FAMILY PLANNING POLICY AND SERVICE DELIVERY STANDARDS for UTTAR PRADESH

March, 1996

State Innovations in Family Planning Services Project Agency Lucknow.

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INTRODUCTION

In Uttar Pradesh (UP), as in many other states of India, population growth has yet to be stabilized. Despite the efforts of the National Family Planning Programme, couples still do not have adequate access to a full range of contraceptive methods. Although birth and death rates in UP have declined faster than in India as a whole, only 19.8% of married women in UP currently use any contraceptive method. There remains an unmet need of 51%. To meet this demand, as well as to increase overall contraceptive prevalence rates, it is necessary to improve the quality of care in family planning services, especially accessibility and availability.

Providing high quality services is based on following sound and reasonable principles of practice. These Family Planning Policy and Service Delivery Standards for Uttar Pradesh will equip the family planning service provider with the tools required to maintain consistently high quality in a professional manner while keeping in mind the clients’ needs and operating within the legal population and policy framework of the country.

These Standards are based on the most up-to-date knowledge on the methods of contraception currently available in UP. For each method, easy-to-use information is provided on:

- Counselling
- Mechanisms of action
- Benefits and limitations
- Medical eligibility
- Management of common side effects
- Client instructions
- Warning signs (where appropriate)

In addition, guidelines are included regarding what type of health care worker can provide the method, and where it can obtained. Finally, special sections covering several related reproductive health topics are included:

- Emergency Contraception
- Infection Prevention
- STDs and Family Planning
- Postabortion Care

Throughout these Standards, every effort has been made to provide clear direction to the service provider on the provision of family planning services and management of side effects and other problems. By providing updated knowledge and consistency of information, it is hoped that:

- the competence and confidence of service providers will improve when assisting clients in making contraceptive choices,
- the quality of family planning will improve (e.g., increased client satisfaction), and
- access to quality contraceptive services will increase.

Finally, we hope that these Family Planning Policy and Service Delivery Standards for Uttar Pradesh will assist service providers service providers working at all levels of the health care system in providing high quality family planning services to clients throughout UP.
ACKNOWLEDGMENTS

Preparation of the *Family Planning Policy and Service Delivery Standards for Uttar Pradesh* (UP) is the result of the joint effort of many individuals and organizations. Prepared under the direction of the State Innovations in Family Planning Services Project Agency (SIFPSA) and the Department of Family Welfare, Government of UP, the document was developed to improve access, quality and demand for family planning services throughout the State.

Plans for the document were formulated in August 1994 at a workshop for Standardizing Clinical Family Planning Training and Service Delivery Guidelines organized by SIFPSA and the Department of Health and Family Welfare in Lucknow. Participants at the workshop included representatives of King George's Medical College, Lucknow; LLRM Medical College, Meerut; the Indian Medical Association; the Family Planning Association of India; Parivar Seva Sansthan, New Delhi; Dufferin Hospital, Lucknow; PRERNA, Lucknow; NIPCID, Lucknow; Indian Council of Medical Research, USAID/Delhi and the JIPIEGO Corporation. Consensus was reached on the need for the development of both a *Reproductive Health Resource Document for Uttar Pradesh* and these policy and service delivery standards. The material included in these policy and service standards has been taken from the resource document.

We are grateful to the task force composed of individuals from the above organizations who reviewed the document as well as to the Government of India, Ministry of Health and Family Welfare who also provided their guidance and support. We are also appreciative of the assistance provided by the JIPIEGO Corporation and USAID/Delhi for their assistance in undertaking this activity.
ABBREVIATIONS

AIDS: acquired immune deficiency syndrome
BBT: basal body temperature
BP: blood pressure
BPM: beats per minute
BTB/S: breakthrough bleeding/spotting
CNS: central nervous system
COC: combined oral contraceptive
CVD: cardiovascular disease
DMPA: depot-medroxyprogesterone acetate
EE: ethinyl oestradiol
FH: familial hyperlipidemia
gms: grams
GNIDs: Gram negative intracellular diplococci
GTI: genital tract infection
Hb/Hct: haemoglobin/haematocrit
HBV: hepatitis B
HDL: high density lipoprotein
HIV: human immunodeficiency virus
HLD: high-level disinfection
IUCD: intrauterine contraceptive device
IV: intravenous
LAM: Lactational Amenorrhoea Method
LMP: last menstrual period
LNG: levonorgestrel
NET-EN: norethindrone enanthate
NFP: natural family planning
NSAID: nonsteroidal anti-inflammatory drug
PID: pelvic inflammatory disease
PMNs: polymorphonuclear neutrophil leukocytes
STD: Sexually transmitted disease
TSS: Toxic shock syndrome
UTI: urinary tract infection
VDRL: the standard nonreponemal antigen serologic test for syphilis
WBC: white blood cells
GOVERNMENT POLICIES REGARDING
FAMILY PLANNING METHOD PROVISION

ORAL CONTRACEPTIVES

- Appropriate for women of reproductive age who want to space or avoid pregnancy.
- The number of children must not be a criterion for determining eligibility of oral contraceptive acceptors.
- There is no age restriction for use.
- When possible, clients should be given at least three packets of pills at one time.

IUCDs

- Appropriate for women of reproductive age who want to space or avoid pregnancy.
- IUCD insertion should be conducted only at sub-centres, primary health centres, community health centres or hospitals.
- IUCDs must not be inserted at the residences of women.
- The Copper T 200B IUCD is approved for 3 consecutive years of use.

CONDOMS

- Appropriate for couples of reproductive age who want to space or avoid pregnancy or avoid sexually transmitted diseases (STDs).

MALE AND FEMALE STERILISATION

- Appropriate for clients who have completed their childbearing.
- The client must be married, and their spouse must be living.
- The female client must be below age 45 and above age 22.
- The male client must be below age 50 and his wife must be below age 45.
- The number of children must not be a criterion for determining the eligibility for sterilisation acceptors.
- The client or spouse must not have undergone previous sterilisation. (This condition may be waived in case of failure of the previous operation.)
- The client must be in the proper state of mind to understand fully the implications of the sterilisation surgery and must be counselled about the permanence of the procedure.
- Appropriate screening of clients is required to assure that patients who are at high risk of complications are referred to an appropriately equipped facility with personnel trained to deal with their medical or surgical problems.
- A couple should be counselled that the simplest sterilisation procedure, with the lowest morbidity, is vasectomy.
- The client must sign an informed consent form indicating her/his agreement to undergo the procedure.
COMPONENTS OF FAMILY PLANNING SERVICES

COUNSELLING

Counselling is an important prerequisite for the initiation and continuation of a family planning method. Service providers should be trained to provide counselling about all available methods of family planning. There should be no incentives or coercion to adopt family planning or a particular contraceptive method.

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 the provision of that method.

FOLLOW-UP AND REFERRAL SYSTEM

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

RECORD KEEPING

All family planning service providers should maintain proper records on each client, the type of contraception provided and any special circumstances associated with its provision.

SUPERVISION

Supervision is an essential component of programme evaluation which also ensures that guidelines are being followed and the needs of clients are being met. The supervisor is a team member who promotes staff motivation, helps in problem solving and ensures that the rights of providers and clients are observed.

LOGISTICS

Maintenance of a logistic system will help service delivery points (SDPs) avoid both understocking and overstocking. In order to maintain quality, the SDP staff should adhere to proper storage and handling of contraceptive commodities for the stipulated shelf life.
QUALITY OF CARE

In quality family planning programmes:

- Care should be personalised.
- Clients should be treated with dignity.
- Privacy should be maintained.
- Clients should not have to wait a long time before being served.
- Service providers should inform clients about the methods available.
- Service delivery points (SDPs) should be clean, with well organized client flow.
- SDPs should provide services at least during normal working hours, and where possible, attempt to meet the special needs of their client population.
- An adequate supply of quality contraceptives and consumable supplies should be maintained.
- Supervision should be dynamic: working together with staff to solve problems is essential to providing quality services.

Successful programmes require well-trained staff who exhibit:

- good clinical judgment in selecting acceptors;
- care, sensitivity and thoroughness in informing the user about the method chosen;
- skill in performing procedures;
- knowledge of and ability to recognize real or potential problems; and
- capability to take appropriate clinical action in response to these problems, including knowing when (and where) to refer clients with serious problems.
Counselling is a vital part of family planning. It helps clients:

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

Good counselling focuses on the individual client’s needs and situation, and good counsellors are willing to listen to the client’s questions and concerns.

<table>
<thead>
<tr>
<th>Keys to good counselling</th>
</tr>
</thead>
<tbody>
<tr>
<td>A good counsellor:</td>
</tr>
<tr>
<td>• Understands and respects the client’s rights</td>
</tr>
<tr>
<td>• Earns the client’s trust</td>
</tr>
<tr>
<td>• Understands the benefits and limitations of all contraceptive methods</td>
</tr>
<tr>
<td>• Provides an area for privacy while counselling</td>
</tr>
<tr>
<td>• Understands the cultural and emotional factors that affect a woman’s (or a couple’s) decision to use a particular family planning method</td>
</tr>
<tr>
<td>• Encourages the client to ask questions</td>
</tr>
<tr>
<td>• Uses a non-judgmental approach which shows the client respect and kindness</td>
</tr>
<tr>
<td>• Presents information in an unbiased, client-sensitive manner</td>
</tr>
<tr>
<td>• Actively listens to the client’s concerns</td>
</tr>
<tr>
<td>• Recognizes when s/he cannot sufficiently help a client and refers the client to someone who can</td>
</tr>
<tr>
<td>• Understands the effect of nonverbal communication</td>
</tr>
</tbody>
</table>

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, and
- the right to privacy and confidentiality.

In using these Standards it is important to remember that while many contraceptive methods are highly effective, method failure can occur. In the case of method failure, the client should be counselled, informed about the availability of MTP and referred to an antenatal clinic if she wishes to continue the pregnancy. Should the client need more advice, she must be referred for appropriate care and management.
COUNSELLING PROCESS

In reviewing contraceptive alternatives with clients, all available methods should be discussed.

Health workers should be aware of a number of client factors that may be important, depending on the method in question. These include:

- the reproductive goals of the woman or couple (spacing or timing births);
- subjective factors including the time, travel costs, pain or discomfort likely to be experienced;
- accessibility and availability of other products that may have to be procured to use the method;
- the benefits and limitations of the method;
- reversibility;
- short- or long-term side effects; and
- the need for protection against GTIs and other STDs (e.g., HBV, HIV/AIDS).

STEPS IN FAMILY PLANNING COUNSELLING

Counselling can be divided into three major phases:

- initial counselling at reception,
- method-specific counselling prior to and immediately after service provision, and
- follow-up counselling.

Counselling, however, should be part of every interaction with the client.

WHO SHOULD PROVIDE COUNSELLING

Because information and counselling preferably may come from more than one source, all staff should be knowledgeable about all available contraceptive methods.

<table>
<thead>
<tr>
<th>METHOD</th>
<th>PREGNANCY RATES (TYPICAL USE)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Vasectomy</td>
<td>0.15–1</td>
</tr>
<tr>
<td>Tubal Ligation</td>
<td>0.2–1</td>
</tr>
<tr>
<td>Progestin-Only Injectable</td>
<td>0.3–1</td>
</tr>
<tr>
<td>Copper IUCD 200B</td>
<td>0.5–3</td>
</tr>
<tr>
<td>Combined Oral Contraceptives (COCs)</td>
<td>1–8</td>
</tr>
<tr>
<td>Lactational Amenorrhoea Method (LAM)</td>
<td>2–3</td>
</tr>
<tr>
<td>Withdrawal (Coitus Interruptus)</td>
<td>5–25</td>
</tr>
<tr>
<td>Condoms</td>
<td>5–25</td>
</tr>
<tr>
<td>Natural Family Planning (Periodic Abstinence)</td>
<td>10–30</td>
</tr>
</tbody>
</table>

CLIENT ASSESSMENT

OBJECTIVES

The primary objectives of screening clients prior to providing family planning are to determine:

- that the client is not pregnant,
- whether any conditions requiring precautions exist for a particular method, and
- whether there are any special problems that require further assessment or more regular follow-up.

For most clients, this 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 sterilisation, does not require performing a physical or pelvic examination.

Where resources are limited, making medical evaluation and/or lab testing a requirement before providing modern contraceptive methods is not justifiable. The requirement of screening, treatment and follow-up activities (e.g., pap smears and routine haemoglobin) that are not essential to the provision of specific contraceptives act as major barriers to contraceptive choice and access to services. Therefore, client assessment should be limited only to those procedures that are essential and mandatory for all clients in all settings.

HOW TO BE REASONABLY SURE THE CLIENT IS NOT PREGNANT

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

- Has not had intercourse since 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.

When a woman is more than 6 months postpartum you can be reasonably sure she is not pregnant if she has kept her breastfeeding frequency high, is still amenorrhoeic and has no clinical signs or symptoms of pregnancy.

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

Pregnancy testing is not necessary 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 or has a retroverted uterus). In these situations, a highly sensitive pregnancy test which is positive within 10 days after conception may be helpful, if readily available and inexpensive.

If pregnancy testing is not available, counsel the client to use condoms until her menses occur or the possibility of pregnancy is confirmed.
MENSTRUAL BLEEDING PATTERNS WITH HORMONAL CONTRACEPTIVES AND IUCDS

All modern contraceptive methods (COCs, injectables and IUCDs) affect the menstrual bleeding pattern. In general, methods in which the bleeding pattern closely mimics those of noncontracepting women are more acceptable to the majority of women. Unfortunately, all of the reversible, modern methods alter the menstrual bleeding pattern in terms of:

- the number of bleeding/spotting days,
- the number of bleeding/spotting periods, or
- a combination of the two.

