Introduction

Pakistan's National Population Welfare Programme is an ongoing social development endeavor operating within the framework of nationally accepted, broad-based, and strategically focused population and development policies. Its mission is to improve and enrich the quality of life through promotion of small family norms and voluntary adoption of birth spacing, ultimately leading to the attainment of population stabilization.

Country Profile

Pakistan is the sixth most populous country in the world, with a population of over 160 million and a growth rate of around 1.86 percent per annum, representing an annual addition of almost three million people. It is facing great challenges to attain socio-economic development and break the vicious cycle of poverty. This annual addition to the population, in the context of low socio-economic indicators, not only dilutes the results of development efforts but also creates overwhelming demand on limited resources. It is estimated that at the current growth rate, the population of Pakistan will touch 217 million by 2020. Based on these growth patterns and trends, the economy will be unable to sustain the growing population with hardly any scope for improvement in the quality of life, even under most favourable circumstances. This situation is, therefore, a matter of deep concern and becomes a central issue in the overall planning perspective as well as the strategy for alleviating poverty in the country.
Pakistan’s Population Welfare Programme: History

Family planning (FP) activities were introduced in Pakistan's First Five Year Plan (1955–60) through the Family Planning Association of Pakistan (FPAP) and other voluntary organizations. In the second Five Year Plan (1960–65), FP services were extended through the health infrastructure; however, in the third Five Year Plan (1965–70) an independent Family Planning set-up was created, mass-scale information, education, and communication (IEC) activities were launched, and a service delivery network was established. In the next plan (1970–75), the "Continuous Motivation Approach" was introduced by employing male-female teams of workers at the Union Council level. During 1975–80, the programme operated at a low key due to re-organization, political unrest, and suspension of IEC activities.

In 1981, an administrative re-organization was undertaken and a broad-based, multi-sectoral, and multi-dimensional strategy was conceived, developed, and introduced. In the sixth plan period (1983–88), field activities were provincialized through a 1983 ordinance, the role of nongovernmental organizations (NGOs) was institutionalized through the NGO Coordination Council (NGO CC), social marketing of contraceptives (SMC) was introduced, and the National Institute of Population Studies (NIPS) was established. The strategies of the sixth Plan were pursued in the seventh Five Year Plan (1988–93), with emphasis on
lowering the fertility level and a focus on a motivational campaign and widening of the range of contraceptive methods for voluntary choice. Also, a special IEC programme and quality FP service delivery facilities were developed for the country’s large cities, with a view to set trends for rural areas. The role of the District Office was expanded, and Divisional and Tehsil tiers were created. In fact, a breakthrough in the programme occurred during the latter part (1990–93) of the seventh Plan.

In the eighth Plan (1993–98) the population programme continued to receive strong political support from the highest levels, but because the Plan was finalized before the International Conference on Population and Development (ICPD) held in 1994, the reproductive health (RH) framework was not fully reflected in it. However, an institutional mechanism to oversee, guide, and strengthen collaborative efforts to advance the FP/RH agenda was established by the creation of a Coordination Committee of Health and Population Welfare. Later, in the ninth Five Year Plan (1998–2003), the programme was realized with a post-ICPD Plan of Action (PoA), while keeping in view the local socio-cultural conditions and priorities.

In March 2000, the Government initiated restructuring and right-sizing of the public sector; an assessment of the Population Welfare Programme was also undertaken, wherein it was noted that the programme was moving in the right direction and the fertility transition had set in and had to be sustained. The process led to formulation of the Population Policy in 2002, setting the long-term vision for the population sector. By end of the ninth Plan and later, the programme has been able to raise the contraceptive prevalence rate (CPR) and reduce the population growth rate (PGR), thereby heading towards achievement of population stabilization.

**Population Policy 2002**

The Government has formulated the Pakistan Population Policy to address population issues in a holistic manner. The policy was approved by the Cabinet in July 2002, with a vision to achieve population stabilization (replacement level) by 2020 through expeditious completion of a demographic transition that entails decline in both fertility and mortality rates. The policy calls for a sustained political commitment and emphasizes the need for mobilizing broad based support from all stakeholders in the public and private sectors. The goals, objectives, and strategies of the policy are described in the following paragraphs.

**Policy goals**

- Attain a balance between resources and population growth within the broad parameters of the ICPD paradigm.
- Address various dimensions of the population issue within national laws and development priorities, while adhering to national, social, and cultural norms.
- Increase awareness of the adverse impact of rapid population growth at the national, provincial, district, and community levels.
- Promote FP as an entitlement, based on voluntary and informed choice.
- Attain a reduction in fertility through improvement in access and quality of RH services.
• Reduce population momentum through delaying the first birth, encouraging change in spacing patterns, and popularizing the small family concept.

Policy objectives

• Ensure universal access to safe FP methods by 2010.
• Reduce the population growth rate from 1.9 percent per annum in 2004 to 1.3 percent per annum by 2020.
• Reduce fertility, through enhanced adoption of voluntary contraception, from 4.0 in 2004 to a replacement level of 2.1 births per woman by 2020.

Strategies

• Develop, launch, and sustain advocacy campaigns to address special groups, such as parliamentarians, policymakers, district government, religious leaders, opinion builders, youth, adolescents, etc.
• Increase ownership of population issues by stakeholders and strengthen their participation in processes of program design and service delivery.
• Reduce unmet need for FP services by addressing social barriers and making available quality FP and RH services.
• Strengthen need-based services.
• Ensure provision of services to the poor, underserved population in difficult-to-reach and far-flung areas.
• Coordinate and monitor the network of FP and RH services in the country.
• Build strong partnerships with concerned line ministries and provincial line departments, particularly in the health sector.
• Strengthen the contribution to population activities through civil society players, particularly NGOs, and involvement of the media community.
• Expand the role of the private sector by making contraceptives available, accessible, and affordable at marketplaces.
• Harness support, cooperation, and involvement of men in strengthening the family as a basic unit of society and in family decision-making.

To attain the above goals and objectives, the Ministry of Population Welfare (MoPW), along with provinces and other stakeholders, has introduced and strengthened the following programmatic interventions in line with the stated strategies:

• Launch a well-conceived IEC campaign to address macro population issues and socio-cultural constraints.
• Introduce a cadre of Male Mobilizers at Union Council level for enhancing male involvement in FP/RH.
• Conduct human resource development (HRD) activities for programme managers to promote result-oriented management through the Management Information System (MIS).
• Facilitate and oversee FP service delivery in health outlets and Provincial Line
Departments and compare against agreed-upon performance indicators.

- Increase the existing level of SMC and engage private sector industrial organizations to undertake FP, advocacy, and service delivery programmes.
- Involve NGOs/civil society organizations through the National Trust for Population Welfare (NATPOW) and strengthen public-private partnership.
- Decentralize operational activities at district level and below for efficiency of fiscal, administrative, and program transfers.
- Enhance involvement of trained private sector service providers in rural and slum areas.

The programme implementation at the national level is the responsibility of the MoPW, and operational activities of the programme are executed by Provincial Population Welfare Departments (PWDs).

The Millennium Development Goals (MDGs)

There are eight goals that 192 United Nations member states have agreed to achieve by the year 2015. The eight Millennium Development Goals (MDGs)—which range from halving extreme poverty, to putting a halt to the spread of HIV/AIDS and providing universal primary education, all by the target date of 2015—form a blueprint agreed to by all of the countries and the entire world's leading development institutions. They have galvanized unprecedented efforts to meet the needs of the world's poorest.

The United Nations Millennium Declaration, signed in September 2000, commits the states to:

1. **Eradicate extreme poverty and hunger**
   - Reduce by half the proportion of people living on less than one U.S. dollar a day.
   - Reduce by half the proportion of people who suffer from hunger.
   - Increase the amount of food for those who suffer from hunger.

2. **Achieve universal primary education**
   - Ensure that all boys and girls complete a full course of primary schooling.
   - Accompany increased enrolment with efforts to ensure that all children remain in school and receive a high-quality education.

3. **Promote gender equality and empower women**
   - Eliminate gender disparity in primary and secondary education, preferably by 2005, and at all levels by 2015.

4. **Reduce child mortality**
   - Reduce the mortality rate among children under five by two-thirds.
5. **Improve maternal health**

- Reduce by three-quarters the maternal mortality ratio.

6. **Combat HIV/AIDS, malaria, and other diseases**

- Halt and begin to reverse the spread of HIV and AIDS.
- Halt and begin to reverse the incidence of malaria and other major diseases.

7. **Ensure environmental sustainability**

- Integrate the principles of sustainable development into country policies and programs; reverse loss of environmental resources.
- Reduce by half the proportion of people without sustainable access to safe drinking water.
- Achieve significant improvement in the lives of at least 100 million slum dwellers by 2020.

8. **Develop a global partnership for development**

- Develop further an open trading and financial system that is rule-based, predictable, and non-discriminatory. This includes a commitment to good governance, development, and poverty reduction, nationally and internationally.
- Address special needs of the least developed countries. This includes tariff- and quota-free access for their exports; enhanced debt relief for heavily indebted poor countries; cancellation of official bilateral debt; and more generous official development assistance for countries committed to poverty reduction.
- Address the special needs of landlocked and small island developing states.
- Deal comprehensively with developing countries' debt problems through national and international measures to make debt sustainable in the long term.
- In cooperation with the developing countries, develop decent and productive work for youth.
- In cooperation with pharmaceutical companies, provide access to affordable essential drugs in developing countries.
- In cooperation with the private sector, make available the benefits of new technologies, especially information and communication technologies.

**Pakistan Population Sector Initiatives**

- National Population Commission, 2006
- Provincial Population Councils, 2006
- Joint Steering Committee of Health and Population, 2005
- Cabinet Committee for Social Sector Coordination (CCSSC)
- Focal points in all relevant Ministries/Divisions
• Revitalization of District Technical Committees
• Expansion of service delivery outlets
• Capacity building of training and research institutes
• Partnership with private and corporate sector organizations
• International Standards Organization (ISO) certification of service delivery outlets
• International Ulema Conference, 2005
• Follow-up of IDPD, 2006
• International Population Summit, 2005
• Follow-up of Population Summit, 2006
• Advocacy seminar for parliamentarians, 2005, and step-down activities to bring advocacy to lower levels of government
• International best practices for scaling up FP/RH
• Donor collaboration
• Friends of Family Welfare Centres:
  - National Commission for Human Development
  - National Voluntary Movement
  - Pakistan Postal Services
• Mass-media campaign for advocacy and behaviour change communication
• Youth/male involvement through interpersonal communication
• Adolescent and men's advisory centres established
• Population issues included in curricula of 9th to 12th classes
• Master's degree program on population sciences
• Youth forum on population and development
• Research on latest/new contraceptives
• Population study circle

Population Welfare Programme—Service Delivery Infrastructure

1. Family Welfare Centres

The Family Welfare Centre (FWC) is the cornerstone of Pakistan's Population Welfare Programme; FWCs constitute the most extensive institutional network in the country to promote and deliver FP services in the urban and rural areas. The FWC operates in a rented building and serves as a static facility for about 7,000 people; furthermore, through its satellite clinics and outreach facilities, it covers an additional population of around 20,000–25,000. The FWC's scope of work includes provision of FP, maternal, and child health (MCH) services and treatment of minor ailments. Post-ICPD, the scope of the FWC was expanded to include RH components like safe motherhood, infant health care, management of reproductive tract infections/sexually transmitted infections (RTIs/STIs), HIV/AIDS, and hepatitis.

2. Mobile Service Units

Mobile Service Units (MSUs) were conceived as an innovative activity during the seventh Five Year Plan period (1988–93) to provide FP services to far-flung,
underserved rural populations. MSUs are located at Tehsil level and provide services to a population of 30,000 people or 5,000 couples scattered in 15–20 villages by holding 10–12 camps regularly each month.

3. Reproductive Health Services Centres

Reproductive Health Services (RHS) Centres are one of the major clinical components of the Population Welfare Programme with its hospital-based service outlets (RHS-A Centres) in teaching hospitals, major hospitals in big cities, all District Health Office (DHO) hospitals, and selected Tehsil Health Office (THO) hospitals. Facilities for contraceptive surgery (CS), along with a full range of contraceptives, including IUCDs, injectables, condoms, oral pills, and sub-dermal implants, are available to FP clients.

There are two categories of RHS Centres, RHS-A Centres and RHS-B Centres, as discussed below:

- **RHS-A Centres**: These are hospital-based service delivery units established by the Ministry/Departments of Population Welfare. The Centres provide a full range of services identified in the National RH Services Package (see Annex I), comprising comprehensive FP services, including facilities for contraceptive surgery (CS) for females and males as an outdoor procedure with safe and effective backup medical support and long-term client follow-up, MCH care, prevention and management of RTIs/STIs and HIV/AIDS, counselling and referral for adolescent youth, management of RH problems of elderly women, referral for men's problems, client education for early screening/detection of cancer of breast and uterus, couple counselling, and referral for treatment of infertility. These centres play a vital role in raising awareness on public health issues, personal hygiene, nutrition and breastfeeding during reproductive age, and preventive gynae/obstetric facilities. These services contribute to reductions in infant and maternal morbidity/mortality, leading to improvement in general health and reduction in fertility. Further, the RHS-A Centres provide treatment for minor/general ailments, especially to women and children.

All RHS-A Centres undertake extension camps for provision of services nearest to the client's doorstep. Camps are arranged at THO Hospitals/Rural Health Centres with operating theatre facilities for provision of contraceptive services, including voluntary surgical contraception.

To enhance men's participation by creating awareness on FP/RH issues and motivation, with a special focus on provision of vasectomy services, preferably no-scalpel vasectomy (NSV), training of male doctors from the MoPW, Ministry of Health (MoH), and NGOs is conducted. Efforts are being made to provide vasectomy services at most of the RHS-A Centres.

**RHS-A Training Centres**: Of all the existing RHS-A Centres, 18 Centres (Punjab-10, Sindh-7, NWFP-1), located in the teaching hospitals with highest contraceptive
surgery performance, have been upgraded to RHS Training Centres, including three RHS Master Training Centres for ensuring availability of trained medical/paramedical staff to manage/provide quality FP/RH services in the Programme. To achieve these objectives, the Master Training/Training Centres are provided with additional staff and logistics.

**RHS-B Centres:** Hospitals of Provincial Line Departments, including health, NGOs, and private sector, with operating theatre facilities and trained staff committed to performing contraceptive surgery along with a complete range of FP methods, are registered as RHS-B Centres. RHS-B Centres are also provided training facilities in contraceptive surgery for their doctors and paramedics at the RHS Training Centres, a regular supply of contraceptives, IEC materials, and institutional reimbursement cost (IRC) for contraceptive surgery.

