babies. Requires no medical or chemical substances.
- Available and convenient.
- Protects baby against diarrhea and other infections by providing antibodies and by avoiding exposure to contaminated milk.
- Provides important nutrients to the baby.
- Promotes bonding with the mother.

What is NOT good about LAM?

- It is only effective for up to six months after delivery when the baby is feeding on breast alone.
- No protection against STIs/HIV infection.

Reasons to initiate clients on another FP Method

- Mother’s menses have returned.
- Mother cannot breastfeed her baby all the time (day and night, more than 8 times).
- Baby cannot suckle well for any reason (i.e., illness).
- If baby has reached six months after delivery.
- Mother has started giving baby other feeds in addition to breast milk.
- Mother wants to start using another FP method.
Moon Beads/Standard Days Method (SDM)

What are Moon Beads?
This is a natural family planning method which is used by women with regular menstrual cycle ranging between 26-32 days. The beads allow women to track when they are most likely to become pregnant so they can avoid unprotected intercourse on those days.

How do Moon Beads/SDM work?
Each bead represents one day in a woman’s cycle. By moving a ring on a bead each day and following the colour-coding on the beads, the couple will know the days when the woman is most likely to become pregnant. During these days the couple can stop having sex or use a condom to avoid pregnancy.

How effective are Moon Beads/SDM?
- As commonly used, 88 out of every 100 women using Moon beads will not become pregnant
- When used correctly 95 out of every 100 women using Moon beads will not become pregnant

Who can use Moon Beads/SDM?
- Couples who have agreed to use the method.
- Couples who will remember to move the ring on a daily basis.
- Women with regular menstrual cycles (26-32 days.)
- Couples with a strong religious affiliation that does not allow use of other methods.
- Women who cannot use hormonal methods.

Who can NOT use Moon Beads/SDM?
- Women with an irregular menstrual cycle.
- Couples who abuse alcohol or drugs.
- Couples who have not agreed to use the method together.

What is good about the method?
- There are no hormonal side effects.
- Both partners actively participate in using the method.
- The major responsibility is remembering to move the ring.
What is NOT good about the method?

- The client can easily forget to move the ring on the beads.
- In typical use, the chances of pregnancy are higher than with other methods.
- If a woman or couple is concerned about the effectiveness of the method, they may not enjoy sex as much as they would with a more effective method.

Reasons to Initiate Client/Couple on another FP Method

- The woman’s cycle becomes irregular (has two or more cycles in one year that are outside the 26-32 day range).
- The couple routinely forgets to move the bead or is not able to abstain or use condoms consistently on fertile days.
Family Planning Methods that Require DSOs to Refer Clients

Long-Acting Methods

Implants

What are implants?
- Implants are small plastic rods or capsules that release the progestin hormone into the woman’s body to prevent pregnancy. There are two types of implants in Uganda, Implanon NXT and Jadelle. Implanon NXT is a single rod which provides contraceptive protection for 3 years. Jadelle consists of two rods and provides protection for 5 years.

How do implants work?
- Thicken the mucous at the mouth of the womb to prevent the sperm passing to the womb.
- Stop the release of the female egg from the egg sack (ovulation).
- They do not work by disrupting an existing pregnancy.

How effective are implants?
- Implants are more than 99% effective.

What is good about implants?
- They do not require the user to do anything once they are inserted.
- They prevent pregnancy very effectively.
- They are long-lasting.
- They do not interfere with sex.
- They are private. No one else can tell that the woman is using contraception. They reduce menstrual flow, thus reducing chances of anaemia.

What is NOT good about implants?
- Many women experience changes in their menstrual bleeding pattern including lighter bleeding and fewer days of bleeding, irregular bleeding, infrequent bleeding, or no monthly bleeding during the first three months and lighter and fewer days of bleeding, irregular bleeding, or infrequent bleeding after one year.
- Some women may experience minor side effects such as weight change, headaches, dizziness, mood changes, abdominal pain, breast tenderness, and nausea.
- Implants do not protect against STIs including HIV.
Who can use implants?

- Any women of reproductive age, including adolescents and women over 40-years old, who desire to use implants, including women who have or have not had children and are not married.
- Women who smoke cigarettes, regardless of the woman’s age or number of cigarettes smoked.
- Women who have just had an abortion or miscarriage.
- Women who are breastfeeding (starting as soon as 6 weeks after childbirth).
- Women who have anemia now or in the past.
- Women who have varicose veins.
- Women who are infected with HIV, whether or not on antiretroviral therapy (ART). [Explain that contraceptive implants may be less effective in women who use certain ARVs, particularly efavirenz. Using condoms in addition to an implant (dual method use), offers protection from STIs and unintended pregnancy if the implant fails.]

Who should NOT use implants?

- Women who are:
  - Already pregnant (implants are not dangerous if accidently used)
  - Breastfeeding mothers with infants less than six weeks old
- Women with
  - Blood clots in legs or lungs
  - Yellow colouring of the eyes (liver disease)
  - Breast cancer
  - Unexplained vaginal bleeding

When and where should DSOs refer clients interested in implants?

- When the client chooses the method.
- Refer client to the nearest health facility that provides the service.
- Refer client to organized family planning camps, if timing and location are appropriate.
Intrauterine Device (copper-bearing IUD)

What is an IUD?
An intrauterine device (IUD) is a small plastic device with copper sleeves or wire around it. It is inserted in the uterine cavity by a specially-trained provider to prevent pregnancy.

What types of IUDs are available in Uganda?
- In Uganda, the Copper T 380A is the common IUD used. It is a T-shaped device with copper on its stem and arms. After insertion, it prevents pregnancy for twelve years.

How do IUDs work?
- IUDs work primarily by causing a chemical change that damages sperm and egg before they can meet.

How effective are IUDs?
- IUDs are more than 99% effective.

What is good about IUDs?
- They do not require the user to do anything once the IUD is inserted.
- They prevent pregnancy very effectively.
- They are long-lasting.
- They do not interfere with sex.
- They are private. No one else can tell that the woman is using contraception.
- They may help protect against cancer of the lining of the uterus (endometrial cancer).

What is NOT good about IUDs?
- Many women experience changes in their menstrual bleeding pattern especially in the first three-to-six months including prolonged and heavy monthly bleeding, irregular bleeding, and more cramps and pain during monthly bleeding.
- IUDs may contribute to anaemia if a woman already has low iron blood stores before insertion and the IUD causes heavier monthly bleeding.
- IUDs do not protect against STIs including HIV.
Who can use IUDs?

- Any women of reproductive age, including adolescents and women over 40-years old, who desire to use IUDs, including women who have or have not had children and are not married.
- Women who have just had an abortion or miscarriage or have had an ectopic pregnancy.
- Women who are breastfeeding.
- Women who have anaemia now or in the past.
- Women who had vaginal infections or who had had pelvic inflammatory disease (PID) in the past.
- Women who are infected with HIV, whether or not on ART.
- Women who do hard physical work.
- Women who are immediately postpartum (up to 48 hours after delivery) and women who are more than four weeks postpartum.

Who should NOT use IUDs?

- Women who are:
  - Already pregnant (may cause a miscarriage if inserted in a pregnant woman).
  - At very high individual risk for gonorrhoea or Chlamydia (there is an increased risk of pelvic inflammatory disease and the infection may result in infertility).
  - More than 48 hours but less than four weeks postpartum (postpartum insertions should be done immediately or delayed four or more weeks to reduce risk of expulsion).
- Women with:
  - AIDS (unless she is clinically well on antiretroviral therapy).
  - Female conditions or problems (i.e., genital cancer or pelvic tuberculosis).
  - Unexplained vaginal bleeding.
  - Current ovarian cancer.
  - An infection following childbirth or abortion.

When and where should DSOs refer clients interested in IUDs?

- When the client chooses the method.
- Refer client to the nearest health facility that provides the service.
- Organized family planning camps, if timing and location are appropriate.
Permanent Methods

What are permanent methods?
These are methods that stop a person from producing children for good. Reversal is usually not possible. There are two types: vasectomy for men and tubal ligation for women.

How do permanent methods work to prevent pregnancy?
- A procedure is performed to tie and cut the tubes which transport the sperms in the male and the eggs in the female so the two do not meet to form a baby.

Who can use permanent methods?
- Permanent methods can be used by any woman, man, or couple who do not want to have more children.

Who should NOT use permanent methods?
- Permanent methods should not be used by a woman, man, or couple who is not certain whether or not they want to have more children. All women and men can use permanent methods; however, there are certain medical conditions that may limit when, where, or how the sterilization procedure should be performed.

Male Sterilization (Vasectomy)

How effective is male sterilization (vasectomy)?
- Over one year of use it is about 99% effective and over 3 years of use about four pregnancies per 1,000 women.
- Vasectomy is not fully effective until three months after the procedure. If the partner of a man who has had a vasectomy becomes pregnant, it may be because:
  - Another method was not used during the first three months after the procedure.
  - The provider made a mistake during the procedure.
  - The cut ends of the vas deferens (tubes) grew back together.

What is good about male sterilization (vasectomy)?
- It is safe, permanent, and convenient.
- It has fewer side effects and complications than many methods for women.
- The man takes responsibility for contraception—takes burden off the woman.
- May increase enjoyment and frequency of sex since concern about unintended pregnancy is reduced.
What is NOT good about male sterilization (vasectomy)?
- It takes three months to become fully effective.
- There is some discomfort after the procedure.

Female Sterilization (Tubal Ligation)

How effective is female sterilization (tubal ligation)?
- Less than one pregnancy per 100 women during the first year (more than 99% effective).
- Over ten years of use, it is about 98% effective (two pregnancies per 100 women).
- Effectiveness varies slightly depending on how the tubes are blocked, but pregnancy rates are low with all techniques. One of the most effective techniques is cutting and tying the cut ends of the fallopian tubes after childbirth.

What is good about female sterilization (tubal ligation)?
- It is safe, permanent, and convenient (nothing to do or remember).
- It has no side effects.
- Helps protect against pelvic inflammatory disease (PID).
- May increase enjoyment and frequency of sex since concern about unintended pregnancy is reduced.

What is NOT good about female sterilization (tubal ligation)?
- Requires a surgical procedure with use of anesthesia.
Activity Sheet—Practice with COC Eligibility Checklist

This activity provides an opportunity to practice using the eligibility checklist. In pairs, participants take turns playing the role of DSO or client.

When playing the **client** role, read the description of the client you are playing and answer the eligibility questions asked by the DSO based on the conditions described.

When playing the role of the **DSO**, use the eligibility checklist to determine whether it is safe for the client to initiate the method. Ask the questions and follow the instructions on the checklist.

After practicing all of the client scenarios, the facilitator will call the group together to answer questions and discuss, affirm, correct, or clarify as needed.

COC Eligibility Practice Scenarios

**Client 1** has heavy and painful periods but no other health problems. She started her period six days ago, and was using condoms every time she and her partner had sex, but now wants to switch to COCs.

*Heavy and painful periods is not a condition that prohibits someone from using COCs. She will answer NO to questions 1–12 of the checklist. Because she and her partner have used condoms consistently, she will answer YES to question 15, making her eligible to start using COCs. However, because she started her period more than 5 days ago, she should abstain or use condoms for the first seven days of taking pills.*

**Client 2** is fully breastfeeding a three-month-old baby and has not resumed menses since giving birth.

*When asked, the client will answer YES to question 1, which means she cannot initiate COCs. She should be counseled that she can start using COCs when she stops breastfeeding or when her baby is six months old, whichever happens first.*

**Client 3** has been taking medicine for tuberculosis (TB) and started her period 5 days ago.

*The client will answer YES to question 6, which means you should not give her COCs because some medicines used to treat TB make COCs less effective. You should refer her to a provider who can determine if taking COCs is appropriate for her TB drug regimen. Give her condoms to use in the meantime.*

**Client 4** had a doctor once tell her she had high blood pressure but she doesn’t think it’s a problem now.

*The client will answer YES to question 9, therefore she is not eligible to start COCs without further evaluation. Refer the woman to a clinical provider for evaluation, and give her condoms to use until she can see the provider.*
Activity Sheet—Practice with Checklist for COC Continuation and Side Effects Management

This activity provides an opportunity to practice using the checklist for COC continuation and the guidance for managing side effects. In pairs, participants take turns playing the role of DSO or client.

When playing the **client** role, read the description of the client you are playing and answer the questions asked by the DSO based on the conditions described.

When playing the role of the **DSO**, use the continuation checklist to determine whether it is safe for the client to continue using the method. Ask the questions and follow the instructions on the checklist. As needed, also refer to the guidelines for managing side effects.

After practicing all of the client scenarios, the facilitator will call the group together to answer questions and discuss, affirm, correct, or clarify as needed.

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**COC Eligibility for Continuation and Side Effects Management Practice Scenarios**

**Client 1** has been taking pills daily for three months and is mostly satisfied. She takes her pill in the morning and sometimes experiences mild nausea. She has developed no other health problems since she started taking COCs.

The client has not developed any conditions that prohibit her from continuing to use COCs. She will answer YES or MAYBE to question 1 of the checklist because of the nausea, YES to question 2, and NO to questions 3-5. The DSO will not observe any yellow skin or eyes (question 6). The DSO should counsel the client to consider taking her pill with a meal at bedtime to reduce nausea.

**Client 2** was diagnosed with tuberculosis two weeks ago and is now taking rifampicin for treatment. She has had no side effects or other problems taking pills.

When asked, the client will answer YES to questions 1-2. She will also answer YES to questions 3 and 5. The rifampicin she is taking for TB treatment reduces the effectiveness of the COCs. Counsel the client to also use condoms until she can switch to another method like injectables or implants which are not affected by the rifampicin.