Vaginal Bleeding

Throughout these Standards, in describing changes in menstrual bleeding patterns for each contraceptive method, the characteristics of vaginal bleeding have been defined as follows:

**Bleeding:** Any bloody vaginal discharge requiring use of sanitary protection (pads or cloths)

- Heavy: More than 2 pads or cloths per hour
- Prolonged: More than 8 days (duration)

**Spotting:** Minimal pink, brown or red discharge which requires no sanitary protection

- Prolonged: More than 8 days duration

**Amenorrhea:**

- Primary (1°): No uterine bleeding/spotting by age 16 (no 2° sexual development) or age 18 (if 2° sexual development)
- Secondary (2°): No uterine bleeding/spotting for at least 3 consecutive months

**Oligomenorrhea:** Menstrual interval > 35 days but < 90 days (may or may not be ovulatory)

**Polymenorrhea:** Menstrual interval 21 days or less (strongly suggests anovulation)

Because of the direct association between vaginal bleeding patterns and reasons for stopping a contraceptive, a clear understanding of the types of bleeding changes is important to counsel clients adequately and to better manage bleeding problems in continuing users.

---

1 The amount of blood lost during a normal menstrual period is 50–80 ml.
## HORMONAL METHODS CHECKLIST (COCs and progestin-only injectables)

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO*</th>
</tr>
</thead>
<tbody>
<tr>
<td>First day of menses more than 7 days ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breastfeeding and less than 6 weeks postpartum^a^</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding/spotting between periods or after intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Jaundice (abnormal yellow skin or eyes)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe headaches or blurred vision</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Smoker over age 35^b^</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Severe pain in calves, thighs or chest or swollen legs (oedema)^c^</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood pressure above 140 mm (systolic) or 90 mm (diastolic)^d^</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Breast cancer or suspicious (firm, nontender or fixed) lump in the breast</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Taking drugs for epilepsy (seizures) or rifampin (for tuberculosis)^e</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*If client answers “NO” to all questions, physical and pelvic examinations are not necessary for the safe provision of the hormonal contraceptive method.

^a COCs are the method of last choice for breastfeeding women, especially in the first 6 weeks postpartum.

^b Does not apply to progestin-only injectables (DMPA or NET-EN).

## IUCD CHECKLIST

<table>
<thead>
<tr>
<th>Condition</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>First day of menses more than 7 days ago</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Client (or partner) has other sex partners</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted genital tract infection (GTI) or other STD (e.g., HBV, HIV/AIDS)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Pelvic infection (PID) or ectopic pregnancy (within last 3 months)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Heavy menstrual bleeding (&gt; 2 pads or cloths per hour)</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Prolonged</strong> menstrual bleeding (&gt; 8 days)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Severe</strong> menstrual cramping (dysmenorrhoea) requiring analgesics and/or bed rest</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Bleeding/spotting between periods or after intercourse</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Symptomatic valvular heart disease^a^</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Give prophylactic antibiotics if not on long-term antibiotics at the time of IUCD insertion.

If all of the above are negative (NO) and pregnancy is not suspected, the client may go directly for method-specific counselling, pelvic examination (IUCD only) and provision of the contraceptive. Any positive response (YES), however, means that the client should be further evaluated before making a final decision.
These standards are intended for use in selecting healthy clients who can safely have the procedure performed in an ambulatory health care facility (family planning clinic or health centre). Not acceptable indicates that the procedure probably should be performed in a facility where additional assistance and back-up services are available (e.g., more experienced physician, general anaesthesia).

### FEMALE VOLUNTARY STERILISATION GUIDELINES

<table>
<thead>
<tr>
<th>Category</th>
<th>Acceptable</th>
<th>Not Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health (assessed by history and limited physical examination)</td>
<td>Negative history and no current symptomatic heart, lung or kidney disease</td>
<td>Uncontrolled diabetes or history of bleeding disorder; current symptomatic heart, lung or kidney disease</td>
</tr>
<tr>
<td>Emotional state</td>
<td>Calm, stable</td>
<td>Unresolved fear and anxiety</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>$\leq 140/90 \text{ mm/Hg}$</td>
<td>$&gt; 140/90 \text{ mm/Hg}$</td>
</tr>
<tr>
<td>Height/weight (H/W)</td>
<td>Normal H/W ratio</td>
<td>$&gt; 75 \text{ kg}$</td>
</tr>
<tr>
<td></td>
<td>Maximum weight: 75 kg (165 lb)</td>
<td>$&lt; 35 \text{ kg}$</td>
</tr>
<tr>
<td>Previous abdominal/pelvic surgery</td>
<td>C-sections—only with mobile abdominal scar and normal pelvic examination</td>
<td>Other abdominal surgery, fixed scar or abnormal pelvic examination</td>
</tr>
<tr>
<td>Previous pelvic disease (PID, ectopic pregnancy) or ruptured appendix</td>
<td>Negative history and normal abdominal pelvic examination</td>
<td>Abnormal abdominal/pelvic examination</td>
</tr>
<tr>
<td>Anaemia (optional)*</td>
<td>Hb $\geq 8 \text{ gms %}$</td>
<td>Hb $&lt; 8 \text{ gms %}$</td>
</tr>
</tbody>
</table>

### MALE VOLUNTARY STERILISATION GUIDELINES

<table>
<thead>
<tr>
<th>Category</th>
<th>Acceptable</th>
<th>Not Acceptable</th>
</tr>
</thead>
<tbody>
<tr>
<td>General health (assessed by history and limited physical examination)</td>
<td>Negative history and no current symptomatic heart, lung or kidney disease</td>
<td>Uncontrolled diabetes or history of bleeding disorder; current symptomatic heart, lung or kidney disease</td>
</tr>
<tr>
<td>Emotional state</td>
<td>Calm, stable</td>
<td>Unresolved fear and anxiety</td>
</tr>
<tr>
<td>Blood pressure</td>
<td>$\leq 140/90 \text{ mm/Hg}$</td>
<td>$&gt; 140/90 \text{ mm/Hg}$</td>
</tr>
<tr>
<td>Anaemia (optional)*</td>
<td>Hb $\geq 10 \text{ gms %}$</td>
<td>Hb $&lt; 10 \text{ gms %}$</td>
</tr>
<tr>
<td>Scrotal/inguinal infection or abnormalities (undescended testes, hernia)</td>
<td>Normal examination</td>
<td>Infection of scrotal or inguinal area, balanitis or anatomic abnormalities</td>
</tr>
</tbody>
</table>

* Laboratory investigation of anaemia should be done when there is clinical (by history or physical examination) suspicion of anaemia.
<table>
<thead>
<tr>
<th>Assessment</th>
<th>NFP or LAM*</th>
<th>Condoms</th>
<th>Hormonal Methods (COCs/Injectables)</th>
<th>IUCD</th>
<th>Voluntary Sterilisation (Female/Male)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Reproductive History</td>
<td>No</td>
<td>No</td>
<td>Yes (See checklist)*</td>
<td>Yes (See checklist)*</td>
<td>Yes (See checklists)*</td>
</tr>
<tr>
<td>GTIs/STDs History</td>
<td>No</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**PHYSICAL EXAMINATIONS**

<table>
<thead>
<tr>
<th>Assessment</th>
<th>NFP or LAM*</th>
<th>Condoms</th>
<th>Hormonal Methods (COCs/Injectables)</th>
<th>IUCD</th>
<th>Voluntary Sterilisation (Female/Male)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Female General (including BP)</td>
<td>No</td>
<td>No</td>
<td>No*</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Abdominal</td>
<td>No</td>
<td>No</td>
<td>No*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pelvic Speculum</td>
<td>No</td>
<td>No</td>
<td>No*</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Pelvic Bimanual</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>N/A</td>
<td>Yes</td>
</tr>
<tr>
<td>Male (Groin, Penis, Testes, Scrotum)</td>
<td>No</td>
<td>No</td>
<td>N/A</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

* NFP: natural family planning; LAM: lactational amenorrhoea method

* Hormonal Methods Checklist

* IUCD Checklist

* Female Voluntary Sterilisation Guidelines and Male Voluntary Sterilisation Guidelines

* If screening checklist all negative (no), examination is not necessary.

* Only necessary if pregnancy is suspected and pregnancy test is not available.
EMERGENCY CONTRACEPTION

When intercourse occurs without contraceptive protection, unplanned and undesired pregnancy can result. Fortunately, there are means available to prevent pregnancy when unprotected intercourse occurs, and clients need not be turned away to anxiously await their menstrual period.

Before providing emergency contraception be sure the client is not already pregnant (i.e., she might have become pregnant in the previous month). Symptoms of early pregnancy may include:

- Breast tenderness
- Nausea
- Change in the last menses (light flow, short duration, etc.)
- Urinary frequency

In addition, women who are at increased risk of vascular problems (current or past blood clotting problems, heart attack or stroke) should be advised that the risk of a serious complication may be increased if they use the high-dose estrogen regimen.\(^1\)

While most contraceptives are appropriate before intercourse, several methods also can be used within a short time after unprotected intercourse. Often called “morning after pills,” these regimens are better named secondary contraceptives or emergency contraceptives to remove the idea that the user must wait until the morning after intercourse to start treatment—or that she will be too late if she cannot obtain the pills until the afternoon or night after intercourse. The name emergency contraception also stresses that these methods, while better than nothing in the event of unprotected intercourse, typically are less effective than the ongoing use of modern contraceptive methods.

TYPES—See COC and IUCD for types available.

BENEFITS

All are very effective (failure rate less than 3%).
IUCDs have few side effects and provide long-term contraception.

LIMITATIONS

- COCs effective only if used within 72 hours of unprotected intercourse. IUCDs effective only if inserted within 5 days of unprotected intercourse.
- High doses of COCs can cause nausea and vomiting.
- Doses of COCs given for emergency contraception should not be used as a regular method.
- IUCD insertion requires minor procedure performed by a trained provider and should not be done in women at risk of GTIs and other STDs (e.g., HBV, HIV/AIDS).

---

\(^1\) COCs taken for a short duration (2 days) in a physically active client are unlikely to cause a serious problem even in women with these problems; therefore, do not withhold treatment if client requests it.
WHO CAN USE EMERGENCY CONTRACEPTION

- Clients in need of emergency protection (e.g., unplanned or unprotected intercourse, broken condom or leakage from condom)

WHO SHOULD NOT USE EMERGENCY CONTRACEPTION

- Women who are pregnant or suspected of being pregnant

INSTRUCTIONS FOR USE

COCs: **Preferred**: Take four tablets of a low-dose COC (30–35 μg ethinyl oestradiol), such as Mala N, orally within 72 hours of unprotected intercourse. Take four more tablets in 12 hours. (Total = 8 tablets).

**Alternative**: Take two tablets of a high-dose COC (50 μg ethinyl oestradiol), such as Lyndiol, orally within 72 hours of unprotected intercourse. Take two more tablets in 12 hours. (Total = 4 tablets)

IUCDs: Insert within 5 days of unprotected intercourse.

For all methods, if no menses (vaginal bleeding) within 14–21 days, the client should consult the clinic or service provider to check for possible pregnancy.

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea, vomiting with COCs.</td>
<td>Counsel client about this side effect.</td>
</tr>
<tr>
<td>If vomiting occurs within 1 hour after taking first or second dose, client may need to repeat the drug.</td>
<td></td>
</tr>
<tr>
<td>IUCD</td>
<td>Same as for interval insertion; see IUCD section.</td>
</tr>
</tbody>
</table>

WHO CAN PROVIDE

- Medical Officers
- Staff Nurses
- LHV's
- ANMs
- Pharmacists (COCs only)

WHERE CAN IT BE PROVIDED

- Hospitals
- CHCs
- PHCs
- Subcentres
- Pharmacies (COCs only)
- Private Clinics

WHAT TO DO IF EMERGENCY CONTRACEPTION FAILS

- If COCs were used, assure the client that the small dose of oestrogen and progestin in the COCs will have no harmful effect on the fetus.
- Counsel and refer her for antenatal care or MTP.
LACTATIONAL AMENORRHOEA METHOD (LAM)

LAM is based on the physiologic effect of suckling to suppress ovulation. To use breastfeeding effectively as a contraceptive requires that the mother either feed the baby nothing but breastmilk, give some infrequent feedings of juice, milk or water, or at the very least breastfeed for almost all feedings (fully breastfeeding).

MECHANISM OF ACTION

- Suppresses ovulation through suckling

BENEFITS

Contraceptive

- Highly effective (2–3 pregnancies per 100 women during first 6 months)
- Effective immediately
- Does not interfere with intercourse
- No physical side effects
- No medical supervision necessary
- No supplies required
- Free

Health

For child
- Passive immunisation
- Best source of nutrition
- Decreased exposure to pathogens in water, other milk or formulas, or on utensils

For mother
- Decreased postpartum bleeding

LIMITATIONS

- User dependent (requires following instructions regarding breastfeeding practices)
- May be difficult to practise due to social circumstances
- Effective only as long as full breastfeeding is practiced and menses have not returned
- Does not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)

WHO CAN USE LAM

- Women who are fully breastfeeding on demand, whose babies are less than 6 months old and whose menses have not returned
USE WITH CARE IN THE FOLLOWING SITUATIONS

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>When regular supplementary feeding begins (replacing a breastfeeding meal)</td>
<td>Help client choose another method. Even if another contraceptive method is required, client should be encouraged to continue breastfeeding.</td>
</tr>
<tr>
<td>When menstruation begins</td>
<td>Help client choose another method. Even if another contraceptive method is required, client should be encouraged to continue breastfeeding.</td>
</tr>
<tr>
<td>Baby does not suck frequently (&gt; 4 hours between feedings during the day; &gt; 6 hours at night)</td>
<td>Help client choose another method. Even if another contraceptive method is required, client should be encouraged to continue breastfeeding.</td>
</tr>
<tr>
<td>Baby is 6 months old or older</td>
<td>Help client choose another method. Even if another contraceptive method is required, client should be encouraged to continue breastfeeding.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE LAM

- Women whose menses have returned
- Women who are not fully breastfeeding
- Women who are more than 6 months postpartum

CLIENT INSTRUCTIONS

How Often to Breastfeed

Breastfeed your baby on demand from both breasts, about 6 to 10 times per day.

Breastfeed your baby at least once during the night (no more than 6 hours should pass between any 2 feedings).

Note: Breastfeeding is primarily used for infant nutrition and health. Your baby may not want to breastfeed 6 to 10 times per day, or your baby may choose to sleep through the night. If either occurs, breastfeeding will be less effective as a contraceptive method.

