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REPRODUCTIVE HEALTH/ FAMILY PLANNING POLICY GUIDELINES AND STANDARDS FOR SERVICE PROVIDERS

MINISTRY OF HEALTH
DIVISION OF PRIMARY HEALTH CARE

Revised June, 1997

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ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANC	Antenatal Care
BP	Blood Pressure
CBD	Community-Based Distributor
COC	Combined Oral Contraceptive
DMPA	Depot-Medroxyprogesterone Acetate
FP	Family Planning
GTI	Genital Tract Infection
HIV	Human Immunodeficiency Virus
IP	Infection Prevention
IUCD	Intrauterine Contraceptive Device
LAM	Lactational Amenorrhoea Method
LMP	Last Menstrual Period
MCH	Maternal and Child Health
NFP	Natural Family Planning
NGO	Nongovernmental Organization
PAC	Postabortion Care
PID	Pelvic Inflammatory Disease
POP	Progestin-Only Pill
RH	Reproductive Health
SDP	Service Delivery Point
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
VSC	Voluntary Surgical Contraception

FOREWORD

Substantial progress has been made in family planning in Kenya as shown by the 1993 Kenya Demographic Health Survey. Contraceptive prevalence increased from 27 percent in 1989 to 33 percent in 1993. There was also a shift on method mix from traditional and less effective methods to more effective modern methods. There remains, however, a large unmet need for family planning services. Thirty-seven percent of couples who wish to delay childbearing are currently not using any method of family planning. To meet this need it is necessary to improve the quality of care in family planning services, especially accessibility and availability.

Providing high-quality services is based on sound and reasonable principles of practice. These *Reproductive Health/Family Planning Policy Guidelines and Standards for Service Providers* will equip the family planning service providers with the tools required to maintain consistently high quality in a professional manner while keeping in mind clients' needs and operating within the legal and population policy framework of the country.

The first version of the *Family Planning Policy Guidelines and Standards for Service Providers* was published in 1991 and has effectively guided the family planning programme activities to date. With the passage of time, however, increasing experience in the delivery of family planning services and recent research findings, new concepts and knowledge have surfaced. These recent changes in contraceptive technology have influenced how, when, where and why family planning services should be provided post-ICPD 1994, this has been compounded by the recent shift from pure FP programmes to a more comprehensive reproductive health approach. In light of this, the Ministry of Health and other family planning organizations agreed to review jointly the existing policy guidelines and standards. In developing these revised guidelines, the service providers and the policymakers used their field experiences, as well as recent scientific literature and research to direct the future of the FP services and current population policies and legislation.

These guidelines provide the most current up-to-date knowledge on the methods of contraception currently approved by the Ministry of Health and other aspects of reproductive health. They also provide direction on the following topics: Quality of Care; Components of Family Planning Services; Method Counselling; Advantages and Limitations; Eligibility; Use; Management of Common Side Effects; and where and from whom the method can be provided; as well as selected broader elements of reproductive health such as Maternal Health/Safe Motherhood; Postabortion Care; Adolescents and Youth; Infertility; Breastfeeding; Cervical Cancer Screening; Pap Smears; and Integration of STIs/HIV/AIDS. This document is designed to assist the service provider in maintaining comprehensive care for her/his clients and patients who may seek family planning or medical attention.

In using these guidelines it is important to remember that when used correctly, contraceptives are highly effective; however, method failure can occur. In the case of method failure, the client should be counselled, reassured, advised that it is safe to continue with the pregnancy and referred to an antenatal clinic. Should the client need more advice, she must be referred for appropriate care and management.

The issues of postabortion care and adolescent health are included in these guidelines to support health providers on how such cases should be managed. Because abortion is not a method of family planning and can only be performed when the health of the mother is endangered, these policy guidelines outline the services for the management of postabortion cases in relation to

fertility management. This document outlines appropriate care for adolescents within the current policy environment.

A major concern of all reproductive health (RH) workers should be the rapid increase in the prevalence of sexually transmitted infections and HIV/AIDS. The only effective means of protection against these infections is safe sexual practices including abstinence and the use of barrier methods. For those at risk of STIs/HIV/AIDS, these guidelines stress the need to use barrier methods such as condoms in addition to any other method of family planning.

The purpose of the revised Policy Guidelines and Standards for Service Providers is to furnish a solid foundation from which service providers can launch reproductive health care. The Ministry of Health also encourage its use by managers and policymakers.

These revised *Reproductive Health and Family Planning Policy Guidelines and Standards for Service Providers* for should meet the expectations of all clients as well as form a solid foundation from which service providers at all health facilities in both public and private sector can launch reproductive health care.

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ACKNOWLEDGMENTS

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- JHPIEGO—Johns Hopkins University, Program for International Education and Training in Reproductive Health
- USAID —United States of America International Development
- UNFPA—United Nations Population Fund
- World Health Organization
- GTZ—Deutsche Gessellschaft fur Technische Zusammenarbeit
- SIDA—Swedish International Development Agency
- DFID—Department for International Development
- World Bank

Finally, a special word of thanks to Emily Iruguthu who tirelessly worked to ensure that all our contributions were recorded in this document.

COMPONENTS OF REPRODUCTIVE HEALTH/ FAMILY PLANNING

1. Counselling

Counselling is an important prerequisite for the initiation and continuation of a family planning method. Service providers should be competent in counselling for all methods of family planning. There should be no incentives or coercion to adopt family planning or any particular method of contraception.

2. Provision of Contraceptives

Contraceptives should be provided to clients in accordance with the approved method-specific guidelines and by providers who have been trained in provision of that method.

3. Followup and Referral System

All clients who choose a family planning method must be informed of the appropriate followup requirements and encouraged to return to the service provider should they have any concerns. Providers should follow the established referral system.

4. Record Keeping

All providers of family planning should maintain proper records on each client and the distribution of contraceptives. NGOs also should follow the Ministry of Health record keeping and service provision guidelines.

5. Supervision

Supervision is an essential component of programme evaluation. Supervision ensures that guidelines are being followed and needs of clients are being met. Facilitative supervision should be encouraged as the supervisor is seen as a team member who ensures staff motivation while providers and clients rights are observed.

6. Logistics

Maintenance of a logistic system will help providers in avoiding both understocking and overstocking. In order to maintain quality, the service provider must adhere to proper storage and handling of contraceptive commodities for the stipulated shelf life.

QUALITY OF CARE

To Provide Good Quality Care:

- Service providers should inform clients about the methods available: how they work, advantages, limitations, side effects, how to use them, resupply and the importance of followup.
- The Service Delivery Points (SDPs) should be clean, with well-organised client flow and should provide services at least during normal working hours.
- Service providers should avoid long waiting times before clients are served.
- Service providers should be trained, and given regular updates.
- Care should be individualised.
- An adequate supply of quality contraceptives should be maintained.
- Privacy should be maintained.
- Clients should be treated with dignity.
- A good supervision system should be followed.
- Care should be provided for adolescents with special needs.
- Regular supervision of clinical services should be ensured.

Successful programmes require well-trained staff who exhibit:

- care, sensitivity and thoroughness in informing the client about the method chosen;
- knowledge, attitudes and skills for providing family planning services;
- knowledge of and ability to recognise real or potential problems;
- capability to take appropriate clinical action in response to these problems, including knowing when (and where) to refer clients with serious problems; and
- good clinical judgment.

COUNSELLING

Counselling is a **vital** part of reproductive health care. It helps clients to:

- arrive at an informed choice of reproductive options,
- select a contraceptive method with which they are satisfied, and
- use the chosen method safely and effectively.

Good counselling focuses on the individual client's needs and situation. Good counsellors are willing to listen and respond to the client's questions and concerns.