**Client 3** has been taking pills for two months and has come in for re-supply. She is mostly satisfied but experienced mild headaches several times which are uncommon for her. She has no other new health problems.

The client has not developed any conditions that prohibit her from continuing to use COCs. She will answer YES or MAYBE to question 1 of the checklist because of the headaches, YES to question 2, and NO to questions 3-5. The DSO will not observe any yellow skin or eyes (question 6). The DSO should counsel the client to consider taking aspirin, ibuprofen or paracetamol to alleviate the headaches.
## Module 3, Session 2: Myths and Misconceptions about Family Planning

<table>
<thead>
<tr>
<th>Myths and Misconceptions</th>
<th>Facts and Realities</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>General Rumors</strong></td>
<td></td>
</tr>
<tr>
<td>It’s better to have your children closely spaced while you are young because it’s the time that a woman’s body is strongest.</td>
<td>Pregnancies with spacing of less than two years are less healthy for both mother and baby.</td>
</tr>
<tr>
<td>It’s more convenient to complete the family fast and then opt for permanent methods of birth control.</td>
<td>Mothers need time to recover from a previous pregnancy. They need to restore their depleted stores of iron and calcium, build their strength and repair the wear and tear they experienced from the previous pregnancy.</td>
</tr>
<tr>
<td>Men with many children can earn respect in the community.</td>
<td>It’s more important for the family to have a healthy mother and children, which is not possible if the births are very close.</td>
</tr>
<tr>
<td>Family planning is for women only.</td>
<td>There are some methods for women and a few for men. Even for women’s methods such as pills and injectables, men can play a role in supporting their wives and discussing with them about how many children they would like to have. There are also some methods that are specifically for men, such as condoms and vasectomy.</td>
</tr>
<tr>
<td>There is nothing we can do to stop rapid population growth in Uganda.</td>
<td>Family planning is an important way that everybody can help address the rapid population growth. If people continue to have the rapid population growth in Uganda will nearly double to 50m people. This means we will need twice as much water, twice as many health centers and schools, twice as much charcoal and wood for burning, twice as much food. This represents a population crisis because Uganda does not have the resources to sustain such population growth.</td>
</tr>
<tr>
<td><strong>Condoms</strong></td>
<td></td>
</tr>
<tr>
<td>If condoms slip off during sexual intercourse, it may get lost inside a woman’s body.</td>
<td>If condoms slip off during sex, it is impossible for the condom to get lost inside a woman’s body; simply reach into the woman’s vagina and pull it out.</td>
</tr>
</tbody>
</table>
Condoms eliminate sexual pleasure. | Condoms are made of extremely thin rubber. Sex with a condom does not feel exactly the same as sex without it; however, it is just as enjoyable for most people. Not worrying about unintended pregnancy or sexually transmitted diseases may increase pleasure for both partners.

HIV can pass through the pores of a condom | Condoms don’t have pores; neither the virus nor the sperm can pass through a condom that is not broken.

**Pills**

Pills make you weak. | Pills do not make a woman weak. A health care worker needs to be consulted to find out what may be causing weakness, if she is feeling weak while taking the pill.

The pill is dangerous and causes cancer. | The pill does not cause cancer. In fact studies show that the pill protects women from some forms of cancer, such as those of the ovary and endometrium.

The pill causes abnormal or deformed babies. | There is no medical evidence that the pill causes abnormal or deformed babies. Women who take the pill for many years go on to have healthy children.

The pill causes infertility or makes it more difficult for a woman to become pregnant once she stops using it. | Studies have clearly shown that pill does not cause infertility or decrease a woman’s chances of becoming pregnant after she stops taking it.

**IUD**

The IUD can move through the womb and pierce other organs. | The IUD never travels to the heart, brain, or any other part of the body outside the abdomen. The IUD normally remains within the uterus like a seed within a shell. In rare cases the IUD may come through the wall of the uterus into the abdominal cavity. This is most often due to a mistake in the insertion.

Men do not like having sex with women using the IUD because they can feel the string with their penis during sex. | Sometimes a man can feel IUD strings during sex. Many men do not find it bothersome. If a couple does, they should talk with a health care provider trained in IUD insertion about their options.

IUDs can make women infertile. | A woman can become pregnant once the IUD is removed just as quickly as a woman who has never used an IUD. Fertility naturally decreases
as a woman ages. Because IUDs are approved to stay in the body for such long periods of time, a woman’s fertility may naturally decrease during the period when she has her IUD, depending on her age.

<table>
<thead>
<tr>
<th>Implants</th>
<th>Injectables</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants delay conception after a woman stops using it.</td>
<td>A woman who uses injectables will never be able to get pregnant again.</td>
</tr>
<tr>
<td>Implants do not delay the fertility of a woman after they are removed. The hormones do not remain in a woman’s body. The bleeding patterns a woman had before she used implants will return soon after they’re removed.</td>
<td>Sometimes there is a delay of a few months after the last injection for the woman’s fertility to return to normal. A woman therefore needs to plan when to stop injections based on when she wants to have her next baby. A woman’s fertility will return.</td>
</tr>
<tr>
<td>Implants can stop monthly bleeding; however, this is not harmful. It’s similar to not having monthly bleeding during pregnancy. Blood is not building up or collecting inside the woman. Many women appreciate not having monthly bleeding.</td>
<td>Injectable contraceptives cause cancer.</td>
</tr>
<tr>
<td>Implants make women fail to menstruate and this is bad for their health.</td>
<td>Injectables do not cause cancer. In fact there is even evidence that it protects against endometrial cancer.</td>
</tr>
<tr>
<td>The implant can move around inside a woman’s body or even fall out.</td>
<td>A woman will not have enough breast milk if she uses the injectable while breastfeeding.</td>
</tr>
<tr>
<td>The implant remains inside the skin in the woman’s upper arm and does not move around. The implant stays there until a health provider removes it.</td>
<td>The amount of breast milk does not decrease when the breastfeeding women are using the injectable six weeks after birth.</td>
</tr>
<tr>
<td>The implant can shatter if it gets bumped and therefore women should avoid heavy work.</td>
<td>Injectable stop menstrual bleeding, and that’s bad for a woman’s health.</td>
</tr>
</tbody>
</table>
| The implant is very flexible and soft and can’t break inside the woman’s body. The woman does not need to worry about putting pressure on her arm, like carrying a child or doing other work. | Most women using injectables stop having monthly bleeding over time, and this is not harmful. It is similar to not having monthly bleeding during pregnancy. Blood is not

Family Planning Training for Drug Shop Operators—Reference Guide 54
<table>
<thead>
<tr>
<th>Procedure</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Injectables</strong></td>
<td>- Most women using injectables stop having monthly bleeding over time, and this is not harmful. A young woman’s fertility will return when she stops taking the injectable. Note that sometimes there is a delay of a few months after the last injection for the woman’s fertility to return to normal.</td>
</tr>
<tr>
<td><strong>Intruterine Device (IUD)</strong></td>
<td>- The copper in an IUD can rust or react and cause infection in the womb. The IUD is rust-free and it has been found safe during tests.</td>
</tr>
<tr>
<td><strong>Tubal Ligation</strong></td>
<td>- TL makes women fail to menstruate and this is bad for their health. Women continue to menstruate even after TL.</td>
</tr>
<tr>
<td><strong>Vasectomy</strong></td>
<td>- Vasectomy makes a man weak. Vasectomy does not make a man weak. He can do all the same things he did before the procedure.</td>
</tr>
<tr>
<td></td>
<td>- After vasectomy a man will look and feel the same as before. His erection will be as hard and last as long as before, and orgasms and ejaculations of semen will be the same.</td>
</tr>
<tr>
<td></td>
<td>- Men have long-lasting pain after vasectomy. Only 1% of men report pain and discomfort in the scrotum or testicles after vasectomy. Treatment for these few men includes elevating the scrotum and taking pain relievers.</td>
</tr>
<tr>
<td></td>
<td>- Men can have a vasectomy reversed if he decides that he wants another child. Vasectomy is intended to be permanent. People who want more children should choose a different family planning method.</td>
</tr>
</tbody>
</table>

Collecting inside her. Some women prefer being free from monthly bleeding.

That depends on the person. Some women do put on a little weight while using injectables, while others don’t.
Responding to Excuses for Not Using Condoms

The following questions and responses can be included as part of counseling for clients who use condoms.

1. “I don’t enjoy sex as much when I wear a condom.”
   Possible response: “If we intensify romancing, you will enjoy sex.”

2. “I don’t need to use a condom—I have not had sex in months. I know I don’t have any diseases.”
   Possible response: “That is good to know. As far as I know, I’m disease-free, too. But I would still like to use a condom because either of us could have an infection from a long time ago and not know it.”

3. “If I have to stop and put it on, I won’t be in the mood for sex anymore.”
   Possible response: “I can help you put it on. That way, you’ll continue to be aroused, and we’ll both be protected.”

4. “Condoms are messy, and they smell funny.”
   Possible response: “The smell goes away in a minute. And sex without a condom can be a little messy sometimes. But this way, we’ll be able to enjoy it and both be protected from pregnancy and HIV/STIs.”

5. “Let’s not use condoms just this once.”
   Possible response: “No. Once is all it takes to get pregnant or get an infection.”

6. “I don’t have a condom with me.”
   Possible responses: “That’s okay, I do have one.” Or, “Then we’ll have to wait and be better prepared next time.”

7. “You never asked me to use a condom before. Are you having an affair?”
   Possible response: “No. I just think we made a mistake by never using condoms before. One of us could have an infection and not know it. It is best to be safe.”

8. “If you really love me, you wouldn’t ask me to wear a condom.”
   Possible response: “If you really love me, you would want to protect yourself—and me—from infections and pregnancy so that we can be together and healthy for a long time.

9. “Why are you asking me to wear a condom? Do you think that I’m dirty or something?”
   Possible response: “It is not about being dirty or clean. It is about avoiding pregnancy and infections.”
10. “Only people who have anal sex need to wear condoms, and I’m not like that.”
   Possible response: “That is not true. A person can get an infection during any kind of sex.”

11. “Condoms don’t fit me.”
   Possible response: “Condoms can stretch a lot! Most condoms will fit any man’s penis.”

12. “Why should we use condoms? They just break.”
   Possible response: “Condoms are tested before they are sent out—and if we use them correctly, they do not break. Let me show you how to use one.”

13. “What happens if it comes off? It can get lost inside you, and you will get sick, or could even die. Do you want that?”
   Possible response: “It is impossible for the condom to get lost inside me. If it came off, it would be inside my vagina, and I could just reach in and pull it out.”

14. “If you don’t want to get pregnant, why don’t you just take the birth control pill?”
   Possible response: “Because the birth control pill only protects against pregnancy. The condom protects against both pregnancy and STI infections.” or “Because I discussed my options with a doctor and we decided that condoms are the best method for me to prevent pregnancy.”

15. “My religion says that using condoms is wrong.”
   Possible response: “Religion also says we should protect those we love. Preventing pregnancy and protecting each other from infection is a good thing to do.”

16. “Well, I am not going to use a condom, and that is it. So, let’s have sex.”
   Possible response: “No. I am not willing to have sex without a condom.”

17. “No one else uses them. Why should we be so different?”
   Possible response: “No, many people use condoms and they continue enjoying sex.”
MODULE 4: Communication and Counseling for FP

Module 4, Session 1: Effective Interpersonal Communication Skills/Techniques

Introduction
This session introduces nonverbal interpersonal communication skills that form a foundation for effective education and counseling.

How do we communicate? Interpersonal communication is:

- **Nonverbal communication:**
  Face-to-face exchange of information, ideas or feelings using facial expressions, gestures and body positions.

- **Verbal communication:**
  Face-to-face exchange of information, ideas or feelings using the voice.

Positive nonverbal communication:
- Paying full attention, listening
- Relaxed and accepting body postures facing client
- Using facial expressions that inspire trust and show interest (e.g., smiling)
- Maintaining eye contact with the client as culturally appropriate
- Encouraging gestures (e.g., nodding the head)
- Avoiding nervous or inappropriate mannerisms

Negative nonverbal communication:
- Reading from a chart
- Glancing at one’s watch
- Yawning or looking at papers or out the window
- Frowning or other facial expressions that indicate judgment
- Fidgeting
- Not maintaining eye contact
- Crossing arms

Family Planning Counseling Skills

Definition of counseling
It is a face-to-face communication between a provider and one or more people where the provider helps an individual or couple to make decisions and act on them.
Qualities of a good counselor
- Knowledgeable
- Attentive, good listener
- Ensures privacy
- Uses good communication and counseling skills
- Tailors the session to the client’s needs
- Ready to help
- Maintains confidentiality
- Tactful
- Respectful

Purposes of FP counseling
- To help a new client to make a decision about using a family planning method
- To help a client select a family planning method
- To help clients with questions and problems related to family planning methods

Counseling skills
- Positive nonverbal communication
- Active listening
- Asking questions (open-ended, or closed-ended coupled with probing)
- Using clear, simple language
- Clarifying and summarizing information
- Talking about sexuality and sexual health without embarrassment
- Using job aids effectively

Active listening
- Giving verbal encouragement
- Using appropriate tone of voice
- Paraphrasing what the client says
- Reflecting feelings

Purpose of paraphrasing and reflecting:
- Lets the client know you are listening
- Checks that you have understood
- Reflects the client’s feelings about situation
- Summarizes or clarifies what client says
Using simple language:
- Use words and explanations that clients can easily understand
- If clients do not understand, they may not:
  - Ask for clarification
  - Make good decisions
  - Follow instructions

Purpose of asking questions:
- Assess client’s needs and concerns
- Involve client in conversation
- Help client express feelings and attitudes
- Show interest and concern
- Determine what client already knows
- Identify misinformation or myths to correct

Closed-ended questions:
- Answered with “yes,” “no,” or one or two words
- Gather basic information
- How old are you?
- How many children do you have?
- When was your last menstrual period?
- Use in combination with probes (e.g., Tell me more, Please explain)

Open-ended questions:
- Require longer responses
- Help clients to express needs/concerns and reveal what they know
  - What have you heard about the Pill?
  - How does that make you feel?
Module 4, Session 2: Counselling FP Clients

The REDI counseling approach has been adopted by MOH and its purpose is to ensure a client makes an informed and voluntary decision. The approach recognizes that many client decisions are never implemented because of barriers that have not been identified at the time of decision-making.