When to Start Solid Foods

As long as the baby is growing well and gaining weight, and as long as you are eating a balanced diet and resting in order to have a good milk supply, the baby does not need any other foods until s/he is 6 months old.

Once you substitute other food or drink for breastfeeding meals, the baby will suckle less, and breastfeeding will no longer be an effective contraceptive method.

Menstrual Periods

When your menstrual period returns it is very likely that you are fertile again and you should begin using a contraceptive method immediately.
For Contraception and Health:

- You will need a contraceptive method if you have a menstrual period, if you no longer breastfeed fully or when your baby is 6 months old.
- Consult your health care provider or clinic before starting another contraceptive method.
- If you or your partner are at high risk for GTIs or other STDs, including the AIDS virus, you should use condoms as well as LAM.

What To Do When You Are Not Fully Breastfeeding or Stop Breastfeeding

- You need to have a temporary supply of lubricated condoms or another method of contraception at home for use when you stop fully breastfeeding your baby.
- Return to the family planning clinic for help in choosing and using a suitable contraceptive method.

WHO CAN COUNSEL ABOUT LAM

- Medical Officers
- ANMs/LHVs
- Staff Nurses
- Dais, Community Health Workers

WHERE CAN IT BE PROVIDED

- Hospitals
- PHCs
- CHCs
- Subcentres
- Community Sites (with instruction from health worker)
- Homes (with instruction from health worker)
- Private Clinics
COMBINED ORAL CONTRACEPTIVE PILLS (COCs)

TYPES
Monophasic: Mala N, Pearl, Ecroz, Mala D, Ovral-L, Novelan, Lyndiol
Triphasic: Triquilar-21, Orthonovum 7/7/7

MECHANISMS OF ACTION

- Suppress ovulation
- Thick cervical mucus (prevents sperm penetration)
- Change endometrium
- Reduce sperm transport in fallopian tubes

BENEFITS

Contraceptive

- Highly effective when taken daily (1–8 pregnancies per 100 women during the first year of use)
- Effective immediately if started by day 7 of the menstrual cycle
- Pelvic examination not required prior to use
- Do not interfere with intercourse
- Few side effects
- Convenient and easy to use
- Can stop use easily
- Can be provided by trained nonmedical staff

Health

- Decrease menstrual flow (lighter, shorter periods)
- Decrease menstrual cramps
- May improve anaemia
- Regulate menstrual cycles
- Protect against ovarian and endometrial cancer
- Decrease benign breast disease
- Prevent ectopic pregnancy
- Protect against some causes of PID

LIMITATIONS

- User dependent (require continued motivation and daily use)
- Effectiveness may be lowered when certain drugs for epilepsy (seizure disorder) and tuberculosis (rifampin) are taken
- Serious side effects (i.e., heart attack, stroke, blood clots in lung or brain, liver tumours), though rare, are possible
- Resupply must be available
- Do not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)
WHO CAN USE COCs

- Women of any reproductive age
- Women of any parity including nulliparous women
- Women who want highly effective protection against pregnancy
- Women who are postpartum and not breastfeeding (> 3 weeks)
- Women who are breastfeeding (6 months or more postpartum)
- Women who are postabortion (start immediately or within 7 days)
- Women with anaemia
- Women with severe menstrual pains or heavy periods
- Women with a history of ectopic pregnancy

USE WITH CARE IF THE FOLLOWING CONDITIONS ARE PRESENT

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>High blood pressure</td>
<td>Initiate and resupply after careful evaluation of condition. Women with BP ≤140/90 can use COCs.</td>
</tr>
<tr>
<td>Diabetes mellitus</td>
<td>Same as above. COCs can be used with uncomplicated diabetes or diabetes of less than 20 years duration.</td>
</tr>
<tr>
<td>Migraines</td>
<td>Same as above. Evaluate. If no focal neurological symptoms are associated with the headaches, COCs can be used.</td>
</tr>
<tr>
<td>Taking medication for epilepsy or tuberculosis</td>
<td>Provide higher oestrogen (50 μg ethinyl oestradiol) pills or help client choose another method.</td>
</tr>
<tr>
<td>Depression</td>
<td>Women with a history of depression require follow-up.</td>
</tr>
<tr>
<td>Breast lumps</td>
<td>Evaluate if suspicious lumps and confirm the diagnosis. Women with benign breast disease can use COCs.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE COCs

- Women who are pregnant (known or suspected)
- Women who are postpartum and not breastfeeding (< 3 weeks)
- Women who are breastfeeding (before 6 months postpartum)
- Women with unexplained vaginal bleeding
- Women with active liver disease (viral hepatitis)
- Women over age 35 who are smokers
- Women with a history of heart disease, stroke or high blood pressure (> 140/90)
- Women with a history of blood clotting disorders or diabetes (> 20 years)
- Women with breast cancer
- Women who cannot remember to take a pill every day
WHEN TO START

- Days 1-7 of the menstrual cycle (preferably first day)
- Anytime during the menstrual cycle when you can be reasonably sure the client is not pregnant
- Postpartum (after 3–4 weeks if not breastfeeding; after 6 months if using LAM)
- Postabortion (immediately or within the first 7 days)

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhoea (absence of any vaginal bleeding or spotting)</td>
<td>Rule out pregnancy. If client is taking COCs correctly, reassure. Explain that absent menses are most likely due to lack of build up of uterine lining. If the client is unsatisfied, try a high-dose oestrogen (50 μg ethinyl oestradiol) pill if available and no conditions requiring precaution exist. Missed pills or pills taken late increase risk of pregnancy. Clients on 21-day packets may forget to leave a pill-free week for menses. If pills are taken continuously, amenorrhoea may result. This is not harmful. If intrauterine pregnancy is confirmed, counsel client regarding options; refer for antenatal care or MTP. If pregnancy will be continued, stop use and assure her that the small dose of oestrogen and progestin in the COCs will have no harmful effect on the foetus. If not pregnant, no treatment is required except counselling and reassurance. If she continues COCs, amenorrhoea usually will persist. Advise client to return to clinic if amenorrhoea continues to be a concern.</td>
</tr>
<tr>
<td>Nausea/dizziness/vomiting</td>
<td>Rule out pregnancy. If pregnant, manage as above. If not, advise taking pill with evening meal or before bed time. Reassure that symptoms usually decrease after first three cycles of use.</td>
</tr>
<tr>
<td>Vaginal bleeding/spotting</td>
<td>Rule out pregnancy and other gynaecological conditions. Advise taking pills at the same time each day. Reassure that spotting/light menstrual bleeding is common during first 3 months of use and then decreases. If it persists, provide higher oestrogen (50 μg ethinyl oestradiol) pills or help client choose another method.</td>
</tr>
</tbody>
</table>

CLIENT INSTRUCTIONS

- Take 1 pill each day, preferably at the same time of day.
- Take the first pill on the first to the seventh day (first day is preferred) after the beginning of your menstrual period.
- Some pill packets have 28 pills. Others have 21 pills. When the 28 day packet is empty, you should immediately start taking pills from a new packet. When the 21 day packet is empty, wait one week (7 days) and then begin taking pills from a new packet.
- If you vomit within 30 minutes of taking your pill, take another pill or use a back-up method if you have sex during the next 7 days.
- If you forget to take 1 pill, take it as soon as you remember, even if it means taking 2 pills on 1 day.
- If you forget to take 2 or more pills, you should take 2 pills every day until you catch up. Use a back-up method (e.g., condoms and spermicide) or else do not have sex for 7 days.
- If you miss 2 or more menstrual periods, you should come to the clinic to check to see if you are pregnant.
General Information

- Tell the client that nausea, dizziness, mild breast tenderness and headaches as well as spotting or light bleeding are common during the first three cycles and then usually disappear.
- Tell her that certain medicines (rifampin and most antiseizure drugs) may reduce the effectiveness of COCs. For this reason, she should tell her health care provider if she starts any new medicines.
- COCs do not provide protection against GTIs and other STDs, including the AIDS virus. If either partner is at risk, they should use condoms as well as COCs.

<table>
<thead>
<tr>
<th>Five Signs</th>
<th>Possible Problem</th>
</tr>
</thead>
<tbody>
<tr>
<td>A Abdominal pain (severe)</td>
<td>• Gall bladder disease, blood clot, pancreatitis</td>
</tr>
<tr>
<td>C Chest pain (severe), cough, shortness of breath</td>
<td>• Blood clot in lungs or heart attack</td>
</tr>
<tr>
<td>H Headache (severe)</td>
<td>• Stroke, hypertension or migraine</td>
</tr>
<tr>
<td>E Eye problem (vision loss or blurring) especially contact lens wearers</td>
<td>• Stroke, hypertension or temporary vascular problems</td>
</tr>
<tr>
<td>S Severe leg pain (calf or thigh)</td>
<td>• Blood clot in legs</td>
</tr>
</tbody>
</table>

Contact health care provider or clinic if you develop any of the above problems.

WHO CAN PROVIDE

- Medical Officers
- Staff Nurse
- ANMs/LHVs
- Pharmacists
- Community Health Workers

WHERE CAN THEY BE PROVIDED

- Hospitals
- PHC
- CHC
- Pharmacies
- Private Clinics
- Community Sites (by CBDs)
CENTCHROMAN

A non-steroidal contraceptive pill taken once a week.

TYPES-BRAND NAMES

Saheli
Centron

MECHANISM OF ACTION

- Hastens tubal transport of the embryo
- Accelerates blastocyst formation
- Suppresses uterine deciduization and biochemical markers of implantation
- Delays zonal shedding and thereby prevents nidation/implantation of ovum in the uterus

BENEFITS

Contraceptive

- Highly effective (pregnancy rate 2 per 100 women during first year of use)
- Only needs to be taken once a week
- Effective immediately if started on day 1 of cycle
- Pelvic examination not required prior to use
- Immediate return to fertility on discontinuation
- No typical hormonal side effects
- Does not interfere with intercourse
- Does not change menstrual bleeding patterns
- Convenient, easy to use and can be provided by nonmedical staff
- Can stop use easily

Health

- Protection against breast cancer

LIMITATIONS

- User dependent: require continued motivation and weekly use
- Forgetfulness increases failure
- Resupply must be available
- Can delay return to fertility
- No protection against GTIs and other STDs (e.g., HBV, HIV/AIDS)

WHO CAN USE CENTCHROMAN

- Women of any reproductive age or parity who want highly effective protection against pregnancy
- Postabortion clients (may begin immediately)
- Breastfeeding mothers (6 months or more postpartum) or when supplementation of infant’s diet begins (if before 6 months)
WHO SHOULD NOT USE CENTCHROMAN

- Women who are pregnant (known or suspected)
- Women with polycystic ovarian disease
- Women with chronic cervicitis, cervical hyperplasia
- Women with present or past history of breast cancer
- Women with liver tumours (adenoma and hepatoma)

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECT</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhoea (absence of vaginal bleeding or spotting)</td>
<td>Check for pregnancy by history, checking symptoms and performing a physical examination (speculum and bimanual) or a pregnancy test, if indicated and available.</td>
</tr>
<tr>
<td></td>
<td>If intrauterine pregnancy is confirmed, counsel client regarding options. If pregnancy will be continued, stop use of Centchroman and assure her that the Centchroman will have no harmful effect on the foetus, nor is it likely to induce abortion.</td>
</tr>
<tr>
<td></td>
<td>If client is taking Centchroman correctly, reassure. Explain that delayed menses may occur with use of Centchroman and that they are most likely due to lack of build up of uterine lining (prolonged proliferative phase).</td>
</tr>
<tr>
<td></td>
<td>If not pregnant, no treatment is required except counselling and reassurance. If she continues Centchroman, amenorrhoea may persist. Advise client to return to clinic if amenorrhoea continues to be a concern (i.e., it persists beyond 90 days). It may be necessary to stop Centchroman until the next cycle; if so, advise the client to use condoms until then.</td>
</tr>
</tbody>
</table>

CLIENT INSTRUCTIONS

- Take the first pill on the first day after the beginning of your menstrual period.
- Take 1 pill twice-a-week on the same days of the week (e.g., Wednesday and Sunday—3 days apart) for 3 months.
- After 3 months, take 1 pill per week on the same day of each week (e.g., every Monday).
- If you forget to take a pills, you should
- If you miss 2 or more menstrual periods, you should come to the clinic to check to see if you are pregnant.

Back-up Method

- The pill is fully protective if started on the first day of the menstrual cycle.
- If you have diarrhoea or vomiting for more than 24 hours, use a back-up contraceptive method (e.g., condoms or spermicide) until you have taken 7 active pills.