4. **Male Mobilizers**

Male Mobilizers are the focal point for the grass roots programme, responsible for interaction with local community leaders, male teachers, shopkeepers, religious leaders (Imam Masjid), and community-based organizations (CBOs) to advocate for and promote the objectives and purposes of the programme.

**Service Delivery Network – 2007**

<table>
<thead>
<tr>
<th>Service Type</th>
<th>Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Family Welfare Centres</td>
<td>2,524</td>
</tr>
<tr>
<td>Mobile Service Units</td>
<td>286</td>
</tr>
<tr>
<td>RHS A-Centres</td>
<td>152</td>
</tr>
<tr>
<td>RHS B-Centres</td>
<td>135</td>
</tr>
<tr>
<td>Male Mobilizers</td>
<td>4,195</td>
</tr>
<tr>
<td>Registered Medical Practitioners</td>
<td>26,080</td>
</tr>
<tr>
<td>Hakeems and Homeopaths</td>
<td>26,550</td>
</tr>
<tr>
<td>Department of Health (DoH)/MoH</td>
<td>7,012</td>
</tr>
<tr>
<td>Lady Health Workers (LHWs)</td>
<td>96,000+</td>
</tr>
<tr>
<td>Public-Private Sector Organizations</td>
<td>98</td>
</tr>
<tr>
<td>Non-Governmental Organizations</td>
<td>600</td>
</tr>
<tr>
<td>Social Marketing of Contraceptives</td>
<td>2</td>
</tr>
</tbody>
</table>

**Quality of Care (QoC)**

Quality of Care (QoC) is a client-centred approach to providing high-quality health care as a basic human right; it is considered a critical element of FP/RH services. It has been promoted by all stakeholders in the public and private sectors as well by NGOs, as affirmed at international conferences. High-quality services ensure that clients receive the care that they deserve. Furthermore, providing better services at reasonable prices attracts more clients, increases the use of FP methods, and reduces the number of unintended pregnancies.
Improving QoC for clients means understanding their cultural values, previous experiences, and perceptions of the role of the health system, and then bringing RH service providers and the community together to map out a shared vision of quality. Similarly, enhancing the QoC of services provided by health care providers requires identifying their motivations, addressing their needs (including general administrative and logistical support), and helping them to better understand and address clients' concepts of quality (Annex II). Creating a shared vision for improved QoC requires that programme managers, service providers, researchers, and consumers advocate the idea that quality matters. Given time and effort, the ongoing attempt to improve the QoC will translate into services that meet minimum quality standards and satisfy the needs of clients and providers to bridge the gap of unmet need.

The elements of quality are given below.

**Choice of FP method** refers both to the number of methods offered on a reliable basis and to their intrinsic variability. The methods offered serve significant subgroups as defined by age, sex, contraceptive intention, lactation status, and health profile.

**Information given to client** refers to the information imparted during service contact that enables clients to freely choose and use contraception with satisfaction.

**Technical competence** involves factors such as the skill of the health care provider, observance of protocols, and meticulous asepsis required for dispensation of clinical methods.

**Inter-personal relations** are the personal dimensions of service provision.

**Mechanisms to encourage continuity** indicate a programme's interest and ability to promote continuity of contraceptive usage.

**An appropriate constellation of services** refers to the location of FP service delivery points at a given locality and their referral linkages.

**ISO Certification**

During 2004, the Standing Committee of the National Assembly desired that service delivery points of the Population Welfare Programme have ISO Certification so that their QoC would be recognized at par with the international standards and protocols. The programme's countrywide network of outlets is mandated with delivering FP services, keeping special focus on QoC. Quality assurance is regularly monitored at district, provincial, and federal levels.

The MoPW is the first ever public sector organization to have (ISO) 9001:2000 certification for its service delivery outlets, through the United Registrars of Systems (URS), UK. This certification had been completed for selected RHS-A Centres, MSUs, and FWCs at Islamabad, Chakwal, and Jhelum by March 2005/July 2006, with financial assistance from
UNFPA. Internal Functional Audits are conducted biannually to review this process and an
External Functional Surveillance Audit for Certificate Renewal is conducted annually for ISO
9001:2000 certification. The overall objective of having international accreditation is to
promote quality services through a system in place for QoC, ongoing training, and periodic
evaluations.

Based on the above experience, the MoPW through the Federal Technical Committee, duly
represented by Population Welfare Departments, developed checklists (Annex III) for QoC
and standardization of services throughout the Population Welfare Programme. Through
these checklists, client-oriented services, feedback, ongoing training, and maintenance of
housekeeping and minimum stock levels according to standards could be ensured. Periodic
quality objectives are a mandatory requirement to be established by all service delivery
outlets. Continued QoC and improvement in services is ensured through timely achievement
of these objectives, monitoring, and periodic reviews.
Annex I: Components of National RHS Package of Pakistan

1. Comprehensive FP services for females and males

2. Maternal health care, including safe motherhood and pre- and postabortion care for complications

3. Infant health care (newborn to children up to 1 year old)

4. Prevention and management of RTIs/STIs and HIV/AIDS

5. Management of RH-related issues of adolescents

6. Management of other RH-related issues of elderly women

7. Management of RH-related issues of men, including male involvement and prostate cancer

8. Management of infertility

9. Screening/detection of breast and cervical cancers
Annex II: List of Quality of Care Indicators

Provider
- Demonstrates good counselling skills.
- Treats client with respect/courtesy.
- Assures confidentiality.
- Asks client about reproductive choice.
- Discusses client's preference among contraceptive mix.
- Discusses methods for preventing pregnancy and STIs/RTIs, HIV and AIDS, and hepatitis through proper use of barrier methods.
- Tailors key information on the accepted method, explaining its use, side effects, and possible complications.
- Gives instructions on when to return or follow up.
- Follows infection prevention and control procedures according to guidelines.
- Recognizes/identifies contraindications, consistent with guidelines.
- Performs clinical procedures according to guidelines.

Staff (other than provider)
- Treats clients with respect.
- Provides relevant information to assist clients in using the facility.

Client
- Participates actively in discussion and selection of method.
- Receives his or her method of choice.
- Believes the provider will keep his or her information confidential.

Facility
- Has all (approved) contraceptive methods available, with minimum stock for 3 months.
- Has basic equipment/items needed for delivery of methods offered by the facility (including sterilizing equipment, gloves, blood pressure apparatus, specula, adequate light source, adequate water supply, and sewerage).
- Ensures privacy for pelvic examination/IUCD insertion.
- Has sufficient flexibility to make local-level changes based on client feedback.
- Should undergo periodic supervisory visits within a certain pre-determined period.
- Has adequate storage of contraceptives and medicines (away from moisture, heat, direct sunlight) on premises.
- Follows standard clinical guidelines.
- Has comfortable waiting area and ensures minimum waiting time.
Annex III: Checklists on QoC for Service Delivery Points

(1) CHECKLIST ON READINESS FOR HANDLING EMERGENCY SITUATION

A. Equipment

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>EQUIPMENT</th>
<th>AVAILABILITY</th>
<th>FUNCTIONAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Airway</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>2</td>
<td>Ambu bag/resuscitator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Laryngoscope</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Endotracheal tube</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5</td>
<td>Oxygen cylinder, regulator, and tubing</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

B. Emergency Medicines List as per National Standards

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>LIST DISPLAYED</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Medicines being checked weekly with reference to:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Availability</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Expiry</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

List of Emergency Medicines attached at Annex I [not in Annex I of this chapter]
(you are right there is no list of emergency medicines in the manual, I have attached a list of medicines I will request Ricky to have a look before putting it in)

(2) CHECKLIST ON SEGREGATION/DISPOSAL OF INFECTIOUS WASTE (IN COLOURED BAGS) AND NON-INFECTIOUS WASTE (IN WHITE BAGS)

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>WASTE DISPOSAL</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Segregation of infectious and non-infectious waste</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>Infectious waste disposed of in black bags to incinerator</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Non-infectious waste disposed of in white bags to the general waste</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(3) CHECKLIST ON INFECTION PREVENTION PROTOCOLS OBSERVED AS PER NATIONAL STANDARDS

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>METHOD</th>
<th>KNOWLEDGE</th>
<th>IN PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Decontamination with 0.5% chlorine solution</td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>1</td>
<td>Cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td>High-level disinfection through boiling</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td>Sterilization</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
(4) CHECKLIST ON CLIENT-ORIENTED SERVICES

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>COUNSELLING</th>
<th>KNOWLEDGE</th>
<th>IN PRACTICE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>YES</td>
<td>NO</td>
</tr>
<tr>
<td>1.</td>
<td>Greet</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Ask/Assess</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Tell</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Help</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Explain</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>Return/follow-up visit</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(5) INSERTION ROOM CHECKLIST

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>INSERTION ROOM</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td><strong>Housekeeping:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Dusting</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Cleaning</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) Things in order</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td><strong>Steps of infection prevention observed:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Hand washing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Hand scrubbing</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>3) Gloving</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td><strong>Decontaminating:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>a) Insertion room table</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>b) Couch</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>c) Buckets</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>d) Floor</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td><strong>Equipment:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Boiler (&quot;sterilizer&quot;)</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Autoclave</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td><strong>Separately packed sterilized or HLD IUCD kits for individual clients:</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1) Insertion kits</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2) Removal kits</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(6) OPERATING THEATRE CHECKLIST

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>OPERATING THEATRE</th>
<th>OBSERVED</th>
<th>FREQUENCY</th>
<th>PROPOSED</th>
<th>PRACTICED</th>
</tr>
</thead>
<tbody>
<tr>
<td>I</td>
<td>Housekeeping</td>
<td>Yes</td>
<td>Twice daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>II</td>
<td>Decontamination</td>
<td>Yes</td>
<td>Twice daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>with 0.5% chlorine solution</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>III</td>
<td>Cleaning</td>
<td>Yes</td>
<td>Twice daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>IV</td>
<td>Carbolization</td>
<td>Yes</td>
<td>Quarterly</td>
<td></td>
<td></td>
</tr>
<tr>
<td>V</td>
<td>Ultraviolet light</td>
<td>Yes</td>
<td>Once daily</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VI</td>
<td>&quot;Sterilized or HLD functional Instrument availability not applicable</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>VII</td>
<td>Instruments in functioning order</td>
<td>Yes</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
<tr>
<td>VIII</td>
<td>Soiled linen placed in a defined</td>
<td>Yes</td>
<td>Not applicable</td>
<td>Not applicable</td>
<td></td>
</tr>
</tbody>
</table>
storage area (Hampers) applicable

(7) CHECKLIST ON CALIBRATION OF FOLLOWING ESSENTIAL EQUIPMENT USED IN RHS-A CENTRE

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>EQUIPMENT</th>
<th>CALIBRATION DATE OF EXPIRY</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Thermometer</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Blood pressure apparatus</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Weighing scale</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Oxygen cylinder gauge</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>Autoclave gauge</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(8) CHECKLIST ON CLIENT FEEDBACK

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>PROFORMA</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Adequately filled</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>6-monthly analysis</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Clients' feedback/suggestions incorporated accordingly for improvement of outlet (service delivery point)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(9) CHECKLIST ON AWARENESS OF QUALITY STANDARDS

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>AUDITABLE AREAS FORM (QUALITY MANAGEMENT SYSTEM)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Quality policy and job description awareness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Quality objective update</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Availability of counsellor's kit</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Availability of consent forms</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(10) CHECKLIST OF CONTRACEPTIVE MIX

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>AUDITABLE AREAS FORM (QUALITY MANAGEMENT SYSTEM)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Availability of all contraceptives according to minimum stock level</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Random checking of contraceptive client record</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Monthly performance report of previous 6 months duly filled in</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>Proper storage of facility medicines in cool and dry Place</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(11) CHECKLIST OF HRD/TRAINING/ RECORDS

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>AUDITABLE AREAS FORM (QUALITY MANAGEMENT SYSTEM)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Training record of previous 1 year</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Payment record of contraceptive surgeries completely filled up</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(12) CHECKLIST ON MAINTENANCE OF INFRASTRUCTURE

<table>
<thead>
<tr>
<th>SR. NO.</th>
<th>AUDITABLE AREAS FORM (QUALITY MANAGEMENT SYSTEM)</th>
<th>YES</th>
<th>NO</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Housekeeping (whitewash)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2.</td>
<td>Sanitation</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>Leakages</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
Introduction
Counselling is one of the most important components of family planning (FP). It is the responsibility of service providers at all levels to offer effective counselling on FP methods in order to increase clients’ satisfaction and ensure continuity in their method of choice.

Three Kinds of Family Planning Communication

Motivation
Motivation is a one-way process influencing the behaviour of a person in a particular direction. Motivational activities are biased. They often attempt to influence an individual or a group. Motivation for FP is the process of bringing about an attitudinal change for creating awareness to accept the advantages of the contraceptives that the provider wants to offer. For example, a service provider tells about the advantages of a method but does not tell about its limitations. The information is biased and incomplete and influences the client.

Giving information
Information-giving activities focus on providing facts about methods. The information presented may be complete or limited and may be correct or incorrect.

Counselling
Counselling is a two-way process in which unbiased information is given to the clients about all available methods so they can make a free, well-informed decision. FP counselling is the process of helping clients to make informed and voluntary decisions about the choice of contraceptives. Counselling focuses on the client's/patient's situation and needs.

Table 2-1. Family Planning/Reproductive Health Communication Activities

<table>
<thead>
<tr>
<th>Activity</th>
<th>Goal</th>
<th>Content</th>
<th>Direction</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Motivation</td>
<td>Influencing behaviour in a particular direction</td>
<td>Propaganda or persuasion</td>
<td>One-way</td>
<td>Anywhere</td>
</tr>
<tr>
<td>Information Giving</td>
<td>Providing facts and raising awareness</td>
<td>Facts complete or incomplete</td>
<td>One- or two-way</td>
<td>Anywhere</td>
</tr>
<tr>
<td>Counselling</td>
<td>A satisfied client having free and informed choice</td>
<td>Facts; Clients’ feelings and motives</td>
<td>Two-way</td>
<td>Private</td>
</tr>
</tbody>
</table>
Six Principles of Good Counselling

- **Treat each client well.** All clients deserve respect, regardless of their age, marital status, ethnic group, sex, or sexual and reproductive health (RH) behaviour. (See Greet.)
- **Interact.** Each client is a different person. Ask questions, listen, and respond to each client's own needs, concerns, and situation. (See Ask.)
- **Give the right amount of information.** Provide enough for the client to make informed choices but not so much that the client is overloaded. (See Tell.)
- **Tailor and personalize information.** Give clients the specific information that they need and want, and help clients see what the information means to them. (See Tell.)
- **Provide the FP method that the client wants.** Provide the method unless a valid medical reason prevents it. (See Help.)
- **Help clients remember instructions.** (See Explain.)