- The approach starts with focusing on the client’s individual circumstances and each counseling session is then tailored to the specific needs of the individual client, taking into consideration their specific circumstances, needs, and desires—e.g. whether they are new or returning; whether they have a specific method in mind, concerns about the method they are using, or changes in their circumstances, and whether they are a member of a special population group.
- In addition to helping providers with counseling for FP, the approach helps providers explore and address clients’ needs and problems in other RH areas (such as sexuality and STIs) in an integrated way.
- The approach helps identify the barriers that a client may face in carrying out this decision, build skills and develop strategies to help the client address the barriers based on each client’s unique set of needs and circumstances.

The Checklist for Evaluating DSO Counseling and Method Provision, located in the Annex, is a guide for assessing a DSO’s skills as they counsel clients.

REDI Counselling Approach—Phases and Steps of REDI

Phase 1: Rapport Building

- Greet client with respect.
- Make introductions and identify category of the client—i.e., new, satisfied return, or dissatisfied return.
- Assure confidentiality and privacy.
- Explain the need to discuss sensitive and personal issues.
- Use communication skills effectively (throughout the phases).

Phase 2: Exploring

- Explore in detail the client’s reason for the visit. This information helps determine the client’s needs and the focus of the counseling session.
- Explore the client’s sexual and reproductive health history and FP goals.
- Explore the client’s sexual relationships, social and gender context for decision-making, and risk of STI/HIV.
• Explain FP and SRH options—focusing on the method(s) of interest to the client. In the case of returning clients, inquire about the client’s satisfaction with the current method.

Phase 3: Decision Making
• Identify the decisions the client needs to make or confirm.
• Identify relevant options for each decision (e.g., FP, STI/HIV risk reduction).
• Confirm medical eligibility for FP methods the client is considering.
• Confirm that any decision the client makes is informed, well-considered, and voluntary.

Phase 4: Implementing the Decision
• Assist the client to make a concrete and specific plan for carrying out the decision(s) e.g. obtaining and using the FP method chosen, risk reduction for STIs, dual protection, and so on.
• Help the client to develop skills to use his or her chosen method.
• Identify barriers that the client may face in carrying out the plan.
• Develop strategies to overcome the barriers.
• Make a plan for follow-up and/or provide referrals as needed.
Activity Sheet—Counselling Scenarios

Practice Counseling FP Clients

This activity provides an opportunity to practice using the guidance outlined in the Checklist for Evaluating DSO Counseling and Method Provision, the job aids booklet, and other resources (e.g., sample methods, wall charts) to counsel clients interested in family planning. In groups of three, participants take turns playing the role of client, DSO, and observer.

When playing the **client** role, read the description of the client you are playing and interact with the DSO as though you were the client described in the scenario.

When playing the role of the **DSO**, follow the guidance outlined in the Checklist for Evaluating DSO Counseling and Method Provision and use the appropriate job aids from your booklet and other resources to address the needs and concerns raised by the client during the role play.

When playing the role of the **observer**, observe the interaction between the DSO and client and use the Checklist for Evaluating DSO Counseling and Method Provision to decide whether the DSO is following the guidance outlined in the checklist. Make notes on the checklist and be ready to provide constructive feedback to the DSO at the end of the role play.

After each participant has an opportunity to play the role of DSO, the facilitator will call the group together to answer questions and discuss, affirm, correct, or clarify as needed.

FP Counseling Practice Scenarios

**Client 1** is a 34-year-old married woman with four children. You have heard about family planning methods at the clinic and read a brochure. You think that the Pill is a good method for you, but you want to know about other methods that are available at the drug shop before making a decision.

**Client 2** is a 26-year-old married woman with four children. You have heard about family planning and think that you might be interested but have never used any method before. Your neighbor mentioned that the drug shop carries some FP methods so you have come to see what is available. You are breastfeeding your 7-month-old infant but your menses returned this week and you don’t want to get pregnant now. You have no other health problems.

**Client 3** is a 22-year-old married woman with two children, one is five months old and one is three years. You have recently learned that you are HIV positive but are still very healthy. Your husband is also HIV positive. You live in a very rural area where access to the FP clinic is not easy. You learned that the drug shop offers some FP methods so have come to talk to the DSO. You are interested in very effective FP methods but are not sure what might be appropriate—you may even consider a permanent method.

**Client 4** is a 17-year-old adolescent male. You have a girlfriend who became pregnant six months ago and miscarried three months later. You are interested in using condoms with your girlfriend until she decides to begin using a more reliable contraceptive method. You have tried male condoms before, but had problems with them. You have come to the drug shop to talk with the DSO since you heard from a friend that the DSO was friendly and helpful.
Module 5: Providing DMPA IM and SC Injectable Contraceptives

Module 5, Session 1: Overview of DMPA IM/SC (see Module 3, Session 1, DMPA)

Module 5, Session 2: Screening/Initiating Clients Who Wish to Use DMPA IM/SC

Activity Sheet—Case Scenarios for Practice with DMPA Eligibility Checklist

This activity provides an opportunity to practice using the eligibility checklist. In pairs, participants take turns playing the role of DSO or client.

When playing the client role, read the description of the client and answer the eligibility questions asked by the DSO based on the conditions described for the client. When playing the role of the DSO, use the eligibility checklist to determine whether it is safe for the client to initiate the method. Ask the questions and follow the instructions on the checklist.

After practicing all of the client scenarios, the facilitator will call the group together to answer questions and discuss, affirm, correct, or clarify as needed.

-----------------------------------------------------------------------------------------

Client 1 has malaria, is otherwise healthy, finished her pack of COCs yesterday, and wishes to switch to DMPA IM or SC. She started her period today.

When asked, the client will answer NO to all eligibility questions (1–9). As discussed earlier, all conditions that prohibit someone from using DMPA or NET-EN are included in questions 1–9, and malaria is not one of those conditions. Since the woman finished her pack of COCs yesterday and was taking pills consistently and correctly, the provider can be certain she is not pregnant and is eligible to have a DMPA (or NET-EN) injection.

Client 2 is fully breastfeeding a four-week-old baby and has not resumed menses since giving birth.

When asked, the client will answer YES to question 9, which means she should wait until her baby is six weeks old to initiate injectables. There is no need to ask her pregnancy-related questions at this time. According to checklist instructions, she should return in two weeks, after her baby is six weeks old. In the interim, she is protected from pregnancy by the lactational amenorrhea method as long as she continues to fully breastfeed, her menses does not return, and her baby is less than six months old.

Client 3 had a blood clot in her leg after surgery five years ago but is now healthy. She started her period 10 days ago and has not had intercourse since her last menses.

When asked, the client will answer NO to all questions (1–9); although she had a blood clot several years ago, she does not currently have a problem with blood clots. She will also answer YES to question 12, which means she is not pregnant and can have a DMPA (or NET-EN) injection immediately. However, because it has been more than seven days since the beginning of her menstrual period, she should use condoms or abstain from sex for the first seven days after the injection.

Client 4 was told that her blood pressure was somewhat high during a recent physical exam.

When asked, the client will answer YES to question 5. If the client desires to use injectables, refer her to a provider to have her blood pressure evaluated. Give her condoms to use in the interim. If the provider determines that her blood pressure is within an acceptable range, she might be eligible to use injectables.
Module 5, Session 3: Safe Storage of DMPA IM and SC, Safe Handling and Disposal of Sharps and Infection Prevention for Injections

Storage
DMPA IM and SC should be:
- Stored at room temperature.
- Stored and transported out of direct sunlight and heat.
- Stored out of reach of children and animals.

Handling Sharps Safely
Safe handling of sharps is an important DSO responsibility—so prior to practicing with needles, it is important to learn how to handle them safely. The DSO can take the following precautions:
- To avoid accidental needle-stick injuries, do not re-cap the needle after use. Immediately after use, place the used syringe into the sharps box.
- Do not touch a needle. If you accidentally touch a needle or stick yourself with a needle, do not use the needle on a client. Simply discard the needle and use a fresh one.
- Do not leave a needle inside the vial to avoid contaminating both the needle and the contents of the vial.
- Do not overfill the sharps box. When the sharps box is ¾ full, return the sharps box to your supervisor and get a new one.

Replacing a sharps' box before it gets too full prevents needle sticks that occur when a provider stuffs a needle and syringe into the box and pricks him/herself on a dirty needle that is already in the box.
- Always place used needles and syringes in the sharps container. Do not put anything into the sharps box other than needles and syringes.

Prevent Infection from a Needle-stick Injury
- Wash hands with soap and running water before and after giving an injection.
- Handle sharps carefully to reduce needle sticks.
- Always use a safety box.

BE SAFE with SHARPS
- Discard the needle immediately.
- Do not touch the needle.
- Do not recap the needle.
- Do not overfill the safety box.
- Do not dispose of sharps in anything other than a safety box.
What to do in case of a needle-stick injury?

- Wash the wound with soap and running water right away.
- Do not put anything else on the site after washing with soap and water.
- Report needle-stick injuries immediately to your supervisor.

Additional Information on Infection Prevention

What is infection prevention?
Refer to the process of rendering objects, equipment and surfaces free of micro-organisms and preventing cross infection from the client to the health worker and vice versa.

Key pillars for infection prevention include:

- Training
- Use of personal protective gear
- Staff protection through mandatory vaccination
- Hand washing, waste and sharps management
- Proper instrument and equipment processing
- Processing of soiled linen
- Sterilization autoclave
- High-level disinfection (boiling and chemical)
- Hard and soft surface disinfection

Importance of Infection Prevention

- Prevents post-procedure infections.
- Results in high quality, safe services.
- Prevents infections in DSOs and their clients.
- Prevents the spread of antibiotic-resistant micro-organisms.
- Lowers the cost of health care services, since prevention is better than treatment.

Infection prevention procedures when giving DMPA IM and SC injections

- Hand washing
  - Hand washing may be the single most important infection prevention procedure.
  - Use clean water and plain soap and rub hands for at least 10 to 15 seconds. Be sure to clean between the fingers and under the finger nails.
  - Air/drip dry.
• Waste management
  o All used needles and syringes should be placed in a safety box and taken for disposal to the nearest health facility when they are ¾ full.
  o Used cotton wool, bottle caps and open syringe packs should be placed in plastic bag (Kaveera) and be burnt.
  o NB: All of the above should be kept out of reach of children.

Module 5, Session 4: Administering DMPA IM injections
  Refer to the Job Aids Booklet for step-by-step instructions.

Module 5, Session 5: Uniject injection system
  Refer to the Reference Manual, Module 3, Session 1, DMPA IM and SC.

Module 5, Session 6: Administering DMPA SC injections
  Refer to the Job Aids Booklet for step-by-step instructions.

Module 5: Session 7: Help Continuing Users of DMPA IM and SC (Reinjections)
  Refer to the Job Aids Booklet for step-by-step instructions.
MODULE 6: Recordkeeping and Reporting

Module 6, Session 1: Family Planning and HMIS Documentation

Introduction
One of the key responsibilities of the drug shop operator/seller is to maintain written data relating to the services s/he provides in his/her drug shop. In this session, participants are helped to examine the meaning of recordkeeping for family planning, the process of recordkeeping, the importance of recordkeeping, the key players in recordkeeping, the challenges of recordkeeping and give the participants a hands-on experience in recordkeeping.

Meaning of Records
Written information collected and kept/stored to help service providers, supervisors, health sub district in-charges, district health officers and the Ministry of Health plan effectively and improve services. More generally, records are written information referred to as administrative memory.

Purposes of Recordkeeping
- To monitor the flow and usage of contraceptives/medicines and other commodities/supplies.
- To provide information for accountability of commodities procured.
- To provide information for monitoring and evaluation of FP services provided at the drug shop.
- To gather information that can be used as the basis for continuous quality improvement to better serve and increase clientele.
- To report results of FP services provided to the district and other relevant stakeholders.

Tools a DSO Uses to Collect Information on FP clients
- **Family Planning Client Card**—provides baseline information on the new clients and for follow up on the client (see sample in Annex).
- **Client Return Appointment Card**—completed by DSO and given to client as a reminder of services provided and when to return (see sample in Annex).
- **Referral Form**—Part A is completed by DSO and given to client to take along to referral appointments. Part B is completed by provider at referral facility to inform DSO of services provided (see sample in Annex).
and additional information about Referrals in Quality Control Module).

- **Daily Activity Register**—captures information on every client served; it provides the total number of clients; new and revisits, shows clients by method, those referred and reasons for referral. The register is also used to track commodities sold (see sample in Annex).

- **Monthly FP Summary Form for Input into the HMIS Report**—requires the DSO to share with the health facility a monthly summary of all FP methods provided by age of client and new/revisit clients. The midwife/records assistant inputs the data into the integrated FP register and HMIS 105 monthly. (see sample in Annex).
MODULE 7: Quality Control
Module 7, Session 1: Referrals, Linkages, and Supervision System

Referral

Meaning of Referral
Referral is when a DSO prepares and sends a client to a higher level of health care because the person has a health problem or need that the DSO is not able to manage.