Essentials to good counselling

A good counsellor:

- Understands and respects the client's rights
- Earns the client's trust
- Understands the benefits and limitations of all contraceptive methods
- Understands the cultural and emotional factors that affect a client's (or a couple's) decision to use a particular contraceptive method
- Encourages the client to ask questions
- Uses a nonjudgmental approach which shows the client respect and kindness
- Presents information in an unbiased, client-sensitive manner
- Actively listens to the client's concerns
- Understands the effect of nonverbal communication
- Recognises when s/he cannot sufficiently help a client and refers the client to someone who can

To be effective, counselling must be based on the establishment of trust and respect between the client and counsellor.

In serving clients, it is important to remember that they have:

- the right to decide whether or not to practice family planning,
- the freedom to choose which method to use,
- the right to privacy and confidentiality, and
- the right to refuse any type of examination.

Also, while many contraceptive methods are highly effective, method failure can occur. In the case of method failure, the client should be counseled, informed about the available options and referred for appropriate services.

COUNSELLING PROCESS

In discussing contraceptive options with clients, service providers should briefly review all available methods, even if a client knows which method s/he wants.

Service providers should be aware of a number of factors about each client that may be important, depending on the method in question. These are:

- reproductive goals of the woman or couple (spacing or timing births);
- personal factors including the time, travel costs, pain or discomfort likely to be experienced;
- accessibility and availability of other products that are necessary to use the method; and
- the need for protection against STIs and HIV/AIDS.

STEPS IN FAMILY PLANNING COUNSELLING

Counselling can be divided into three phases:

- **initial counselling** at reception (all methods are described and the client is helped to choose the method most appropriate for her/him);
- **method-specific counselling** prior to and immediately following service provision (the client is given instructions on how to use the method and common side effects are discussed); and
- **followup counselling** (during the return visit, use of the method, satisfaction and any problems that may have occurred are discussed).

The provision of counselling, however, should be part of **every interaction** with the client.

WHO SHOULD PROVIDE COUNSELLING?

Information and counselling commonly will come from more than one source. Therefore, **all staff** should be knowledgeable about **all** available contraceptive methods.

CLIENT ASSESSMENT

OBJECTIVES

The **primary objective** of assessing clients prior to providing family planning services is to determine:

- that the client is not pregnant,
- whether any conditions requiring additional care exist for a particular method, and
- whether there are any special problems that require further assessment, treatment or regular followup.

This usually can be accomplished by asking a few key questions. Unless specific problems are identified, the safe provision of most contraceptive methods, except IUCDs and voluntary sterilization, does **not** require **performing a physical or pelvic examination.**

Where resources are limited, requiring medical evaluation and/or laboratory testing (e.g., blood sugar and hemoglobin) before providing modern contraceptive methods is **not** justifiable. Where demand for family planning services is high, medical requirements that are **not** essential to the provision of specific contraceptives act as a major barrier to contraceptive choice and access to services. To enable clients to obtain the contraceptive method of their choice, **only** those procedures that are essential and mandatory for **all** clients in **all** settings should be required.

With the exception of condoms (and diaphragms to a lesser degree), no contraceptive method provides protection against GTIs or other STIs (e.g., hepatitis B, HIV/AIDS). All clients should be made aware of the risks of GTI and STI transmission (see **STIs and Family Planning** chapter for details on client screening).

HOW TO BE REASONABLY SURE A CLIENT IS NOT PREGNANT

You can be reasonably sure a client is not pregnant if she has no signs or symptoms of pregnancy (e.g., breast tenderness or nausea) and:

- has not had intercourse since her last menses; or
- has been correctly and consistently using another reliable contraceptive method; or
- is within the first 7 days after the start of her menses (days 1–7); or
- is within 4 weeks postpartum (for nonbreastfeeding women); or
- is within the first 7 days postabortion; or
- is fully breastfeeding, less than 6 months postpartum and has had no menstrual bleeding.

Pelvic examination is seldom necessary, except to rule out pregnancy of more than 6 weeks, measured from the last menstrual period (LMP).

Pregnancy testing is unnecessary except in cases where:

- it is difficult to confirm pregnancy (i.e., 6 weeks or less from the LMP); or
- the results of the pelvic examination are equivocal (e.g., the client is overweight, making sizing the uterus difficult).

In these situations, a sensitive urine pregnancy test may be helpful, if readily available and affordable. If pregnancy testing is **not** available, counsell the client to use barrier methods or abstain from intercourse until her menses occur or pregnancy is confirmed.

INFECTION PREVENTION

Infection prevention (IP) in reproductive health and health care facilities has two primary objectives:

- To prevent major postoperative infections when providing surgical contraceptive methods (e.g., IUCDs, injectables, implants and voluntary sterilization)
- To prevent the transmission of serious diseases such as hepatitis B and AIDS not only to clients but also to service providers and staff, including cleaning and housekeeping personnel

In the following sections, the recommended infection prevention practices are based on the following principles:

- **Consider every person** (client or staff) potentially infectious.
- **Wash hands**—the most practical procedure for preventing cross-contamination (person to person).
- **Wear gloves** before touching anything wet—broken skin, mucous membranes, blood or other body fluids (secretions or excretions)—or soiled instruments and other items.
- **Use safe work practices**, such as not recapping or bending needles, safely passing sharp instruments and properly disposing of medical waste.
- **Isolate patients** only if secretions (airborne) or excretions (urine or feces) cannot be contained.

HANDWASHING

- Wash hands **before** and **after** examining any client (direct contact).
- Wash hands after removing gloves because the gloves may have holes in them.
- Wash hands after exposure to blood or any body fluids (secretions and excretions), even if gloves were worn.

Experience has shown that the most effective way to increase handwashing is to have senior health workers or other respected individuals (role models) consistently wash their hands and encourage others to do the same.

The Programme Manager should work with hospital administration to ensure provision of soap and continued supply of clean water.

GLOVES

Wear gloves:

- When performing a procedure in the clinic or operating room
- When handling soiled instruments, gloves and other items
- When disposing of contaminated waste items (cotton, gauze or dressings)

A separate pair of gloves must be used for each client to avoid cross-contamination. Using disposable gloves is preferable, but where resources are limited, surgical gloves can be reused if they are:

- decontaminated by soaking in 0.5% chlorine solution for 10 minutes,
- washed and rinsed, and
- sterilised (by autoclaving) or high-level disinfected (by steaming or boiling).

WHO GETS NEEDLESTICK INJURIES

If you handle needles in any way, accidental needlesticks may occur.

- **Surgeons** are most often stuck by needles in the operating room—by accidentally sticking themselves during suturing.
- **Nurses** are most often stuck by needles in the hospital—by accidentally sticking themselves while handling hypodermic needles and syringes or being accidentally stuck by surgeons.
- **Cleaning staff** are most often stuck by needles when processing soiled instruments.
- **Housekeeping staff** are most often stuck by needles when disposing of waste material.

HOW TO HANDLE HYPODERMIC NEEDLES, SCISSORS AND OTHER SHARP ITEMS

Operating Room

- Use a kidney dish (safe zone) to carry and pass sharp items (e.g., pass suture needles on a needleholder).
- Do not leave sharps in places other than safe zones.
- Tell other workers before passing sharps.

Safety Tips When Using Hypodermic Needles and Syringes

- Use each needle and syringe only once.
- Do **not** disassemble needle and syringe after use.
- Do **not** recap, bend or break needles prior to disposal.
- Decontaminate needle and syringe prior to disposal.

- Dispose of needle and syringe in a puncture-proof container.
- Make hypodermic needles unusable by burning them.

> **NOTE**: Where disposable needles are not available and recapping is practiced, use the "one-handed" recap method:
>
> - First, place the cap on a hard, flat surface; then remove hand.
> - Next, with one hand, hold the syringe and use the needle to "scoop up" the cap.
> - Finally, when the cap covers the needle completely, hold the needle at the base near the hub and use the other hand to secure the cap on the needle.