The Counselling Process

Elements of counselling

**GATHER Approach**

FP counselling has six elements, which can be remembered by the word GATHER.

- **G** = GREET the client in a friendly and polite manner.
- **A** = ASK and assess the client's knowledge, needs, and feelings. Remove any doubts/concerns the client has and listen actively.
- **T** = TELL the client about all available FP methods with the help of samples, flip charts, leaflets, and brochures.
- **H** = HELP the client choose a method. A particular method may not be suitable for a particular client. Explain this clearly and help the client choose another method. If this method is not available, help by referring the person to a relevant facility.
- **E** = EXPLAIN the use of the chosen method. This would include how it should be used, its effectiveness, advantages and limitations, possible side effects, warning signs, and follow-up regime. To ensure that the client has understood, ask the client to repeat the information given. The client must also be informed of the warning signs for which return to the facility is important.
- **R** = RETURN for follow-up. At the follow-up visit, inquire if the client is still using the method. If the answer is "yes", ask if there are any problems or side effects; also confirm that the method is being correctly used. Give appropriate advice about any minor side effects, and refer for treatment if side effects are severe.

In discussing contraceptive options with clients, the counsellor should briefly review all available methods, even if a client has a preference for a specific method. The counsellor should be aware of a number of factors about each client that may be important, depending on the method in question. These are:
- Reproductive goals of the client or couple (spacing or timing births)
- Personal factors including the time, travel costs, pain, or discomfort likely to be
• Accessibility and availability of other methods at referral facilities
• The need for protection against STIs (e.g., hepatitis B and C, HIV/AIDS)

Counselling can be divided into three phases (see Figure 2-1 for the steps in counselling):
• **Initial counselling:** all methods are described and the client is helped to choose the most appropriate methods.
• **Method specific counselling** prior to and immediately following service provision: the client is given instructions on how to use the method and common side effects, warning signs, and follow-up regime are discussed.
• **Follow-up counselling:** during the return visit, use of the method, satisfaction with it, and any problem that may have occurred are discussed.

These important elements should be followed during counselling for every contraceptive method.

**SAHR Approach:**
Another approach to counselling is SAHR. It is a client-centred approach and assures two-way exchange of information between the health care provider and the client in an environment of equality. In this approach, the provider and the client mutually negotiate a solution that helps in meeting the client’s need. This approach has been developed and tested by the Population Council in Pakistan.
The acronym SAHR stands for:
- **S** - Salutation (Treat the client with dignity)
- **A** - Assess the client's RH needs
- **H** - Help negotiate a solution to the client's RH needs
- **R** - Reassure the client

This framework ensures that clients select the best option/solution to their needs in a relaxed and friendly environment. See details at the end of this chapter.

**Benefits of Counselling**
Counselling is a vital part of FP. It helps clients:
• Arrive at an informed choice of reproductive options;
• Select a contraceptive method with which they are satisfied; and
• Use the chosen method safely and effectively.
Figure 2-1. Steps in Counselling

*Initial Counselling*

- Greet the client warmly and introduce yourself.
- Obtain basic information (name, address, etc.).

- Ask about the client’s reproductive goals and possible need for protection against STIs, including hepatitis B and C, HIV and AIDS. Ask if the client wants to space or limit births.
- Discuss the client's needs, concerns, and fears in a thorough and empathetic manner. Explore any attitudes or cultural or religious beliefs that either favour or eliminate one or more methods.
- Provide information about all contraceptive choices available and the risks and benefits of each. Help the client to choose an appropriate method.

*Method-Specific Counselling*

Once the client chooses a method:
- Make sure that the client has no medical condition that would be a problem or require more frequent follow-ups.
- Clearly discuss the characteristics of the method emphasizing the following points:
  - Effectiveness
  - Use
  - Convenience, comfort, and reversibility
  - Protection against STIs, including hepatitis B and C and HIV and AIDS
- Explain common side effects or problems associated with the method, especially any changes in the menstrual bleeding pattern, and be sure they are fully understood.
- If the client is at risk for STIs, inform that use of a barrier contraceptive is a must.
- Correct doubts and misinformation about methods.
• Review client assessment data to determine if the client is an appropriate candidate for the method or if there is any problem that should be monitored more frequently while the client is using it.

• Counsel how to use the method and what to do if any problem or side effect arises. Special emphasis should be given to menstrual bleeding patterns.

• Provide information on warning signs, medical problems, and the need to return to the clinic immediately, should any occur.

• Assure that the client can return to the clinic at any time to receive advice and medical attention.

• Ask the client to repeat the instructions.

• Answer the client’s questions.

• Complete the client's record.

**Follow-Up/Return Visit Counselling (Continuing Client)**

• If the client has problems, resolve them. This can include offering a new method or referring the client to an appropriate facility.

• Check whether the client is satisfied.

• Inquire about problems and respond to concerns about side effects or problems.

• Ask the client to repeat the instructions related to the selected method to confirm that the client understood well.

**Qualities of a Good Counsellor**

**Knowledge**

A good counsellor should have knowledge of:

• Demographic profile: national and global perspective

• Hazards of rapid population growth on the socio-economic infrastructure of the country

• Legal status of FP in the country

• Government policies regarding population and development

• Influence of FP on the health of mother and child

• Fertility regulation in the Islamic context

• Common myths, misunderstandings, and misconceptions regarding FP and how they can be countered

• Local customs and traditions

• The human reproductive system (anatomy and physiology)

• Contraceptive technology update

• Client eligibility criteria, policies, and administrative procedures of the facility

• Concepts, principles, and goals of counselling

• Record keeping/reporting
• Follow-up/referral systems and procedures

Skills
A good counsellor should be able to:
• Build up a good rapport with the clients.
• Deal with clients at their level of education and understanding.
• Show empathy.
• Deal tactfully with sensitive issues.
• Listen patiently to the client's point of view.
• Be discreet and maintain confidentiality.
• Pay full attention to the client's need.
• Help the client to make a decision.

Attitude
A good counsellor should:
• Have a positive attitude towards FP.
• Be unbiased towards different population groups.
• Give unbiased information on FP methods.
• Have a desire to work with people.
• Be punctual.
• Be a hard worker.
• Be pleasant and polite.
• Be helpful.
• Be empathetic.
• Be attentive to the client's problems
• Not ridicule the client over any issue
• Show tolerance for values that differ from her/his own values
• Be aware of factors that affect decision-making.
• Provide counselling in local languages.
• Be well-versed in the local language(s) of the client population
• Show respect for the right and ability of people to make their own decisions.
• Be comfortable with issues related to human sexuality and people’s expressions of their feelings.

The provision of counselling should be part of every interaction with the client. Information and counselling commonly will come from more than one source. Therefore, all staff should be knowledgeable about all available contraceptive methods.

Counselling helps to establish a positive interpersonal relationship between service providers and clients. When providers treat clients as valued customers and give them good service by listening to, understanding, and responding to their needs, their clients are more likely to be satisfied. When clients are satisfied with their treatment at a clinic, they will tell their friends and relatives about their good experience (and conversely, if they are dissatisfied they will pass along their bad experience, too).
Standards of a Good Counsellor

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

- Understands and respects the client's rights.
- Earns the client's trust.
- Understands the benefits and limitations of all contraceptive methods.
- Understands the cultural and emotional factors that affect a client's or a couple's decision to use a particular contraceptive method.
- Encourages the client to ask questions.
- Uses a non-judgemental approach that shows the client respect and kindness.
- Presents information in an unbiased, client-sensitive manner.
- Listens to the client's concerns actively.
- Understands the effect of nonverbal communication.
- Recognizes when to refer the client to an appropriate facility.
- Attends to the client as quickly as possible.

Guidance tools can improve counselling

Using audiovisual aids, such as flipcharts, can help providers communicate effectively with the clients and tailor information according to clients' individual situations and needs at both the initial and return visits. Checklists can be a useful screening tool for health care providers in resource-poor settings.

Instructions to the Counsellor

Give information clearly so that the clients understand

- Use simple words and short sentences in a language the client understands.
- Use pictures and models adapted to the local culture.
- Show samples of different contraceptives, and let the client handle them.
- Stop from time to time to ask if the client has understood.
- Ask if the client has any questions.
- Repeat instructions.
- Ask the client to repeat the instructions.
- Give the client written or printed information to take home.

Counsellor's kit

- Diagrams of male and female reproductive anatomy/modules/flip chart
- Samples of all available contraceptive methods
- A checklist of the minimum information that all clients should receive
- A leaflet on common questions and answers about Islam and FP
- A list of referral outlets
- A list of contra-indications of all methods

Informed Choice
Informed choice means that a person freely makes a carefully considered decision based on accurate, useful information. An important purpose of FP counselling is to help the client make informed choices about FP and RH.

“Informed” means that:
- Clients have the clear, accurate, and specific information required to make the reproductive choices, including a choice among FP methods.
- Good-quality FP programs explain each FP method as needed, without overloading clients with information, and helping clients to use each method effectively and safely.
- Clients understand their own needs because they have thought about their own situations through interpersonal communication and through mass-media messages.

“Choice” means that:
- **Clients have a range of FP methods to choose.** Health care providers offer different methods to suit clients’ needs. If a method cannot be provided, then the clients are referred to another facility.
- **Clients make their own decisions.** Counsellors help the clients think through their decisions, but do not persuade the clients to make a certain choice.

**Informed Consent**

Informed consent is the client's voluntary decision to opt for any contraceptive after receiving all relevant information regarding the requested method.

Special care should be taken when a client is:
- Pregnant, and specifically, consent should not be obtained when a woman is in labour
- Mentally retarded

**Client Assessment**

The primary objectives of assessing clients prior to providing FP services are to determine:
- That the client is not pregnant;
- Whether any conditions requiring precaution exists for a particular method; and
- Whether there are any special problems that require further assessment, treatment, or regular follow-up.

This information usually can be determined by asking a few key questions. Unless specific problems are identified, the safe provision of most contraceptive methods, except IUCDs and voluntary sterilization, does not require performing a physical or pelvic examination because:
- The currently available low-dose combined (oestrogen and progestin) contraceptives, such as combined oral contraceptives (COCs) and combined injectable contraceptives (CICs), are quite safe.
- Progestin-only implants, injectables, and pills are free of oestrogen-related effects and the amount of progestin delivered per day is lower than with COCs.
With the exception of condoms, no contraceptive method provides protection against STIs (e.g., hepatitis B and C, HIV/AIDS). All clients should be made aware of the risks of STI transmission.

**How to be reasonably sure that the client is not pregnant**

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

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

When a woman is more than 6 months postpartum, the health care provider can be reasonably sure that the client is not pregnant if:

- Breastfeeding frequency is kept high;
- She has no menstrual bleeding (amenorrhoeic); and
- No clinical signs or symptoms of pregnancy are present.

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

**Pregnancy testing** is unnecessary except in cases where:

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

In these situations, a sensitive urine pregnancy test may be helpful, if readily available and affordable. If pregnancy testing is not available, counsel the client to use a temporary contraceptive method like condoms or abstain from intercourse until menses occur or pregnancy is confirmed.

**Counselling of Clients with Special Needs**

FP offers freedom from fear of unplanned pregnancy and can improve sexual life, partner relations, and family well-being. Many contraceptive methods are available, including methods that are short- or long-acting, permanent or reversible, hormonal or non-hormonal, and for use by women or men. When properly provided and used, currently available contraceptives are safe and effective for the vast majority of users.

Most healthy women are eligible to use any method of contraception and can select a method that best meets their needs. As a woman moves through the different stages of reproductive life, her contraceptive needs and her health status may change. Not all methods are equally acceptable at each stage of a woman’s life. Adolescents, postpartum
and postabortion women, breastfeeding women, and women over the age of 35 are groups with special contraceptive and counselling needs.

**Adolescents**

Adolescents who are married need access to safe and effective contraception. Many adolescents use no contraception or use a method irregularly, so they are at high risk of unwanted pregnancy, unsafe abortion, and STIs. In general, adolescents are eligible to use any method of contraception. Services should avoid unnecessary procedures that might discourage or frighten teenagers, such as requiring a pelvic examination when they request contraceptives.

**Postabortion women**

Women who recently have had an abortion have special RH needs that influence the contraceptive options. Counsellors should be aware of these health issues so that they can provide appropriate counselling. Most important are the postabortion women who may face immediate, acute, and possibly life-threatening medical problems. Women with abortion-related complications need immediate medical attention as well as appropriate information and counselling with respect to FP once their condition has stabilized.

**Postpartum women**

Women who recently have given birth also have special RH needs that influence their contraceptive options. In postpartum women, return to fertility is influenced by whether the woman is breastfeeding. In women who are not breastfeeding, the first postpartum ovulation may occur at any time from day 30 to day 90 after delivery. Women who are not breastfeeding or who have weaned their infants are eligible to use any contraceptive method, provided that there are no delivery-related complications and they are screened for any existing health conditions.

**Breastfeeding Women**

Women who are breastfeeding also have special health needs and concerns. They should not use a contraceptive method that will affect breast milk or the health of the infant, such as a combined oral contraceptive pill or injectables. These methods should be delayed until after 6 months. Progestin-only methods should be delayed until after 6 weeks, and an IUCD may be inserted either within 48 hours of delivery or after 6 weeks postpartum.

**Women over age 35**

Although many women achieve the desired family size by the time they reach 35 years, women remain fertile until menopause, which generally occurs between the ages of 45 and 55 years. Contraception is recommended until 1 year after the menstrual cycle ceases. In addition, women over age 35 may need protection against STIs, including HIV. Access to appropriate and acceptable contraceptives is important for women in the later reproductive years because pregnancy after age 35 carries increased health risks for both the woman and child. A woman's choice and use of contraceptives during this time may be influenced by whether she wants more children, has health problems (such as diabetes, hypertension, anaemia, or genital tract disorders), or smokes, as well as by her previous experience with contraceptives. For women who are experiencing uncomfortable menopausal symptoms,
oestrogen-containing hormonal methods may be a good choice, as they can alleviate some symptoms. Because older women are more likely to have pre-existing health problems, FP programmes should provide careful screening and counselling for these women when providing contraception.

**Services for clients with chronic health problems**

Clients with chronic or serious health problems still need access to safe and effective contraception. Providing an appropriate contraceptive method for these clients can be complicated since the health condition may limit the contraceptive choices. The counsellor must know about possible interactions between medical conditions, drugs, and contraceptives, and must be able to provide appropriate counselling. Women who have chronic or serious medical conditions may need medical follow-up and monitoring more often than other women. In balancing the needs and desires of the client, counsellors must consider that, for women with serious health conditions that make pregnancy dangerous, providing no contraceptive method would be even more dangerous than providing a method with minor side effects. Issues of mentally handicapped clients also need to be addressed through proper counselling of their spouses and family members.