Reasons for Referral
- The service to be provided is not part of the DSO’s job description.
- The DSO has no expertise, training or technical ability to handle the situation.
- The person referred gets appropriate services from a provider with technical expertise (i.e., post-exposure prophylaxis (PEP) in case of sexual violence, rape, or defilement).

Referral Places in the Community
Clients can be referred to:
- Nearest health facility (government and non-governmental hospitals, health centre or dispensary) with the services required
- Trained health workers, such as private midwives or trained TBAs.
- Resource person within the community, for example, professional counsellor for STI/HIV/AIDS at AIC or TASO, field supervisors or community health workers for NGOs.

Steps for Preparing a Client for Referral
- Assure the client that the referral is for his or her own benefit.
- Explain to the client the reasons why he or she is being referred.
- Discuss with the client where he/she should be referred.
- Where possible, explain to the client what is likely to happen at the place of referral based on the problem or need at hand.
- Explain where to go, directions to the facility, distance involved and transportation options.
- Explain to the client the terms of services, including any service charge and how charges are to be paid.
- Inform the client of the days and times when the services are available.
• Allow the client to ask questions and express any concerns and respond accordingly.
• Ask client if she/he understands the reason why she/he is being referred

Steps for Conducting a Referral

• Fill in a referral form (see sample in Annex) specifying the reasons for referral and note it on the Client Card.
• Give the completed form to the person being referred and ask him or her to present the form to the service provider at the referral site.
• Give the client any additional instructions, such as whether the client is to bring back a referral feedback form to you.
• Ask the client a few questions and/or to repeat instructions to make sure the client understands what has been said.
• Reinforce if responses are correct and complete, or correct if answers are incomplete or wrong.
• Discuss with the client the possibility of being escorted to the referral site and what to do if the referral form gets lost.
• Follow up with client and/or obtain feedback on the referral from facility or supervisor.

Contact List for Referral Services

With guidance from the trainer, locate this chart in your Job Aids Booklet and fill in the name and location of the referral sites in your area so that you will have contact information ready to give clients who need a referral.

<table>
<thead>
<tr>
<th>Service</th>
<th>Where to refer</th>
</tr>
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<tbody>
<tr>
<td>Tubal Ligation</td>
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<tr>
<td>Vasectomy</td>
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<tr>
<td>Implants</td>
<td></td>
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<tr>
<td>Coil (IUD)</td>
<td></td>
</tr>
<tr>
<td>Moon Beads</td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS testing and counselling</td>
<td></td>
</tr>
<tr>
<td>AIDS treatment (ART)</td>
<td></td>
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<tr>
<td>PMTCT services</td>
<td></td>
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<tr>
<td>STI treatment:</td>
<td></td>
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<tr>
<td>Other:</td>
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Support Supervision

Meaning of Support Supervision
A process of building the knowledge and skills of a DSO on-the-job in order to improve performance and programme quality.

Levels of Supervision and Types of Support at Each Level
DSOs should receive supportive supervision (non-punitive) from their supervisors and peers on an ongoing basis. Types of supervision include:

- **Peer-to-peer**
  - Frequency: monthly meetings (as decided by DSOs in the village)
  - Purpose: share experiences; support and mentor each other; “cleaning” of records; identify gaps to be addressed during health centre (HC) meeting with supervisors

- **Facility-based FP provider to DSOs (directly-observed supervision)**
  - Frequency: monthly meetings.
  - Purpose: provide technical information and updates to DSOs as needed; answer questions raised by DSOs; consult on problems related to service provision; skill reinforcement; fill out monthly summary form; replenish supplies

- **District Health Office in Health Sub-district (field-based supervision)**
  - Frequency: quarterly on-site visit to DSO’s shop
  - Purpose: contribute to quality assurance with regard to storage of supplies, recordkeeping, and infection control; verify that clients are properly screened for FP use and that job aids are being used appropriately
Supervisory Checklist

This sample checklist was developed to guide regular monthly discussions between supervisors and Drug Shop Operators (DSOs) on the routine provision of family planning services. It should be adapted to complement existing supervision guidelines and established review/re-supply intervals. During the discussion, DSOs should be prepared to share their client records and summary forms with their supervisors. Topics to include in the discussion are types of services provided, problems and concerns related to particular clients, waste disposal, re-supply, referral, and needle-stick injuries.

Questions for supervisor to ask each month while reviewing the DSO monthly summary

1. How many and what types of services did you provide over the past month?
   - How many were new clients? (Cross check with DSO’s Client List to ensure it is up-to-date.)
   - How many were continuing? (Cross check with the DSO’s Activity Planner to ensure it is up-to-date and that follow-up visits are being scheduled at appropriate intervals.)
   - Are you comfortable with the number of clients to which you are providing services? (Please explain)

   ________________________________
   - Were any clients late returning for scheduled visits? (Please explain how you dealt with them)

   ________________________________
   - Did any clients refuse services from you? (Please explain)

2. Did you refer any clients to another facility or provider?
   - No
   - Yes (probe for what issues required referral and whether the DSO followed up to see whether the client followed through on the referral; review actual referral form for completeness and accuracy; record examples of any problems experienced by the clients)

3. Did you experience any problems while screening your clients with the checklists provided?
   - No
   - Yes (explore the nature of the problems, record below, and clarify issues for the DSO)
4. Did you deny any methods to any of your clients based on the screening checklists?
   - No
   - Yes (record the reasons for not providing a method)

5. Briefly describe your counselling sessions with new clients. (Probe for whether the DSO is using the counselling tool provided during training and whether s/he addressed the following points):
   - Safety and effectiveness
   - How method prevents pregnancy
   - How method is used
   - Side effects
   - Return to fertility
   - When to return for the next visit
   - Where to go in case of symptoms, questions, or concerns

6. Briefly describe your counselling sessions with returning clients. (Probe for whether the DSO addressed):
   - Whether the client had any new health conditions since the last visit
   - Whether the client had any questions or concerns
   - Whether there were any side effects and reassured as needed or referred client to a health facility
   - When the client should return for another visit

7. Did you encounter problems providing any of the methods? (Probe for whether the DSO had any problems, such as giving injections, helping a client determine what to do when pills were missed.)
   - No
   - Yes (Review the appropriate skills checklist and demonstrate proper technique as needed.)

8. Did you provide information on FP to any individual or group of people? (Probe for DSO's assessment of the activity and whether the DSO had any problems, such as, questions that s/he did not feel comfortable answering, insufficient informational materials for distribution.)
   - No
   - Yes (record comments offered by the DSO)
Questions for supervisor to ask each month while reviewing the DSO Stock Tracking Form

9. Do you have any concerns with the supplies in your shop?
   (Probe for whether the re-stocking equation is providing ample monthly supplies or if the DSO needs to return more often than scheduled to re-stock; decide what can be done differently if needed.)
   □ Supplies sufficient
   □ Supplies insufficient (record comments offered by the DSO)

10. What supplies do you need to provide services for the coming month?
   (Use the equation on the stock tracking form to determine quantities and re-stock the shop with the supplies required for the next month.)
   □ Place commodities that will be first to expire at front/top of shelf/bin
   □ Refill containers with cotton balls and soap bar
   □ Ensure blank forms are available (Client Tracking Form, Client Reminder Cards, Referral Forms)
   □ Start a new DSO’s Client Register and a new DSO’s Stock Tracking Form for the next month

11. Describe how you are disposing of used syringes. (Note whether the DSO does the following):
    □ Places the sharps container within reach when giving an injection
    □ Does not recap the needle
    □ Places the syringe with needle in the sharps container immediately after use
    □ Does not overfill sharps containers
    □ Does not re-use containers; return to facility when they are full (Inquire whether the DSO needs a new sharps container.)

12. Did you suffer any needle-stick injuries?
    □ No
    □ Yes (Record if the DSOs reported the incident and sought counselling and treatment).
Questions for supervisor to ask bi-monthly while reviewing the DSOs Client Register

13. Do you have any questions about how to document a particular issue(s) on a Client Register?

☐ No
☐ Yes

14. Is there a particular client(s) that you had a question about that you would like to discuss?

☐ No
☐ Yes (Ask the DSOs to retrieve the Client Tracking Form for that client and to describe the concerns s/he has with regard to that client; note any follow-up required by the DSOs or the supervisor.)

_________________________________________________________________
_________________________________________________________________
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_________________________________________________________________
Module 8: Orientation to the Clinical Practicum

Module 8, Session 1: Overview of Practicum Expectations

Practicum/Clinical Objectives

During the clinic practicum, each participant will perform the following minimum number of FP procedures according to established standards:

- Conduct individual counselling for informed choice - 3
- Use screening checklist to assess client’s suitability (medical eligibility) for DMPA IM/SC Injections - 3
- Administer DMPA IM injection - 1
- Administer DMPA /SC injection - 2
- Follow the steps for safe handling and disposal of sharps - 3
- Correctly fill the FP Client Card, Return Appointment Card, FP Register and HMIS Forms - 3

During the practicum, the Checklist for Evaluating DSO Counselling and Method Provision (see Annex of this Reference Manual) will be used to observe and document the DSO’s compliance with established standards for the clinical procedures. Facilitators will provide details regarding the logistics of the practicum.

In some situations, it may be necessary for trainees to complete the clinical procedures required for certification outside of the formal practicum. In these cases, arrangements will be made with the trainee’s supervisor or an in-charge (mentor) at a local health care facility who is able to observe the trainee and certify that the trainee has met the performance standards for the required procedures.
Definitions

Laws
Laws are rules that govern human conduct and are binding to all persons within a given state or nation. Laws command what is right and prohibit what is wrong. Laws are often called Acts or Statutes. They are enacted in writing by a law-making body of state or nation such as the Parliament of Uganda. The Acts or Statutes are usually stated in general terms and their implementation may require development of Regulations, Guidelines and Policies.

Regulations
Regulations are more specific rules controlling or restricting a specific activity. They are made by the authority responsible for the matters in question, for example the Minister for Health who is responsible for matters of health and medical services. The Minister makes these regulations after consultation with the technical authoritative body or agency or group of individuals who are experts on the area or matter in question, e.g., the National Drug Authority (NDA) of Uganda. These regulations come into force on the date of their being published in the government gazette. The examples of such regulations are the NDA regulations of 1993.

Guidelines
These are instructions on how to implement or to enforce the laws. They are normally drawn up or laid down or issued by government or an authority or policy making body like the NDA Boards.

The difference between Guidelines and Laws is based on how they are enforced. While violations of law are punishable by Courts of Law, violations of guidelines are punishable by withdrawal of certain rights and privileges one enjoys when he adheres to the guidelines, e.g., withdrawal of the license.

Policy
A policy is a point of reference or general understanding to guide or influence decision-making regarding long-term actions e.g., policy on establishment of ADS outlets.
Drug policy
A drug policy is a statement indicating the objectives and strategies to be undertaken to improve the national pharmaceutical sector to ensure availability, accessibility and affordability of drugs while emphasizing their quality and rational use.

Regulation of medicines
Regulation of medicines and medicinal devices is a system of laws, regulations, guidelines and policies that provide a basis of legal and administrative control over the manufacture, distribution, marketing and post-marketing surveillance of these products. They prescribe and impose duties and responsibilities of the different parties/intermediaries involved in the process as medicines and medicinal devices go through from research & design to post-marketing surveillance of these products. Breach of such duties is enforceable by regulatory authorities, through sanctions applied by administrative authorities or ultimately by the criminal courts.

In relation to ADS there are specific regulations regarding:
- What medicines can be procured
- Where medicines can be procured
- Who should handle medicines
- What documentation must be kept

What products are regulated?
Any product that is presented for diagnosing, treating, preventing or alleviating disease or compensating for an injury or handicap including control of contraception both in humans and animals is by law regulated.

Grounds for Regulating Medicines
1. The increased number of individuals involved in the manufacture and sale of medicines created the need to regulate and control activities at the different levels in order to protect the public.

2. Patients dependence on health workers for medicines’ advice. Patients generally do not select their own medicines; they depend on the expert opinions of the health workers. The health workers also depend on the distributors who depend also on the manufacturers. The quality of information that is generated by the manufacturer should be verifiable as it influences what will happen at the proceeding stages in the lifecycle of a medicine. This interdependence necessitates regulating activities that may affect the use of medicines by the final consumer.
3. **Conflict of Interest.** Health workers also act as sellers of medicines. There is a potential conflict of interest between financial gains and their professional obligations. Health workers may be motivated to sell more rather than taking the welfare of the patient as primary, e.g., giving an injectable medicine for a condition where tablets could suffice.

4. **Possibility of the medicines causing harm.** Medicines are not like any other commodity of commerce; they are a social commodity that is potentially harmful to the individual using it, or the community, if not used properly. The consequence of misuse of medicines may be fatal, hence the need to put in place system that will moderate the design, manufacture, distribution and use of medicines.

**Objectives in Regulating Medicines**

- To ensure that quality medicines are available to retailers and consumers.
- To safeguard the welfare of the patient and the community.
- To ensure that qualified personnel are involved in the handling of medicines.
- To ensure that medicines are supplied and sold in suitable premises, using suitable equipment.

**Bodies Responsible for the Control of Class C Drug Shops**

There are several bodies involved in the regulation of the Class C drug shops in Uganda. These include:

1. National Drug Authority (NDA)
2. The Office of the District Health Officer (DHO)
3. The Association of Drug Shops Owners and Sellers

The NDA takes the central role in the regulation while the other bodies provide support in various areas.

**The National Drug Authority (NDA)**

The NDA was established by Section 4 of the National Drug Policy and Authority Act 1993 to implement the policy.

**Functions of the NDA**

1. Deal with development and regulation of pharmacies and drug shops in the country.
2. Approve the national list of essential drugs and revise it periodically.
3. Estimate drug needs and ensure the needs are met as economically as possible.
4. Control imports, exportation and sale of pharmaceuticals.
5. Quality control of drugs.
6. Promote local production of drugs.
7. Encourage research and development of herbal medicines.
8. Promote the rational use of drugs through training.
9. Establish and revise professional guidelines and disseminate information to health professionals and the public.