HOW TO WITHDRAW MEDICATION FROM A STERILE MULTIDOSE VIAL

- Wipe the top of the vial with a cotton swab soaked in 60–90% alcohol or other locally available disinfectant. Allow to dry.
- If using a new disposable needle and syringe, open the sterile pack.
- If using a sterile or high-level disinfected needle and syringe, remove from covered container using dry, sterile or high-level disinfected forceps.

Never use a syringe for more than one injection. Studies have shown that changing **only** the needle, not the syringe, between clients can result in transmission of hepatitis B virus, and presumably HIV/AIDS.

- Attach needle to syringe by holding the hub (base) of the needle and the barrel of the syringe.
- Turn the vial containing the drug upside down and draw the fluid into syringe using the **same** needle you will use for the injection.
- Withdraw needle from vial.

Do not leave a needle inserted in the rubber stopper of a multiple dose vial. This practice is **dangerous** because it provides a direct route for bacteria to enter the drug vial and contaminate the fluid between each use.

WASTE DISPOSAL

The **purpose** of waste disposal is:

- to prevent the spread of infection to clinic personnel who handle the waste,
- prevent the spread of infection to the local community, and
- to protect those who handle wastes from accidental injury.

Medical waste may be noncontaminated or contaminated. Noncontaminated waste (e.g., paper from offices, boxes) poses no infectious risk and can be disposed of according to local guidelines. Proper handling of contaminated waste (blood- or body fluid-contaminated items) is required to minimise the spread of infection to clinic personnel and to the local community. Proper handling means:

- Wearing utility gloves
- Transporting solid contaminated waste to the disposal site in covered containers
- Disposing of all sharp items in puncture-resistant containers
- Carefully pouring liquid waste down a utility drain or flushable toilet
- Burning or burying contaminated solid waste
- Washing hands, gloves and containers after disposal of infectious waste

HORMONAL METHODS

COMBINED ORAL CONTRACEPTIVE PILLS (COCs)

TYPES

Biphasic pills such as Microgynon, Eugynon, Neogynon, Nordette and triphasic pills, such as Logynon and Trinordial

(Higher dose pills, for example, Eugynon and Neogynon, are preferable for clients with special needs.)

ADVANTAGES

Contraceptive Benefits

- Highly effective
- Effective immediately
- Easy to use
- Can be provided by nonmedical staff
- Pelvic exam is not required to initiate use

Non-Contraceptive Benefits

- Reduce menstrual flow (lighter, shorter periods)
- Decrease dysmenorrhoea (painful periods)
- Improve anaemia
- Protect against ovarian and endometrial cancer
- Decrease benign breast disease
- Prevent ectopic pregnancy

LIMITATIONS

- Their effectiveness may be lowered when certain drugs are taken concurrently (e.g., anti-tuberculosis and anti-epileptic drugs).
- Serious side effects, though rare, are possible. They include myocardial infarction, stroke, venous thrombosis/embolism and benign liver tumors (adenomas).
- The combined pills offer no protection against STIs, including hepatitis B and HIV/AIDS and therefore individuals at risk should use a barrier method to ensure protection against STIs/HIV/AIDS.

- COCs must be taken daily to be effective.

WHO CAN USE COMBINED ORAL CONTRACEPTIVE PILLS

- Sexually active women of reproductive age
- Women with established menses
- Women of any parity, including nulliparous with established menses
- Women who want highly effective protection against pregnancy
- Breastfeeding mothers more than 6 months postpartum
- Women who can follow a daily routine of pill taking
- Postabortion clients (should begin within 7 days)
- Women with anaemia from heavy menstrual bleeding
- Women with severe menstrual pains
- Women with a history of ectopic pregnancy

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Women over 40 years	CBD should not initiate. CBD may resupply but only after initial clinic assessment.
Women with migraine	CBD should not initiate. CBD may resupply but only after initial clinic assessment.
Women taking medication for epilepsy or tuberculosis	Help client to select alternative methods.
Women with breast lumps	Evaluate the lump and confirm diagnosis. Women with benign breast disease can use COCs.
Hypertension	CBD should not initiate or resupply. Women with BP less than 160/100 may be initiated under guidance from a doctor. Ensure medical followup for hypertension Women with BP more than 160/100 should not use.
Uncomplicated diabetes	CBD should not initiate or resupply. Nurses should not initiate but may resupply under medical specialist guidance. Decision to initiate pill use to be made by medical specialists managing the patient.

WHO SHOULD NOT USE

- Breastfeeding mothers before 6 months postpartum
- Women who are pregnant or suspected of being pregnant
- Women with unexplained or suspicious abnormal vaginal bleeding
- Women with a history of blood clotting disorders
- Women with a history of heart disease
- Women with active liver disease
- Women with hypertension (BP equal to or more than 160/100)
- Women with diabetes mellitus complicated by vascular disease
- Women who smoke and are older than 35 years
- Women with sickle cell disease

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Nausea and dizziness	Assess for pregnancy. Advise to take pills with meals.
Spotting	Assess for pregnancy. Assess for other illnesses. Encourage to take pills at the same time each day. If spotting persists, switch to higher oestrogen (50 mcg) pills or select alternative method.
Amenorrhoea	Assess for pregnancy.

NOTE: Contraceptive pills should be taken at about the same time each day.

If one pill is missed, take as soon as remembered even if it means taking two pills the next day.

If two or more pills are missed in a row, the client should take two pills each day until all missed pills have been taken **AND** the couple should use a back-up method (e.g., condom or foaming tablets) for seven days.

If two pills will be taken in one day, take the second pill 6 hours later. Taking two pills at once increases the chance of nausea and vomiting.

WHO CAN PROVIDE

- Physicians
- Nurses/Midwifes
- Clinical Officers
- Trained Community Workers and Community-Based Distributors (CBDs)
- Pharmacists/Pharmaceutical Technologists

Nonclinical providers such as pharmacists and CBDs can:

- Initiate use of COCs using the approved Ministry of Health checklist. They should not initiate supply to clients with chronic medical conditions.

- Supply no more than three cycles before evaluation by a clinical provider.

After review by a clinical provider, nonclinical providers may resupply up to six cycles per visit. They should ensure that the client will keep drugs in safe custody and return all unused pills to the provider if she changes to another method. All clients, however, should be encouraged to attend a clinic for any problems or concerns.

WHERE THEY CAN BE PROVIDED

All Service Delivery Points:

- Hospitals
- Health Centres
- Dispensaries
- Outreach/Mobile Services
- Pharmacies
- Private Clinics

PROGESTIN-ONLY PILLS (POPs)

TYPES

Microlut, Micronor, Ovrette

ADVANTAGES

Contraceptive Benefits

- Effective
- Immediate return to fertility on discontinuation
- Pelvic exam is not required to initiate use

Non-Contraceptive Benefits

- Does not affect breastfeeding
- Lighter and shorter periods
- Decrease breast tenderness
- Do not increase blood clotting
- Decrease dysmenorrhoea
- Protect against endometrial cancer

LIMITATIONS

- Slightly lower level of contraceptive protection than COCs
- Requires strict daily pill taking, preferably at the same time
- Effectiveness may be lowered when certain drugs are taken concurrently (e.g., anti-tuberculosis and anti-epileptic drugs)
- Does not protect one against STIs including hepatitis B and HIV/AIDS and therefore individuals at risk should use a barrier method to ensure protection against STIs/HIV/AIDS

WHO CAN USE POPs

- Women of reproductive age
- Women of any parity, including nulliparous women
- Breastfeeding mother after 6 weeks postpartum
- Heavy smokers of any age
- Women who cannot use COCs, due to oestrogen-related contraindications

- Postabortion clients
- Women with sickle cell disease, diabetes, hypertension, valvular heart disease

NOTE:

- All clients with medical conditions should have regular followup and treatment of the medical condition while on POPs.
- For women who have had ectopic pregnancy, POPs **will not** effectively prevent intrauterine pregnancy because they do not consistently suppress ovulation.
- For women who have had problems with ovarian cysts, POPs **will** not protect against the development of future ovarian cysts.