WHO CAN PROVIDE

- Medical Officers
- Staff Nurse
- ANMs/LHWs
- Pharmacists
- Community Health Workers

WHERE CAN THEY BE PROVIDED

- Hospitals
- PHC
- CHC
- Pharmacies
- Private Clinics
- Community Sites (by CBDs)
PROGESTIN-ONLY INJECTABLES

TYPES

Depo-Provera\textsuperscript{®} (DMPA): 150 mg of depot-medroxyprogesterone acetate given every 3 months but can be given up to 4 weeks (28 days) early or 4 weeks late

Noristerat\textsuperscript{®} (NET-EN): 200 mg of norethindrone enanthate given every 2 months but can be given up to 2 weeks (14 days) early or 2 weeks late

MECHANISMS OF ACTION

- Suppress ovulation
- Thicken cervical mucus (prevent sperm penetration)
- Change endometrium
- Reduce sperm transport in upper genital tract (fallopian tubes)

BENEFITS

Contraceptive

- Highly effective (0.3–1 pregnancies per 100 women during the first year of use)
- Rapidly effective (< 24 hours) if started by day 7 of the menstrual cycle
- Intermediate-term method (2 or 3 months per injection)
- Pelvic examination not required prior to use
- Do not interfere with intercourse
- Do not affect breastfeeding
- Few side effects
- No supplies needed by client
- Can be provided by trained nonmedical staff
- Contain no oestrogen

Health

- May decrease menstrual cramps
- May decrease menstrual bleeding
- May improve anaemia
- Protect against endometrial cancer
- Decrease benign breast disease
- Decrease ectopic pregnancy
- Protect against some causes of PID

LIMITATIONS

- Cause changes in menstrual bleeding pattern (irregular bleeding/spotting initially) in most women
- Weight gain (±2 kg) is common, especially with DMPA
- Do not prevent all ectopic pregnancies
- Resupply must be available
- Do not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)
- Must return for injections every 2 months (NET-EN) or 3 months (DMPA)
- Return of fertility may be delayed for about 7–9 months on average after discontinuation
WHO CAN USE PROGESTIN-ONLY INJECTABLES

- Women of any reproductive age
- Women of any parity including nulliparous women
- Women who want highly effective protection against pregnancy
- Women who are breastfeeding (after 6 weeks)
- Women who are postpartum and not breastfeeding
- Women who are postabortion (inject immediately or within 7 days)
- Women who smoke (any age, any amount)
- Women taking drugs for epilepsy (seizure disorder) or tuberculosis (rifampin)
- Women who have high blood pressure, blood clotting problems or sickle cell disease
- Woman who prefer not to or should not use oestrogen
- Women who cannot remember to take a pill every day

USE WITH CARE IF THE FOLLOWING CONDITIONS ARE PRESENT

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Active liver disease (viral hepatitis)</td>
<td>Women with viral hepatitis should avoid using injectable contraceptives unless other more appropriate methods are not available or acceptable.</td>
</tr>
<tr>
<td>Heart disease</td>
<td>Women with heart disease should avoid using injectable contraceptives unless other more appropriate methods are not available or acceptable.</td>
</tr>
<tr>
<td>Stroke (current)</td>
<td>Women recovering from a stroke should avoid using injectable contraceptives unless other more appropriate methods are not available or acceptable.</td>
</tr>
<tr>
<td>Depression</td>
<td>Women with a history of depression require follow-up.</td>
</tr>
<tr>
<td>Breast lumps</td>
<td>Evaluate suspicious lumps and confirm the diagnosis. Women with benign breast disease can use injectable contraceptives.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE PROGESTIN-ONLY INJECTABLES

- Women who are pregnant (known or suspected)
- Women with unexplained vaginal bleeding
- Women who cannot tolerate any changes in their menstrual bleeding pattern, especially amenorrhoea
- Women with active ischemic cardiovascular disease
- Women with present or past history of breast cancer
- Women with liver tumours (adenoma and hepatoma)
WHEN TO START

- Days 1–7 of the menstrual cycle
- Anytime during the menstrual cycle when you can be reasonably sure the client is not pregnant
- Postpartum (after 6 weeks if not breastfeeding; after 6 months if using LAM)
- Postabortion (immediately or within the first 7 days)

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECT</th>
<th>MANAGEMENT</th>
</tr>
</thead>
</table>
| Amenorrhoea (absence of vaginal bleeding or spotting) | Rule out pregnancy.  
If not pregnant, no treatment is required except reassurance. Explain that blood does not build up inside the uterus with amenorrhoea. The continued action of small amounts of the progestin shrinks the endometrium, leading to decreased menstrual bleeding and, in some women, no bleeding at all. Finally, advise client to return to clinic if amenorrhoea continues to be a concern.  
If intrauterine pregnancy confirmed, counsel client regarding options. Stop injectable contraceptive if pregnancy will be continued and assure her that the small dose of progestin will have no harmful effect on the foetus.  
If ectopic pregnancy suspected, refer at once for complete evaluation. Do not give hormonal treatment (COCs) to induce withdrawal bleeding. It is not necessary and usually is not successful unless 2 or 3 cycles of COCs are given. |
| Vaginal bleeding/spotting | If no problem found and not pregnant, counsel client that bleeding/spotting is not serious and usually does not require treatment. Most women can expect the altered bleeding pattern to become more regular after 6 to 12 months.  
If the client is not satisfied after counselling and reassurance, but wants to continue using the injectable contraceptive, two treatment options are recommended:  
- a cycle of COCs (30–35 µg EE), or  
- ibuprofen (up to 800 mg 3 times daily for 5 days) or other NSAID.  
Be sure to tell the client to expect bleeding during the week after completing the COCs (21 pill pack) or during the last 7 pills if 28 pill pack.  
For heavy bleeding give 2 COC pills per day for remainder of cycle (at least 3 to 7 days) followed by 1 cycle of COCs or switch to 50 µg of oestrogen (EE) or 1.25 mg conjugated oestrogen for 14–21 days. |
| Headache | Determine if there has been a change in pattern or severity of headaches since beginning the injectable contraceptive. If not, and headaches are mild, treat with analgesics and reassure. If headaches are worse or changed, stop injectable contraceptive and help the client choose another (nonhormonal) method. |
| Nausea/Dizziness/ Nervousness | Check for pregnancy. If pregnant, treat as above. If not pregnant, reassure as above. |
| Weight gain or loss (change in appetite) | Counsel client that fluctuations of 1–2 kg are common with use of injectable contraceptives.  
Review diet if weight change is more than 2 kg. If weight gain (or loss) is unacceptable, even after counselling, stop use and help client choose another method. |
CLIENT INSTRUCTIONS

- Return to the health clinic for an injection every 3 months (DMPA) or every 2 months (NET-EN).

General Information

- Changes in menstrual bleeding patterns are common, especially following the first two or three injections. They often are temporary and rarely are a risk to health.
- Other minor side effects may include weight gain, mild headaches and breast tenderness. These symptoms are not dangerous and gradually disappear.
- In women using DMPA the delay in return of fertility is temporary (on average 10 months from the last injection). DMPA, however, does do not decrease fertility in the long term.
- With DMPA, about 50% of women will stop having any bleeding by the end of the first year of use. (Not having menses is not serious and in the absence of pregnancy symptoms does not require treatment.)
- Injectable contraceptives do not provide protection against GTIs and other STDs, including the AIDS virus. If either partner is at risk, they should use condoms as well as the injectable.

WARNING SIGNS
FOR PROGESTIN-ONLY INJECTABLE CONTRACEPTIVE USERS

- Delayed menstrual period after several months of regular cycles (may be a sign of pregnancy)
- Severe lower abdominal pain (may be a symptom of ectopic pregnancy)
- Heavy bleeding (more than 2 pads or cloths per hour) or prolonged bleeding (more than 8 days in duration)
- Pur or bleeding at the injection site (may indicate infection)
- Migraine (vascular) headaches, repeated very painful headaches or blurred vision

Contact health care provider or clinic if you develop any of the above problems.

WHO CAN PROVIDE

- Medical Officers
- Staff Nurses

WHERE CAN THEY BE PROVIDED

- Private Clinics
INTRAUTERINE CONTRACEPTIVE DEVICES (IUCDs)

TYPES                  EFFECTIVE LIFE
Copper T 200B           3 yrs
Multiload 250 and 375   3 yrs

MECHANISMS OF ACTION

• Interfere with ability of sperm to pass through uterine cavity (copper-releasing)
• Interfere with the reproductive process before fertilisation occurs (copper-releasing)

BENEFITS

Contraceptive

• Highly effective (0.5–1 pregnancies per 100 women during the first year of use)
• Effective immediately
• Long-term protection
• Do not interfere with intercourse
• Do not affect breastfeeding
• Immediate return to fertility upon removal
• Few side effects
• After follow-up visit, only need to return to clinic if problems
• No supplies needed by client
• Can be provided by trained nonphysician
• Inexpensive

Health

• Decrease ectopic pregnancy

LIMITATIONS

• Pelvic examination required and screening for genital tract infections (GTIs) recommended before insertion
• Require trained provider for insertion and removal
• Need to check for strings after every menstrual period
• Increase menstrual bleeding and cramping during the first few months of use
• May be spontaneously expelled
• Rarely (< 1/1000 cases) perforation of the uterus may occur during insertion
• Do not prevent all ectopic pregnancies
• Do not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)
WHO CAN USE IUCDs

- Women of any reproductive age
- Women of any parity including nulliparous women
- Women who want highly effective protection against pregnancy
- Women who want long-term protection against pregnancy
- Women who are breastfeeding
- Women who are postpartum and not breastfeeding (insert immediately or after 4–6 weeks)
- Postabortion clients who do not show signs of pelvic infection (insert immediately or within 7 days)
- Women at low risk for GTIs and other STDs (e.g., HBV, HIV/AIDS)
- Women who prefer not to or should not use hormonal methods
- Women who cannot remember to take a pill every day

USE WITH CARE IF THE FOLLOWING CONDITIONS ARE PRESENT

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Severe menstrual pains</td>
<td>Counsel about possible increase in menstrual pain and bleeding with IUCD.</td>
</tr>
<tr>
<td>History of previous ectopic pregnancy</td>
<td>Teach client signs and symptoms of ectopic pregnancy and to seek medical attention if they occur.</td>
</tr>
<tr>
<td>Symptomatic valvular heart disease</td>
<td>Give antibiotic prophylaxis at time of insertion.</td>
</tr>
<tr>
<td>Anaemia (haemoglobin &lt; 8 gms %)</td>
<td>Choose IUCD only if it is best overall method for client. Treat and follow-up anaemia.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE IUCDs

- Women who are pregnant (known or suspected)
- Women with unexplained vaginal bleeding
- Women who have multiple sexual partners or whose partners have multiple sexual partners
- Women with active genital tract infection (vaginitis, cervicitis, PID)
- Women with current, recent (within the past 3 months) or recurrent PID or septic abortion
- Women with congenital uterine abnormalities or benign tumours (fibroids) of the uterus which distort the uterine cavity
- Women with severe cervical stenosis

WHEN TO INSERT

- Days 1–7 of the menstrual cycle
- Anytime during the menstrual cycle you can be reasonably sure the client is not pregnant
- Breastfeeding women (after 4–6 weeks; after 6 months if using LAM)
- Postpartum and not breastfeeding (immediately following delivery, during the first 48 hours postpartum or after 6 weeks or more)
- Postabortion (immediately or within the first 7 days) provided no evidence of pelvic infection
## MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Amenorrhoea (absence of vaginal bleeding or spotting)</td>
<td>Rule out pregnancy. If not pregnant, do not remove IUCD. Provide counselling and reassurance. Refer for investigation to identify the cause of amenorrhoea, if client remains concerned. If pregnant, counsel and refer for antenatal care or MTP. Advise removal of IUCD if strings visible and pregnancy is less than 13 weeks. If strings not visible or pregnancy is more than 13 weeks, do not remove IUCD. If client is pregnant and wishes to continue pregnancy but does not want IUCD removed, advise her of increased risk of miscarriage and infection and that pregnancy should be closely followed.</td>
</tr>
<tr>
<td>Cramping</td>
<td>Rule out PID and other causes of cramping. Treat cause if found. If no cause found, give analgesics for mild discomfort. If cramping is severe, remove IUCD and help client choose another method.</td>
</tr>
<tr>
<td>Irregular or heavy vaginal bleeding</td>
<td>Rule out pelvic infection and ectopic pregnancy. Treat or refer for treatment as appropriate. If no pathology and bleeding is prolonged or heavy, counsel and advise on follow-up. Give ibuprofen (800 mg 3 times daily for 1 week) to decrease bleeding, and give iron tablets (1 tablet daily for 1 to 3 months). IUCD may be removed if client desires. If client has had IUCD for longer than 3 months and is markedly anaemic (haemoglobin &lt; 8 gms %), recommend removal and help client choose another method.</td>
</tr>
<tr>
<td>Missing Strings</td>
<td>Rule out pregnancy. Inquire if expelled. If not pregnant and IUCD not expelled, give condoms as a back-up method and explore endocervical canal for strings after next period. If not found, refer for X-ray or ultrasound localisation. If not pregnant and IUCD has fallen out or is not found, insert new IUCD or help client choose another method.</td>
</tr>
<tr>
<td>Vaginal Discharge/ Suspected PID</td>
<td>Examine for GTI. Remove IUCD if gonorrhoeal or chlamydial infection is confirmed or strongly suspected. If PID, treat and remove IUCD.</td>
</tr>
</tbody>
</table>

## CLIENT INSTRUCTIONS

- Return for checkup after the first postinsertion menses, 3 to 6 weeks after insertion.
- During the first month after insertion, check the strings several times, particularly after your next menstrual period.
- After the first month, you only need to check the strings after menses if you have:
  - cramping in the lower part of the abdomen,
  - spotting between periods or after intercourse, or
  - pain after intercourse (or if your partner experiences discomfort during sex).
- Return to the clinic if you:
  - cannot feel the strings,
  - feel the hard part of the IUCD,
  - expel the IUCD, or
  - miss a period.
General Information

- The IUCD is effective immediately.
- The IUCD can come out of the uterus spontaneously, especially during the first few months.
- There may be some bleeding or spotting the first few days after insertion.
- Menstrual bleeding usually will be heavier and longer (copper-releasing IUCDs).
- The IUCD may be removed any time before it is due to come out if the client wishes.
- Tell her what type of IUCD she has and when it should be removed. If possible, provide a card with this information on it.
- IUCDs do not provide protection against GTIs and other STDs, including the AIDS virus. If either partner is at risk, they should use condoms as well as IUCDs.

Return Visit

There is no medical reason for the client to return after the postinsertion checkup (4–6 weeks after insertion) unless there is a problem or she wants to have the IUCD removed. All clients should, however, be encouraged to return for routine reproductive health care.

WARNING SIGNS FOR IUCD USERS

- Period late with pregnancy symptoms (nausea, breast tenderness, etc.)
- Persistent or crampy lower abdominal pain, especially if accompanied by not feeling well, fever or chills (these symptoms suggest possible pelvic infection)
- Strings missing or the plastic tip of the IUCD can be felt when checking for the strings
- Either you or your partner begin having sexual relations with more than one partner; IUCDs do not protect women from GTIs and other STDs (e.g., HBV, HIV/AIDS).

Contact health care provider or clinic if you develop any of the above problems.

WHO CAN PROVIDE

- Medical Officers
- Staff Nurses
- ANMs/LHVs

WHERE CAN IT BE PROVIDED

- Hospitals
- Subcentres
- PHCs
- CHCs
- Private Clinics
CONDOMS

The condom is the only available barrier method for men.