How does NDA execute its functions?
NDA executes its functions by:
• Inspecting and licensing manufacturers, importers and distributors of medicines.
• Monitoring the quality of medicines at the point of manufacture and importation.
• Registering all medicines on the Ugandan drug market.
• Controlling the marketing of medicine in Uganda.
• Establishing an independent drug information system.
• Post marketing surveillance to ensure safety, efficacy and quality.

Classification of Medicines
For purposes of effective management of medicines in the country, medicines are classified into three classes A, B and C.

Medicines are classified to avoid misuse such as irrational dispensing, abuse, potential toxicity, emergence of resistance, etc.

Several criteria are followed when classifying medicines. The following criteria are used when classifying medicines as prescription-only medicines:
• If the medicine is likely to present danger either directly or indirectly even when used correctly, e.g. digoxin.
• If a medicine is frequently abused or misused, e.g., narcotics.
• Compounds that are still under research.
• Medicines administered parenterally, e.g., medicines meant for injection.

All Class A medicines and many Class B medicines are prescription-only medicines.

By law, Class C drug shops are only allowed to sell Class C medicines, those that are available without a prescription.
Licensing of Class C Drug Shops

Section 15 of the NDA ACT allows a licensed person to carry out business or supply by retail, drugs other than class A or class B. It also provides that license will be given for business to be carried out in an area which is not sufficiently served by existing retail pharmacies.

Conditions of Licensing Class C Drug Shops

- The person should have a medical background, e.g., nurses, midwives, paramedical, veterinary or any other person authorized by the Minister.
- The applicant must receive certification from the local authorities.
- The applicant must pay the prescribed fees
- The applicant must not have committed an offence involving wrongful or illegal dealing in supply or possession of drugs
- The premises where business is supposed to be carried out should satisfy the requirements for suitability of premises as per the statute
- A class C drug shop shall be required to keep proper records of all the transactions taking place in the shop, and will allow inspection by NDA or a police officer.

Standards for Operating a Class C Drug Shop

The standards for operating were developed to provide a basis for which services will be measured.

A standard refers to a level of quality or a specified level of quality that will be measured. Services will be considered to be of poor quality if they are perceived to fall below the stipulated standard.

1. Standards for Personnel
   a) Every class C drug shop should have a licensed person or in-charge with at least one of the following minimum qualifications
      o pharmacy technician
      o nurse/midwife (enrolled or registered)
      o medical clinical officer and other cadres of the allied health profession with basic training in pharmacology
   b) Commitment letters shall be written and signed by the drug sellers committing to work with a drug shop for a specific period of time. The letters should be endorsed by the drug shop owner.

2. Standards for Premises
   2.1 Every Class C drug shop premise is required to meet minimum requirements as follows, namely:
a) be of a permanent nature;
b) be roofed with materials which make it free from leakages and with a leak-proof ceiling;
c) be well protected from entry of rodents, birds, vermin and pests;
d) have adequate space to carry out primary functions of storage, dispensing and sales;
e) have a design which includes:
   i. doors and windows which are well secured to prevent theft and unauthorized entry;
   ii. one room that shall be at least of 16m$^2$ (sixteen square meters) and height of 2.5m;
   iii. a separate lockable dispensing area with no access to the public. Approved prescription medicines should be kept in the dispensing area in secure fixed lockable cupboards.
f) have surfaces/floors with smooth finish that can be washed with disinfectants;
g) painted with washable white or any bright colour;
h) have adequate supply of clean and safe water, soap and clean and safe drinking water;
i) have facilities to wash hands;
j) have adequate toilet facilities in clean and good working order;
k) observe general hygiene in and outside the premises;
l) shall not be shared with any medical clinic, veterinary surgery or any other business of a similar nature.

If a new pharmacy is opened within 500m from the Class C drug shop, the drug shop shall be given an opportunity to upgrade to a pharmacy, relocate as per the equitable distribution guidelines or wind up operation within one calendar year or from the time a new retail pharmacy starts operation in the location.

3. Standards for Dispensing

3.1 Dispensing procedure

a) Every drug shop operator shall bear legal liability and professional responsibility for the pharmaceutical products and services provided under his/ her care.

b) Every drug shop shall only dispense pharmaceutical products registered by the National Drug Authority in accordance with the National Drug Policy and Authority Act, 1993.
c) The drug shop operator/seller shall not dispense damaged, counterfeit, substandard or expired medicines.
d) The drug shop operator/seller shall not dispense or sell medicines to infants (from birth to 2 months).
e) Dispensing procedures must ensure that dispensing takes place with reasonable promptness.
f) Patients whose conditions cannot be handled should be referred to the nearest health facility.
g) Every drug shop operator shall ensure that:
   i. Prescription drugs are only dispensed against a prescription.
   ii. A full dose is dispensed.
   iii. Tablets and capsules are dispensed using an appropriate device for counting the tablets or capsules, such as a counting tray.
   iv. A record of all medicines dispensed by him/her is maintained in a register approved by the NDA.
   v. No drug is dispensed unless in accordance with the Accredited Drug shop dispensing and training guidelines and in accordance with the existing NDA laws.
   vi. For each prescription dispensed, the date of issue, the quantity of drug supplied and the signature of the one who dispenses the prescription must be indicated (preferably in red ink).

3.2 Counseling of patients
a) A drug shop operator/seller must ensure that the patient or their agent understands the information and advice given (including directions on the labels of dispensed products) well enough to ensure safe and effective use of the medicine.
b) Information for drugs requiring particular instructions for use must be clearly pointed out to the patient before he/she or their agent leaves the drug shop.
c) Patients or their representatives must be warned to keep medicines well out of reach of children.

3.3 Dispensing containers
a) All oral liquid preparations must be dispensed in their original re-closable containers.
b) All containers for medicinal products must be protected from and free of contamination.
c) The containers must be appropriate for both the product dispensed and the user.
3.4 **Labels**
   a) Labeling of dispensed products must be clear and legible.
   b) Dispensed medicines must bear the necessary cautionary and advisory labels.
   c) The label on the container must indicate the name, strength, dosage and total quantity of the product sold.

3.5 **Sources of supply**
   a) Drugs shall be procured from wholesale pharmacies registered in Uganda.
      i. It is the responsibility of the wholesale pharmacy to verify the credentials of a Class C drug shop prior to the sale of drugs.
      ii. Wholesale pharmacies selling prescription drugs to drug shops shall be required to keep easily retrievable documents related to sales and shall also provide to the drug shop an invoice/sales receipt in respect of all drugs sold to them.
   b) No drug shop shall stock medicines and health supplies meant for public health facilities.

3.6 **Storage**
   a) All pharmaceutical products held in inventory shall be stored in the manufacturer’s original packaging and properly labeled with the manufacturer’s original label.
   c) Removal of labels from containers is prohibited and it renders the product unfit for dispensing.
   d) Repackaging and re-labeling of pharmaceutical products not for the purpose of immediate dispensing to the patients is prohibited.
   e) Measures shall be taken to protect pharmaceutical products from heat, sunlight, moisture, adverse temperatures, insects, rodents and contamination.
   f) Damaged and/or expired drugs shall be recorded, sealed, quarantined and labeled with red ink with the statement “Expired/damaged Drugs – Not for sale” by the drug shop operator/seller.

3.7 **Hygiene**
   a) Drug shop personnel should not be allowed to work if they are suffering from contagious diseases such as scabies, tuberculosis, etc.
   b) Dispensing must always be carried out under conditions which meet acceptable standards of hygiene including high standards of personal cleanliness
   c) Use of bare hands for counting tablets and capsules must be avoided.
4. Standards for Recordkeeping and Documentation

(For use in Module 9, Session 3.)

4.1 All invoices and receipts for non-prescription drugs and permitted prescription drugs shall be stored on the premises in an easily retrievable file for not less than two years.

4.2 A purchases record book or order book obtained from NDA shall be kept, which shall minimally include (see sample in Annex):
   a. Name of supplier;
   b. Date of purchase;
   c. Name and quantity of the drugs;
   d. Manufacturer, batch number and expiry date.

4.3 All drug shops shall maintain for each permitted prescription drug a dispensing log book, which shall minimally include (see sample in Annex):
   a. Name of the patient and condition/disease for which the prescription was written;
   b. Name of drug and quantity dispensed;
   c. Date on which the drug was dispensed; and
   d. Origin of the prescription and the prescribing doctor.

4.4 The records relating to prescription drugs shall be kept and maintained within the premises for not less than two years and they shall be available for inspection at all times.

4.5 There shall be a record for expired products which shall be kept and maintained by the drug shop operator/seller (see sample in Annex).
   a. Expired or damaged medicines must not be dispensed to patients or dumped illegally. The DSO should confirm the appropriate method of disposing of these items.
   b. The owner of a drug shop shall, quarterly, provide the list of all expired products to the NDA Drug Inspector and meet the costs of their destruction.

4.6 There shall be NDA adverse drug reaction forms maintained in each drug shop for the purpose of recording patient drug related adverse reactions (see sample in Annex).

4.8 Reference Materials
Each drug shop shall have and maintain for easy reference, the recent editions of the following reference materials:
   a) National Standard Clinical Guidelines
   b) Other recommended references include:
      a. Essential Medicines List for Uganda
b. The British National Formulary

c. Relevant legislations, including:
   1. The National Drug Policy and Authority Statute 1993
   2. The Allied Health Professionals Statute 1996
   3. The Nurses and Midwives Statute 1996

5. Offences and Penalties

Any person who contravenes any provisions of these standards commits an offence and shall be liable upon conviction to a fine and/or to imprisonment specified under the National Drug Authority Act, 1993. Under this, the violator may be subjected to appear before a court of law and upon conviction; he may be punished by either paying a prescribed amount of fee or serve an imprisonment sentence or both.

Activity Sheet—Offences and Penalties

This activity provides an opportunity for participants to consider the NDA guidance outlined on the preceding pages regarding Class C drug shops. The answer key for the scenarios appears in the Trainer’s Guide.

Scenario 1: You are found selling expired medicines or medicines outside the approved list for Class C drug shops.

Scenario 2: A person who opens a drug shop without a license.

Scenario 3: Like any other business, drug shops shall be liable for taxation. What happens if you neglect paying taxes?

Scenario 4: Purchase of medicines from non-licensed dealers.

Scenario 5: Dispensing to patients medicines purchased from unauthorized dealers.

Scenario 6: A DSO sells a pack of five condoms for three thousand Uganda shillings. The package is clearly marked with the government of Uganda logo and available at no charge from government facilities.

Scenario 7: A man comes to your drug shop asking for contraceptive pills saying he wants to take it home to his wife. Can you dispense the pills?
Module 9, Session 2: The ADS Extended Medicines List

The list has been drawn up taking into consideration the prescribing levels in line with the national Standard Treatment Guidelines. A consideration has also been made to ensure that the public get reasonable access to the most essential (key) drugs needed to treat the common diseases found in the community.