**Contraception for HIV-infected women**

Women infected with HIV face a variety of RH decisions involving their desire for pregnancy, their contraceptive practices, and choices and decisions if an unintended pregnancy occurs. HIV-infected women should be allowed to make these decisions freely. Interventions to offer voluntary FP can give these women more control over their reproductive lives and serve as a strategy to prevent perinatal HIV infection.

Male condoms, used consistently and correctly, are effective in preventing HIV transmission if either partner is infected with HIV. Female condoms also offer significant protection from STIs, but their use has been limited by cost and user acceptability. Other methods of contraception such as hormonal contraceptives and IUCDs are effective in preventing unplanned pregnancies, but do not prevent HIV transmission.

**Special needs of abused women**

Abused women clearly have special needs, including medical, psychological, and legal support, and safe housing for themselves and their children. To be effective, solutions must acknowledge the whole problem. Health care planners and other health care providers are in an excellent position to intervene because they represent one of the few institutions to come in contact with most women during their reproductive lives, the time of highest risk for domestic violence. FP providers must become aware of power imbalances and the resulting health effects. They cannot do their jobs effectively without being concerned about how the issue of power affects women's RH.

The most important contraceptive service for women in violent relationships is counselling, which must include recognition of the woman's difficulties with her partner and help in choosing a method that will not make those difficulties worse. Ideally, it will include referral or in-house professional counselling regarding violence issues and the resources available.
in the community.

Battered women who cannot protect themselves from STIs through condom use may need repeated screening and treatment for STIs. Emergency contraception is also a pressing need for many battered women.

**Counselling Men**

Men have special counselling needs and should receive special attention from health care providers to motivate them to make responsible choices regarding RH practices.

**Men's special counselling needs**

- Men should be encouraged to support women's use of FP methods or to use FP methods themselves.
- It is important to talk to young men about responsible and safe sex before they become sexually active.
- Men often have less information or are more likely to be misinformed about FP methods, male and female anatomy, and reproductive functions because they tend to talk less about these issues than women.
- Men are often more concerned about sexual performance and desire than women.
- Men often have serious misconceptions and concerns that FP methods will negatively affect their sexual pleasure and/or performance.
- Men are often concerned that women will become promiscuous if they use FP.
- Many men do not know how to use condoms correctly. Health care providers should always demonstrate correct condom use, using a model when possible.
- Men are often not comfortable going to a health facility, especially if it serves women primarily.

**Encourage men to participate in FP.** Involving men can be crucial to a continuing client strategy. Men are more likely to support continued contraceptive use when they participate.

Counsellors can involve men and serve them better if they take four steps:

- Offer men FP and other RH services.
- Provide men with accurate information about FP.
- Explain how men can assure their own RH as well as that of their partners.
- Encourage couples to talk to each other about FP, as well as talking to health care providers.

Counsellors can often encourage men to talk with their partners about practicing FP and sharing decision-making by appealing to their sense of responsibility in family matters.

**Rumours and Misconceptions**

Rumours are unconfirmed stories that are transferred from one person to another by word of mouth. In general, rumours arise when:

- An issue or information is important to people, but it has not been clearly explained.
- There is nobody available who can clarify or rectify the incorrect information.
• The source of the rumour is perceived to be credible.
• People are motivated to spread them for political reasons.

A misconception is a mistaken interpretation of ideas or information. If a misconception is imbued with elaborate details and becomes a fanciful story, then it acquires the characteristics of a rumour.

Methods for counteracting rumours and misinformation
• When a client mentions a rumour, always listen politely. Do not ridicule her/him.
• Define what a rumour or misconception is.
• Find out where the rumour came from and talk with the people who started it or repeated it. Check whether there is some basis for the rumour.
• Explain the facts.
• Use strong scientific facts about FP methods to counteract misinformation.
• Always tell the truth. Never try to hide side effects or problems that might occur with various methods.
• Clarify information with the use of demonstrations and visual aids.
• Give examples of people who are satisfied users of the method (only if they are willing to have their names used). This kind of personal testimonial is most convincing.
• Reassure the client by examining and informing her/him about the findings.
• Counsel the client about all available FP methods.
• Reassure and let the client know that further care will be provided through home visits.

Relationship between Contraceptive Methods and Sexual Life

FP has much to do with sexual life and health protection and is not restricted to decisions relating to procreation. Any member of the community who is of reproductive age should be considered a potential FP client.

FP services are a type of preventive health service. Therefore, the rights of FP clients should be seen in the overall context of the rights of the clients for any health services.

The Rights of Family Planning Clients
1. Right to Information
All individuals in the community have a right to information about the benefits of FP for themselves and for their families.

2. Right to Access
All individuals in the community have a right to receive services from FP programs, regardless of their social status, economic situation, religion, political belief, ethnic origin, marital status, geographical location, or any other group identity.

3. Right of Choice
Individuals and couples have the right to decide freely whether or not to practice FP. A client's concept of acceptability and appropriateness changes with circumstances.
Therefore, the right of choice also involves clients’ decisions concerning discontinuation or switching of method.

4. **Right to Safety**
Family planning clients have a right to safety while practicing FP. This right to safety implies the following:

- Clients have a right to protection against any possible negative effect of a contraceptive method on their physical and mental health.
- Since unwanted pregnancies may represent a risk to health, the right of the client to safety also includes the right to effective contraception.
- When receiving FP services, clients also have a right to protection against the possibility of acquiring infection from contact with a contaminated instrument.

5. **Right to Privacy**
When discussing needs or concerns, the client has a right to an environment in which she/he feels confident and relaxed. Auditory privacy should be ensured.

6. **Right to Confidentiality**
The client should be assured that any information disclosed or any details of the services received will not be communicated to others without consent.

7. **Right to Dignity**
FP clients have a right to be treated with courtesy, consideration, and attentiveness, and with full respect of their dignity, regardless of their level of education and social status.

8. **Right to Comfort**
The client has a right to comfort. This right of the client is intimately related to adequacy and quality of services (e.g., service delivery sites should have proper ventilation, lighting, seating, and toilet facilities). The environment in which the services are provided should be in keeping with the cultural values, characteristics, and demands of the community.

9. **Right of Continuity**
Clients have a right to receive contraceptive services and supplies for as long as they need them. The services provided to a particular client should not be discontinued unless the decision is made jointly between the counsellor and the client.

10. **Right of Opinion**
Clients have the right to express their positive or negative views (thanks or complaints) about the quality of services they receive at the facility.
### Table 2-2. Comparative Statement of Failure Rate of Different Contraceptives in First Years of Use

<table>
<thead>
<tr>
<th>Family Planning Method</th>
<th>Consistent and Correct Use</th>
<th>As Commonly Used</th>
<th>As Commonly Used</th>
</tr>
</thead>
<tbody>
<tr>
<td>Implants</td>
<td>0.05</td>
<td>0.05</td>
<td></td>
</tr>
<tr>
<td>Vasectomy</td>
<td>0.1</td>
<td>0.15</td>
<td></td>
</tr>
<tr>
<td>Levonorgestrel IUCD</td>
<td>0.2</td>
<td>0.2</td>
<td></td>
</tr>
<tr>
<td>Female sterilization</td>
<td>0.5</td>
<td>0.5</td>
<td></td>
</tr>
<tr>
<td>Copper-bearing IUCD</td>
<td>0.6</td>
<td>0.8</td>
<td>2</td>
</tr>
<tr>
<td>Lactational amenorrhoea method (LAM) (for 6 months)</td>
<td>0.9</td>
<td>2</td>
<td>Effective</td>
</tr>
<tr>
<td>Monthly injectables</td>
<td>0.05</td>
<td>3</td>
<td></td>
</tr>
<tr>
<td>Progestin-only injectables</td>
<td>0.3</td>
<td>3</td>
<td>2</td>
</tr>
<tr>
<td>Combined oral contraceptives</td>
<td>0.3</td>
<td>8</td>
<td>7</td>
</tr>
<tr>
<td>Progestin-only oral pills</td>
<td>0.3</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Combined patch</td>
<td>0.3</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Combined vaginal ring</td>
<td>0.3</td>
<td>8</td>
<td></td>
</tr>
<tr>
<td>Male condoms</td>
<td>2</td>
<td>15</td>
<td>10</td>
</tr>
<tr>
<td>Ovulations method</td>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>TwoDay Method</td>
<td>4</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Standard Days Method</td>
<td>5</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diaphragms with spermicide</td>
<td>6</td>
<td>16</td>
<td></td>
</tr>
<tr>
<td>Female condoms</td>
<td>5</td>
<td>21</td>
<td></td>
</tr>
<tr>
<td>Other fertility awareness methods</td>
<td>25</td>
<td>24</td>
<td></td>
</tr>
<tr>
<td>Withdrawal</td>
<td>4</td>
<td>27</td>
<td>21</td>
</tr>
<tr>
<td>Spermicides</td>
<td>18</td>
<td>29</td>
<td></td>
</tr>
<tr>
<td>Cervical cap</td>
<td>26&lt;sup&gt;b&lt;/sup&gt; 9&lt;sup&gt;a&lt;/sup&gt;</td>
<td>32&lt;sup&gt;b&lt;/sup&gt; 16&lt;sup&gt;a&lt;/sup&gt;</td>
<td></td>
</tr>
<tr>
<td>No method</td>
<td>85</td>
<td>85</td>
<td>85</td>
</tr>
</tbody>
</table>


---

Figure 2-2. The SAHR Approach to Counselling

SAHR

A systematic approach to meeting the client's reproductive health needs

<table>
<thead>
<tr>
<th>TREAT THE CLIENT WITH RESPECT AND DIGNITY</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Welcome in a courteous and friendly manner</td>
</tr>
<tr>
<td>- Show interest, empathy, and concern</td>
</tr>
<tr>
<td>- Ensure an atmosphere of privacy and confidentiality</td>
</tr>
<tr>
<td>- Maintain atmosphere of equality</td>
</tr>
<tr>
<td>- Show respect to the client and other family members</td>
</tr>
<tr>
<td>- Call the client by his/her name</td>
</tr>
<tr>
<td>- Create a tension-free and relaxed atmosphere</td>
</tr>
</tbody>
</table>

We have the complete soft copy of this and will replace it.
Introduction

Infection prevention and infection control are fundamental to the success of any family planning (FP) program that offers a variety of options to its clients, ranging from IUCD insertion/removal, injectables, and implants to surgical contraception.

To prevent infection, remember that expensive, sophisticated equipment is not essential. A simple procedure such as handwashing, or using protective gloves before handling contaminated instruments or soiled linen, is effective in preventing or reducing the risk of spreading infection. Likewise, inexpensive equipment and facilities can provide a safe environment for performing FP procedures, including surgery. An example is the drastic reduction in the risk of all types of hepatitis viruses and HIV transmission by decontamination of table surfaces, gowns, gloves, and instruments with the use of chlorine solution. High-level disinfection (HLD) preceded by decontamination and proper cleaning is acceptable only where autoclaving is not possible.

Standard Precautions

The key components of the Standard Precautions and their use are outlined in the table on the next page. Placing a physical, mechanical, or chemical barrier between micro-organisms and an individual or a client is a highly effective means of preventing the spread of infections. For example, the following actions create protective barriers for preventing infections and provide the means for implementing the new Standard Precautions:

Consider every person (client or staff) as potentially infectious and susceptible to infection.

Wash hands, the most important procedure for preventing cross-contamination (person to person or contaminated object to person).

Wear gloves (both hands) before touching anything wet, broken skin, mucous membranes, blood or other body fluids, or soiled instruments and contaminated waste materials, or before performing invasive procedures.

Use physical barriers (protective goggles, face masks, and aprons) if splashes and spills of any body fluids (secretions and excretions) are likely (e.g., cleaning instruments and other items).

Use antiseptic agents for cleansing the skin or mucous membrane prior to surgery, cleaning wounds, or doing hand rubs or surgical hand scrubs with an antiseptic product.

Use safe work practices such as not recapping or bending needles, safely passing sharp instruments, and suturing with blunt needles.

Safely dispose of infectious waste materials to protect those who handle them and prevent injury or spread of infection to the community.
**Standard Precautions: Key Components**

**Handwashing (or using an antiseptic hand rub)**
- Before and after client/patient contact
- After touching blood, body fluids, secretions, excretions, and contaminated items
- Immediately after removing gloves
- After examining each client/patient

**Gloves**
- For contact with blood, body fluids, secretions, and contaminated items, mucous membranes, and broken skin

**Masks, goggles, face masks**
- Protect eyes, nose, and mouth when contact with blood and body fluids is likely

**Gowns**
- Prevent infection by minimizing shedding/contamination from provider (shedding of dead skin, micro-organism and dirt carried by clothes)
- Protect skin from blood or body fluid contact
- Prevent soiling of clothing during procedures that may involve contact with blood or body fluids

**Linen**
- Handle soiled linen in a manner that prevents it touching skin or mucous membranes

**Client care equipment**
- Handle soiled equipment in a manner that prevents contact with skin or mucous membrane and prevents contamination of clothing or the surrounding
- Clean reusable equipment prior to use

**Environmental cleaning**
- Clean and disinfect equipment and furnishings in client care areas

**Sharps**
- Safe passing of sharps during surgical procedures like tubal ligation
- Used needles must not be recapped
- Used needles must not be removed from disposable syringes
- Bending, breaking or manipulating used needles by hand must not be done
- Place used sharps in specific puncture-resistant containers and transport in specified containers

**Client resuscitation**
- Use mouthpieces/gauze, resuscitation bags, or other ventilation devices to avoid infection during mouth-to-mouth resuscitation

**Client placement**
- Clients who are potential source of infection should be dealt with separately
Hand Hygiene

**Handwashing:** The purpose of handwashing is to mechanically remove soil and debris from the skin, and reduce the number of transient micro-organisms. Handwashing with plain soap and clean water is as effective as washing with antimicrobial soaps. In addition, plain soap causes less skin irritation.

Handwashing is different from surgical hand scrub and should be done before:
- Examining a client/patient
- Prior to wearing gloves for any routine procedure/examination

Handwashing should be done after:
- Any situation in which hands may become contaminated, such as:
  - Handling soiled instruments and other items,
  - Touching mucous membranes, blood, or other body fluids (secretions or excretions), and
  - Having contact with a client.
- Removing gloves.

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

**Antiseptic hand rub:** It is done when simple handwashing is not possible or is difficult. Use of an antiseptic hand rub is more effective in killing transient and resident flora than handwashing with antimicrobial agents or plain soap and water. It is quick and convenient to perform, and gives a greater initial reduction in hand flora. Antiseptic hand rubs also contain a small amount of an emollient such as glycerin, propylene glycol, or sorbitol that protects and softens skin.

To be effective, an adequate amount of hand rub solution should be used. For example, by increasing the amount of hand rub from 1 ml to 5 ml per application (about 1 teaspoonful), the effectiveness increases significantly.