TYPES

Nirodh, Bliss, Masti, Sawan, Kohinoor

MECHANISMS OF ACTION

- Prevent sperm from gaining access to female reproductive tract
- Prevent passage of microorganisms (GTIs and other STDs, including HBV and HIV/AIDS) from one partner to another (latex and vinyl condoms only)

BENEFITS

Contraceptive

- Effective immediately
- Do not interfere with breastfeeding
- No method-related health risks
- No systemic side effects
- Available in community shops
- Inexpensive

Health

- Only family planning method that protects against GTIs and other STDs [e.g., HBV, HIV/AIDS] (latex and vinyl only)
- May increase time to ejaculation

LIMITATIONS

- High failure rate if not used correctly and with every act of intercourse (5-25 pregnancies per 100 women during the first year)
- User dependent (require continued motivation and use with each act of intercourse)
- May reduce sensitivity of penis making maintenance of erection more difficult
- Disposal of used condoms may be a problem
- Adequate storage must be available at the client’s home
- Supplies must be readily available before intercourse begins
- Resupply must be available
- Poor long-term method

WHO CAN USE CONDOMS

- Men who wish to participate actively in family planning
- Couples who need contraception immediately
- Couples needing a temporary method while awaiting another method
- Couples needing a back-up method
- Couples who have intercourse infrequently
- Couples in which either partner has more than one sexual partner, even if using another method (at high risk for GTIs and other STDs, including HBV and HIV/AIDS)
WHO SHOULD NOT USE CONDOMS

- Couples in which pregnancy would pose a serious health risk to the woman
- Couples who are allergic to the materials from which condoms are made
- Couples who need a highly effective method of contraception
- Couples who want a long-term contraceptive method
- Couples who want a method not related to intercourse
- Couples not willing to use correctly and with each act of intercourse

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Allergy/Irritation</td>
<td>Rule out infection, allergic or mechanical reaction. Help the client choose another method.</td>
</tr>
<tr>
<td>Broken or breakage suspected (before intercourse)</td>
<td>Check condom for a hole or demonstrable leak. Discard and use new condom or use spermicide in conjunction with condom.</td>
</tr>
<tr>
<td>Condom breaks or slips off (during intercourse)</td>
<td>Consider a method of emergency contraception.</td>
</tr>
</tbody>
</table>

CLIENT INSTRUCTIONS

- Use a condom every time you have intercourse.
- Use a spermicide with the condom for maximum effectiveness and protection.
- The condom should be unrolled onto the erect penis before the penis enters the vagina, because the pre-ejaculatory semen contains active sperm.
- If the condom does not have an enlarged end (reservoir tip), about 1–2 cm should be left at the tip for the ejaculate.
- While holding on to the base (ring) of the condom, withdraw the penis before losing the erection. This prevents the condom from slipping off and spilling semen.
- Each condom should be used only once.
- Dispose of used condoms by placing in a waste container or toilet, or burying.
- Keep an extra supply of condoms on hand. Do not store them in a warm place or they will deteriorate and may leak during use.
- Do not use a condom if the package is broken or the condom appears damaged or brittle.
- Do not use mineral oil, cooking oils, baby oil or petroleum jelly as lubricants for a condom. They damage condoms in seconds. If lubrication is required, use saliva or vaginal secretions.

WHO CAN PROVIDE

- Medical Officers
- Staff Nurses
- LHV/ANMs
- Pharmacists
- Dais, Community Health Workers

WHERE CAN THEY BE PROVIDED

- Hospitals
- CHCs
- PHCs
- Subcentres
- Pharmacies
- Private Clinics
- Retail Shops
NATURAL FAMILY PLANNING (NFP) METHODS

TYPES

Calendar (Rhythm) Method (least effective), Basal Body Temperature, Cervical Mucus Method (Billings) and Symptothermal Method (most effective)

MECHANISM OF ACTION

For Contraception

Intercourse is avoided during the phase of the menstrual cycle when conception is most likely.

For Conception

Intercourse is planned for near the mid-cycle (usually days 10–15) when conception is most likely.

BENEFITS

Contraceptive

• Can be used to avoid or achieve pregnancy
• No method-related health risks
• No systemic side effects
• Immediate return to fertility
• Inexpensive
• Increase male involvement in family planning

Health

• Improve knowledge of reproductive system
• Possible closer relationship between couple

LIMITATIONS

• Effectiveness depends on willingness to follow instructions (5–30 pregnancies per 100 women during the first year of use)
• Considerable training required to use most effective types of NFP correctly
• Require trained provider (nonmedical)
• Require abstinence during fertile phase
• Require daily record keeping
• Vaginal infections make cervical mucus difficult to interpret
• Do not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)
• Require thermometer (some methods)
WHO CAN USE NATURAL FAMILY PLANNING

- Women of any reproductive age
- Women of any parity including nulliparous women
- Couples with religious or philosophical reasons for not using other methods
- Women unable to use other methods
- Couples willing to abstain from intercourse for more than 1 week each cycle
- Couples willing and motivated to observe, record and interpret fertility signs

USE WITH CARE IF THE FOLLOWING CONDITIONS ARE PRESENT

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular menses</td>
<td>Counsel and help client choose another method.</td>
</tr>
<tr>
<td>Persistent vaginal discharge</td>
<td>Counsel client that it will be more difficult to predict fertility using the cervical mucus method. If client wishes, help her choose another method.</td>
</tr>
<tr>
<td>Breastfeeding</td>
<td>Counsel client that it will be more difficult to predict fertility using the cervical mucus method. If client wishes, help her choose another method.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE NATURAL FAMILY PLANNING

- Women whose age, parity or health problems make pregnancy high risk
- Women without established menstrual cycles (breastfeeding, immediately postabortion)
- Women with irregular cycles (calendar method only)
- Women whose partner will not cooperate (abstain) during certain times in the cycle
- Women who dislike touching their genitals

CLIENT INSTRUCTIONS

Calendar Method

You can determine your fertile period by monitoring your menstrual cycles.

For Conception

Have intercourse during the fertile days.

For Contraception

Calculate Your Fertile Period:

- Monitor the length of at least 6 menstrual cycles. Then calculate when the fertile days occur following the instructions below.
- From the number of days in your longest cycle, subtract 11. This identifies the last fertile day of your cycle.
- From the number of days in your shortest cycle, subtract 18. This identifies the first fertile day of your cycle.

**Example**: Longest cycle: 30 days minus 11 = 19
Shortest cycle: 26 days minus 18 = 8
- Your fertile period is calculated to be days 8 through 19 of your cycle (12 days of abstinence needed to avoid pregnancy).
- Abstain from sexual intercourse during the fertile days.
Basal Body Temperature (BBT) Method

You can determine your fertile phase by taking accurate measurements with a special thermometer which detects even a slight increase in your temperature.

Use the Thermal Shift Rule

- Take your temperature at about the same time each morning (before rising) and record the temperature on the chart provided by the NFP instructor. (See Completed Basal Body Temperature Chart below.)
- Use the temperatures recorded on the chart for the first 10 days of your menstrual cycle to identify the highest of the “normal, low” temperatures (i.e., daily temperatures charted in the typical pattern without any unusual conditions). Disregard any temperatures that are abnormally high due to fever or other disruptions.
- Draw a line 0.05–0.1°C above the highest of these 10 temperatures. This line is called a cover line or temperature line.
- The infertile phase begins on the evening of the third consecutive day that the temperature stays above the cover line (Thermal Shift Rule).

Completed Basal Body Temperature Chart

![Completed Basal Body Temperature Chart](image)

For Contraception

Abstain from sexual intercourse from the beginning of the menstrual period until the evening of the third consecutive day that the temperature stays above the cover line.

Notes:

- If any of the three temperatures falls on or below the cover line during the 3 day count, this may be a sign that ovulation has not yet taken place. To avoid pregnancy, wait until three consecutive temperatures are recorded above the cover line before resuming intercourse.
- After the infertile phase begins, it is not necessary to keep taking your temperature. You may stop until the next menstrual cycle begins and continue to have intercourse until the first day of the next menstrual period.
Cervical Mucus Method

You can determine your fertile phase by monitoring your cervical mucus.

A simple, accurate record is the key to success.

A series of codes is used to complete the record. These codes should be both appropriate to the local culture and widely available to NFP users. In some areas, colored stamps or inks are used; in others, it is more convenient to develop symbols that are written by hand; while in still others, both methods are combined resulting in handwritten symbols that are recorded with colored pens. Examples of the two systems are given below.

Examples of Codes Used in Fertility Record Keeping

Use the symbol * or red to show bleeding.

Use the letter D or green to show dryness.

Use the letter M with a circle around it or white to show wet, clear, slippery, fertile mucus.

Use the letter M or yellow to show sticky, white, cloudy, infertile mucus.

Definitions

- **Dry Days:** After menstrual bleeding ends, most women have 1 to a few days in which no mucus is observed and the vaginal area feels dry. These are called dry days.

- **Fertile Days:** When any type of mucus is observed before ovulation, you are considered to be fertile. Whenever mucus is seen, even if the mucus is of a sticky, pasty type, the wet fertile mucus may be present in the cervix and the fertile days have started.

- **Peak Day:** The last day of slippery and wet mucus is called the peak day; it indicates that ovulation is near or has just taken place.

For Conception

- Have intercourse during each cycle on the days when your vaginal discharge feels elastic, wet and slippery.

For Contraception

- As mucus may change during the day, observe it several times throughout the day. Every night before you go to bed, determine your highest level of fertility (see list of codes) and mark the chart with the appropriate symbol.

- Abstain from sexual intercourse for at least 1 cycle so that you will know the mucus days.

- Avoid intercourse during your menstrual period. These days are not safe; in short cycles, ovulation can occur during your period.

- During the dry days after your period, it is safe to have intercourse every other night (Alternate Dry Day Rule). This will keep you from confusing semen with cervical mucus.

- As soon as any mucus or sensation of wetness appears, avoid intercourse. Mucus days, especially fertile mucus days, are not safe (Early Mucus Rule).

- Mark the last day of clear, slippery, stretchy mucus with an X. This is the peak day. It is the most fertile time.
• After the peak day, avoid intercourse for the next 3 dry days and nights. These days are not safe (Peak Day Rule).
• Beginning on the morning of the fourth dry day, it is safe to have intercourse until your menstrual period begins again.

Symptothermal Method—You should have instructions for both the Cervical Mucus and Basal Body Temperature methods.

You can determine your fertile days by monitoring both your temperature and your cervical mucus.

• After menstrual bleeding stops, you may have intercourse on the evening of every other dry day during the infertile days before ovulation. This is the Alternate Dry Day Rule, the same rule used with the Cervical Mucus Method.
• The fertile phase begins when wet vaginal sensations or any mucus is experienced. This is the Early Mucus Rule, the same rule used with the Cervical Mucus Method. Abstain from intercourse until the fertile phase ends.
• Abstain from intercourse until both the Peak Day and Thermal Shift Rules have been applied.
• When these rules do not identify the same day as the end of the fertile phase, always follow the most conservative rule, that is, the rule that identifies the longest fertile phase.

The following example refers to the Completed Basal Body Temperature Chart (see above). Following the Thermal Shift Rule, the woman is infertile after day 16. If, however, she follows the Peak Day Rule, she is not infertile until the 18th day. Therefore, she should use the conservative rule, the Peak Day Rule, and wait until the 18th day before resuming intercourse.

Note: You may have intercourse during the first 5 days of the menstrual cycle beginning with the first day of menstrual bleeding, if the Peak Day and Thermal Shift Rules were applied during the previous cycle. This is referred to as the Menses Rule and ensures that this is truly menstrual bleeding and not due to some other cause.

WHO CAN COUNSEL ABOUT NFP
• Medical Officers
• Staff Nurses
• ANMs/LHVs
• Pharmacists
• Dais

Note: Lay persons also can provide NFP instruction. They must, however, be trained in NFP.

WHERE CAN IT BE PROVIDED
• Hospitals
• Subcentres
• CHCs
• PHCs
• Private Clinics

Note: Staff specially trained in NFP must be available.
WITHDRAWAL (COITUS INTERRUPTUS)

Withdrawal is a traditional family planning method in which the man completely removes his penis from the woman's vagina before he ejaculates.

MECHANISM OF ACTION

By withdrawing the penis from the vagina prior to ejaculation, viable sperm do not enter the vagina and fertilisation is prevented.

BENEFITS

Contraceptive

- Effective immediately
- Does not interfere with breastfeeding
- No method-related side effects
- Always available
- Immediate return to fertility

Health

- Possible closer relationship between the couple

LIMITATIONS

- Effectiveness depends on willingness of couple to use withdrawal with every act of intercourse (5-25 pregnancies per 100 women during the first year of use)
- Effectiveness may be further decreased by sperm from a recent (< 24 hours) ejaculation remaining in the penis (urethra)
- May diminish sexual pleasure
- Does not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)

WHO CAN USE WITHDRAWAL

- Men who wish to actively participate in family planning
- Couples with religious or philosophical reasons for not using other methods
- Couples who need contraception immediately
- Couples needing a temporary method while awaiting another method
- Couples needing a back-up method
- Couples who have intercourse infrequently

WHO SHOULD NOT USE WITHDRAWAL

- Men who experience premature ejaculation
- Men who have difficulty withdrawing the penis from the vagina prior to ejaculation
- Men who have other physical or psychological conditions that may affect timely withdrawal
- Couples in which pregnancy would pose a serious health risk to the woman
- Couples who need a highly effective method of contraception
- Couples who want a long-term contraceptive method
- Couples who want a method not related to intercourse
- Couples not willing to use withdrawal with every act of intercourse

CLIENT INSTRUCTIONS

- Before intercourse, the couple should discuss their intention to use withdrawal to enhance cooperation and avoid misunderstanding.
- Before intercourse, the man should urinate and wipe off the tip of his penis to remove any remaining sperm from a prior ejaculation.
- When he feels he is about to ejaculate, the man should withdraw his penis from his partner’s vagina, making sure the ejaculation occurs away from his partner’s genitalia. The woman can help by moving away at this time.
VOLUNTARY SURGICAL CONTRACEPTION

METHODS FOR WOMEN

Tubal ligation

TYPES

Laparoscopy and minilaparatomy

MECHANISM OF ACTION

By blocking the fallopian tubes (cutting [Pommeroy] or rings) sperm are prevented from reaching ovum and causing fertilisation.