<table>
<thead>
<tr>
<th>DRUG AND FORM</th>
<th>INTENDED AILMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Anti-Asthmatics &amp; Cough Preparations</strong></td>
<td></td>
</tr>
<tr>
<td>Aminophylline tablet 100mg</td>
<td>Wheezing and bronchitis</td>
</tr>
<tr>
<td>Salbutamol tablet 4mg</td>
<td>Wheezing and bronchitis</td>
</tr>
<tr>
<td>Non-narcotic cough preparations (e.g., cough linctus, expectorants and herbal)</td>
<td>Symptomatic relief of dry and chesty cough</td>
</tr>
<tr>
<td><strong>Antibacterials/Antibiotics</strong></td>
<td></td>
</tr>
<tr>
<td>Amoxicillin capsules/tablets 250mg &amp; 500mg</td>
<td>Upper respiratory tract infections (URTIs), urinary tract infections (UTIs)</td>
</tr>
<tr>
<td>Amoxicillin oral suspension 125mg/5ml &amp; 250mg/5ml</td>
<td>URTIs, UTIs, skin infections</td>
</tr>
<tr>
<td>Co-trimoxazole suspension 240mg/5ml</td>
<td>URTIs</td>
</tr>
<tr>
<td>Co-trimoxazole tablets 480mg and 960mg</td>
<td>URTIs</td>
</tr>
<tr>
<td>Doxycycline capsules/tablets 100mg</td>
<td>UTIs</td>
</tr>
<tr>
<td>Erythromycin oral suspension 125mg/5ml</td>
<td>URTIs, UTIs</td>
</tr>
<tr>
<td>Erythromycin tablets 250mg</td>
<td>URTIs, UTIs</td>
</tr>
<tr>
<td>Metronidazole tablets 200mg</td>
<td>Amoebiasis, trichomoniasias</td>
</tr>
<tr>
<td>Metronidazole suspension 200mg/5ml &amp; 125mg/5ml</td>
<td>Amoebiasis</td>
</tr>
<tr>
<td>Nitrofurantoin tablets 100mg</td>
<td>UTIs</td>
</tr>
<tr>
<td>Phenoxyymethyl Penicillin suspension 125mg/5ml</td>
<td>URTIs</td>
</tr>
<tr>
<td>Phenoxyymethyl Penicillin tablets 250mg</td>
<td>URTIs</td>
</tr>
<tr>
<td>Ciprofloxacin 250mg &amp; 500mg tablet</td>
<td>Gonorrhoea and other UTIs</td>
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<tr>
<td><strong>Dermatological Products</strong></td>
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<td>-----------------------------------------------------------------</td>
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<tr>
<td>Silver sulfadiazine cream 1%</td>
<td>Wounds and burns</td>
</tr>
<tr>
<td>Iodine tincture 2%</td>
<td>Wounds</td>
</tr>
<tr>
<td>Calamine lotion 15%</td>
<td>Anti-inflammatory and Pruritus</td>
</tr>
<tr>
<td>Benzyl benzoate lotion 25%</td>
<td>Scabies</td>
</tr>
<tr>
<td>Malathion lotion aqueous 0.5%</td>
<td>Pediculosis</td>
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<tr>
<td>Hydrocortisone cream 1%</td>
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<table>
<thead>
<tr>
<th><strong>Anti-Helminthics</strong></th>
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<tbody>
<tr>
<td>Mebendazole tablet 100mg</td>
<td>Intestinal worms</td>
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<tr>
<td>Mebendazole suspension 100mg/5ml</td>
<td>Intestinal worms</td>
</tr>
<tr>
<td>Albendazole tablets 200mg &amp; 400mg</td>
<td>Intestinal worms</td>
</tr>
<tr>
<td>Albendazole suspension 100mg/5ml &amp; 200mg/5ml</td>
<td>Intestinal worms</td>
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<tr>
<th><strong>Anti-Inflammatory/Analgesics</strong></th>
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<tbody>
<tr>
<td>Diclofenac sodium tablets 50mg &amp; 100mg</td>
<td>Musculo-skeletal pain and fever</td>
</tr>
<tr>
<td>Ibuprofen tablet 200mg &amp; 400mg</td>
<td>Musculo-skeletal pain and fever</td>
</tr>
<tr>
<td>Ibuprofen syrup 100mg/5ml</td>
<td>Musculo-skeletal pain and fever</td>
</tr>
<tr>
<td>Acetylsalicylic acid tablet 300mg</td>
<td>Musculo-skeletal pain and fever</td>
</tr>
<tr>
<td>Paracetamol tablet 500mg</td>
<td>Musculo-skeletal pain and fever</td>
</tr>
<tr>
<td>Paracetamol suspension 120mg/5ml</td>
<td>Musculo-skeletal pain and fever</td>
</tr>
<tr>
<td><strong>Anti-Allergic</strong></td>
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</tr>
<tr>
<td>Chlorpheniramine tablet 4mg</td>
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<tr>
<td>Chlorpheniramine syrup 2mg/5ml</td>
<td></td>
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<tr>
<td>Promethazine tablet 25mg</td>
<td></td>
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<tr>
<td>Promethazine syrup 5mg/5ml</td>
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<tr>
<td>Cetirizine tablet 10mg</td>
<td></td>
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<tr>
<td>Cetirizine syrup 5mg/5ml</td>
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<tr>
<th><strong>Anti-Fungal</strong></th>
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<tbody>
<tr>
<td>Nystatin oral suspension 100,000 IU/5ml</td>
<td></td>
<td>Oral candidiasis</td>
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<tr>
<td>&amp; 100,000 IU/ml</td>
<td></td>
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<tr>
<td>Nystatin tablets 100,000 IU 500,000 IU</td>
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<td>Oral candidiasis</td>
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<tr>
<td>Nystatin lozenges 100,000 IU</td>
<td></td>
<td>Oral candidiasis</td>
</tr>
<tr>
<td>Nystatin pessaries 100,000 IU</td>
<td></td>
<td>Vaginal candidiasis</td>
</tr>
<tr>
<td>Clotrimazole pessaries 100mg</td>
<td></td>
<td>Vaginal candidiasis</td>
</tr>
</tbody>
</table>
| Clotrimazole cream 1%                   |                                | Skin infections (e.g.,
|                                        |                                | ringworm)                      |
| Sulphur ointment 10%                    |                                | Skin infections (e.g.,
|                                        |                                | ringworm)                      |
| Benzoic acid + salicylic acid ointment  |                                | Skin infections (e.g.,
| 6% + 3%                                 |                                | ringworm)                      |
|                                        |                                |                      |

<table>
<thead>
<tr>
<th><strong>Anti-Malarial Medicines</strong></th>
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<tbody>
<tr>
<td>Artemether/Lumefantrine tablet 20/120</td>
<td></td>
<td>Uncomplicated malaria</td>
</tr>
<tr>
<td>mg (Coartem) &amp; 40/240mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Artesunate/Amodiaquine tablet 50/200</td>
<td></td>
<td>Uncomplicated malaria</td>
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<tr>
<td>mg and other ACTs</td>
<td></td>
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<tr>
<td>Quinine tablet 300mg</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Quinine suspension 100mg/5ml</td>
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<tr>
<td><strong>Disinfectants &amp; Antiseptics</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>---</td>
<td>---</td>
<td></td>
</tr>
<tr>
<td>Cetrimide + chlorhexidine solution 0.5% + 0.05%</td>
<td>Skin wounds antiseptic</td>
<td></td>
</tr>
<tr>
<td>Chlorhexidine gluconate solution 20%</td>
<td>Skin wounds</td>
<td></td>
</tr>
<tr>
<td>Hydrogen peroxide solution 6%</td>
<td>Skin wounds and mouth gargle</td>
<td></td>
</tr>
<tr>
<td>Calcium or sodium hypochlorite solution 5%</td>
<td>Disinfectant</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Contraceptives</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Ethinylestradiol + Norethisterone</td>
<td>Combined contraceptive</td>
</tr>
<tr>
<td>Ethinylestradiol + Levonorgestrel</td>
<td>Combined contraceptive</td>
</tr>
<tr>
<td>Norgestrel 0.075mg tablet (Ovrette)</td>
<td>Progestin-only oral contraceptive</td>
</tr>
<tr>
<td>Levonorgestrel 1.5mg tablet (Revoke)</td>
<td>Emergency oral contraceptive</td>
</tr>
<tr>
<td>Levonorgestrel 750mcg tablet (Postinor)</td>
<td>Emergency oral contraceptive</td>
</tr>
<tr>
<td>Depot medroxyprogesterone acetate (DMPA 150mg for IM injection)</td>
<td>Progestin-only injectable contraceptive</td>
</tr>
<tr>
<td>Depot medroxyprogesterone acetate (DMPA 104mg for SC injection)</td>
<td>Progestin-only injectable contraceptive</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Anti-Diarrhoea</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Zinc sulphate tablets</td>
<td>Diarrhoea in children</td>
</tr>
<tr>
<td>ORS</td>
<td>Diarrhoea in children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Anti-Convulsant</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Diazepam rectal tube 2mg/mL</td>
<td>Convulsions in children</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Antidotes</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Charcoal activated tablet 250mg</td>
<td>Food poisoning</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Eye/Ear/Nasal Preparations</strong></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Chloramphenicol eye ointment 1%</td>
<td>Eye infections</td>
</tr>
<tr>
<td>Chloramphenicol eye/ear drops 0.5%</td>
<td>Eye infections</td>
</tr>
<tr>
<td>Medicine</td>
<td>Indication</td>
</tr>
<tr>
<td>---------------------------------------------------</td>
<td>---------------------</td>
</tr>
<tr>
<td>Tetracycline eye ointment 1%</td>
<td>Eye infections</td>
</tr>
<tr>
<td>Combined antibiotic plus steroid eye/ear/nasal drops</td>
<td>Eye infections</td>
</tr>
<tr>
<td><strong>Anti-A anaemia Medicines, Vitamins &amp; Minerals</strong></td>
<td></td>
</tr>
<tr>
<td>Ferrous salt tablet 60mg</td>
<td>Anaemia</td>
</tr>
<tr>
<td>Folic acid tablet 5mg</td>
<td>Anaemia</td>
</tr>
<tr>
<td>Ferrous/Folic acid 200mg/0.5mg &amp; 100mg/0.5mg</td>
<td>Anaemia</td>
</tr>
<tr>
<td>Multivitamin tablets and suspensions</td>
<td>Appetite</td>
</tr>
<tr>
<td>Vitamin A capsules</td>
<td></td>
</tr>
<tr>
<td>Vitamin C tablets 100mg</td>
<td></td>
</tr>
</tbody>
</table>
Module 9, Session 3: NDA-required Records/Documentation for Drugs in ADS

See section above, Standards for Operating a Class C Drug Shop, 4. Standards for Recordkeeping and Documentation and sample forms in the Annex.

Consequences of Adverse Drug Reaction

<table>
<thead>
<tr>
<th>Examples of adverse drug reactions</th>
<th>Remarks</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Septin reaction</strong></td>
<td></td>
</tr>
<tr>
<td>• This was a male HIV + patient who was given septrin for prophylaxis.</td>
<td></td>
</tr>
<tr>
<td>• He developed severe reactions and the drug was stopped.</td>
<td></td>
</tr>
<tr>
<td><strong>Reaction to ARVs</strong></td>
<td></td>
</tr>
<tr>
<td>• This adult female patient reacted to one of the antiretroviral drugs in the combination which had been given to her to treat HIV infection.</td>
<td></td>
</tr>
<tr>
<td><strong>Body deformity</strong></td>
<td></td>
</tr>
<tr>
<td>• It occurred when a drug which was thought to be safe for use in pregnancy was given to a pregnant mother.</td>
<td></td>
</tr>
<tr>
<td>• The baby was born with deformities.</td>
<td></td>
</tr>
<tr>
<td>• This explains the need to report adverse drug reactions so that such cases can be minimized.</td>
<td></td>
</tr>
</tbody>
</table>
Module 9, Session 4: Medicines and FP Commodities Management

Medicines Management
A system of processes and behaviours for coordinating or supervising medicines handling, those delivering services to patients and usage of medicines by patients and those delivering health care services to patients in order to optimize the contribution that medicines make in producing the desired patient outcomes.

The Medicines Management Cycle
The medicines management cycle includes selection, procurement, distribution, and use of medicines. These activities are interlinked and reinforced by appropriate management support systems (i.e., tools), and are regulated by a legal and policy framework.

The Medicine Management Cycle

Selection
Selection of medicines at the drug shop ensures that the medicines that are stocked meet the health needs of the community. For the case of FP, the following products will be selected: Condoms, Combined Oral Contraceptives (COCs), Progestin-Only Pills (POPs), Emergency Contraceptive Pills (ECPs), and DMPA IM and SC (Uniject).
GOOD INVENTORY MANAGEMENT PRACTICES
FOR ADS COMMODITIES

1. Ordering
- Know what to order
- Know how much to order
- Adjust for stock on hand
- Use manual tools to quantify needs
- Know when to order

2. Receiving
- Inspect goods for quantity and quality
- Sign delivery notes
- Enter received items in stock ledger and stock card

3. Storing
- Ensure appropriate storage
- Maintain updated stock cards and track expiry dates
- Secure storage areas

Inspection Checklist

Packaging
- Broken
- Ripped

Labels
- Missing
- Incomplete
- Unreadable

Tablets or capsules
- Discoloured
- Sticky
- Crushed or crumbled
- Unusual smell

Liquids
- Discoloured
- Sedimentation
- Cloudiness
- Unusual smell
- Broken seal on bottle
- Cracked bottles
- Dampness inside packages
Procurement/Buying of Medicines

It is important to estimate the quantity of medicine to be procured to avoid:

- Overstocking which may lead to expiry of medicines and wastage.
- Stock out of medicines which may lead to loss of trust, credibility and confidence by the community.

The quantity of medicines to purchase will be estimated on the basis of what is consumed/sold per month (average monthly consumption).

PROCUREMENT

To procure medicines, a DSO must:

- Identify a source of drugs (i.e., a wholesaling pharmacy)
- Estimate the quantity of each medicine needed based on the rate of product consumption
- Determine precisely the dosage form, strength, and pack size of the product required (Note: To maintain the integrity of the product, some packages should not be broken into smaller units.)
- Ask the wholesaling pharmacy about the prices of the different dosage forms and pack sizes required.
- Allocate funds for each medicine item depending on:
  - Priority nature of the medicine and dosage form
  - Available finances

How to Determine Average Monthly Consumption (AMC)

- First, determine how much was used over a specific period (e.g., 3 months). Refer to the dispensing log for a daily record what has been sold.
- Calculate the average per month by dividing the total consumption over a specified period by that period (e.g., for a specified period of three-months, divide by 3).
- Establish the maximum (5 months) and minimum quantity (2 months stock).
- Deduct what is available in stock from the minimum quantity to get the actual quantity to buy.

Use Stock Cards to Track Inventory (see sample in Annex)

- Keep a stock card (pre-printed or homemade) for every item stocked.
- A stock card shows the quantity in, quantity out, balance and expiry date
- If the balance on the card drops below your minimum stock quantity, place an order for more stock.
Example:

Below is information on the packets of condoms sold over the last 3 months at Joy Drug Shop. The current balance on the shelf is 10. Calculate how much should be stocked.

<table>
<thead>
<tr>
<th>January</th>
<th>February</th>
<th>March</th>
</tr>
</thead>
<tbody>
<tr>
<td>12</td>
<td>15</td>
<td>9</td>
</tr>
</tbody>
</table>

Total consumption = 12 + 15 + 9 = 36 (total from last three months)

Average Monthly Consumption (AMC) = 36/3 = 12 (divide by 3 to get the average)

Minimum stock = 2 x 12 = 24 (multiply by 2 for two-month supply)

Maximum stock = 5 x 12 = 60 (multiply by 5 for five-month supply)

Quantity to order (subtract amount currently in stock from minimum or maximum)

= 24 - 10 = 14 (amount to order to maintain a two-month supply)

= 60 - 10 = 50 (amount to order to maintain a five-month supply)

Consider the factors mentioned below when deciding the final order quantity.