A non-irritating, antiseptic hand rub can be made by adding glycerin, propylene glycol, or sorbitol to alcohol (2 ml in 100 ml of 60–90 percent ethyl or isopropyl alcohol solution). Use 5 ml (about one teaspoonful) for each application and continue rubbing the solution over the hands until they are dry (15–30 seconds).

**Surgical hand scrub:** The purpose of the surgical hand scrub is to mechanically remove soil, debris, and transient organisms and to reduce resident flora during surgery. The goal is to prevent wound contamination by micro-organisms from the hands and arms of the surgeon and assistants.

For many years, preoperative hand scrubbing protocols required at least a 6- to 10-minute
vigorous scrub with a brush or sponge, using soap containing an antiseptic agent (chlorhexidine or an iodophor). This practice, however, has been shown to damage the skin and can result in increased shedding of bacteria from the hands. Several studies suggest that neither a brush nor sponge is necessary to reduce bacterial counts on the hands of surgical staff to acceptable levels. For example, a 2-minute handwashing with soap and clean water followed by application of 2–4 percent chlorhexidine or 7.5–10 percent povidone iodine was shown to be as effective as a 5-minute hand scrub with an antiseptic soap. As a result, the guidelines for performing the general surgical scrub technique have been made less harsh and take less time to perform.

Applying an antiseptic minimizes the number of micro-organisms on hands under the gloves and minimizes the growth of flora during surgery. This is important because gloves may have inapparent holes or tears, or may be nicked during surgery.

Alternatively, handwashing with plain soap and water followed by use of an antiseptic hand rub containing chlorhexidine has been shown to yield significantly greater reductions in microbial counts on hands, improve skin health, and reduce time and resources.

The steps for performing this simpler and shorter surgical hand scrub technique are:

- **Step 1:** Remove rings, watches, and bracelets.
- **Step 2:** Thoroughly wash hands, especially between fingers, and forearms to the elbows with soap and water.
- **Step 3:** Clean nails with a nail brush.
- **Step 4:** Rinse hands and forearms with water and dry thoroughly with a clean, dry towel or air dry.
- **Step 5:** Apply 5 ml (about 1 teaspoonful) of an antiseptic hand rub to hands and forearms and rub until dry, then repeat application and rubbing two more times for a total of at least 2 minutes, using a total of about 15 ml (3 teaspoonfuls) of the hand rub.
- **Step 6:** Keep hands up and away from the body; do not touch any surface or article prior to putting sterile or high-level disinfected surgical gloves on both hands.

**Gloves**

Although the effectiveness of gloves in preventing contamination of health care providers' hands has been repeatedly confirmed, wearing gloves does not replace the need for handwashing. For example, even the best quality latex surgical gloves may have inapparent defects, gloves may be torn during use, and hands can become contaminated during glove removal. A separate pair of gloves must be used for each client to avoid cross-contamination.

**Types of Gloves**

There are three types of gloves used in health care facilities:

- Surgical gloves should be used when performing invasive medical or surgical
• Examination gloves provide protection to health care workers when they are performing many of their routine procedures.
• Utility or heavy-duty household gloves should be worn for processing instruments, equipment, and other items, for handling and disposing of contaminated waste, and when cleaning contaminated surfaces.

When surgical gloves are reused, they must be checked carefully for tears or cuts before final processing.

**Table 3-1. Glove Requirements for Common Medical and Surgical Procedures**

<table>
<thead>
<tr>
<th>Task/ Activity</th>
<th>Gloves Needed</th>
<th>Gloves Preferred</th>
<th>Gloves Acceptable</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>IV injection</td>
<td>No</td>
<td>--------</td>
<td>--------</td>
</tr>
<tr>
<td>Pelvic examination</td>
<td>Yes</td>
<td>Examination</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>IUCD insertion (loaded in sterile package and inserted using no-touch technique)</td>
<td>Yes</td>
<td>Examination</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>IUCD removal (using no-touch technique)</td>
<td>Yes</td>
<td>Examination</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Norplant® implants insertion and removal</td>
<td>Yes</td>
<td>Sterile Surgical</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Vasectomy or laparoscopy</td>
<td>Yes</td>
<td>Sterile Surgical</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Handling and cleaning instruments</td>
<td>Yes</td>
<td>Utility/Examination</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Handling contaminated waste</td>
<td>Yes</td>
<td>Utility/Examination</td>
<td>HLD Surgical</td>
</tr>
<tr>
<td>Cleaning blood or body fluid spills</td>
<td>Yes</td>
<td>Utility/Examination</td>
<td>HLD Surgical</td>
</tr>
</tbody>
</table>

**Personal Protective Equipment and Drapes**

Protective barriers, now commonly referred to as personal protective equipment (PPE), have been used for many years to protect clients from micro-organisms present on staff working
in the health care setting. More recently, with the emergence of AIDS and HCV and the resurgence of tuberculosis and strains of influenza in many countries, use of PPE has become important for protecting the health care staff as well.

PPE includes gloves, masks/respirators, eyewear (face shields, goggles, or glasses), caps, gowns, aprons, and other items. In many countries, caps, masks, gowns, and drapes are made of cloth or paper. The most effective barriers, however, are made of treated fabrics or synthetic materials (e.g., plastic) that do not allow water or other liquids (blood or body fluids) to penetrate them. These fluid-resistant materials are not widely available because they are expensive. Lightweight cotton cloth (with a thread count of 140/inch²) is the material most commonly used for surgical clothing (masks, caps, and gowns) and drapes. Unfortunately, lightweight cotton does not provide an effective barrier because moisture can pass through it easily, allowing contamination. Denims, canvas, and heavy twill, on the other hand, are too dense for steam penetration (i.e., they cannot be sterilized), are hard to wash, and take too long to dry. When fabric is used, it should be white or light in color in order to show dirt and contamination easily.

Types of personal protective equipment

**Gloves** protect hands from infectious materials and protect clients from micro-organisms on health care providers’ hands. They are the most important physical barrier for preventing the spread of infection, but they must be changed between each client contact to avoid cross-contamination. For example, examination gloves should be worn when handling blood, body fluids, and surfaces or equipment contaminated with secretions or excretions and while touching non-intact skin or mucous membranes.

**Masks** should be large enough to cover the nose, lower face, jaw, and facial hair. They are worn in an attempt to contain the moisture droplets expelled when health care providers or surgical staff speak, cough, or sneeze, as well as prevent accidental splashes of blood or other contaminated body fluids from entering the health care provider’s nose or mouth. Unless the masks are made of fluid-resistant materials, they are not effective in preventing either.

**Eyewear** protects health care providers in the event of an accidental splash of blood or other body fluid by covering the eyes. Eyewear includes clear plastic goggles, safety glasses, etc. Prescription glasses or glasses with plain lenses also are acceptable. Masks and eyewear should be worn when performing any task in which an accidental splash into the face is likely (e.g., performing a surgical procedure or cleaning instruments).

**Caps** are used to keep the hair and scalp covered so that flakes of skin and hair are not shed into the wound during surgery. Caps should be large enough to cover all hair. While caps provide protection to the client, their primary purpose is to protect the wearer from blood or body fluid splashes and sprays.

**Scrub suits or cover gowns** are worn over or instead of regular clothes. The main use of cover gowns is to protect the health care providers’ clothing. Scrub suits usually consist of
drawstring pants and a shirt. The neck of the shirt must not be cut so low as to slide off the wearer's shoulders. There is little evidence that scrub suits are needed during routine procedures when soiling of clothes is not likely (Goldman 1991).

**Surgical gowns** were first used to protect clients from micro-organisms present on the abdomen and arms of health care providers during surgery. Surgical gowns made of fluid-resistant materials do play a role in keeping blood and other fluids, such as amniotic fluid, away from clients and health care workers, particularly in operating, delivery, and emergency rooms. Lightweight cotton gowns, which are available in most countries, offer little protection. Under these circumstances, if large spills occur, the best things to do is shower or bathe as soon as possible after completing the operation or procedure. If surgical gowns are worn, sleeves should either taper gently towards the wrists or end with elastic or ties around the wrists. (Large, droopy sleeves invite accidental contamination.)

In addition, the cuffs of the surgical gloves should completely cover the end of the sleeves.

**Footwear** is worn to protect feet from injury by sharps or fluids on the operating theatre floor. Theatre shoes/slippers must be kept clean and free of contamination from blood or other body fluid spills. All the theatre shoes/slippers must be washed daily with antiseptic solutions and must not be worn outside the theatre. Any shoe taken outside the operating theatre must not be taken to the theatre again unless it is thoroughly cleaned and washed with an antiseptic solution and dried properly.

**Drapes** are usually made of hemmed linen in squares of varying sizes. They are used to create an operative field around an incision, wrap instruments and items for sterilization, cover tables in the operating room, and keep clients warm during surgical procedures. The main types of drapes are:

- **Towel drapes** are used for drying hands, covering around the operative site, and wrapping small instruments. They are often made of heavier cotton cloth than other linen items, which makes them more water-resistant.
- **Drapes or lap sheets** are used for covering the client. They are large, usually made of lightweight cotton, and provide only limited protection to clients and health care providers.
- **Pack wrapper drapes** are large drapes that become a table cover when the sterile instrument pack is opened. This drape needs to be large enough only for wrapping the instruments and, when opened, to cover the tabletop completely.

**Using drapes for surgical procedures**

Using sterile towel drapes to create a work area around the incision limits the amount of skin that needs to be cleaned and prepared with antiseptic solution prior to placing the drapes. Although this area is often called the sterile field, it is not completely sterile. Cloth drapes allow moisture to soak through them and can help spread organisms from skin, even after surgical cleansing with an antiseptic agent, into the incision. Thus, gloved hands (sterile or high-level disinfected), sterile or high-level disinfected instruments, and other items should not touch the towel drapes once they are in place. Because cloth drapes do not serve as an
effective barrier, clean, dry towel drapes can be used if sterile towel drapes are not available.

The way in which the operative site is prepared and draped depends on the type of procedure to be performed. The following guidelines for draping are designed to reduce overuse of costly sterile items and avoid unnecessary draping:

- All drapes should be applied around a completely dry, widely prepared area.
- If sterile drapes are used, sterile or high-level disinfected surgical gloves should be worn when placing the drapes. (When putting drapes in place, health care workers must take care not to touch the client's body with gloved hands.)
- Drapes should be handled as little as possible and should never be shaken or flapped.
- Always hold drapes above the area to be draped and discard if they fall below this area.

Use of Antiseptic

Although antiseptics are sometimes used as disinfectants (e.g., Savlon or Dettol for processing instruments and other inanimate objects), they are not formulated for this use. They do not have the same killing power as chemical disinfectants (e.g., glutaraldehyde, hypochlorite, and peroxides) and should not be used for this purpose.

Plain soap is as effective as antimicrobial soap, provided the water is clean. Water that contains large amounts of particulate matter (makes the water cloudy) or is contaminated (high bacterial count) should not be used for performing a surgical hand scrub. In addition, antimicrobial soaps are costly and are more irritating to the skin than plain soap.

Skin Preparation Prior to Surgical Procedures

Although skin cannot be sterilized, applying an antiseptic solution minimizes the number of micro-organisms around the surgical wound that may contaminate and cause infection.

Instructions

Step 1: Trim the hair close to the skin surface with scissors immediately before surgery. Do not shave hair around the operative site as it increases the risk of infection 5–10 fold because the tiny nicks in the skin provide an ideal setting for micro-organisms to grow and multiply.

Step 2: Ask the client about allergic reactions (e.g., pyodine preparations) before selecting an antiseptic solution.

Step 3: If the skin or external genital area is visibly soiled, gently wash it with soap and clean water and dry the area before applying the antiseptic. Select the antiseptic solution from the following recommended products:
- Alcohol-based solutions (tinctures) of pyodine or chlorhexidine
- Alcohols (60–90 percent ethyl, isopropyl or methylated spirit)
- Chlorhexidine gluconate (2–4 percent) (e.g., Hibitane, Hibiscrub, Hibiclens®)
- Chlorhexidine gluconate and cetrimide, various concentrations at least 2
percent (e.g., Savlon)

- Iodine (3 percent); aqueous iodine iodophors (7.5–10 percent), various other concentrations (e.g., Betadine), Chloroxylenol (Para-chloro-metaxylenol or PCMX 0.5-3.75 percent), various other concentrations (e.g., Dettol)

**Step 4:** Using dry, high-level disinfected forceps and new cotton or gauze squares soaked in antiseptic, thoroughly cleanse the skin. Work from the operative site outward for several centimeters. (A circular motion from the center out helps to prevent contamination of the operative site with local skin bacteria.)

**Step 5:** Allow enough time for the antiseptic to be effective before beginning the procedure. For example, when an iodophor is used, allow 2 minutes or wait until the skin is visibly dry before proceeding, because the active agent is released slowly.

*Do not allow the antiseptic to pool underneath the client's body because it can irritate the skin.*

**Instructions for Cervical or Vaginal Preparation**

For cervical and vaginal antisepsis, prior to inserting a uterine elevator for minilaparotomy or IUCD, select an aqueous (water-based) antiseptic such as an iodophor (povidone-iodine) or 2–4 percent chlorhexidine gluconate (e.g., Hibiclens or Savlon if properly prepared). Do not use alcohol or alcohol-containing preparations, such as Dettol. Alcohols cause burn and they also dry and irritate mucous membranes, which in turn promote the growth of microorganisms. In addition, hexachlorophene (PhisoHex®) is neurotoxic and should not be used on mucous membranes, such as the vaginal mucosa, because it is readily absorbed.

**Skin Preparation for Injections**

According to WHO (World Health Organization) and its Safe Injection Global Network (SIGN), swabbing of clean skin with an antiseptic solution prior to giving an injection is unnecessary, because in controlled trials no infections were noted. In addition, a review of microbiologic studies did not suggest that wiping the skin with an antiseptic, before giving an intradermal, subcutaneous, or intramuscular injection, reduces the risk of infection.

If the injection site is visibly soiled, wash the site with soap and water and dry with a clean towel, and then give the injection.

**Safe Practices in Operating Rooms**

In the past decade, awareness of the risk of exposure to blood and body fluids containing HIV, HBV, and most recently HCV have created a new era in surgical infection prevention practices. Just as clients must be protected from wound contamination and infections, the health care providers must also be protected from intra-operative injuries and exposure to clients' blood and other body fluids.
Preventing infections following an operation is a complex process that begins in the operating room by preparing and maintaining a safe environment for performing the surgery. Surgical aseptic techniques are designed to create such an environment by controlling the four main sources of infectious organisms: the client, health care providers, equipment, and the operating room surroundings. Although the client is often the source of surgical infections, the other three sources are important and should not be overlooked.