BENEFITS

Contraceptive

- Highly effective (0.2–1 pregnancies per 100 women during the first year of use)
- Effective immediately
- Permanent
- Does not interfere with breastfeeding
- Does not interfere with intercourse
- Good for client if pregnancy would pose a serious health risk
- Simple surgery, usually done under local anaesthesia
- No long-term side effects
- No change in sexual function (no effect on hormone production by ovaries)

Health

- Decreased risk of ovarian cancer

LIMITATIONS

- Must be considered permanent (not reversible)
- May regret later
- Small risk of complications
- Requires trained physician (gynaecology specialist or surgeon for laparoscopy)
- Does not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)

CLIENT ISSUES

- The client has the right to change her mind anytime prior to the procedure.
- A standard consent form must be signed by the client for the procedure. Spousal consent is not required (see Appendix A).
- In mobile programmes (i.e., camps), counselling and follow-up should be the same as at fixed sites and all recommended infection prevention practices should be followed.
WHO CAN USE TUBAL LIGATION

- Women of age ≥ 22 and ≤ 45
- Women who are married and whose spouse is living
- Women of any parity, including nulliparous women
- Women who want highly effective, permanent protection against pregnancy
- Women who are breastfeeding (within 48 hours or after 6 weeks)
- Women who are postpartum (within 3 days) or immediately postabortion
- Women who are certain they have achieved their desired family size
- Women who understand and voluntarily consent to the procedure

USE WITH CARE IF THE FOLLOWING CONDITIONS ARE PRESENT

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No living children</td>
<td>Counsel very carefully and allow additional time to make an informed decision. Help client choose another method, if appropriate.</td>
</tr>
<tr>
<td>Significant medical problems (e.g., symptomatic heart disease or clotting disorders, previous/current PID, overweight, diabetes mellitus)</td>
<td>Clients with significant medical problems may need special surgical and follow-up management. For example, the procedure may need to be done in a high-level facility and not in an ambulatory facility (fixed or mobile). Where possible, significant medical problems should be controlled prior to surgery.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE TUBAL LIGATION

- Women who are pregnant (except following MTP)
- Women with acute pelvic or systemic infections (until resolved or controlled)
- Women who cannot withstand the surgery
- Women who are uncertain of their desire for future fertility
- Women who do not give voluntary, informed consent

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Wound infection</td>
<td>If skin infection is present, treat with antibiotics. If abscess is present, drain and treat as indicated. Routine antibiotics are not needed if recommended infection prevention practices are followed.</td>
</tr>
<tr>
<td>Pain at incision site</td>
<td>Determine presence of infection or abscess and treat based on findings.</td>
</tr>
<tr>
<td>Postoperative fever</td>
<td>Treat infection based on findings.</td>
</tr>
<tr>
<td>Bladder, intestinal injuries (rare)</td>
<td>Diagnose problem and manage appropriately. If bladder or bowel are injured and recognized intraoperatively, perform primary repair. If discovered postoperatively, refer to appropriate centre as necessary.</td>
</tr>
<tr>
<td>Hematoma (subcutaneous)</td>
<td>Apply warm, moist packs to site. Observe, it usually will resolve over time but may require drainage if extensive.</td>
</tr>
<tr>
<td>Gas embolism with laparoscopy (very rare)</td>
<td>Intensive resuscitation may be necessary, including:</td>
</tr>
<tr>
<td></td>
<td>- intravenous fluids.</td>
</tr>
<tr>
<td></td>
<td>- cardiopulmonary resuscitation (CPR), and</td>
</tr>
<tr>
<td></td>
<td>- other life support measures.</td>
</tr>
<tr>
<td>SIDE EFFECTS</td>
<td>MANAGEMENT</td>
</tr>
<tr>
<td>----------------------------------</td>
<td>-----------------------------------</td>
</tr>
<tr>
<td>Superficial bleeding</td>
<td>Treat based on findings.</td>
</tr>
<tr>
<td>(skin edges or subcutaneously)</td>
<td></td>
</tr>
</tbody>
</table>

CLIENT INSTRUCTIONS

- Keep the operative site dry for 2 days. Resume normal activities as is comfortable. (You should be able to return to normal activities within 7 days after surgery.)
- Avoid sexual intercourse for 1 week. After resuming intercourse, stop if it is uncomfortable.
- Avoid heavy lifting for 1 week.
- For pain, take 1 or 2 analgesic tablets (acetaminophen, ibuprofen or paracetamol) every 4 to 6 hours.
- Schedule a routine follow-up visit between 7 and 10 days from time of surgery.

General Information

- Tubal ligation is effective from the time the operation is completed.
- Menstrual periods will continue as usual. (If using COCs the amount and duration of menses may increase after surgery.)
- Tubal ligation does not provide protection against GTIs or other STDs, including the AIDS virus. If either partner is at risk, they should use condoms even after tubal ligation.

WARNING SIGNS
FOR TUBAL LIGATION CLIENTS

- Fever (greater than 38° C or 100.4° F)
- Dizziness with fainting
- Persistent or increasing abdominal pain
- Bleeding or fluid coming from the incision
- Missed menstrual period

Contact health care provider or clinic if you develop any of the above problems.

WHO CAN PROVIDE

- Medical Officers

WHERE CAN IT BE PROVIDED

- Hospitals
- CHCs
- PHCs
- Private Clinics

Note: Tubal ligation can be performed in any facility with a minor operating theatre, appropriate equipment, recommended infection prevention practices and the ability to provide drugs and equipment to handle emergencies.
METHODS FOR MEN

Vasectomy

TYPES

No-scalpel and scalpel

MECHANISM OF ACTION

By blocking the vas deferens (ejaculatory duct) sperm are not present in the ejaculate.

BENEFITS

Contraceptive

• Highly effective (0.2–1 pregnancies per 100 women during the first year of use)
• Permanent
• Does not interfere with breastfeeding
• Does not interfere with intercourse
• Good for couples if pregnancy would pose a serious health risk to the woman
• Simple surgery done under local anaesthesia
• No long-term side effects
• No change in sexual function (no effect on hormone production by the testes)

LIMITATIONS

• Must be considered permanent (not reversible)
• May regret later
• Delayed effectiveness (requires 3 months and up to 20 ejaculations)
• Risks and side effects of minor surgery, especially if general anesthesia is used
• Requires trained physician
• Does not protect against GTIs and other STDs (e.g., HBV, HIV/AIDS)

CLIENT ISSUES

• The client has the right to change his mind anytime prior to the procedure.
• A standard consent form must be signed by the client for the procedure. Spousal consent is not required (see Appendix A).
• In mobile programmes (i.e., camps), counselling and follow-up should be the same as at fixed sites and all recommended infection prevention practices should be followed.

WHO CAN USE VASECTOMY

• Men of age ≤ 50
• Men who want a highly effective, permanent contraceptive method
• Men whose wives have age, parity or health problems that might pose a serious health risk if they become pregnant
• Men who understand and voluntarily consent to the procedure
• Couples who are certain they have achieved their desired family size
USE WITH CARE IF THE FOLLOWING CONDITIONS ARE PRESENT

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>CARE</th>
</tr>
</thead>
<tbody>
<tr>
<td>No living children</td>
<td>Counsel very carefully and allow additional time to make an informed decision.</td>
</tr>
<tr>
<td>Symptomatic heart disease or clotting disorders, diabetes mellitus, severe anaemia</td>
<td>Clients with significant medical problems may need special surgical and follow-up management. This procedure may need to be done in a high-level facility, and not in an ambulatory facility. Significant medical problems should be controlled before surgery.</td>
</tr>
<tr>
<td>GTI/Orchitis</td>
<td>Treat before the procedure.</td>
</tr>
<tr>
<td>Local skin or scrotal infection</td>
<td>Delay procedure until infection is resolved.</td>
</tr>
<tr>
<td>Other problems: Large varicocoele, inguinal hernia, filariasis, scar tissue, previous scrotal surgery, intrascrotal mass</td>
<td>With any of these conditions, the procedure must be performed by a provider with extensive experience and skill in performing vasectomy.</td>
</tr>
</tbody>
</table>

WHO SHOULD NOT USE VASECTOMY

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

MANAGEMENT OF COMMON SIDE EFFECTS

<table>
<thead>
<tr>
<th>SIDE EFFECTS</th>
<th>MANAGEMENT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Excessive swelling</td>
<td>If swollen scrotum is present and is large and painful, it may require surgical management. If infection or hematoma is present, observe, it usually resolves spontaneously within 1 to 3 weeks, or refer. Provide scrotal support as needed.</td>
</tr>
<tr>
<td>Hematoma (scrotal)</td>
<td>If infection or abscess is present, apply warm, moist packs to site and provide scrotal support. Observe, it will resolve over time, or refer.</td>
</tr>
<tr>
<td>Wound infection</td>
<td>If skin infection is present, treat with antibiotics. If abscess is present, drain and treat as indicated, or refer.</td>
</tr>
</tbody>
</table>

CLIENT INSTRUCTIONS

- Wear a scrotal support, keep the operative site dry and rest for 2 days.
- If comfortable, you may resume sexual intercourse in 2 or 3 days, but delay sexual activity if you are uncomfortable. Remember to use condoms or another family planning method until you have ejaculated at least 20 times (or waited 3 months).
- Avoid heavy lifting and hard work for 3 days.
- For pain, take 1 or 2 analgesic tablets (acetaminophen, ibuprofen or paracetamol) every 4 to 6 hours and apply ice packs.
- Return after 1 week for removal of nonabsorbable stitches. (If no stitches or if absorbable stitches were used to close the skin, there is no need to return unless there are problems.)
- Come back for a semen test 3 months after the operation if you wish to have proof that the vasectomy is completely effective.
General Information

- Vasectomy does not provide protection from pregnancy until after 20 ejaculations or 3 months or until no sperm are seen in a microscopically examined semen specimen.
- Vasectomy will not affect sexual performance because the testes still function normally.
- Vasectomy will not cause weakness or limit a man's ability to provide for his family.
- Vasectomy does not provide protection against GTIs or other STDs, including the AIDS virus. If either partner is at risk, the couple should use condoms even after vasectomy.

**WARNING SIGNS FOR VASECTOMY CLIENTS**

- Bleeding or fluid coming from the incision area
- A very painful or swollen scrotum
- Fever (greater than 38° C or 100.4° F)

Contact health care provider or clinic if you develop any of the above problems.

**WHO CAN PROVIDE**

- Medical Officers

**WHERE CAN IT BE PROVIDED**

- Hospitals
- CHCs
- PHCs
- Private Clinics

Note: Vasectomy can be performed in any facility with a minor theatre, appropriate equipment, the ability to provide drugs and equipment to handle emergencies.
INFECTION PREVENTION

PURPOSE

- To prevent serious postoperative infections when providing invasive contraceptive methods (e.g., IUCDs, injectables and voluntary sterilisation)
- To minimise the risk of transmitting these diseases not only to clients but also to service providers and staff, including cleaning and housekeeping personnel
- To lower the cost of providing health care services and maximise access to quality services
- To protect the environment

HANDWASHING IS THE SINGLE MOST IMPORTANT INFECTION PREVENTION PROCEDURE

- Wash hands before and after examining any client (direct contact).
- Wash hands after removing gloves because they may have holes in them.
- Wash hands after any exposure to blood or body fluids, even if gloves are worn.
- Use fresh water and soap to wash hands.
- Air dry or use sterile towel.

Studies have shown that the most effective way to increase handwashing is to have physicians or other respected individuals (role models) consistently wash their hands and for them to encourage others to do the same.

To encourage handwashing, program managers should make every effort to provide soap and a continuous supply of fresh water, either from the tap or a bucket.

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:

- 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).
GLOVE REQUIREMENTS FOR COMMON PROCEDURES IN FAMILY PLANNING SETTINGS

<table>
<thead>
<tr>
<th>Task or Activity</th>
<th>Are Gloves Needed?</th>
<th>Preferred Gloves</th>
<th>Acceptable Gloves</th>
</tr>
</thead>
<tbody>
<tr>
<td>Blood pressure check</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Temperature check</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Injection</td>
<td>no</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Blood drawing/Starting an IV</td>
<td>yes</td>
<td>Exam</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Pelvic examination</td>
<td>yes</td>
<td>Exam</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>IUCD insertion (loaded in sterile package and inserted using &quot;no-touch technique&quot;)</td>
<td>yes</td>
<td>Exam</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>IUCD removal (using &quot;no-touch technique&quot;)</td>
<td>yes</td>
<td>Exam</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Surgery (minilaparotomy, laparoscopy, vasectomy)</td>
<td>yes</td>
<td>Sterile Surgical</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>MVA (using &quot;no-touch technique&quot;)</td>
<td>yes</td>
<td>Exam</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Handling and cleaning instruments</td>
<td>yes</td>
<td>Heavy Rubber</td>
<td>Exam or Surgical</td>
</tr>
<tr>
<td>Handling contaminated waste</td>
<td>yes</td>
<td>Heavy Rubber</td>
<td>Exam or Surgical</td>
</tr>
<tr>
<td>Cleaning blood or body fluid spills</td>
<td>yes</td>
<td>Heavy Rubber</td>
<td>Exam or Surgical</td>
</tr>
</tbody>
</table>

WHO GETS NEEDLESTICK INJURIES

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

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

HOW TO HANDLE HYPODERMIC NEEDLES, SCISSORS AND OTHER SHARP ITEMS

Operating Theatre

- Use a pan to carry and pass sharp items (e.g., pass suture needles on a needleholder).
- Create a **safe zone** on the instrument trolley when working with sharps.
- Avoid hand to hand passing of sharps.
- 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.

If needles will be reused, after decontamination and cleaning, sterilise by autoclaving. If HLD is the only alternative, boil or steam them. Do not high-level disinfect needles by soaking them in chemicals.