FACTORS TO CONSIDER WHEN ESTIMATING ORDER QUANTITY

When estimating the quantity of medicines to procure a DSO must consider:

- Consumption rate of the medicine (determined using the guidance above)
- Population which the outlet serves
- Disease patterns and the seasonal variation in disease the pattern (e.g., during rainy season there is increase in diarrhoeal diseases)
- Frequency of procurement
- Available space for storage of medicine
- Distance to the pharmacy where the medicines are to be procured
- Amount of money available for purchasing stock
Individual Activity Sheet—Calculating Order Quantities and Costs

Instructions: Using the information below, estimate the quantity and cost of Amoxycillin capsules needed for God Cares Drug Shop. Calculate the minimum (two-month) and the maximum (five-month) supply of stock.

From the dispensing log, the consumption over the previous month was 400 capsules. The two months prior showed similar rates of consumption, 375 capsules one month and 425 during the other.

Each carton of 100 capsules costs 4500 UGX

Current stock is 150 capsules

Calculate the quantity and cost of Amoxycillin to be ordered

Total consumption (total from last three months) =

Average Monthly Consumption (AMC) (divide by 3 to get average) =

Minimum stock—Two-month supply (multiply AMC by 2) =

Quantity to order to maintain a two-month supply
(subtract amount currently in stock) =

Decide # of cartons to maintain a two-month supply
(round # of capsules to nearest 100) =

Cost of order to maintain a two-month supply
(multiply number of cartons by 4500 UGX) =

Maximum stock—Five-month supply (multiply AMC by 5) =

Quantity to order to maintain a five-month supply
(subtract amount currently in stock) =

Decide # of cartons to maintain a five-month supply
(round # of capsules to nearest 100) =

Cost of order to maintain a five-month supply
(multiply number of cartons by 4500 UGX) =
GOOD STORAGE PRACTICES FOR ADS COMMODITIES

Ensure security
- Control access
- Use lockable cupboards

Use orderly arrangement
- Provide sufficient shelving
- Use a system for arranging
  (e.g., dosage form, alphabetically or by
generic name)

Place bulky stock off the floor
- Ensure bulky goods are stored off the floor
  on pallets
- Do not overstack items to avoid crushing
- Stack boxes in upright position

Use FEFO for stock rotation
- Place medicines on the shelf according to
  “First Expire First Out”

Use stock cards or ledger
- Maintain an updated stock card for
  every medicine and commodity
- Place stock card next to the item

Remove expired / damaged
  medicine
- Do not keep expired / damaged
  medicine with non-expired stock
- Follow procedure for disposing
  unusable stock

Control lighting and ventilation
- Minimize direct light exposure on stock
- Allow air circulation between stock
- Consider use of appropriate mechanical
  ventilation tools (e.g., fan)

Adhere to safety precautions
- Prohibit smoking in the storage areas
- Maintain a first aid kit within easy reach
Receiving Medicine

- When receiving medicines take note that the medicines supplied match your order including: strength, package size and quantity.
- Check the prices and expiry dates.
- Any discrepancies noted should immediately be communicated to the supplier who should correct them.

Storage of Medicines

Medicines and related supplies are expensive and valuable. They need care otherwise they may deteriorate. If they deteriorate, they may lose their potency or may have the wrong effects on patients.

- All pharmaceutical products held in inventory shall be stored in the manufacturer’s original packaging and properly labeled with the manufacturer’s original label.
- Removal of labels from containers is prohibited and it renders the product unfit for dispensing.
- Repackaging and re-labeling of pharmaceutical products not for the purpose of immediate dispensing to the patients is prohibited.
- Measures shall be taken to protect pharmaceutical products from heat, sunlight, moisture, adverse temperatures, insects, rodents and contamination.
- Damaged and/or expired drugs shall be recorded, sealed, quarantined and labeled with red ink with the statement “Expired/damaged Drugs – Not for sale” by the drug shop operator/seller.

ARRANGING MEDICINES IN THE DRUG SHOP

- Top shelves: Store solid medicines, i.e., tablets, capsules, packets. If the top shelf is near the ceiling or out of your reach, use that shelf to store items that are NOT sensitive to heat and are NOT used regularly.
- Middle shelves: Store liquids, i.e., syrups and ointments. Do NOT put solid medicines below them. If liquids leak, the medicines below may spoil.
- Bottom shelves: Store other supplies, i.e., surgical items, condoms, labels.
- NO medicines should be stored directly on the floor.
- Medicines should be arranged in a systematic way following this format: 1-Dosage form, 2-Pharmacological order, 3-Alphabetical order using generic names of the medicine.
- Each dosage form of a drug is arranged in a separate, distinct area.
- Sufficient empty space should demarcate one medicine item or dosage form from another.
ARRANGING MEDICINES IN THE DRUG SHOP (continued)

- Most recently received medicines should be placed behind older stock on the shelf except where new drugs have shorter expiration dates.
  - FIFO = first in, first out, and
  - FEFO = first expiry, first out
- The medicine package should be placed such that the name of the medicine is well displayed.
- Heavy medicine packages should be placed on the lower shelves and lighter ones on top.
- Clean or dust the shelves before placing medicines on them.
- Regularly dust the medicine containers and shelves. Dust contaminates supplies and makes labels difficult to read.
Activity Sheet—What’s wrong/right with the storage practices shown?

List the storage problems shown in this photo:

Note how items are correctly stored in this photo:
GOOD DISPENSING PRACTICES FOR ADS

1. Greet customer and ask about reason for visit

If customer has prescription—
- Check accuracy of patient information
- Check prescription validity
- Communicate with prescriber / customer to verify any discrepancy
- Check medicine name
- Check if dosage is appropriate for patient

If customer has no prescription—
- Ask about signs and symptoms
- Refer patient with danger signs
- Refer patient / customer if you are unsure of problem
- Otherwise, suggest appropriate action to take or recommend treatment

2. Retrieve medicine from storage
- Select the appropriate medicine
- Check the general condition of the medicine
- Use “first expire first out” principle
- Double check medicine identity, strength, and dosage form

3. Prepare and process
- Wash your hands
- Count tablets / capsules using dispensing tray or counter
- Put in appropriate container, such as dispensing envelope
- Label medicine appropriately

4. Counsel the customer
- Communicate with the customer on correct way to take the medicine
- Ensure customer understands all instructions

5. Keep records
- Enter details of customer encounter in register
- Complete all inventory records for medicine dispensed
Distribution/Dispensing

- At the drug shop, medicine distribution is mainly by dispensing medicines to patients.
- Dispensing requires an understanding of the patients (who may not speak or understand the language of the dispenser) and practical skills in dispensing and recordkeeping.

DISPENSING PROCESS

1. Receive the prescription.
2. Understand and interpret the prescription.
3. Prepare the medicine for issue.
4. Record the medicine in the dispensing book.
5. Issue medicine to the patient with clear instruction and advice.

DISPENSING MEDICINES

DSOs dispense medicines to patients, often in response to a prescription. A prescription is written by a clinician who has examined the patient, identified the problem, and indicated what needs to be done for the patient, including any necessary medicines.

Example of a Properly Written Prescription

<table>
<thead>
<tr>
<th>Kakumiro Health Centre IV</th>
<th>OPD NO. 340/09</th>
</tr>
</thead>
<tbody>
<tr>
<td>P.O. BOX 68 Kakumiro</td>
<td>Date: 04.05.2009</td>
</tr>
<tr>
<td>Name: M/S Kibuuka John</td>
<td>Address: Kukumiro</td>
</tr>
<tr>
<td>Age: Adult</td>
<td>Weight: 70 kg</td>
</tr>
<tr>
<td>Rx</td>
<td></td>
</tr>
<tr>
<td>Co-trimoxazole tablets (480mg) i i b.i.d. x 5/7</td>
<td></td>
</tr>
<tr>
<td>Paracetamol tablets (500mg) ii tds x 3/7</td>
<td></td>
</tr>
<tr>
<td>Name of prescriber/qualifications</td>
<td>Dr. Mwesiga Emanuel MBChB (MUK)</td>
</tr>
<tr>
<td>Signature__________________</td>
<td></td>
</tr>
</tbody>
</table>
INTERPRETING PRESCRIPTIONS

The dosage form and the instructions for use on a prescription are often written in an abbreviated code. This code is based on the ancient language of Latin so special training is required to interpret it. For example, b.d. or b.i.d means “twice daily” p.o. means “take by mouth.” A list of the common abbreviations used in prescriptions is included below.

Prescription Abbreviations Decoded

Ever wonder what all of those cryptic initials mean on the prescription your doctor hands you to be filled by the pharmacist? Many of the abbreviations you see are derived from Latin, which can make it even more difficult to try and make sense of them. Here’s a handy guide to some of the most frequently used abbreviations for prescriptions:

a.c. = before meals
a.d. = right ear
a.m. = morning
a.s. = left ear
a.u. = each ear
aq. = water
b.i.d. = twice daily
b.i.n. = twice a night
b.i.s. = twice
BP = blood pressure
c. = with
cap. = capsule
CBC = complete blood count
c.c. = cubic centimeter
D = dose
delb. = every other day
dieb. tert. = every third day
dil. = dilute
disc or D.C. = discontinue
disp. = dispense
div. = divide
dos. = dose
dr. = dram
e.m.p. = as directed
et. = and
ex aq. = in water
fi or fid = fluid
gr. = gram
gr. or gr. = grain
gtt. = drop

b. or hs. = hour
h.s. = at bedtime
HBP = high blood pressure
HT = hypertension
IM = Intramuscular
IV = Intravenous
Iq = liquid
m. et n. = morning and night
mg = milligram
ml = milliliter
N.R. = do not repeat
NPO = nothing by mouth
o.d. = right eye
o.l.or o.s. = left eye
oz = ounce
p.c. = after meals
p.m. = afternoon, evening
p.o. = by mouth
p.r.n. = as needed
q = every
qd = every day
qh = every hour
qid = four times a day
qod = every other day
R = rectal
s. = without
Sig. = write on label
S0B = shortness of breath
sol. = solution
ss. = one-half
stat. = immediately
Subc or subq = subcutaneously
sum. tal. = take one each
sup. = suppository
susp. = suspension
syr. = syrup
tab. = tablet
tsp = tablespoon
tid = three times a day
th = three times a week
top = topically
tsp. = teaspoon
U or u = unit
U.d. or ut dict = as directed
URI = upper respiratory infection
UTI = urinary tract infection
w/ = with
w/o = without
x = times
y.o. = year old
PACKAGING AND LABELLING OF MEDICINE

- Write the label before counting or measuring and packaging the drug. It will be easier to write clearly without damaging or spilling the medicine.
- If you are dispensing more than one drug, finish one drug before starting the next so that you are less likely to mix up the drugs/labels.
- What information should be written on the label?
  - Name of the patient
  - Name of the drug
  - Strength of the drug
  - Quantity of the drug supplied
  - The instructions on how the drug is to be used: How much each time, How often per day
  - Special instructions: With or without meals, With plenty of fluids
  - Date supplied
  - Name and address of the healthcare facility and medicine outlet.
- Package solid dosage forms (tablets/capsules) in:
  - Plastic dispensing bags
  - Paper envelopes
  - Small sterilized bags (typically very expensive)
- Package liquids/semisolid dosage forms (mixtures/syrups, ointments, creams, etc.) in original/primary pack (e.g., hydrogen peroxide)
Proper Use of Drugs by Clients
This is by the patients to whom the medicines have been given. It is important that they be counseled on how to use the medicines properly.

INFORMATION FOR PATIENTS
Reinforce the instructions written on the label; give the patient information in a language the patient speaks/understands, including:

- How often to take the medicine.
- When to take the medicine (e.g., before or after the meals).
- How long the treatment is to last (e.g., why the entire course of an antibiotic treatment must be taken).
- How to take the medicine (e.g., with water, chewing, or swallowing).
- How to store the medicine (e.g., avoid heat, light, and dampness)
- Not to share the medicine with another person.
- To keep medicine out of the reach of children.
ANNEXES

Sample Forms
- Stock card
- Purchases record book
- Dispensing log book
- Expiries record book
- Adverse drug reaction report form
- FP Client Card
- Client Return Appointment Card
- Referral Form
- Daily FP Activity Register
- Monthly FP Summary Form for Input into HMIS Report

Checklist for Evaluating DSO Counseling and Method Provision

Knowledge and Skills Application Plan
Sample Form:

**Stock Card**

The simplest form of stock record keeping for an ADS is a stock card. A stock card is made for each contraceptive in the drug shop. It may be used for all other medicines. There are two types of stock cards: a pre-printed stock card or a “home-made” stock card. A home-made stock card means that the shop owner creates his or her own stock card. It can be easily made from an exercise book or a counter book. An example of a page in a counter book would look like this:

<table>
<thead>
<tr>
<th>Date</th>
<th>Quantity In</th>
<th>Quantity Out</th>
<th>Balance</th>
<th>Expiry Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>30/3/2018</td>
<td>30</td>
<td>3</td>
<td>27</td>
<td>31/12/2020</td>
</tr>
<tr>
<td>31/3/2018</td>
<td>27</td>
<td>4</td>
<td>23</td>
<td></td>
</tr>
</tbody>
</table>
## Sample Form: Purchases Record Book

<table>
<thead>
<tr>
<th>Invoice/Receipt Number</th>
<th>Name of Supplier</th>
<th>Batch Number</th>
<th>Quantity</th>
<th>Manufacturer</th>
<th>On Hand/Expiry Date</th>
<th>Total Cost/Price</th>
<th>Selling price per unit</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
### Sample Form: Dispensing Log Book