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Women with a history of pre-eclampsia, depression, tuberculosis, thyrotoxicosis, epilepsy and women who are taking anti-epileptic and anti-tuberculosis drugs	Initiate and provide regular followup at service delivery point. CBD should not initiate or resupply.
Women with breast lumps	Evaluate before providing POPs. Women with benign breast disease can use POPs.
Sickle cell disease, diabetes, hypertension, valvular heart disease	Initiate, resupply and provide regular followup at service delivery point in consultation with the doctors managing the patient for the mentioned ailments. CBD should not initiate or resupply.

WHO SHOULD NOT USE

- Breastfeeding women less than 6 weeks postpartum
- Women who are pregnant or suspected of being pregnant
- Women with unexplained abnormal vaginal bleeding
- Women who have breast cancer or a history of breast cancer
- Women with active liver disease

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Spotting	Assess for pregnancy. If no other causes, reassure. If causes identified, refer to appropriate level.
Amenorrhoea	Assess for pregnancy. If pregnant, stop use of POPs.
Headache or dizziness	Determine cause. If no cause, counsell; if severe and no cause, help client select alternative method.
Abnormal suspicious vaginal bleeding	Refer to a higher level for management.
Mood changes or nervousness	Counsell. If it worsens, help client select alternative method.

WHO CAN PROVIDE

- Physicians
- Nurses/Midwifes
- Pharmacists/Pharmaceutical technologists
- Trained Community Workers and Community-Based Distributors
- Clinical Officers

Nonclinical Providers (pharmacists and community-based distribution workers) can:

- Initiate use of POPs using the approved Ministry of Health checklist. They should not initiate supply to clients with chronic medical conditions.

- Supply no more than three cycles before evaluation by a clinical provider.

After review by a **clinical provider**, nonclinical providers may resupply up to six cycles per visit. They should ensure that the client will keep the drugs in safe custody and return all unused pills to the provider if she changes to another method. All clients, however, should be encouraged to attend a clinic for any problems or concerns.

WHERE THEY CAN BE PROVIDED

All Service Delivery Points:

- Hospitals
- Pharmacies
- Private Clinics
- Outreach/Mobile Services
- Dispensaries
- Health Centres

EMERGENCY HORMONAL CONTRACEPTION

TYPES

Combined Oral Contraceptives

Two tablets of a 50 microgram pill (e.g., Eugynon) to be taken within 72 hours of unprotected intercourse. Repeat same dose in 12 hours. Requires total of 4 tablets of 50 mcg pill.

Or

Four tablets of a 30 microgram pill (e.g., Microgynon) to be taken within 72 hours of unprotected intercourse. Repeat same dose in 12 hours. Requires total of 8 tablets of 30 mcg pill.

Or

One tablet of a 75 microgram pill (e.g., Postinor) to be taken within 72 hours of unprotected intercourse. Repeat same dose in 12 hours. Requires total of 2 tablets of 75 mg pill.

ADVANTAGES

Provides emergency protection in about 75% of those at risk

LIMITATIONS

- Only effective within 72 hours of unprotected intercourse
- Not to be used as a regular method
- Does not protect against STIs/HIV/AIDS
- May cause nausea

WHO CAN USE EMERGENCY CONTRACEPTION

- Clients in need of emergency protection (e.g., leakage from condoms; unplanned, unprotected intercourse)

WHO SHOULD NOT USE

- Clients who require regular protection
- Clients who are known to be pregnant

The success of emergency contraception depends on knowledge of its availability/efficacy prior to an unprotected, unplanned act. The method is only effective if potential users are aware of the method by prior information and counselling.

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Nausea, dizziness, breast tenderness, spotting	Counsell of possible occurrence at the time of supply.
Vomiting	If vomiting occurs within 2 hours, repeat dose orally or give vaginally.

WHO CAN PROVIDE

- All Health Workers

WHERE IT CAN BE PROVIDED

Any appropriate site with a qualified staff

INJECTABLES

TYPES

Depot-medroxyprogesterone acetate (DMPA): **Depo-Provera®, Megestron**:
Given every three months **but** can be given up to four weeks (28 days) earlier or two weeks later (14 days).

Noristerat®: Given every two months **but** can be given up to two weeks (14 days) earlier or one week later (7 days).

ADVANTAGES

Contraceptive Benefits

- Highly effective
- Pelvic exam is not required to initiate use
- No oestrogen, therefore does not have the cardiac and blood clotting effects which are rarely associated with oestrogen-containing pills
- Long-acting method

Non-Contraceptive Benefits

- Protects against endometrial cancer
- Reduces menstrual flow, therefore beneficial for women with iron deficiency anaemia
- Decreases sickle cell crises

LIMITATIONS

- Return of fertility may be delayed for about four months or more after discontinuation
- Causes menstrual changes
- Does not protect one against STIs including hepatitis B, HIV/AIDS and therefore individuals at risk should use a barrier method to protect themselves from STIs/HIV/AIDS

WHO CAN USE INJECTABLES

- Women of reproductive age
- Women of any parity including nulliparous with established menses
- Women who want highly effective, long-term protection against pregnancy
- Breastfeeding mothers after 6 weeks postpartum
- Immediate postpartum if not breastfeeding
- Women with cancer of reproductive organs (e.g., endometrial cancer)

- Women who cannot remember to take the pill everyday
- Postabortion clients
- Women with sickle cell disease, diabetes, hypertension, valvular heart disease

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Women with breast lumps	Evaluate prior to initiation, it is advisable to consult surgeons to confirm lumps are benign. Method can only be used if lumps are benign.
Women with sickle cell disease, depression, migraine, epilepsy	Initiate and provide injectable contraceptives after careful evaluation and in consultation with the doctor managing the patient for the chronic ailment. Ensure regular followup in SDP and clinic for medical conditions.

WHO SHOULD NOT USE

- Breastfeeding women less than 6 weeks postpartum
- Women who are pregnant or suspected of being pregnant
- Women with active liver disease
- Women with unexplained suspicious abnormal vaginal bleeding
- Women who have breast cancer or a history of breast cancer
- Women with active ischaemic cardiovascular disease
- Women with diabetes mellitus complicated by vascular disease
- Women with blood pressure equal to or more than 160/100

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Spotting/Abnormal bleeding	Assess for infections, uterine fibroids, cervical polyps and treat according to the cause or refer. Assess for pregnancy or incomplete abortion. If pregnant, stop the injectable, counsell, reassure and refer to antenatal clinic. If not pregnant and the uterus is enlarged, counsell and refer to a higher level. If the client is still concerned about spotting, give COCs (one tablet daily for seven days) and reassure. For heavy bleeding, give one packet of COCs (one tablet daily for 21 days) or progesterone oestradial injection and iron tablets if necessary.
Amenorrhoea	Assess for pregnancy. If pregnant, stop use, counsell, reassure and refer to antenatal clinic. If client is bothered by lack of menses despite reassurance, change to another method.
Headache or dizziness	If mild, treat with analgesics and reassure. Check blood pressure and if normal, and headaches persist, counsell and help client to select another method.