HOW TO WITHDRAW MEDICATION FROM A STERILE MULTIDOSE VIAL

- Wipe the top of the vial with a cotton swab soaked in 70% "methylated spirits" 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. Hold needle by the hub (base) and attach to the barrel of the syringe.

Never use a reusable syringe for more than one injection without processing. 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 and use as directed.

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 proper waste disposal is:

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

Waste may be non-contaminated or contaminated. Non-contaminated waste (e.g., paper from offices, boxes, etc.) poses no infectious risk and can be disposed of according to local guidelines.
Proper handling of contaminated waste items (blood or body fluid contaminated) minimizes the spread of infection to clinic personnel and to the local community.

- While wearing thick rubber gloves, transport solid contaminated waste to the disposal site in covered containers.
- Dispose of all sharp items in a puncture-resistant container.
- Carefully pour liquid waste down a drain or flushable toilet.
- Contaminated waste should be burned or buried.
- Wash hands, gloves and containers after disposal of infectious waste.

INFECTION PREVENTION TIPS FOR FAMILY PLANNING METHOD PROVISION

Skin Preparation Prior to DMPA or NET-EN Injection

STEP 1: Before cleaning the skin with an antiseptic, be sure to remove all visible soil from the proposed injection site by washing.

STEP 2: With antiseptic applied to a fresh cotton swab, wipe the injection site thoroughly using a circular, overlapping motion starting at the center.

STEP 3: Allow antiseptic to dry before giving the injection.

Cervical/Vaginal Preparation Prior to IUCD Insertion or Removal

Although the cervix and vagina cannot be sterilised, cleaning with antiseptic solutions decreases the number of microorganisms and reduces the risk of postinsertion infection.

For cervical and vaginal preps, prior IUCD insertion or removal, select an aqueous (water-based) antiseptic, such as an iodophor or chlorhexidine gluconate (e.g., Hibiclens or Savlon). Do not use alcohols or alcohol-containing preparations (e.g., tincture of iodine). Alcohols burn; they also dry and irritate mucous membranes, which in turn, promotes the growth of microorganisms.

Instructions

STEP 1: Ask the client about allergic reactions (e.g., to iodine preparations) before selecting an antiseptic solution.

STEP 2: If visibly soiled, thoroughly clean the client’s skin or external genital area with soap and water before applying an antiseptic.

STEP 3: After inserting the speculum, apply antiseptic solution liberally to the cervix and vagina (2 or 3 times). (It is not necessary to prep the external genital area if it appears clean. If heavily soiled, it is better to have the client wash her genital area thoroughly with soap and water before starting the procedure.)

STEP 4: If iodophors are used, allow time (1 to 2 minutes) before proceeding.
OVERVIEW

- GTIs are genital tract infections caused by a small number of microorganisms (bacteria, viruses and protazoa) which usually are sexually transmitted.
- Most STDs are GTIs, although some STDs such as hepatitis B and AIDS (which are primarily but not exclusively sexually transmitted) also are systemic diseases.
- Most GTIs can be treated. All can be prevented; and if not prevented, early diagnosis and treatment can decrease the possibility of serious complications such as infertility in both women and men.
- Because family planning and STD clinic services overlap substantially, it is important to link STD screening and family planning.

GTIs ARE A SIGNIFICANT PROBLEM

GTIs are almost as common as malaria: > 250 million new cases each year.

The consequences of untreated GTIs are devastating, they include:

- Ectopic pregnancy (7-10 times increased risk in women with history of PID)
- Increased risk of acquiring HIV/AIDS if exposed
- Increased risk of cervical cancer
- Chronic abdominal pain (18% of females with a history of PID)
- Infertility:
  - 20-40% of males with untreated chlamydia and gonorrhoea
  - 55-85% of females with untreated PID (8-20% of females with untreated gonorrhoea develop PID)
  - Infertility can lead to divorce

In addition, infants can be infected at birth with blinding eye infections and pneumonia (chlamydia, genital herpes and gonorrhoea) or central nervous system damage and death (syphilis or genital herpes).

STDs AND FAMILY PLANNING

- The main linkages between STD services and family planning involve:
  - Prevention
  - Client screening
  - Diagnosis and treatment

CLIENT SCREENING

Because a thorough examination (including microbiologic and serologic studies) usually is not possible on all family planning clients, it is important at least to assess the risk of GTIs and other STDs in all clients.
Health care providers should:

- Be knowledgeable of high-risk sexual practices
- Be aware of the signs and symptoms of GTIs and other STDs
- Be aware of which GTIs are particularly common in their client population
- Carefully evaluate clients in whom GTIs are suspected, based on the medical history or physical examination findings

What should a STD screening history include?

- Are you having a vaginal discharge?
- In the past year, have you had a genital tract problem such as a vaginal discharge, ulcers or skin lesions in your genital area?
- Has your sex partner (spouse) been treated for a genital tract problem, such as discharge (drip) from the penis or swollen groin glands, in the last 3 months? Which?
- Does your sex partner (spouse) have other sex partners?
- Have you had more than one sex partner in the last 2 months?
- Do you think that you might have a GTI or other STD?

DIAGNOSIS AND TREATMENT

- In primary health care facilities diagnosis 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 sexually transmitted GTIs often is possible.

HISTORY AND RISK ASSESSMENT FOR STDs

The first step in screening clients is to do a STD screening history and risk assessment.

Remember: Because some of these questions are very sensitive, it may not be possible to ask them in a direct way. Always maintain a respectful and non-judgmental attitude toward your client. This will help to establish good rapport and prompt the most truthful responses from your client. It is very important to only ask for information that will help you better manage the client. Confidentiality must be ensured for all clients.

Taking a History

- Reassure the client that absolute confidentiality will be maintained
- Find out what symptoms and signs, if any, prompted the visit
- Conduct a risk assessment (see below)
- Obtain information on drug allergies, current medications and contraceptive use

Risk Assessment for STD Clients

A risk assessment is particularly useful in the management of clients who have no clinical signs or symptoms of STDs. The risk assessment is considered positive if the client answers “yes” to one or more of the following questions.

- Is the client a sexual contact of a person who has had an STD within the last 2–3 months?
• Is the client or his or her partner in a high-risk profession? (for example: commercial sex worker, carpet factory worker, driver, police man, military man, etc.)
• Has the client had sexual contact(s) outside of her/his relationship in the past 2 months?
• Does the client suspect that her/his partner has had sexual contact(s) outside of their relationship in the past 2 months?

The risk assessment includes questions about the client’s partner (most often the husband). Some individuals are at risk because of their own behaviour. Others are at risk because of their partner’s behaviour. In most societies, women are mostly at risk because of their husband’s behaviour. This is why questions about the male partner are included in the risk assessment for women.

THE SYNDROMIC APPROACH TO THE DIAGNOSIS AND TREATMENT OF STDs

Since most health workers have no access to laboratory facilities for the diagnosis of STDs, the diagnostic and treatment approach used in this section is based on signs and symptoms exhibited by clients. Most important, the syndromic approach allows clients to be treated effectively at their first visit, which is often also their only visit to the health facility. Because the syndromic approach relies on the presence of signs and symptoms, it cannot be used to manage infections that do not have signs or symptoms.

To assist the health worker in determining the cause of the client’s problem, syndromic flowcharts which are based on groups of symptoms are presented. Each is accompanied by Treatment Guidelines followed by a brief discussion of Diagnostic Tips and Family Planning Considerations for that group of symptoms, or syndrome.

Follow the appropriate syndromic flowchart and provide the full course of treatment recommended under Treatment Guidelines. In the Guidelines, you will find that alternate drugs are suggested for some of the recommended drug regimens. For example, wherever doxycycline is recommended as part of the treatment for a syndrome, tetracycline and erythromycin are suggested as alternatives. Always give the recommended drug (e.g., doxycycline) if it is available; it is the most effective medication for that syndrome and should be used whenever possible. Only if it cannot be provided or purchased should you use one of the alternate drugs (e.g., tetracycline or erythromycin).

It is also important that when multiple drugs are prescribed for one syndrome, all of the medicines prescribed be taken exactly as outlined. Do not substitute drugs and doses that are not recommended in this manual. Ineffective treatment is a sure way of losing the confidence of your clients. It can also contribute to the spread of the infection and drug resistance. For the same reasons, it is important that your clients accurately follow and complete the full treatment.

There are many reasons why clients may not accurately follow or complete their treatment:

• The client does not understand the instructions
• The treatment schedule is too complicated
• The drug(s) are too expensive: clients may not want to purchase the full treatment or may want to save some for next time
• There are unpleasant side effects
To overcome these difficulties:
- Give instructions in a way that the client can understand and remember
- Ask the client to repeat the instructions
- Discuss any potential problems such as multi-dose, multi-drug schedules, drug cost and potential side effects

**VAGINAL DISCHARGE**

Client complains of abnormal vaginal discharge

<table>
<thead>
<tr>
<th>Take history and examine</th>
</tr>
</thead>
<tbody>
<tr>
<td>Conduct risk assessment</td>
</tr>
<tr>
<td>Risk assessment positive?</td>
</tr>
<tr>
<td>OR</td>
</tr>
<tr>
<td>Vaginal discharge containing pus?</td>
</tr>
</tbody>
</table>

- YES
  - Treat for cervicitis and vaginitis
  - Educate
  - Provide condoms
  - Manage partner
  - Tell client to return if symptoms persist

- NO
  - Treat for vaginitis
  - Educate
  - Provide condoms
  - Tell client to return if symptoms persist

**Treatment Guidelines for Vaginal Discharge**

**Cervicitis and Vaginitis**

- Ciprofloxacin\(^1\), 500 mg as a single oral dose
  \(^1\) Contraindicated in pregnancy and in children up to 14 years of age.

  **Plus:**

  - Doxycycline, 100 mg orally 2 times a day for 7 days
    - Alternative regimen: If Doxycycline is not available use Tetracycline, 500 mg orally 4 times a day for 7 days
    - Alternative regimen (for clients who cannot tolerate tetracyclines or who are pregnant), use Erythromycin, 500 mg orally 4 times a day for 7 days

      **Plus:**

      - Clotrimazole, 200 mg vaginal suppository each night for 3 nights or 100 mg vaginal tab for 7 nights.

      **Plus:**
• Metronidazole or Tinidazole, 500 mg orally 2 times a day for 7 days
  2 In the first trimester of pregnancy only Erythromycin and Clotrimazole, 100 mg vaginal tabs to be inserted high into the vagina at night for 7 nights, should be used.

Vaginitis

• Clotrimazole, 200 mg vaginal suppository each night for 3 nights or 100 mg vaginal tab for 7 nights.
  Plus:

• Metronidazole or Tinidazole, 400 mg orally 3 times a day for 5 days
  2 In the first trimester of pregnancy only Clotrimazole, 100 mg vaginal tabs to be inserted high into the vagina at night for 7 nights.

Diagnostic Tips

• The presence of a vaginal discharge does not necessarily indicate the presence of a genital tract infection.
  • A variable amount of clear or white vaginal discharge consisting of normal cervical secretions and vaginal fluids is normal.
  • An increase in the amount of normal vaginal discharge is common in women who are taking COCs or using an IUCD.

• A change in the quantity, consistency, color or smell of the discharge is usually suggestive of a genital tract infection.

• An abnormal discharge may accompany the following complaints:
  • irritation and itching of the vulva (vulvitis)
  • external or internal burning when passing urine
  • lower abdominal pain
  • irregular menstrual periods
  • painful intercourse

• An abnormal vaginal discharge may result from:
  • infections of the vagina (vaginitis)
  • infections of the cervix (cervicitis)
  • vaginal and cervical infections at the same time (vaginitis and cervicitis)

• Cervicitis is the more serious condition because if left untreated it can result in:
  • pelvic inflammatory disease (PID)
  • ectopic pregnancy
  • infertility
  • complications during pregnancy
  • infections in the newborn

• In the absence of laboratory testing, conducting a STD Risk Assessment is helpful in deciding whether or not to treat a client with a vaginal discharge for cervicitis at the same time that you treat her for vaginitis.

• Women with a history of vaginal discharge but without a visible discharge on exam, should be re-examined within 7 days, if the symptoms persist.
Safety Tip: The presence of a foul-smelling or purulent vaginal discharge should warn the health worker to proceed with caution.

Family Planning Considerations

- Women who are diagnosed with vaginitis should have their infection treated and cured before an IUCD is inserted. They should use a back-up method of contraception until the IUCD can be inserted.
- IUCDs should not be inserted in women at risk for, currently suffering from or with a documented recent history (within the past 3 months) of cervicitis. Treat any existing infection and wait for 3 months after it is cured to insert the IUCD. The client should use a back-up method of contraception until then.
- IUCDs should be removed from women who are diagnosed with cervicitis.
- Women at risk for, or currently suffering from a STD should also be counseled to use condoms for each act of intercourse even if they are using another family planning method. Both the client and her partner should be counselled and treated.

GENITAL ULCERS

Client complains of genital sore(s) or ulcer(s)

Take history and examine

Blister-like (vesicular) lesions present?  
OR

History of vesicular lesions, often recurrent?

YES

- Herpes management
- Educate
- Provide condoms
- Advise to return only if lesions are not improved within 7 days

NO

- Treat for chancroid and syphilis
- Educate
- Provide condoms
- Partner management
- Advise to come back in 7 days, if not improved refer

Treatment Guidelines for Genital Ulcers

Chancroid and Syphilis

Since both syphilis and chancroid are prevalent in many countries, clients with genital ulcers should be treated for both conditions to ensure adequate therapy in case of loss to follow-up.

- Erythromycin, 500 mg orally three times a day for 7 days.
  Alternative regimen: If Erythromycin is not available, use Ciprofloxacin, 500 mg orally 2 times a day for 3 days

Plus:
- Benzathine penicillin\(^1\), 2.4 million units in a single dose by intramuscular injection
  Alternative regimen: If Benzathine penicillin is not available, use Procaine penicillin, 800,000 units intramuscularly once a day for 7 days.
  \(^1\) For clients allergic to penicillin who are not pregnant, use Doxycycline 100 mg orally 2 times a day for 15 days or Tetracycline, 500 mg orally 4 times daily for 15 days.
  For clients allergic to penicillin who are pregnant, use Erythromycin 500 mg orally 4 times a day for 15 days.