Specific techniques required to establish and maintain surgical asepsis and make the surgical surroundings safer include the following:

- **Client considerations:** Skin cleaning pre-operatively, skin antisepsis, and wound covering.
- **Health care provider considerations:** Hand hygiene (handwashing and/or hand rub with waterless, alcohol-based antiseptic agents) or hand scrubbing; use and removal of gloves and gowns.
- **Equipment and room preparation considerations:** Traffic flow and activity patterns as well as housekeeping practices and decontamination, cleaning and either sterilization or high-level disinfection of instruments, gloves, and other items.
- **Surrounding considerations:** Maintaining an aseptic operating field and using safer operating practices and techniques.

### Instruments Causing Injuries

The vast majority of sharps injuries in hospitals occur in the operating room and most are due to scalpel and suture needles being most frequently used during operations. Many other items can also cause sharps injuries and glove tears resulting in exposure to blood. Some of the most important items that are used in an FP clinic and can cause injury are:

- Skin hooks and towel clips
- Sharp-pointed scissors and sharp-tipped mosquito forceps and dissecting forceps used in no-scalpel vasectomy (NSV)
- Sharp-toothed tenaculi
- Scalpel blades
  - Hypodermic needles
  - Suture needles
  - Laparoscopy and implant trocars

Almost all of these injuries can be easily avoided with no extra expenditure. For example:

- Use a small Mayo forceps (not fingers) when holding the scalpel blade, putting it on or taking it off, or loading the suture needle. (Alternatively, use disposable scalpels with a permanent blade that cannot be removed.)
- Always use tissue forceps, not fingers, to hold tissue when using a scalpel or suturing.
- Use a hands-free technique to pass or transfer sharps (scalpel, needles, and sharp-tipped scissors) by establishing a Safe or Neutral Zone in the operative field.
- Always remove sharps from the field immediately after use.
- Make sure that sharps containers are replaced when they are only three-quarters full and place containers as close to and convenient for the health care provider as possible.
A safer method of passing sharps (scalpels, suture needles, and sharp scissors) during surgery, called the hands-free technique, has recently been recommended. This technique for sharps is inexpensive, simple to use, and ensures that the surgeon, assistant, or scrub assistant never touches the same instrument at the same time.

Instruments passed with the hands-free technique (besides those listed above) include anything sharp enough to puncture a glove (e.g., trocars, sharp-tipped mosquito forceps, and loaded needle holders). Using the hands-free technique, the assistant places a sterile or high-level disinfected kidney tray/basin, or other suitable small container, on the operative field between the assistant and the surgeon. The container is designated as the Safe or Neutral Zone in which sharps are placed before and immediately after use.

Another way to do this is to have the assistant place the instrument in a container and pass it to the surgeon. The surgeon lifts the instrument out of the container, which is left on the operative site until the surgeon returns the instrument to it. The assistant then picks up the container and returns it to the Mayo stand.

### Table 3-2. Reducing the Risk of Exposure

<table>
<thead>
<tr>
<th>Function</th>
<th>Safer</th>
<th>Less Safe</th>
<th>Least Safe!</th>
</tr>
</thead>
<tbody>
<tr>
<td>Skin incision</td>
<td>cautery</td>
<td>disposable scalpel</td>
<td>scalpel with removable blade</td>
</tr>
<tr>
<td>Cutting</td>
<td>scissors, blunt tip or cautery probe</td>
<td>scissors, sharp tip</td>
<td>scalpel</td>
</tr>
<tr>
<td>Haemostasis</td>
<td>blunt suture needles, staples, or cautery</td>
<td>sharp suture needles</td>
<td>wire sutures</td>
</tr>
<tr>
<td>Sponging with gauze while using a scalpel</td>
<td>surgeon does sponging; assistant only retracts</td>
<td>assistant sponges only on request</td>
<td>assistant sponges spontaneously (no communication)</td>
</tr>
<tr>
<td>Retraction</td>
<td>blunt retractor</td>
<td>sharp retractor</td>
<td>fingers or hands</td>
</tr>
<tr>
<td>Sharps transfer</td>
<td>Neutral Zone</td>
<td>hand-to-hand (communication)</td>
<td>hand-to-hand (no communication)</td>
</tr>
<tr>
<td>Surgical gloves</td>
<td>double-gloving</td>
<td>single pair of gloves or double-gloving with reprocessed gloves</td>
<td>single pair of reprocessed gloves</td>
</tr>
<tr>
<td>Closing peritoneum (small, 2–3 cm incision)</td>
<td>do not close</td>
<td>purse-string closure using tissue forceps to grasp needle</td>
<td>purse-string closure using fingers to grasp needle</td>
</tr>
</tbody>
</table>
Safe Handling of Hypodermic Needles and Syringes

In the operating room, scalpels and suture needles are the leading source of penetrating injuries. Hypodermic (hollow-bore) needles cause the most injuries to health care providers at all levels. Consider:

- Surgeons and assistants are most often stuck by hypodermic needles during procedures.
- Cleaning staff are most often stuck by needles when washing soiled instruments.
- Housekeeping staff are most often stuck by needles when disposing of infectious waste material.

Safety tips for using hypodermic needles and syringes

- Use needle and syringe only once.
- Do not disassemble the needle and syringe after use.
- Do not recap, bend, or break needles prior to disposal.
- Decontaminate the needle and syringe prior to disposal.
- Dispose of the needle and syringe in a puncture-resistant container.

If the needle has to be recapped, use the one-handed recap method:

- First, place the needle cap on a firm, flat surface; then remove your hand.
- Next, with one hand holding the syringe, use the needle to "scoop" up the cap.
- With the cap now covering the needle tip, turn the syringe upright (vertical) so the needle and syringe are pointing towards the ceiling.
- Finally, using the forefinger and thumb of your other hand, grasp the cap just above its open end and push the cap firmly down onto the hub (the place where the needle joins the syringe under the cap).

Figure 3-1. One-Handed Recap Method
Sharps containers
Using sharps disposal containers helps prevent injuries from sharps. Sharps containers should be fitted with a cover, and should be puncture-proof, leak-proof, and tamper-proof (difficult to open or break). If plastic or metal containers are unavailable, use containers made of dense cardboard (cardboard safety boxes) that meet WHO specifications. If cardboard safety boxes are unavailable, easily available objects can substitute as sharps containers:
• Tin with a lid
• Thick plastic bottle
• Heavy plastic box
• Heavy cardboard box

Recommendations for safe use of sharps containers
• All sharps containers should be clearly marked “SHARPS” and have pictorial instructions for their use and disposal.
• Place sharps containers away from high-traffic areas and as close as possible to where the sharps will be used. Do not place containers near light switches, overhead fans, or thermostat controls where people might accidentally put one of their hands into them.
• Attach containers to walls or other surfaces if possible. Position the containers at a convenient height so staff can use and replace them easily.
• Never reuse or recycle sharps containers.
• Mark the containers clearly so that people will not unknowingly use them as garbage receptacles.
• Do not fill the safety box beyond three-quarters of its capacity.
• Avoid shaking a container to settle its contents to make room for more sharps.

Infection Prevention Techniques
Asepsis and aseptic techniques are general terms used to describe the combination of efforts made to prevent entry of micro-organisms into any area of the body where they are likely to cause infection. The goal of asepsis is to eliminate or reduce to a safe level the number of micro-organisms on both animate (living) surfaces such as skin and other body tissues, and inanimate objects (e.g., surgical instruments).

Antisepsis is the prevention of infection by killing or inhibiting the growth of micro-organisms on skin and other body tissues.

Instrument Processing
Steps for infection prevention techniques are necessary for all surgical procedures, including FP and maternal and child health care. The steps are:

1. Decontamination
Decontamination is the first step in handling large surfaces (e.g., examination or operating
tables), surgical instruments, and linen and gloves contaminated with blood or body fluids during or following surgical procedures. This step, taken before cleaning, makes the handling of these contaminated objects safer for the health care providers, especially cleaning personnel, and it reduces the risk of transmitting infections.

Chlorine solutions for decontamination and high-level disinfection: WHO recommends 0.5 percent chlorine solution for decontaminating surfaces and instruments before cleaning. The solution is fast-acting, very effective against hepatitis and HIV viruses, inexpensive, and readily available as common bleaching agents (sodium hypochlorite solutions). It is extremely useful for decontaminating large surfaces such as examination table. These surfaces should be wiped with 0.5 percent chlorine solution, and rinsed with water and dried to prevent corrosion.

To decontaminate examination/operating table tops, wipe the surface with 0.5 percent chlorine solution. For articles such as linen, gloves, and instruments, soak them in 0.5 percent chlorine solution for 10 minutes. This solution can be prepared from household liquid bleach or powder available in different concentrations.

Chlorine solution is also effective in high-level disinfection of instruments. A major disadvantage is corrosion of metals if instruments are left too long in the solution. Using a plastic container, however, you can safely soak stainless steel instruments in 0.1 percent chlorine solution for up to 20 minutes for high level disinfection. Afterwards, rinse them with boiled water and dry them promptly to prevent corrosion. The solution deteriorates rapidly; hence, use a fresh one daily and also whenever the solution becomes visibly cloudy.

**Preparation of Chlorine Solution**

**Precautions**
- Turn off the fan.
- Wear gloves, cap, mask, and eye glasses to avoid splashing in eyes and preventing irritating effects.
- Always use plastic containers and spoons.
- Make fresh solution, every day; discard the solution if it becomes cloudy.
- Do not expose the solution to direct sunlight.

**Method of Preparation**

Formula for preparing 0.5 percent chlorine solution:
- Bleaching powder
  Grams per litre = % of dilution required / % of concentration of powder x 1000
- Liquid bleach
  Parts of water = % of concentrate given on container (liquid bleach) / % of dilution required - 1

**Steps of preparation**
- Calculate the amount of water and bleach.
- Put the calculated parts of clean tap water in a plastic container.
• Add calculated parts of liquid bleach/powder (when preparing with powder, add small amount of water to make the paste and then add the rest of the water).
• Stir well.

2. Cleaning
Cleaning is the process that physically removes all visible blood, body fluids, or any other foreign material such as dust or soil from the inanimate objects. It improves the quality of subsequent high-level disinfection or sterilization.

To clean examination/operation table tops, linen, gloves, and storage containers, wash organic material that remains after decontamination with detergent and water. Then wipe the table top and rinse other items with clean water. For cleaning instruments, use a brush to remove all particles.

3. Sterilization
Sterilization is the process that eliminates all micro-organisms, including bacterial endospores, from inanimate objects. Some of the sterilization techniques are mentioned below:

A. Sterilization through Autoclaving
For this purpose, temperatures of 121°C and 15 pounds pressure (pounds per square inch) are required for 20 or 30 minutes (when unwrapped or wrapped respectively), depending upon the article to be sterilized. These temperatures are achieved by the use of an autoclave in which steam generated drives out the air, increases the pressure, and raises the temperature to the required level.

Remember to properly load the autoclave with appropriately wrapped and positioned instruments and other equipment; otherwise, sterilization will be inadequate. Also, insert a sterilization indicator tape to ensure that all objects are exposed to the hot steam.

Sterilization of many instruments, such as those with cutting edges and glass syringes, is better performed with dry heat. Temperatures of 170°C are required for 20 or 30 minutes (when unwrapped or wrapped respectively). To ensure even heating, an electric oven fitted with a fan is necessary.

B. Chemical Sterilization
Chemical sterilization achieves disinfection by using liquid chemicals and is recommended for equipment and items that cannot be autoclaved. Chemicals destroy or inhibit the growth of bacteria and other micro-organisms similar to heating, i.e., by protein coagulation or enzyme inhibition. The objects that are easiest to sterilize chemically are those with a smooth, flat, and firm surface such as a laparoscopic instrument.

Items are sterilized by soaking them in a particular chemical solution (such as the one containing glutaraldehyde), followed by rinsing them in sterile/boiled water.
Cidex, which contains glutaraldehyde, is a commonly available solution used for sterilization. Other products containing glutaraldehyde or other chemical sterilizers may be locally available, but make sure that the solution to be used is appropriate for sterilization.

Remember that:

- Glutaraldehyde is irritating to the skin, eyes, and respiratory tract. While using it, wear gloves, limit exposure time, and keep the area well ventilated.
- The length of time that glutaraldehyde solutions can be used varies, usually from 14–30 days. Always follow the manufacturer's instructions regarding proper storage temperatures and expiry date. Solutions should be replaced any time they become cloudy.

Formaldehyde is potentially cancer-causing and extremely irritating to the skin, eyes, nose, and respiratory tract. Therefore, routine use of formaldehyde for sterilizing instruments and other items is not recommended.

*Instruction for chemical sterilization:*

- Choose the appropriate disinfectant.
- Follow directions for proper dilution of the chemical.
- Soak items in the solution for the required period of time.
- Completely immerse clean items in disinfectant.
- Rinse items thoroughly with sterile or boiled water or sterilized normal saline.
- If needed, dry the items with a sterile towel, or let them air dry.
- Use the sterile items immediately, or store them in suitable, tightly closed sterile container for up to 1 week.

4. High-Level Disinfection

High-level disinfection (HLD), through boiling or the use of chemicals, eliminates all microorganisms, viruses, bacteria, parasites, and fungi, with the exception of some bacterial endospores such as tetanus and gangrene. HLD for instruments that perforate skin and mucous membranes is acceptable only when autoclaving is not possible and all earlier stages of processing are observed.

*High-Level Disinfection by Boiling*

- Use a container with a lid for boiling instruments.
- Make sure that the items being processed for HLD are completely immersed in water.
- Boil all instruments for 20 minutes, calculating the time after the boiling point is reached.
- Do not add to or remove anything from the pot/container after water begins to boil.
- Air dry before use or storage.

*High-Level Disinfection by Chemicals*

Where boiling is not possible, HLD can also be done by using chemicals like glutaraldehyde or 0.1 percent chlorine solution.

*When using a glutaraldehyde solution:*
• Prepare it according to the instructions.
• If possible, use an indicator strip each time to determine if the solution is still effective.
• After preparing the solution, put it in a clean container with a lid.
• Mark the container with the date the solution was prepared and the date it expires.