<table>
<thead>
<tr>
<th>Date</th>
<th>Time of Day</th>
<th>Client ID</th>
<th>Initials</th>
<th>Name</th>
<th>Age</th>
<th>Gender</th>
<th>Indication</th>
<th>Medication</th>
<th>Quantity</th>
<th>Dosage</th>
<th>Method of Administration</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/01/2023</td>
<td>10:00 AM</td>
<td>123456</td>
<td>ABC</td>
<td>Jane</td>
<td>25</td>
<td>F</td>
<td>Menstrual Regulator</td>
<td>Levonorgestrel</td>
<td>1 tab</td>
<td>0.5 mg</td>
<td>Oral</td>
</tr>
<tr>
<td>01/02/2023</td>
<td>2:00 PM</td>
<td>654321</td>
<td>DEF</td>
<td>John</td>
<td>30</td>
<td>M</td>
<td>Emergency Contraception</td>
<td>Copper IUD</td>
<td>1 piece</td>
<td></td>
<td>Insertion</td>
</tr>
<tr>
<td>01/03/2023</td>
<td>5:00 PM</td>
<td>789012</td>
<td>GHI</td>
<td>Mary</td>
<td>28</td>
<td>F</td>
<td>Birth Control Pill</td>
<td>Norgestimate</td>
<td>1 pill</td>
<td>0.035 mg</td>
<td>Oral</td>
</tr>
</tbody>
</table>

Notes: Use this log book to record all dispensing activities for contraceptive medications. Keep it updated daily to maintain accurate records.
## Sample Form:
### Expiries Record Book

<table>
<thead>
<tr>
<th>No.</th>
<th>Name of Medicine</th>
<th>Quantity</th>
<th>Expiry Date</th>
<th>Batch Number</th>
<th>Inspectors Comments</th>
</tr>
</thead>
</table>
### Sample Form:
**Suspected Adverse Drug Reaction Report**

#### A. PATIENT DETAILS
- **Patient name**
- **Patient Number**
- **Sex: M/F**
- **Age at time of onset (yrs)**
- **Health Facility**
- **Last Menstrual Period**
- **Weight (kg)**
- **District**
- **Trimester (if pregnant)**

#### B. SUSPECTED DRUG (S) DETAILS
- **Generic Name**
- **Brand Name**
- **Dose/Route**
- **Frequency**
- **Date started**
- **Date stopped**
- **Prescribed for**
- **Expiry date**
- **Batch No**

#### C. SUSPECTED REACTIONS
Please describe the reaction as observed and any treatment given to manage the reaction.

- **Outcome**
  - Recovered
  - Recovering
  - Continuing
  - Death due to reaction

- **Date reaction started**
- **Date reaction stopped**
- **Date of notification**

#### SERIOUSNESS OF THE REACTION
- Patient died
- Prolonged inpatient Hospitalization
- Involved disability
- Life Threatening
- Congenital abnormality

#### D. CONCOMITANT DRUGS
Please give information on the drug(s) the patient has been taking together with the suspected drug including those taken for chronic diseases (include self medication and herbal preparations).

- **Generic Name**
- **Brand Name**
- **Dosage**
- **Date started**
- **Date stopped**
- **Indication (prescribed or OTC)**

- **Relevant laboratory tests including dates**
- **Additional relevant information (medical history, allergies, failure of efficacy)**

#### E. REPORTER'S DETAILS
- **Name/designation**
- **Telephone and Email Address**
- **Date of reporting**
- **Health facility**

* Mandatory field
Sample Form:
Family Planning Client Card

**FAMILY PLANNING CLIENT CARD**

Client Number............... Health unit .............. Date ..............

Name ......................... Occupation .................. Address ...........

Age .................. L.M.P. ..............

Total pregnancies: Live ...... Still ...... Misc .... Total ...... Living children ......

Last pregnancy: Live 
Still 

Birth ....... Birth ..... Abortion ..... Date .... Lactating ......

Delivered by/at .................. Returned for P.P check (yes/no) ..............

Previous contraception (Yes/No) if yes, name method ..................................

Supplies given.................................................................

Immunization status dates for:

<table>
<thead>
<tr>
<th>TT1</th>
<th>TT2</th>
<th>TT3</th>
<th>TT4</th>
<th>TT5</th>
</tr>
</thead>
</table>

Initial assessment

Medical history .................................................................

Gynae history ..................................................................

Surgical history .................................................................

Physical exam (yes/no) ...........................................................

Pelvic exam (yes/no) .............................................................

<table>
<thead>
<tr>
<th>Date</th>
<th>L.M.P.</th>
<th>BP</th>
<th>WT</th>
<th>Comments</th>
<th>Type of method</th>
<th>Quantity</th>
<th>Signs</th>
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</table>
Sample Form:
Client Return Appointment Card

FP CLIENT APPOINTMENT CARD

Client number: __________________________________________

DSO #: _____________________________________________

Date: _______________________________________________

<table>
<thead>
<tr>
<th>Date of visit</th>
<th>Type of method</th>
<th>Quantity</th>
<th>Comments</th>
<th>Return Date</th>
<th>Signature</th>
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</table>

Please bring this card every time you visit a DSO
Sample Form:
Referral Form—Part A and B

Drug Shops-Client Referral Form

Referring Drug Shop: ________________________________ Drug Shop ID ________

Part A
(To be filled by the Drug Shop Operator)

Date: __________________

Dear Health Worker/Staff

I am referring Mr. / Ms ______________________________ Client ID _________

Of Village __________________ Parish __________ Subcounty ____________

To you for (please tick as appropriate)

1. Contraceptive method (specify) ________________________________
2. Side effect management (Specify) ______________________________
3. Injection site reaction (Specify) ________________________________
4. STD Management (Specify) ________________________________
5. Other (Specify) ______________________________________________

Name of drug shop operator: ________________________________________

Signature __________________________ Date: ___________________________

Part B
(To be filled by the service provider)

Date _________________

Client’s Name: Mr/Ms __________________________ Client ID _____________

Has received the following services at this health facility as per the above referral

1. Contraceptive method (specify) ________________________________
2. Side effect management (Specify) ______________________________
3. Injection site reaction (Specify) ________________________________
4. STD Management (Specify) ________________________________
5. Other (Specify) ______________________________________________

Name of service provider __________________________________________

Name of health facility __________________________________________

Signature __________________________ Date ________________________
Sample Form:
Daily FP Activity Register

<table>
<thead>
<tr>
<th>Visit Date</th>
<th>Client ID</th>
<th>Sex</th>
<th>Age</th>
<th>Village</th>
<th>M or F</th>
<th>Has the client used FP before</th>
<th>Counselling</th>
<th>Service/Method dispensed today</th>
<th>New client or returning to Drug Shop</th>
<th>Return Date</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
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<td></td>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes Individual</td>
<td>Injectable/IM</td>
<td></td>
<td>New/Returning Date</td>
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<td></td>
<td>No</td>
<td>Yes Couple</td>
<td>Condoms (Pieces)</td>
<td></td>
<td>New/Returning Date</td>
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<tr>
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</tbody>
</table>
Sample Form:
**Monthly FP Summary Form for Input into HMIS Report**

**Summary for HMIS Input**

Monthly, two copies the summary will be completed by the drug shop operator, one copy kept in drug shop file and the other copy given to the midwife for the health facility file. The midwife/records assistant will use the summary to input the data into the integrated FP register and HMIS 10S monthly.

<table>
<thead>
<tr>
<th>Contraceptives dispensed</th>
<th>10 – 19 years</th>
<th>20 – 24 years</th>
<th>&gt;=25 Years</th>
<th>Total</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>New</td>
<td>Revisit</td>
<td>New</td>
<td>Revisit</td>
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<tr>
<td>D1: Oral: Lo-Femenal (cycles)</td>
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<tr>
<td>D2: Oral: Microgynon (cycles)</td>
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<tr>
<td>D3: Oral: Ovrette or other POP (cycles)</td>
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<tr>
<td>D4: Oral: Others (cycles)</td>
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<tr>
<td>D5: Female condoms (pieces)</td>
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<tr>
<td>D6: Male condoms (pieces)</td>
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<tr>
<td>D7: IUDs (pieces)</td>
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<tr>
<td>D8. Injectable (doses).</td>
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<tr>
<td>a. Injectable (DMPA SC “Sayana Press”)</td>
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<tr>
<td>b. Injectable (DMPA IM)</td>
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</tbody>
</table>

**Sub-total injectables**

| D9: Emergency contraceptive pills |     |         |     |         |     |         |     |         |
| Standard days (SDM)               |     |         |     |         |     |         |     |         |
| Lactational Amenorrhea Method (LAM) |     |         |     |         |     |         |     |         |

| Total                             |     |         |     |         |     |         |     |         |

Compiled by (DSO): __________________ Date: __________ Signature: __________________
**Checklist for Evaluating DSO Counseling and Method Provision**

**Provide Services that Address Client’s Needs and Concerns**

- Greet client.
- Ask about reason for visit.
- Give information to address client’s issues/options.
- Help client identify/select suitable solution.
- Fulfill client’s request/support decision.
- Inform client when needs/concerns are beyond DSO capability and refer.

**Communicate/Counsel Effectively**

- Be friendly and attentive (make eye contact).
- Show respect and avoid judging client.
- Use simple, clear language.
- Encourage client to ask questions.
- Listen carefully.
- Respond to client questions or concerns.
- Ensure confidentiality and privacy.
- Use job aids appropriately.

**Steps to Follow for Any Client Choosing an FP Method**

- Gather equipment/supplies/job aids/forms needed to supply the method.
- Use screening checklist to determine if client can use the method.
- Explore STI risk and what client does to avoid STIs (if indicated).
- Explain and/or demonstrate correct method use.
- Ask client to explain/demonstrate use; provide correction as needed.
- Remind client about side effects, reasons to return (re-supply, ECPs).
- Give contraceptive method and condoms for dual-method use, if needed.
- Arrange follow-up, resupply, and referral to outside services, as needed.
- Correctly record information on data-collection forms.

**Tasks specific to giving COCs or POPs**

1. Give client COC or POP pack(s).
2. Show/explain pack to client (e.g., arrows, hormone-free pills).
3. Explain how to take pills, (one each day until pack is empty).
   a. Advise taking pills at bedtime.
   b. Advise taking pills at bedtime or with food to reduce nausea.
4. Explain when to start a new pack.
5. Give missed-pill instructions.
6. Explain when to use backup method and provide condoms.

**Tasks specific to providing DMPA IM or NET-EN**

1. Ask client where she would like to receive the injection.
2. Show sealed bottle and expiration date on label to client.
3. Wash hands well with soap and water.
4. Dry hands with a clean towel or let them air dry.
5. If skin is dirty, clean injection site with water-soaked cotton ball.
6. Double-check the bottle for content, dose, and expiration date.
7. Roll bottle between palms or shake gently (DMPA only).
8. Remove plastic cap from bottle.
10. Fill syringe with contents of the bottle.
11. Expel air from syringe.
12. Locate the exact site for injection.
13. Insert needle straight into the muscle.
14. Inject the entire contents of the syringe.
15. Gently press the injection site with a clean cotton ball.
16. Place used syringe into the sharps container*.
17. Place non-sharps waste in bin.
18. Wash hands with soap and water.
19. Instruct the client not to massage the site.
20. Calculate reinjection date (13 weeks DMPA; 8 weeks NET-EN).
### Checklist for Evaluating DSO Counseling and Method Provision (continued)

<table>
<thead>
<tr>
<th>Tasks specific to providing DMPA SC</th>
<th>Yes</th>
<th>No</th>
<th>N/A</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Ask client where she would like to receive the injection; the back of the upper arm, the abdomen (not at the navel), or the front of the thigh.</td>
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<tr>
<td>2. Wash hands well with soap and water.</td>
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<tr>
<td>3. Dry hands with a clean towel or let them air dry.</td>
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<tr>
<td>4. If skin is dirty, clean injection site with water-soaked cotton ball.</td>
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<tr>
<td>5. Open the pouch by tearing the notch.</td>
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<tr>
<td>6. Check expiration date and show it to client.</td>
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<tr>
<td>7. Hold the Unject by the port.</td>
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<tr>
<td>8. Shake Unject vigorously for 30 seconds.</td>
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<tr>
<td>9. Check to make sure the solution is mixed and there is no damage or leaking.</td>
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<tr>
<td>10. Hold the Unject by the port and keep it pointed upward to prevent spilling the drug during activation.</td>
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<tr>
<td>11. Push the needle shield and port together to fully to activate the device for use.</td>
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<tr>
<td>12. Remove the needle shield.</td>
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<tr>
<td>13. Pinch the “skin” at injection site to form a tent.</td>
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<td>14. Hold port and insert needle straight into the skin at a 90 degree angle until port touches the skin.</td>
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<td>15. Move fingers from the port to the reservoir while still pinching the skin.</td>
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<td>16. Press the reservoir slowly to inject the contraceptive (about 5–7 seconds).</td>
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<tr>
<td>17. Place the used Unject into the sharps container; do not replace the needle shield.*</td>
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<tr>
<td>18. Place non-sharps waste in bin.</td>
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<tr>
<td>19. Wash hands with soap and water.</td>
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<tr>
<td>20. Instruct the client not to massage the site.</td>
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<tr>
<td>21. Calculate reinjection date (13 weeks DMPA SC).</td>
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</table>

* Ask DSO to explain the shop’s procedure for managing disposal of sharps containers.

---

### Specific Notes/Observations Regarding DSO Performance

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### Overall Score for this Observation

- Passed
- Failed

DSO signature: ____________________________

Trainer/Supervisor signature: ____________________________
Knowledge and Skills Application Plan—Suggested Format

<table>
<thead>
<tr>
<th>Activity</th>
<th>Beginning Date</th>
<th>Completing Date</th>
<th>Person(s) Responsible</th>
<th>Resource(s) Required</th>
<th>Comments</th>
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</thead>
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</table>

Names of Participant(s)____________________________________ Date of Training____________________________
Name of Health Facility: _______________________________ HSD _______________________________
District:________________________________________