**Herpes**

- Herpes lesions should be kept clean by washing affected sites with soap and water and drying carefully. The client should avoid sexual contact while lesions are present and use condoms after the lesions are healed.
- During the first clinical episode if there is considerable pain, give paracetamol. If there are complications, refer to a hospital.

**Diagnostic Tips**

- The major causes of Genital Ulcer Disease (GUD) are:
  - genital herpes
  - chancroid
  - syphilis

- Note on Genital Herpes: Genital Herpes is a viral disease with eruptions of the skin that result in painful lesions. It cannot be cured and the ulcers often recur; this recurrence is often triggered by stress. Treatment is only symptomatic.

- Note on Syphilis: With or without treatment, the signs and symptoms of early syphilis will disappear and the only evidence of infection will be a positive blood test. Without effective treatment, however, the disease is not cured and can progress to the late stages of syphilis (including neurosyphilis, cardiovascular syphilis and death). During pregnancy, untreated syphilis in the mother can result in stillbirth, premature delivery and congenital syphilis.

- It is important to remember that:
  - Chancroid and syphilis are the most common curable causes of GUD
  - It is often **not** possible to distinguish between chancroid and syphilis with any reliability even when a laboratory is available
  - Infection with chancroid and syphilis at the same time occurs frequently
  - The treatment of chancroid alone may hide the signs and symptoms of syphilis
  - Left untreated, syphilis is a debilitating disease

- It is therefore recommended to treat all patients with genital ulcers other than herpes for both chancroid and syphilis.

- If ulcers are chronic, refer for further evaluation and management.

**Family Planning Considerations**

- The IUCD should **not** be the first choice for contraception in clients with genital ulcers because of the risk of exposure to other STDs.
- Clients who have an IUCD and develop genital ulcers should consider using another form of contraception. If they elect to continue using the IUCD for contraception, they should be carefully counselled about the risk of developing PID and be advised to use condoms to minimize their risk of getting another STD.
LOW ABDOMINAL PAIN

Women complains of lower abdominal pain

Take history and perform abdominal exam

Missed/overdue period? OR
Recent delivery-abortion? OR
Abdominal rebound tenderness? OR
Abdominal guarding? OR
Abnormal vaginal bleeding?

---

YES

- Refer

NO

Fever (≥ 38°C)?

OR

Vaginal discharge?

---

YES

- Treat for PID
- Educate
- Provide condoms
- Partner management
- Advise to return after 5 days
  or sooner if pain gets worse

Improved after 5 days?

---

YES

- Continue treatment

NO

- Advise to return if pain persists
- Educate
- Provide condoms

Treatment Guidelines for Lower Abdominal Pain (PID)

For non-pregnant women, give:

- Ciprofloxacin, 500 mg as a single oral dose
  Plus:

- Doxycycline, 100 mg orally 2 times a day for 14 days
  Alternative regimen: If Doxycycline is unavailable, use Tetracycline:
  a day for 14 days
  Plus:
• Metronidazole or Tinidazole, 500 mg orally two times a day for 14 days

If the client has an IUCD, refer her to a centre where the IUCD can be removed. Antibiotic treatment must be started immediately, even if the client must be referred to another centre for IUCD removal.

For pregnant women, do not give medicine. Refer to a hospital immediately.

Diagnostic Tips

• In diagnosing lower abdominal pain in women it is important to identify the cause:
  • Pelvic Inflammatory Disease (PID), or
  • Surgical emergencies such as ectopic pregnancy, appendicitis, septic abortion and pelvic abscess

• PID is caused by a wide variety of bacteria. Therapy for PID must, therefore, provide coverage against a wide variety of microorganisms.
• Women who are found to have acute PID must be followed closely until the infection begins to resolve. Treatment should begin immediately, and clients should be seen within 3 to 5 days following the start of treatment. If they are not improved, they should be referred to a facility which manages more complicated cases (i.e., has laboratory services and the most effective antibiotics available).

Family Planning Considerations

• Because of the increased risk of PID in women who have (or whose husbands have) multiple sex partners, the IUCD should not be their first choice as a contraceptive method.
• Women who have had PID are at a greater risk of ectopic pregnancy following recovery and should use highly effective contraception, such as COCs or injectables.
• Family planning clients should be advised that no method of birth control will totally eliminate the risk of developing PID; however, barrier methods such as condoms with spermicide, when used consistently and properly, provide the best protection and reduce the risk of acquiring those microorganisms associated with PID.
• COCs are associated with reduced rates of PID. It is thought that the thick, tacky cervical mucus and decreased menstrual bleeding accompanying COC use reduce the likelihood of upward movement of microorganisms.
URETHRAL DISCHARGE

Client complains of a discharge and/or dysuria

Take history and examine

Discharge confirmed?

YES

- Treat for gonorrhoea and chlamydial infection
- Educate
- Provide condoms
- Partner management
- Advise to return if necessary

If discharge persists

Is patient compliant with treatment AND Reinfection is NOT likely?

YES

- Refer

NO

- Reassure and educate
- Provide condoms
- Advise to return if symptoms persist

Treatment Guidelines for Urethral Discharge

Gonorrhoea and Chlamydial Infections

- Ciprofloxacin, 500 mg as a single oral dose
  Plus:

- Doxycycline, 100 mg orally 2 times a day for 7 days
  Alternative regimen: If Doxycycline is not available, use Tetracycline, 500 mg orally 4 times a day for 7 days
  Alternative regimen (for clients who cannot tolerate tetracyclines or are pregnant): use Erythromycin, 500 mg orally 4 times a day for 7 days

Diagnostic Tips

- Urethral discharge is:
• the most common STD syndrome in men
• often accompanied by pain or burning when passing urine (dysuria) and occasionally by urethral itching
• occasionally accompanied by one-sided scrotal pain and swelling (epididymitis)

• A urethral discharge can be quite variable in appearance:
  • pus-like or mucus-like
  • clear, white or yellowish-green
  • abundant or scant (perhaps only seen in the morning or noted as crusting at the urethral opening or staining on underwear)

• A urethral discharge is most frequently due to gonorrhoea and/or chlamydia.

• It is important to remember that:
  • infections with gonorrhoea and chlamydia often occur at the same time
  • many men who are infected with both gonorrhoea and chlamydia will still be infected with chlamydia after being treated for gonorrhoea, even though they have no symptoms

• It is therefore recommended that all clients with urethral discharge be treated for both gonorrhoea and chlamydia.

**INGUINAL BUBO(ES) [enlarged inguinal lymph node(s)]**

Patient complains of enlarged and/or painful inguinal lymph node(s)

Take history and examine

Ulcer present?

- YES
  - Follow Genital Ulcer(s) syndromic flow chart
- NO
  - Treat for LGV
  - Refer if bubo is fluctuant
  - Educate
  - Provide condoms
  - Partner management
  - Tell client to return in 7 days

Bubo improved?

- YES
  - Complete remaining treatment
- NO
  - Refer
Treatment Guidelines for Inguinal Bubo(es)

*Lymphogranuloma venereum (LGV)*

- Doxycycline, 100 mg orally twice a day for 14 days
  Alternative regimen: If Doxycycline is not available, use Tetracycline, 500 mg orally 4 times a day for 14 days
  Alternative regimen (if client unable to tolerate tetracyclines or is pregnant) use Erythromycin 500 mg orally 4 times a day for 14 days or Trimethoprim (80 mg)/Sulphamethoxazole (400 mg) 2 tablets orally 2 times a day for 14 days

Diagnostic Tips

- An inguinal bubo is an enlarged inguinal lymph node (an enlarged gland in the groin). Infectious causes of inguinal buboes include:
  - Lymphogranuloma venereum (LGV)
  - chancroid
  - syphilis
  - genital herpes
  - tuberculosis

- A fluctuant bubo is an enlarged inguinal lymph node that is filled with pus or fluid. In addition to the medications prescribed above, fluctuant buboes should be aspirated (the pus should be removed with a large bore needle). This cannot be done safely in a health post and the client should be referred for this treatment. A bubo is ready for aspiration when the overlying skin is shiny and the area underneath is soft.
SCROTAL SWELLING/PAIN

Patient complains of scrotal swelling/pain with or without urethral discharge

Take history and examine

Swelling/tenderness confirmed?

YES

Testes rotated/elevated?

OR

History of trauma?

YES

DOT: Refer immediately

NO

Reassure and educate

Provide condoms

NO

Treat for gonococcal and chlamydial epididymitis

Educate

Provide condoms

Partner management

Advise to return in 10 days or sooner if necessary

Patient improving?

YES

Complete any remaining medication(s)

NO

Refer for evaluation of non-STD pathogens, TB or tumour

Treatment Guidelines for Scrotal Swelling/Pain

Gonococcal and chlamydial epididymitis

- Ciprofloxacin, 500 mg orally in a single dose
  Plus:

- Doxycycline, 100 mg orally 2 times a day for 10 days
  Alternative regimen: If Doxycycline is not available, use Tetracycline, 500 mg orally 4 times a day for 10 days
  Alternative regimens (if client unable to tolerate tetracyclines): use Erythromycin, 500 mg orally 4 times a day for 10 days or Trimethoprim (80mg)/Sulphamethoxazole (400 mg), 2 tablets orally twice a day for 14 days
Diagnostic Tips

- In diagnosing scrotal swelling and pain it important to identify the cause:
  - epididymitis, often with a history of urethritis (urethral discharge), or
  - torsion (twisting) of the testes which is more common in adolescents. This is a surgical emergency and must be treated immediately.

- Infectious causes of epididymitis include:
  - sexually transmitted chlamydial and gonococcal infections (more common in men under 35)
  - enteric (intestinal) bacteria that also cause urinary tract infections (more common in men over 35)
  - chronic infections such as tuberculosis and filariasis (elephantiasis)
POSTABORTION CARE

Comprehensive postabortion care services should include both medical and preventive health care. The key elements of postabortion care are:

- 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)
- Stabilisation of emergency conditions (shock, haemorrhage or sepsis)
- Prompt referral and transfer if the woman requires treatment beyond the capability of the facility where she is seen
- Uterine evacuation to remove retained products of conception (POC)

The prompt treatment of postabortion complications is an important part of obstetric care that should be available at every district-level hospital. In addition, through the use of manual vacuum aspiration (MVA), treatment of uncomplicated incomplete abortions can be provided even at the primary care level, including family planning clinics.

WHY MVA

MVA is the preferred method of uterine evacuation to treat incomplete abortion because relative to traditional treatment (D&C):

- the risk of complications is decreased,
- access to services is increased, and
- the cost of postabortion services is reduced.

In addition, use of MVA offers the potential for earlier access to care, when management is easier and serious complications less likely.

POSTABORTION FAMILY PLANNING

In many instances, the emergency postabortion care setting may be one of the few contacts a woman and her partner(s) have with the health care system. Therefore, it represents an important opportunity for providing contraceptive information and services.

Postabortion family planning should include all essential components of good family planning care including:

- 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 follow-up care
• Counselling about contraceptive needs in the context of the client’s reproductive goals and need for protection against sexually transmitted diseases

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 cycle day 11 and usually occurs before the first menstrual bleeding. At a minimum, all women receiving postabortion care need counselling and information to ensure 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.

WHAT CONTRACEPTIVE METHODS CAN BE USED

All modern methods of contraception are appropriate for use after abortion 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 each method section.

LINKS TO OTHER REPRODUCTIVE HEALTH SERVICES

It is important to identify any other reproductive health services that a woman may need following an abortion and 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, and there is no reason to discourage them from doing so, barring medical reasons.
• Providers should be alert to symptoms of genital tract infections (GTIs) and other sexually transmitted diseases (e.g., trichomoniasis or mucopurulent cervicitis) and provide the appropriate treatment for them.
• 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.
APPENDIX A
CONSENT AND APPLICATION
FOR STERILISATION OPERATION

Name  Shri/Smt. __________________________
Husband’s name and address  __________________________
Parent’s name and address  __________________________
PHC/Urban centre  __________________________

Dear Sir:

Please arrange to have me sterilised. My age is ________ and my husband’s/wife’s name is __________________________. We are married and my wife/husband is alive. We have ______ male and ______ female living children. The age of the youngest child is ________ years. The decision to undergo the sterilisation operation has been taken independently by me without any outside pressure, inducement or force. I am aware that other methods of contraception are available to me. I know that for all practical purposes this operation is permanent and that after the operation I will be unable to have any more children. I also know that there are some chances of failure of the operation, for which the government hospital and operating surgeon will not be held responsible by me or my relatives or any other person whatsoever. My spouse has not been sterilised previously. I am also aware that I am undergoing an operation which carries an element of risk. The eligibility criteria for the operation have been explained to me, and I affirm that I am eligible to undergo the operation according to these criteria. I agree to undergo the operation under any kind of anaesthesia which the surgeon thinks suitable for me and to be given other medicines as considered appropriate by the doctors concerned.

Religion: __________________________
Income: __________________________
Education: __________________________
Occupation: __________________________

__________________________
Signature of acceptor
1. I know Shri/Smt. _______________________________. To the best of my knowledge the information given by him/her is correct. His/her number in the eligible couple register of the PHC/Urban centre ________________ is ____________________

________________________________________ ___________ 
Signature of counsellor Signature of motivator

______________________________
Full address

2. I certify that I have satisfied myself that Shri/Smt. __________________________ is within the eligible age group and is mentally and medically fit for a sterilisation operation. There is no evidence that he/she has undergone a sterilisation operation previously. I have explained to the acceptor that this form has the authority of a legal document.

________________________________________ ___________ 
Signature of surgeon Signature of medical officer

(name and address)

DENIAL OF STERILISATION

I certify that Shri/Smt. ______________________________ is not a suitable case for sterilisation for the following reasons:

1. 

2. 

He/she has been provided the following alternative method of contraception

________________________________________
Signature of counsellor or surgeon making decision
REFERENCES