WHO CAN PROVIDE

- Physicians
- Clinical Officers
- Nurses/Midwives

WHERE THEY CAN BE PROVIDED

All Service Delivery Points:

- Hospitals
- Health Centres
- Dispensaries
- Outreach/Mobile Services
- Pharmacies
- Private Clinics

NORPLANT® IMPLANTS

TYPES

Norplant Implants

ADVANTAGES

Contraceptive Benefits

- Highly effective
- Immediate return to fertility
- Offer continuous, long-term protection

Non-Contraceptive Benefits

- Reduce menstrual flow
- Protect against endometrial cancer
- Protect against ectopic pregnancy
- Do not affect breastfeeding

LIMITATIONS

- Must only be inserted and removed by trained providers
- Requires minor surgical procedure with appropriate infection prevention practices for insertion and removal
- May cause menstrual changes
- Removal services must be available at sites where insertion is done
- Does not protect one against STIs including hepatitis B, HIV/AIDS and therefore individuals at risk should use a barrier method to protect themselves against STIs/HIV/AIDS

WHO CAN USE NORPLANT IMPLANTS

- Women of reproductive age
- Women of any parity, including nulliparous with established menses
- Women who want highly effective long-term protection against pregnancy
- Women with sickle cell disease

- Breastfeeding mothers after 6 weeks postpartum or immediate postpartum if not breastfeeding
- Women who have achieved desired family size but do not want a permanent method
- Women who prefer not to use contraceptives that contain oestrogen or have developed oestrogen-related complications while taking COCs
- Postabortion clients

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Migraine, depression, heavy smokers (over 15 cigarettes per day and over 35 years of age) and epilepsy, tuberculosis	Evaluate with care prior to provision and follow up in SDP or/and clinic for medical conditions.

WHO SHOULD NOT USE

- Women who are pregnant or suspected of being pregnant
- Women who have active liver disease
- Women who have undiagnosed suspicious abnormal vaginal bleeding
- Women who have breast lumps—should be diagnosed before insertion
- Women who have breast cancer or women with a history of breast cancer
- Women who cannot tolerate menstrual changes

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECT	MANAGEMENT
Amenorrhoea	Assess for pregnancy. If pregnant, remove the implants. If not pregnant, reassure and continue method.
Bleeding/Spotting	Assess for infections, uterine fibroids or cervical polyps. Counsell, treat or refer for further management but do not remove the Norplant implants. If pregnant or spontaneous abortion suspected, examine and perform a pregnancy test. If pregnant, counsell and remove the Norplant implants, and refer to antenatal clinic.
Recurrent and persistent headaches especially with blurred vision	Assess for other causes. Reassure if mild. If severe, remove Norplant implants and assist client to select another method.
Implants expulsion	If one capsule is expelled, open a new package and insert one capsule. If more than one is expelled, remove all capsules and insert a new set in the other arm or in the reverse direction in the same arm, or help the client to select alternative method.

WHO CAN PROVIDE

- Trained Provider

WHERE THEY CAN BE PROVIDED

- Hospitals
- Health Centres
- Private Clinics
- Outreach/Mobile Services

NOTE:

- The facility must follow appropriate infection prevention practices.
- Sites that offer insertion must provide removal facilities, including counselling and other alternative methods.

BARRIER METHODS FOR WOMEN

TYPES

Diaphragm, cervical cap, spermicide and sponge, female condom

ADVANTAGES

Contraceptive Benefits

- Effective immediately
- Do not affect breastfeeding

Non-Contraceptive Benefits

- No health risk associated with the methods
- Protect against STIs/HIV/AIDS; however, this protection is not complete
- Protect against PID

LIMITATIONS

- The diaphragm and cervical cap require an initial fitting by a trained provider.
- Efficacy is improved if diaphragm is used together with spermicides.
- Water and soap are needed to wash diaphragm.
- All of these methods have to be inserted before sexual intercourse; spermicides must be inserted before each act.
- Sponge can cause infection if not removed promptly. Infection may result from sponge that is forgotten in the vagina.

WHO CAN USE BARRIER METHODS

- Women needing to rule out possible pregnancy before proceeding with another method
- Women needing a back-up method
- Women needing temporary methods of contraception
- Postabortion clients
- All women of reproductive age

- Women of any parity, including nulliparous
- Women with sickle cell, diabetes, hypertension
- Breastfeeding women

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Repeated intercourse over several hours	Apply more spermicide with each act of intercourse. Do not remove diaphragm or sponge between acts of intercourse until no more intercourse is expected.

WHO SHOULD NOT USE

- Women who dislike touching their genitals or are unable to feel their own cervix or posterior fornix (for diaphragm)
- Women who desire highly effective protection against pregnancy
- Women with vaginitis
- Couples (or either partner) who are allergic to the spermicide or the material from which the device is made
- Women with vaginal abnormalities, or poor vaginal muscle tone
- Women with frequent urinary tract infections

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Allergic reaction to spermicides or material from which diaphragm or sponge is made	Assess for infection. Advise to use another method.
Discomfort with diaphragm	Assess for appropriate size or choose another method.

WHO CAN PROVIDE

Diaphragm and cervical cap:

- Physicians
- Nurses/Midwifes
- Clinical Officers

Spermicides and sponge:

- All trained providers including CBD workers

WHERE IT CAN BE PROVIDED

Diaphragm and cervical cap provided at all SDPs. Spermicides and sponges can be provided at any appropriate site.

BARRIER METHODS FOR MEN

TYPES

Condom

ADVANTAGES

Contraceptive Benefits

- Fairly effective if used properly
- Immediately effective

Non-Contraceptive Benefits

- Highly effective protection against STIs/HIV/AIDS
- May prevent premature ejaculation

LIMITATIONS

- Must be worn for each act of sexual intercourse
- Have a high failure rate but efficacy can be improved when condoms are used together with spermicide
- May reduce sensitivity

> NOTE: Condoms should not be used with non-water soluble lubricants or jellies, such as petroleum products and oils, as these lead to rapid degeneration and may reduce their effectiveness in preventing pregnancy and protection against STIs/HIV/AIDS.

WHO CAN USE CONDOMS

- Men who wish to participate actively in family planning
- Couples needing a back-up method (e.g., for missed pills)
- Couples who have sex infrequently and who do not need continual protection
- Couples needing temporary methods while awaiting another method

- Couples not using another method or those who are using another method but are at risk of acquiring an STI/HIV (e.g., those with more than one partner). Condoms when used correctly, have been shown to provide a high degree of protection against exposure to STIs/HIV.

- Postabortion clients

WHO SHOULD NOT USE

- Couples who are allergic to the material from which the condom is made
- Couples who want highly effective protection against pregnancy

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Allergy/Irritation	Advise to use another method. Rule out infection.

WHO CAN PROVIDE

- Physicians
- Nurses/Midwifes
- Clinical Officers
- Trained Community Workers/CBDs
- Pharmacists/Pharmaceutical Technologists

WHERE IT CAN BE PROVIDED

All Service Delivery Points:

- Hospitals
- Health Centres
- Dispensaries
- Outreach/Mobile Services
- Pharmacies
- Private Clinics
- Retail Outlets
- Through dispensers at almost any convenient point

INTRAUTERINE CONTRACEPTIVE DEVICES (IUCDs)

TYPES	DURATION OF EFFECTIVENESS
Copper T 380A	10 yrs
NOVA T	5 yrs
Multiload-375	5 yrs
Multiload-250	3 yrs
Lippes Loop	indefinite
Copper T 220	3 yrs

ADVANTAGES

Contraceptive Benefits

- Highly effective
- Immediately effective
- Long-term protection
- Immediate return to fertility upon removal

Non-Contraceptive Benefits

- Do not interfere with intercourse
- Can be used in women who are breastfeeding

LIMITATIONS

- Requires appropriate infection prevention practices during insertion and removal
- May increase menstrual bleeding and cause cramping during the first few months of use
- Do not prevent against all ectopic pregnancies
- Do not protect against STIs/HIV/AIDS
- May be expelled or translocated
- Perforation of the uterus may occur if provider is unskilled
- Should not be used in women at risk of STIs

WHO CAN USE THE IUCD

- Women of reproductive age
- Women of any parity, including nulliparous with established menses
- Women who want long-term, highly effective protection against pregnancy

- Women who are at low risk of STIs
- Women whose partners have low risk of STIs
- Breastfeeding mothers
- Women after six weeks postpartum (using standard insertion procedure)
- Women immediately (within 10 minutes) postpartum or within 48 hours when provider has been trained in postpartum insertion

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Women with severe menstrual pains	Counsell about possible increase in menstrual pain and bleeding.
History of previous ectopic pregnancy	Advocate frequent followup at SDP and advise on signs and syndromes of ectopic gestation.
Women with known heart disease, diabetes	Advise on frequent followup at SDP and at clinical site for medical problems.
Anaemia	Correct cause of anaemia before inserting IUCD and advise frequent followup with Hb check.