When using a chlorine solution:
• Prepare the 0.5 percent chlorine solution as described for decontamination using boiled water. Fresh solution should be made each day or more often if the solution becomes cloudy.
• Items must be completely immersed in solution. Open all hinged instruments and disassemble items with sliding or multiple parts.
• Soak for 10 minutes.
• Prepare 0.1 percent chlorine solution.
• Immerse the solutions for 20 minutes.
• Rinse items thoroughly with boiled water.
<table>
<thead>
<tr>
<th>Instruments/Equipment</th>
<th>Decontamination</th>
<th>Cleaning</th>
<th>High-Level Disinfection</th>
<th>Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Process</strong></td>
<td>It is the first step in handling dirty instruments; reduces risk of hepatitis B, C and HIV</td>
<td>It removes particulate matter and improves the quality of subsequent HLD disinfection or sterilization</td>
<td>It destroys all viruses, bacteria, parasites, fungi, and some endospores</td>
<td>It destroys all microorganisms, including endospores</td>
</tr>
<tr>
<td>Pelvic exam table top or other large surface area</td>
<td>Wipe off with 0.5% chlorine</td>
<td>Wash with detergent and water if organic material remains after decontamination procedure</td>
<td>Not necessary</td>
<td>Not necessary</td>
</tr>
</tbody>
</table>
| Linens (caps, gowns, masks, and surgical drapes) | • Soak in 0.5% chlorine solution for 10 minutes if contaminated with blood or body fluids prior to cleaning  
• Rinse and wash immediately² | • Wash with detergent and water, removing all particles  
• Rinse with clean water  
• Air dry | Not necessary for caps, gowns, and masks.  
For surgical drapes³:  
• Boil or chemically HLD  
• Air-dried surgical drapes should be ironed before use | Not necessary for caps, gowns, and masks.  
For surgical drapes:  
• Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in²) for 20 minutes  
• Do not use for 24–48 hours |
| Gloves (rubber or plastic) | • Soak in 0.5% chlorine solution for 10 minutes prior to cleaning  
• Rinse or wash immediately² | • Wash with detergent and water, removing all particles  
• Rinse with clean water and check for holes  
• Air dry | If touching only mucous membranes or broken skin (e.g., for pelvic exam or IUCD insertion):  
• Boil for 20 minutes in a container with a lid (start timing when water begins to boil)  
• Gloves must be immersed completely in water  
• Do not add anything to container after water begins to boil  
• Air dry before use or storage | If used for surgery:  
• Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in²) for 20 minutes |
<table>
<thead>
<tr>
<th>Instruments/Equipment</th>
<th>Decontamination</th>
<th>Cleaning</th>
<th>High-Level Disinfection</th>
<th>Sterilization</th>
</tr>
</thead>
<tbody>
<tr>
<td>Instruments for pelvic examination and IUCD insertion (e.g., specula, tenacula, forceps, and uterine sounds)</td>
<td>• Soak in 0.5% chlorine solution for 10 minutes</td>
<td>• Using a brush, wash with detergent and water, removing all particles</td>
<td>Boiling</td>
<td>• Dry heat for 1 hour after reaching 170°C (340°F) or Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in²) for 20 minutes (30 minutes if wrapped)</td>
</tr>
<tr>
<td></td>
<td>• Rinse or wash immediately&lt;sup&gt;2&lt;/sup&gt;</td>
<td>• Rinse with clean water</td>
<td>• Boil for 20 minutes in a container with a lid (start timing when water begins to boil)</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Air dry</td>
<td>• Instruments must be immersed completely in water during boiling</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Do not add anything to container after water begins to boil</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>• Air dry before use or storage</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Chemical:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>Soak for 20 minutes in:</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• A glutaraldehyde and rinse well in water that has been boiled for 20 minutes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instruments for voluntary sterilization and Norplant insertion</td>
<td>Soak in 0.5% chlorine solution for 10 minutes prior to cleaning (Rinse or wash immediately)&lt;sup&gt;2&lt;/sup&gt;</td>
<td>• Using a brush, wash with detergent and water removing all particles</td>
<td>Acceptable&lt;sup&gt;3&lt;/sup&gt;:</td>
<td>• Dry heat for 1 hour after 170°C (340°F)</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rinse with clean water</td>
<td>• Boil or do chemical HLD as above</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Air or towel dry</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Needles and syringes</td>
<td>• Fill assembled needle and syringe with 0.5% chlorine solution</td>
<td>• Disassemble, then wash with detergent and water, removing all particles</td>
<td>Acceptable&lt;sup&gt;3&lt;/sup&gt;:</td>
<td>• Dry heat for 1 hour after 170°C (340°F) or Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in²) for 20 minutes (30 minutes if wrapped)</td>
</tr>
<tr>
<td></td>
<td>• Soak for 10 minutes prior to cleaning</td>
<td>• Rinse with clean water</td>
<td>• Boil or do chemical HLD as above</td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Rinse by flushing three times with clean water</td>
<td>• Air dry</td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>Place items that float in a weighted, processed bag</td>
<td></td>
</tr>
<tr>
<td>Storage containers for instruments</td>
<td>• Soak in 0.5% chlorine solution</td>
<td>• Wash with detergent and</td>
<td>Boil container and lid as above; if container is too large, then:</td>
<td>• Dry heat for 1 hour after reaching 170°C (340°F) or Autoclave at 121°C (250°F) and 106 kPa (15 lbs/in²) for 20 minutes (30 minutes if wrapped)</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Instruments/Equipment</td>
<td>Decontamination</td>
<td>Cleaning</td>
<td>High-Level Disinfection</td>
<td>Sterilization</td>
</tr>
<tr>
<td>----------------------</td>
<td>----------------</td>
<td>---------</td>
<td>-------------------------</td>
<td>--------------</td>
</tr>
<tr>
<td>Endoscopes (laparoscopes)</td>
<td>• Rinse or wash immediately&lt;sup&gt;2&lt;/sup&gt;</td>
<td>• Rinse with clean water</td>
<td>• Rinse with water which has been boiled for 20 minutes and air dry before use</td>
<td>106 kPa (lbs/in&lt;sup&gt;2&lt;/sup&gt;) for 20 minutes (30 minutes if wrapped)</td>
</tr>
<tr>
<td></td>
<td>• Wipe exposed surfaces with gauze pad soaked with 60–90% alcohol</td>
<td>• Air dry</td>
<td></td>
<td>Disinfect weekly, and when empty or contaminated</td>
</tr>
<tr>
<td></td>
<td>• Rinse immediately</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>• Disassemble, then wash with detergent and water removing all particles</td>
<td>• Rinse with water which has been boiled for 20 minutes and air dry before use</td>
<td>Soak for 20 minutes in:</td>
<td>Sterilize daily if possible, using chemical sterilization. Soak in:</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Rinse with clean water</td>
<td>• Glutaraldehyde solution</td>
<td>• Glutaraldehyde for 10 hours</td>
</tr>
<tr>
<td></td>
<td></td>
<td>• Air dry</td>
<td>• Rinse in water that has been boiled for 20 minutes</td>
<td>• Rinse with sterilize water or water that has been boiled for 20 minutes</td>
</tr>
</tbody>
</table>

1 If unwrapped, use immediately; if wrapped, may be stored up to 1 week prior to use. I could not find the asterisk 1
2 Avoid prolonged exposure to chlorine solution to minimize corrosion of instruments and deterioration of rubber or cloth products.
3 If sterilization (dry heat or autoclave) not available, these items can be HLD either by boiling or soaking in chemical disinfectant.
4 Instruments with cutting edges or needles should not be sterilized at temperature above 160°C to avoid dulling.

Adapted from: Perkins 1983.
Waste Management

Wastes from hospitals and health care facilities may be contaminated (potentially infectious) or non-contaminated.

Contaminated wastes include blood, pus, urine, stool, and other body fluids, as well as items that come in contact with them, such as used dressings. Wastes from operating rooms (human tissue, blood or blood soaked sponges, gauze, or cotton) and laboratories (blood, faeces, sputum, urine specimens, and microbiological cultures) should be considered contaminated. Soiled medical devices or items that can inflict injury (e.g., used needles and scalpel blades) are capable of spreading blood-borne diseases such as hepatitis B, hepatitis C, and AIDS and are also considered contaminated waste.

The purpose of waste management is to:
- Protect people who handle waste items from accidental injury.
- Prevent the spread of infection to health care providers who handle the waste.
- Prevent the spread of infection to the local community.

Open piles of waste should be avoided because they:
- Are risks to those who scavenge and unknowingly reuse contaminated items.
- Allow persons to accidentally step on sharp items and injure themselves.
- Produce foul odours.
- Attract insects and animals.

Proper disposal of contaminated waste may include:
- Pouring liquids or wet waste directly into a safe sewerage system.
- Incinerating (burning) items to destroy the item as well as any micro-organisms. (This is the best method for disposal of contaminated waste. Burning also reduces the bulk volume of waste and ensures that the items are not scavenged and reused.)
- Burying all contaminated wastes to prevent further handling.

Handling of contaminated waste
It minimizes the spread of infection to health care personnel and to the local community. Whenever possible, contaminated waste should be collected and transported to disposal sites in leak-proof, covered waste containers.
- Use plastic or galvanized metal containers with tight-fitting covers for contaminated wastes. Many facilities now use colour-coded plastic bags to alert handlers to the contents and to keep the general (non-contaminated) waste separate from contaminated waste.
- Use puncture-resistant sharps containers for all disposable sharps (sharps that will not be reused).
- Place waste containers close to where the waste is generated and where convenient for users (carrying waste from place to place increases the risk of infection for handlers). This is
especially important for sharps, which carry the highest risk of injury for healthcare providers.

- Equipment that is used to hold and transport wastes must not be used for any other purpose in the clinic or hospital. (Contaminated waste containers should be marked.)
- Wash all waste containers with a disinfectant cleaning solution (0.5 percent chlorine solution plus soap) and rinse with water regularly.
- When possible, use separate containers for combustible and non-combustible wastes prior to disposal. This step prevents workers from having to handle and separate wastes by hand later.
- Use PPE when handling wastes (e.g., heavy-duty utility gloves and closed protective shoes).
- Wash hands or use a waterless, alcohol-based antiseptic hand rub after removing gloves when handling wastes.

### Disposal of sharps

Disposal of sharp items (hypodermic needles, suture needles, razors, and scalpel blades) require special handling because they are the items most likely to injure healthcare providers who handle them as well as people in the community if these items go to the municipal landfill.

**Encapsulation:** Encapsulation is recommended as the easiest way to safely dispose of sharps. Sharps are collected in puncture-resistant and leak-proof containers. When the container is three-quarters full, a material such as cement (mortar), plastic foam, or clay is poured into the container until it is completely filled. After the material has hardened, the container is sealed and may be land-filled, stored or buried. It is also possible to encapsulate chemical or pharmaceutical waste together with sharps (WHO 1999). This information is available at the website mentioned in the comment box. Click the topic waste disposal and is mentioned under encapsulation.

**Step 1:** Do not recap needle or disassemble needle and syringe.

**Step 2:** After use, hold the needle tip under the surface of a 0.5 percent chlorine solution, fill the syringe with solution, and push out (flush) three times.

**Step 3:** Place assembled needles and syringes to be disposed of in a puncture-resistant sharps container such as a heavy cardboard box, plastic bottle, or tin can with lid. The opening in the lid should be large enough so that items can be easily dropped through it, but small enough that nothing can be removed from inside. (Old intravenous fluid bottles may also be used, but they can break.)

**Step 4:** When the container is three-quarters full, it should be removed from the procedure area for disposal.

### Disposing of the sharps container

**Step 1:** Wear heavy-duty utility gloves.
Step 2: When the sharps container is three-quarters full it should be capped, plugged, or taped tightly closed. Be sure that no sharp items are sticking out of the container.

Step 3: Dispose of the sharps container by burning, encapsulating, or burying.

Step 4: Remove utility gloves (wash daily or when visibly soiled, and dry).

Step 5: Wash hands and dry them with a clean cloth or towel or air dry. (Alternatively, if hands are not visibly soiled, apply 5 ml, about 1 teaspoonful, of an antiseptic hand rub and rub the solution vigorously into hands until dry.)

How to Dispose Of solid contaminated waste
Solid contaminated waste (e.g., surgical specimens, used dressings, and other items contaminated with blood and organic materials) may carry micro-organisms.

Step 1: Wear heavy-duty or utility gloves when handling and transporting solid wastes.

Step 2: Dispose of solid wastes by placing them in a plastic or galvanized metal container with a tight-fitting cover.

Step 3: Collect the waste containers on a regular basis and transport the burnable ones to the incinerator or another area for burning.

Step 4: Remove utility gloves (wash daily or when visibly soiled and dry).

Step 5: Wash and dry hands or use an antiseptic hand rub as described above.

Incineration

Types of Incinerators
Incineration is a high-temperature process that reduces the volume and weight of waste. This process is usually selected to treat waste that cannot be recycled, reused, or disposed of in a sanitary landfill or dumpsite.

Incinerators can range from extremely sophisticated, high-temperature ones to very basic units that operate at much lower temperatures. All types of incinerators, if operated properly, eliminate micro-organisms from waste and reduce it to ashes.

Four basic types of incinerators are used for treating waste:
1. Double-chamber, high-temperature incinerators are designed to burn infectious waste.
2. Single-chamber, high-temperature incinerators are less expensive and are used when double-chamber incinerators are not affordable.
3. Rotary kilns operate at high temperatures and are used for destroying cytotoxic substances and heat-resistant chemicals.
4. Drum or brick (clay) incinerators operate at lower temperatures and are less effective, but can be made locally using readily available materials.
Open burning is not recommended because it is dangerous, unsightly, and the wind will scatter the waste.

For health care facilities with limited resources and where high-temperature incinerators are not affordable, waste may be incinerated in a drum incinerator. A drum incinerator is the simplest form of single-chamber incinerator. It can be made inexpensively and is better than open burning.

**How to Build and Use a Simple Drum Incinerator for Waste Disposal**

**Step 1:** Where possible, select a site downwind from the clinic.

**Step 2:** Build a simple incinerator using local materials (mud or stone) or a used oil drum (e.g., a 55-gallon drum). The size depends on the amount of daily waste collected.

**Step 3:** Make sure the incinerator has:
- Sufficient air inlets underneath for good combustion.
- Loosely placed fire bars to allow for expansion.
- An adequate opening for adding fresh refuse and removing ashes.
- A long enough chimney to allow for a good draft and evacuation of smoke.

**Step 4:** Place the drum on hardened earth or a concrete base.

**Step 5:** Burn all combustible waste, such as paper and cardboard, as well as used dressings and other contaminated wastes. If the waste or refuse is wet, add kerosene so that a hot fire burns all of the waste. Ash from incinerated material can be treated as non-contaminated waste.

**Figure 3-2. Design for a Simple Oil Drum Incinerator**

**How to Make and Use a Small Burial Site for Waste Disposal**

**Step 1:** Find an appropriate location.

**Step 2:** Dig a pit 1 metre (3 feet) square and 2 metres (6 feet) deep. The bottom of the pit should be 2 metres (6 feet) above the water table.
Step 3: Dispose of the contaminated waste in the pit and cover the waste with 10–15 em (4–6 inches) of dirt each day. The final layer of dirt should be 50–60 em (20–24 inches) and compacted to prevent odours and attraction of insects, and to keep animals from digging up the buried waste. Depending on the volume of waste, the capacity of the pit should last for 30 to 60 days.
MEDICAL ELIGIBILITY CRITERIA

Introduction

Over the past 30 years, there have been significant advances in the development of new contraceptive technologies, including transitions from high-dose to low-dose combined oral contraceptives and from inert to copper- and levonorgestrel-releasing IUCDs.