WHO SHOULD NOT USE

- Women who have multiple sexual partners (except for stable polygamous unions)
- Women whose partners have multiple sexual partners (except for stable polygamous unions)
- Women who are pregnant or suspected of being pregnant
- Women with current, recent (within the past 3 months) or recurrent PID
- Women with anaemia
- Women with unexplained abnormal uterine bleeding
- Women with cancer of reproductive organs
- Women with congenital uterine abnormalities or tumours of the uterus which distort the cavity
- Women with a recent septic abortion (past 3 months)

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECT	MANAGEMENT
Irregular or heavy vaginal bleeding	Assess for pelvic pathology-including PID and ectopic gestation. If no pathology, counsell and advise on analgesics and follow up. IUCD may be removed if client desires.
Amenorrhoea	Assess for pregnancy. If pregnant, advise removal of IUCD, if strings are visible and pregnancy is less than 12 weeks; if strings are not visible or pregnancy is more than 12 weeks or client does not wish, do not remove IUCD. If not pregnant, do not remove IUCD. Refer for investigation to identify the cause of amenorrhoea.
Missing strings	Assess for pregnancy. Inquire if expelled; if not pregnant and IUCD not expelled, explore endocervical canal for strings after next period. If not found, refer for X-ray or ultrasound localization.
Suspected PID/Cervical discharge	Examine for STI. If STI without PID, treat appropriately. If PID, treat and remove IUCD.

WHO CAN PROVIDE

- Physicians
- Clinical Officers
- Nurses/Midwives

WHERE IT CAN BE PROVIDED

- Hospitals
- Health Centres
- Private Clinics

NOTE: The facility **must** follow appropriate infection prevention practices.

NATURAL FAMILY PLANNING (NFP)

TYPES

Basal Body Temperature, Billings Ovulation Method, Calender or Rhythm Method and Symptothermal Method

ADVANTAGES

Contraceptive Benefits

- No physical side effects

Non-Contraceptive Benefits

- Free
- No need for prescriptions by medical person
- Improved knowledge of reproductive system and possible closer relationship between couples

LIMITATIONS

- Low effectiveness
- Requires daily record keeping
- Long period of training required before use of the methods
- Requires varying periods of sexual abstinence during fertile phase
- Requires active cooperation of both partners

WHO CAN USE NATURAL FAMILY PLANNING

- All clients of reproductive age
- Women with regular menstrual cycles
- Clients willing to abstain from intercourse for more than one week each cycle
- Couples who are able to maintain effective events record

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Irregular menses	Counsell to use alternative method.
Menstruation beginning (Menarche)	Counsell to use alternative method.

WHO SHOULD NOT USE

- Women with irregular cycles (e.g., menarche and premenopausal) or without established cycles
- Women who dislike touching their genitals
- Women whose partners will not cooperate

WHO CAN PROVIDE

Trained health professionals and lay persons

WHERE IT CAN BE PROVIDED

Any appropriate site with a qualified staff

LACTATIONAL AMENORRHOEA METHOD (LAM)

ADVANTAGES

Contraceptive Benefits

- Protection against pregnancy as long as full breastfeeding is practiced
- Does not interfere with sexual activity

Non-Contraceptive Benefits

- Provides passive immunization for the child
- Decreases exposure to pathogens in water or other milk
- Best source of nutrition for infants

LIMITATIONS

- Effective only as long as breastfeeding is being practiced
- Does not protect one against STIs including hepatitis B, HIV/AIDS and therefore may be used with a barrier method to protect individuals from these diseases

WHO CAN USE LACTATIONAL AMENORRHOEA METHOD

- Women whose babies are less than 6 months old and who are fully or nearly fully breastfeeding and amenorrhoeic

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
When supplementary feeding begins	Counsell to express regularly or assist client to select another method.
Menstruation begins	Counsell to use another method.
If baby does not suckle frequently	Counsell to use another method.

WHO SHOULD NOT USE

- Women who are not breastfeeding at least nearly fully
- Women with resumed menses

WHO CAN PROVIDE

- All trained providers including CBD workers

WHERE IT CAN BE PROVIDED

Any appropriate site with qualified staff

LACTATION

UNTARY SURGICAL
ACEPTION

ADVANTAGES

Contraceptive B

- Protection
- Does not

Non-Con'

- Pro
- D
-

unction—does not interfere with intercourse

ide effects

lient if pregnancy would be a serious health risk

s not affect breastfeeding

on-Contraceptive Benefits

- Decreases risk of ovarian cancer

LIMITATIONS

- Irreversible
- Minimal risks and side effects of anaesthesia
- Risks associated with surgical procedures
- Does not protect against STIs/HIV/AIDS
- Short-term pain
- Can only be offered by a trained provider

NOTE: Informed consent must be obtained and a standard consent form must be signed by the client for the procedure. Spousal consent is **not** mandatory but counselling should be provided to and consent obtained from both partners if possible (see Appendix I).

In outreach programmes, all appropriate infection prevention practices, counselling and followup should be arranged as per procedures done at static sites. No more than 30 procedures should be performed in one theatre or by one surgeon in a day.

No incentives are to be given to clients to accept any form of contraception or to providers to recruit clients and perform the surgical procedure.

The client is free to change her mind anytime prior to accepting the procedure.

WHO CAN USE TUBAL LIGATION

- Women of reproductive age
- Women who are certain they have achieved the desired family size
- Clients in whom pregnancy would pose a serious health risk
- Women who understand and voluntarily follow informed consent procedure
- Women who want a permanent method

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Single women below 18 years of age and/or with no living children	Counsell very carefully and allow additional time to make informed decision. Recommend long-term non-permanent method.
Heart disease, previous/current PID, pelvic infections, hypertension, diabetes mellitus, respiratory disorders	Should be recommended by specialist and done in well-equipped facility.

WHO SHOULD NOT USE

- Clients who are uncertain of their desire for future fertility
- Clients who cannot withstand surgery
- Clients who do not give voluntary informed consent

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECT	MANAGEMENT
Pain at incision site	Determine presence of infection and treat. If no infection, reassure and provide analgesics.
Wound infection, fever	If skin infection, clean, dress and treat with antibiotics; if abscess, incise and drain.
Haematoma	Apply warm, moist packs on site, observe for few days; if increasing, evacuate.

WHO CAN PROVIDE

- Trained physicians

WHERE IT CAN BE PROVIDED

Any health facility with minor theatre, appropriate equipment and ability to provide infection prevention measures and with drugs and equipment to handle emergencies.

MALE VOLUNTARY SURGICAL CONTRACEPTION: VASECTOMY

TYPES

Scalpel and non-scalpel vasectomy

ADVANTAGES

Contraceptive Benefits

- Highly effective
- No change in sexual function—does not interfere with sexual intercourse
- Permanent; no side effects
- Does not affect breastfeeding

LIMITATIONS

- Irreversible
- Minimal risks and side effects of local anaesthesia
- Risks associated with surgical procedures
- Does not protect against STIs/HIV/AIDS
- Can only be offered by a trained provider
- Delayed effectiveness once the procedure has been performed

NOTE: Informed consent must be obtained and a standard consent form must be signed by the client for the procedure (see Appendix I).

In outreach programmes, all appropriate infection prevention practices, counselling and followup should be arranged as per procedures from a static sites. No more then 30 procedures should be performed in one theatre or by one surgeon in a day.

No incentives are to be given to clients to accept VSC or to providers to recruit clients and perform the surgical procedure.

The client is free to change his mind anytime prior to the procedure.

WHO CAN USE VASECTOMY

- Men of reproductive age
- Men who have achieved desired family size

- Men who understand and voluntarily give informed consent for the procedure

USE WITH CARE IN THE FOLLOWING SITUATIONS

CONDITION	CARE
Single and/or with no living children below 18 years of age	Counsell very carefully and allow additional time to make informed decision.
Heart disease, hypertension, diabetes mellitus, respiratory disorders	Should be recommended by a specialist and done in well-equipped facility.
STI/Orchitis	Treat before procedure.

WHO SHOULD NOT USE

- Clients who are uncertain of their desire for future fertility
- Clients who cannot withstand surgery
- Clients who do not give voluntary informed consent

MANAGEMENT OF COMMON SIDE EFFECTS

SIDE EFFECTS	MANAGEMENT
Bleeding	Control bleeding
Haematoma	Evacuate or apply warm packs

WHO CAN PROVIDE

- Trained physicians

WHERE IT CAN BE PROVIDED

Any facility with minor theatre, appropriate equipment and ability to provide infection prevention measures and with drugs and equipment to handle emergencies.

REPRODUCTIVE HEALTH ISSUES

PREAMBLE

The MCH/FP provider must provide or arrange for the provision of comprehensive reproductive health care to all clients who need such care. This will include counselling and treatment of STIs and other reproductive health problems as well as advice to clients on general health issues.

ADOLESCENTS/YOUTH (Below 19 years)

Providers should make comprehensive reproductive health information and counselling freely available for health reasons in good faith to adolescents and youth seeking this information. The areas on which service providers should place emphasis include:

- Morals of responsible parenthood
- Family values
- Physiology of reproductive system
- Avoidance of sexual activities
- Risks associated with early initiation of sexual activities (such as STIs/HIV/AIDS, pregnancy, cervical cancer and miscarriage)

Adolescents/youth who are sexually active, especially those who have been pregnant, have had a miscarriage or have been treated for STIs, need special attention in terms of reproductive health care. This includes appropriate treatment for the existing condition and counselling and provision of a full range of RH services. In particular, these counselling and services should be offered to adolescent women who are married. Adolescents below the age of 15 years require special attention that includes counselling and followup by social workers to rule out any indications of child abuse.

INFERTILITY

Infertility is an important health problem that affects a substantial proportion of couples. Causes of infertility affect men and women equally. Family planning providers have a major role to play in the prevention of infertility and assisting infertile patients/clients.

Role of an MCH/FP clinic in management of infertility:

Prevention of Infertility

- Counsell on protection against STIs and risky sexual behaviors and advocate safe sexual practices.
- Promote the use of condoms for protection against STIs.
- Prompt treatment of STIs and GTIs.

Management of Infertility

- Discuss fertility desires with a client.
- Counsell about fertility awareness and fertile period.
- Discuss whether clients have sexual difficulties and advise on means of overcoming them.
- Refer clients with infertility to medical officers for appropriate management.

BREASTFEEDING

- Breastfeeding, especially exclusive breastfeeding in the first six months, should be encouraged as it is good for the health of the mother and the child.
- Providers should promote breastfeeding and follow baby-friendly guidelines.
- Providers should advise breastfeeding mothers on nutrition.

Contraceptives suitable for breastfeeding mothers:

- The Lactational Amenorrhoea Method (LAM) can be used for a period of up to six months postpartum.
- All barrier methods can be used.
- The progestogen-only contraceptives (minipill, injectables and implants) can be used after six weeks if not practicing LAM.
- Combined oral contraceptives can only be used after six months if breastfeeding.
- Voluntary surgical contraception can be performed in the immediate postpartum period or as an interval procedure.

CERVICAL CANCER SCREENING

Service providers in all SDPs should be encouraged to carry out visual inspection of the cervix.

Visual Screening

If there are lesions noted, refer to centres where pap smears can be done.

Frequency

Visual screening should be done at least once every year.

Pap Smear

Clients should be counselled on the advantages of pap smears and be encouraged to have a pap smear.

Frequency

All women aged 25–64 years should have a pap smear at least once every five years.

MATERNAL HEALTH/SAFE MOTHERHOOD

All service providers must familiarise themselves with the MOH's guidelines for safe motherhood.

ANTENATAL CARE (ANC)

Antenatal care is an important component of an integrated MCH/FP service.

COUNSELLING

Should include information on:

- Child spacing
- Good nutrition
- Breastfeeding
- Complications of pregnancy
- Postpartum contraception including immediate postpartum IUCD insertion
- Advantages of an assisted delivery by a trained person

BENEFITS OF ANTENATAL CARE

- Early detection of complications
- Awareness of other reproductive health issues
- Ensures a healthy mother and baby

WHO IS ELIGIBLE FOR ANTENATAL CARE

- All women who are pregnant

WHO CAN PROVIDE ANTENATAL CARE

- Obstetricians, Physicians, Nurses/Midwives and TBAs

WHERE IT CAN BE PROVIDED

- All SDPs with appropriate staff and equipment
- In the home

COMPLICATIONS OF PREGNANCY

- Counsell, reassure, manage minor cases and refer complicated cases for further management.

POSTNATAL CARE

COUNSELLING

Should include information on:

- The importance of attending postnatal clinic
- LAM
- Tubal ligation
- Postpartum IUCD
- Vasectomy
- Condom use
- Maternal nutrition
- Progestagen-only pill
- Personal hygiene
- Breastfeeding
- Baby care
  - Prevention of infections
  - Immunizations
  - Prevention of ophthalmia neonatorum
- Emergency contraception

BENEFITS OF ATTENDING POSTNATAL CLINIC

- Ensures a healthy mother and baby

WHO IS ELIGIBLE FOR POSTNATAL CARE

- All mothers who have delivered in SDPs and at home
- All women who have had abortion at home or in an SDP

WHO CAN PROVIDE POSTNATAL CARE

- Physicians, Nurses/Midwives, Trained Clinical Officers

WHERE IT CAN BE PROVIDED

- All SDPs with appropriate staff and equipment

IN-REACH SERVICES

In-reach services: FP services can be provided in all sections of the health facility where the health providers are in contact with clients/patients and not just in FP clinics. Every opportunity must be taken to provide counselling and services for FP. For example, in an emergency gynaecological ward, postabortion clients should be offered FP services after counselling.

POSTABORTION CARE (PAC)

Abortion is a common problem and often occurs under unsafe conditions. After an abortion, women are liable to get pregnant within the first ten days.

Service providers must provide counselling and services to postabortion patients at the first available opportunity.

PURPOSE

Comprehensive postabortion care services should include both medical and preventive health care. The objectives of postabortion care are to provide:

- Emergency treatment of incomplete abortion and potentially life-threatening complications
- Postabortion family planning counselling and services
- Links between postabortion emergency services and the reproductive health care system

EMERGENCY TREATMENT

Emergency treatment for postabortion complications includes:

- Initial screening (vital signs, temperature and amount of bleeding) to assess the patient's condition
- Talking to the woman regarding her medical condition and the treatment plan
- Medical assessment (brief history, limited physical and pelvic examinations)
- Stabilization of emergency conditions (shock, hemorrhage or sepsis)
- Prompt referral and transfer to an appropriate facility if the woman requires treatment beyond the ability of the facility where she is seen
- Uterine evacuation to remove retained products of conception

The prompt treatment of postabortion complications is an important part of health care that should be available at every district-level hospital.

POSTABORTION FAMILY PLANNING

In many instances, provision of emergency postabortion care may be one of the few occasions that a woman and her partner come into contact with the health care system. Therefore, it represents an important opportunity for providing contraceptive information and services.

Postabortion family planning should include the following components of good family planning:

- Counselling about contraceptive needs in terms of the client's reproductive goals

- Information and counselling about all available methods, their characteristics, effectiveness and side effects
- Choices among methods (e.g., short- and long-term, hormonal and nonhormonal)
- Assurance of contraceptive resupply
- Access to followup care
- Information about the need for protection against STIs
- Information about emergency contraceptive pills

Postabortion family planning also should be based on an individual assessment of each woman's situation:

- her personal characteristics,
- clinical condition, and
- the service delivery capabilities in the community where she lives.

WHEN TO START FAMILY PLANNING

Postabortion family planning services need to be initiated immediately because ovulation may occur as early as 11 days following treatment of the incomplete abortion and usually occurs before the first menstrual bleeding. At a minimum, all women receiving postabortion care need **counselling** and **information** to ensure that they understand:

- they can become pregnant again before the next menses,
- there are safe contraceptive methods to prevent or delay pregnancy, and
- where and how they can obtain family planning services and methods.

WHICH CONTRACEPTIVE METHODS CAN BE USED

All modern methods of contraception are appropriate for use after treatment for incomplete abortion including hormonal methods, IUCD, implants and barrier methods, as long as the provider:

- screens the woman for the standard precautions for use of a particular method, and
- gives adequate counselling.

Information on the provision of postabortion contraception, including indications and precautions for specific methods, is provided in the section of this manual pertaining to each contraceptive method.

NOTE: A high number of abortions is an indication of unmet need for family planning.

LINKS TO OTHER REPRODUCTIVE HEALTH SERVICES

It is important to identify any other reproductive health services that a woman may need following an incomplete abortion and to offer her as wide a range of services as possible. For example:

- Some women may want to become pregnant soon after having an incomplete abortion, barring any medical reasons.
- For women over age 30–35, it may be possible to offer cervical cancer screening at the time of treatment or to provide referral to a facility where screening is available.
- Some women may need treatment for STIs. (Providers should be alert to any symptoms.)

INTEGRATION OF STI/HIV/AIDS CONTROL INTO THE MATERNAL CHILD HEALTH AND FAMILY PLANNING PROGRAMME

PREAMBLE

Midwives and family planning providers have the opportunity to discuss matters related to sex and sexual habits during counselling for FP methods. The rising prevalence of STIs and HIV/AIDS requires that FP and other health workers play a leading role in screening, diagnosis, and treatment of STIs as well as providing clients with the information and skills needed to assess and reduce their risk of acquiring these service providers.

PREVENTION

- Service providers should provide clients with information on dangers of contracting STIs and HIV/AIDS through high-risk sexual behavior.
- Service providers should promote the use of condoms and other barrier methods for those clients who are at risk of acquiring STIs even when they are using other methods of family planning.
- Treatment of clients with STIs using syndromic approach can be done by trained FP service providers at the SDP.
- Service providers offering treatment should follow contact-tracing guidelines.
- CBDs and TBAs should be trained to recognise STIs, ophthalmia neonatorum and refer.

It is important to educate all clients about:

- high-risk sexual behaviors,
- the protective benefits of condom use (as well as the limited effectiveness of diaphragms and spermicides), and
- the need to have her/his sex partner(s) evaluated and treated if a client is found to have a STI.

CLIENT SCREENING

Because a thorough examination (including microbiologic and serologic studies) of all clients is usually not possible, at a minimum, the risk of STIs in all clients should be assessed. Effective screening does not require the use of complicated protocols or costly laboratory tests. To do this, health care providers should:

- be knowledgeable about high-risk sexual practices,
- be aware of the signs and symptoms of STIs,
- be aware of which STIs are particularly common in their client population, and

- carefully evaluate clients in whom STIs are suspected based on their medical history or physical examination findings.

Questions STI screening history should include:

- Do you have a vaginal discharge that is especially unusual for you?
- In the previous year, have you had a genital tract problem such a s a vaginal discharge, ulcers or skin lesions in your genital area?
- Has your sex partner been treated for a genital tract problem, such as discharge from the penis or swollen groin glands, in the last three months?
- Do you know or think your sex partner has other sex partners?
- Are you or your partner in a profession that puts you at high risk (e.g., commercial sex worker, long-distance truck driver)?
- Have you had more than one sex partner in the last two months?
- Do you think that you might have a STI?

DIAGNOSIS AND TREATMENT

In primary health care facilities, diagnosis of GTIs usually rests solely on clinical findings (signs/symptoms) or risk assessment. For secondary health care facilities, however, where pelvic examinations can be done and a microscope and simple laboratory testing are available, greater accuracy in managing the most frequently encountered GTIs often is possible.

Service providers should be able to recognise genital discharge, genital ulcers, ophthalmia neonatorum and treat using syndromic approach. However genital discharge in women is difficult to diagnose properly and may requires specific tests and training.

At higher levels of care (e.g., health centres, district hospitals, provincial hospitals and private clinics/hospitals), clients with STIs should be managed according to outlined guidelines on STIs/HIV/AIDS.

APPENDIX I

INFORMED AND VOLUNTARY CONSENT FORM— SURGICAL CONTRACEPTION

I, ..., the undersigned, wish to be sterilised by the following procedure:

.....

I understand the following:

1. There are temporary methods of contraception that I can use instead of sterilisation for family planning.

2. Sterilisation is a surgical procedure, the details of which my doctor/nurse/midwife has explained to me.

3. The sterilisation operation involves risks, complications and side effects which my doctor/nurse/midwife has explained to me.

4. The sterilisation procedure will permanently prevent future pregnancies.

5. In a small number of cases the sterilisation operation may fail and pregnancy may occur.

6. I have chosen a sterilisation procedure of my own free will without any coercion or inducement.

7. I know that I can change my mind at any time before the procedure is done and decide against the procedure and I will continue to be provided with medical services from my doctor/nurse/midwife.

..... Date:
Client's name (print)

..... Date:
Client's signature

..... Date:
Spousal name (where applicable) (print)

..... Date:
Spousal signature (where applicable)

..... Date:
Doctor's signature

..... Date:
Witness (can be doctor, nurse, midwife)

APPENDIX II

PREGNANCY RATES PER 100 WOMEN DURING FIRST YEAR OF USE

METHOD	PREGNANCY RATES
Vasectomy	0.1–0.15
Tubal Occlusion	0.2–0.4[a]
Progestin-Only Implants (e.g., Norplant)	0.2–1
Progestin-Only Injectable Contraceptives (e.g., DMPA)	0.3–1
Intrauterine Devices	0.5–1
Progestin-Only Pills	0.5–10
Combined Oral Contraceptive Pills	0.1–8
Lactational Amenorrhoea Method	1–2[b]
Condoms	2–12
Spermicides	3–21
Withdrawal (Coitus Interruptus)	4–18
Diaphragms with Spermicides	6–18
Natural Family Planning	9–20

[a] Recent data suggest that failure rates at 5 and 10 years are higher depending on the woman's age at the time of the procedure and the method of sterilization used.

[b] If fully breastfeeding, no vaginal bleeding and infant less than 6 months old.

Adapted from: Labbok, Cooney and Coly 1994; Trussel 1990; WHO 1993.