In addition, combined injectable contraceptives, a combined hormonal patch and ring, progestin-only injectables and implants have been introduced.

However, current policies and health care practices in some countries are based on scientific studies of contraceptive products that are no longer in wide use, on long-standing theoretical concerns that have never been substantiated, or on the personal preference or bias of service providers. These outdated policies or practices often result in limitations to both the quality of, and the access to, family planning (FP) services for clients.

This chapter is intended to update the medical eligibility criteria (MEC) used in the provision of fertility awareness methods, lactational amenorrhoea methods, barrier method, all hormonal methods, IUCDs, male and female sterilization, and emergency contraception.

Barriers to Contraceptive Use

In recent years, attention has been focused on minimizing administrative barriers to FP, that is, unnecessary rules and regulations that burden clients and narrow their contraceptive choices. One type of administrative barrier, so-called medical barriers, has a medical rationale even though it is scientifically unjustified. These barriers include:

- Outdated contraindications that remain part of a programme's official guidelines or providers' informal screening routine, for example, refusing to supply oral contraceptives to women with varicose veins or tuberculosis.
- Eligibility requirements that needlessly limit the use of certain methods based on a woman's age, parity, or lack of spousal consent.
- Demands for additional procedures that may benefit women's overall health but are unnecessary for safe and effective contraceptive use, for example, requiring women to undergo a pelvic examination before receiving oral contraceptives.
- Creating hurdles for women by making extra visits mandatory.
- Requiring certain provider qualifications to deliver a method, for example, restricting IUCD insertions to physicians when nurses can be trained to perform the task.

---

• Provider biases for or against specific methods.
• Regulatory mechanisms that prevent certain contraceptive methods from being approved or that hinder their advertising.

Global investigations into medical barriers in the early 1990s found that there was a lack of consensus on medical eligibility requirements as well as delays in acting on new research findings. As a result, practices varied widely among individual providers. To help overcome these problems and eliminate medical barriers, international experts have codified medical eligibility requirements for contraception. In addition, they have developed checklists to rule out pregnancy among FP clients. Some critics worry, however, that the drive to eliminate medical barriers is decreasing the quality of care by removing safeguards to contraceptive use and by eliminating procedures with broad health benefits, such as pelvic exams. Even with changes in official guidelines, unnecessary medical barriers have persisted in many countries because they are rooted in providers’ personal beliefs and cultural values.³

What are unjustified medical barriers?
• Practices derived (at least partly) from a medical rationale.
• Non-evidence–based barriers that result in denial of contraception.
• Eligibility restrictions, based on providers’ limitations/personal biases.

Examples of Unjustified Medical Barriers
• Unnecessary barriers to initiation: menstruation
• Other client eligibility criteria: age, parity, marital status
• Inappropriate follow-up schedule: IUCD follow-up every 6 months
• Rest periods required: every 2–3 years for pills
• Unnecessary procedures required: pelvic exam, pregnancy test
• Provider bias: DMPA better for thin women

Addressing Medical Barriers: World Health Organization Medical Eligibility Criteria

What are the Medical Eligibility Criteria?
• Recommendations on the specific conditions (medical and non-medical) to safely use contraceptive methods for:
  – Initiation; and
  – Continuation.
• These recommendations are based on evidence that depends on:
  – Direct studies on users with and without the conditions;
  – Theoretical considerations; and
  – Expert opinions.

Identification of conditions

- Conditions represent either:
  - An individual's characteristics (e.g., age, parity, etc.);
  - Known pre-existing medical conditions (e.g., hypertension, etc.); and
  - Use of medications (e.g., rifampicin).

Table 4-4 on the following pages summarizes the World Health Organization (WHO) Medical Eligibility Criteria for starting contraceptive methods.

### Table 4-1. World Health Organization Categories for Temporary Methods

<table>
<thead>
<tr>
<th>WHO Category</th>
<th>Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Can use the method. No restriction on use. All trained services providers can give.</td>
</tr>
<tr>
<td>2</td>
<td>Can use the method. Advantages generally outweigh theoretical or proven risks. Category 2 conditions could be considered in choosing a method. If the client chooses the method, more than usual follow-up may be needed.</td>
</tr>
<tr>
<td>3</td>
<td>Use of method not usually recommended unless other more appropriate methods are not available or not acceptable. Should only use the method if according to clinical judgement the risk of pregnancy is greater than the use of contraceptive. Method of choice, for which careful follow-up will be needed.</td>
</tr>
<tr>
<td>4</td>
<td>Should not use the method. Condition represents an unacceptable health risk if the method is used.</td>
</tr>
</tbody>
</table>

#### Simplified 2-category system

In case of limited clinical judgement, the WHO four-category classification system can be simplified into a two-category system as shown in this table:

### Table 4-2. Simplified Medical Eligibility Criteria Classification Categories

<table>
<thead>
<tr>
<th>Category</th>
<th>With Clinical Judgement</th>
<th>With Limited Clinical Judgement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td>Use method in any circumstances</td>
<td>YES (Use Method)</td>
</tr>
<tr>
<td>2</td>
<td>Generally use method</td>
<td></td>
</tr>
</tbody>
</table>

---

<table>
<thead>
<tr>
<th></th>
<th>Use of method not usually recommended unless other more appropriate methods are not available or not acceptable</th>
<th>NO (Do not Use Method)</th>
</tr>
</thead>
<tbody>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td>Method not to be used</td>
<td></td>
</tr>
</tbody>
</table>

NOTE: In the table that follows, category 3 and 4 conditions are shaded to indicate the method should not be provided where clinical judgement is limited.
Table 4-3. World Health Organization Categories for Female Sterilization and Vasectomy\(^5\)

<table>
<thead>
<tr>
<th>Category</th>
<th>Rationale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Accept (A)</td>
<td>No medical reason prevents performing the procedure in a routine setting.</td>
</tr>
<tr>
<td>Caution (C)</td>
<td>The procedure can be performed in a routine setting but with extra</td>
</tr>
<tr>
<td></td>
<td>preparation and precautions.</td>
</tr>
<tr>
<td>Delay (D)</td>
<td>Delay the procedure. Condition must be treated and resolved before the</td>
</tr>
<tr>
<td></td>
<td>procedure can be performed. Provide temporary methods.</td>
</tr>
<tr>
<td>Special (S)</td>
<td>Refer client to a centre where an experienced surgeon and staff can</td>
</tr>
<tr>
<td></td>
<td>perform the procedure. Setting should be equipped for general anaesthesia</td>
</tr>
<tr>
<td></td>
<td>and other medical support. Provide temporary methods.</td>
</tr>
</tbody>
</table>

*NOTE: In the table that follows, “Delay” and “Special” conditions are shaded.*

Table 4-4. Medical Eligibility Criteria for Contraceptive Use\(^6\)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined Oral Contraceptives</th>
<th>Monthly Injectables</th>
<th>Combined Patch and Combined Vaginal Ring</th>
<th>Progestin-Only Pills</th>
<th>Progestin-Only Injectables</th>
<th>Implants</th>
<th>Emergency Contraceptive Pills*</th>
<th>Copper-Bearing Intrauterine Device</th>
<th>Levonorgestrel Intrauterine Device</th>
<th>Female Sterilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Pregnant</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
<td>NA</td>
</tr>
<tr>
<td>Age</td>
<td>Menarche to &lt; 40 years</td>
<td>Menarche to &lt; 18 years</td>
<td>Menarche to &lt; 20 years</td>
<td>Young Age</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>C</td>
</tr>
<tr>
<td></td>
<td>= 40 years</td>
<td>18 to 45 years</td>
<td>= 20 years</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td></td>
<td>&gt; 45</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>-</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

---


<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined Oral Contraceptives</th>
<th>Monthly Injectables</th>
<th>Combined Patch and Combined Vaginal Ring</th>
<th>Progestin-Only Pills</th>
<th>Progestin-Only Injectables</th>
<th>Implants</th>
<th>Emergency Contraceptive Pills*</th>
<th>Copper-Bearing Intrauterine Device</th>
<th>Levonorgestrel Intrauterine Device</th>
<th>Female Sterilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Smoking</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Age &lt; 35 years</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Age = 35 years</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>= 15 cigarettes/day</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Obesity</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>C</td>
</tr>
<tr>
<td>Blood pressure measurement</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
<td>NA*</td>
</tr>
</tbody>
</table>

* In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, it may be made accessible to breastfeeding women immediately postpartum.

Postpartum IUCD use: For breastfeeding women and women not breastfeeding, IUCD insertion at <48 hours is category 2 for copper-bearing IUCD and category 3 for the levonorgestrel IUCD. For both IUCD types, insertion from 48 hours to <4 weeks is category 3; =4 weeks, category 1; and puerperal sepsis, category 4.

* For additional conditions relating to emergency contraceptive pills and female sterilization, see page 65. Please add the page number of the National Standards where the chapter on EC starts.
### CARDIOVASCULAR DISEASE

**Multiple risk factors for arterial cardiovascular disease (older age, smoking, diabetes, and hypertension)**

| 3/4 | 3/4 | 3/4 | 2 | 3 | 2 | - | 1 | 2 | S |

**Hypertension**

| History of hypertension, where blood pressure CANNOT be evaluated (including hypertension in pregnancy) | 3 | 3 | 3 | 2 | 2 | 2 | - | 1 | 2 | NA |
| Adequately controlled hypertension, where blood pressure CAN be evaluated | 3 | 3 | 3 | 1 | 2 | 1 | - | 1 | 1 | C |

**Elevated blood pressure (properly measured)**

- **Systolic 140–159 or Diastolic 90–99**
  - 3 | 3 | 3 | 1 | 2 | 1 | - | 1 | 1 | C |
- **Systolic = 160 or Diastolic = 100**
  - 4 | 4 | 4 | 2 | 3 | 2 | - | 1 | 2 | S |

(Continued)

- In settings where pregnancy morbidity and mortality risks are high and this method is one of few widely available contraceptives, women should not be denied access simply because their blood pressure cannot be measured.
- When multiple major risk factors exist, any of which alone would substantially increase the risk of cardiovascular disease, use of the method may increase her risk to an unacceptable level. However, a simple addition of categories for multiple risk factors is not intended. For example, a combination of factors assigned a category 2 may not necessarily warrant a higher category.
- Assuming no other risk factors for cardiovascular disease exist. A single reading of blood pressure is not sufficient to classify a woman as hypertensive.
- Elevated blood pressure should be controlled before the procedure and monitored during the procedure.
- This condition may make pregnancy an unacceptable health risk. Women should be advised that because of relatively higher pregnancy rates, as commonly used, spermicides, withdrawal, fertility awareness methods, cervical caps, diaphragms, or female or male condoms may not be the most appropriate choice.

<table>
<thead>
<tr>
<th>Use the method.</th>
<th>Do not use the method.</th>
<th>Initiation of the method.</th>
<th>Continuation of the method.</th>
<th>Condition not listed; does not affect eligibility for method.</th>
<th>NA = Not applicable</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>CONDITION</strong></td>
<td>Combined Oral Contraceptives</td>
<td>Monthly Injectables</td>
<td>Combined Patch and Combined Vaginal Ring</td>
<td>Progestin-Only Pills</td>
<td>Progestin-Only Injectables</td>
</tr>
<tr>
<td>Vascular disease</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>History of high blood pressure during pregnancy (where current blood pressure is measurable and</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
</tr>
</tbody>
</table>
### Deep venous thrombosis (DVT)/Pulmonary embolism (PE)

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>4</th>
<th>4</th>
<th>2</th>
<th>2</th>
<th>2</th>
<th>*</th>
<th>1</th>
<th>2</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>History of DVT/PE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current DVT/PE</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>*</td>
<td>1</td>
<td>3</td>
<td>D</td>
</tr>
<tr>
<td>Family history of DVT/PE (first-degree relatives)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>*</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
</tbody>
</table>

### Major surgery

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>4</th>
<th>4</th>
<th>2</th>
<th>2</th>
<th>2</th>
<th>-</th>
<th>1</th>
<th>2</th>
<th>D</th>
</tr>
</thead>
<tbody>
<tr>
<td>With prolonged immobilization</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without prolonged immobilization</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>Minor surgery without prolonged immobilization</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
</tbody>
</table>

### Known thrombogenic mutations (e.g., Factor V Leiden, Prothrombin mutation; Protein S, Protein C, and Antithrombin deficiencies)^9

<table>
<thead>
<tr>
<th></th>
<th>4</th>
<th>4</th>
<th>4</th>
<th>2</th>
<th>2</th>
<th>2</th>
<th>*</th>
<th>1</th>
<th>2</th>
<th>A</th>
</tr>
</thead>
</table>

### Superficial venous thrombosis

<table>
<thead>
<tr>
<th></th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>1</th>
<th>-</th>
<th>1</th>
<th>1</th>
<th>A</th>
</tr>
</thead>
<tbody>
<tr>
<td>Varicose veins</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Superficial thrombophlebitis</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
</tbody>
</table>

### Ischemic heart disease^9

<table>
<thead>
<tr>
<th></th>
<th>I</th>
<th>C</th>
<th>I</th>
<th>C</th>
<th>I</th>
<th>C</th>
</tr>
</thead>
<tbody>
<tr>
<td>Current History of</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
<tr>
<td>Stroke (history of cerebrovascular accident)^9</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>3</td>
</tr>
</tbody>
</table>

### Known hyperlipidemias

|                        | 2/3 | 2/3 | 2/3 | 2 | 2 | 2 | - | 1 | 2 | A |

---

^2 Access according to the type and severity of hyperlipidemia and the presence of other cardiovascular risk factors.
<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined Oral Contraceptives</th>
<th>Monthly Injectables</th>
<th>Combined Patch and Combined Vaginal Ring</th>
<th>Progestin-Only Pills</th>
<th>Progestin-Only Injectables</th>
<th>Implants</th>
<th>Emergency Contraceptive Pills</th>
<th>Copper-Bearing Intrauterine Device</th>
<th>Levonorgestrel Intrauterine Device</th>
<th>Female Sterilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Valvular heart disease</td>
<td>Use the method.</td>
<td>Do not use the method.</td>
<td>Initiation of the method.</td>
<td>Continuation of the method.</td>
<td>Condition not listed; does not affect eligibility for method.</td>
<td>NA = Not applicable</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncomplicated</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>C</td>
</tr>
<tr>
<td>Complicated (pulmonary hypertension, atrial fibrillation, history of sub-acute bacterial endocarditis)*</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>S*</td>
</tr>
<tr>
<td>NEUROLOGICAL CONDITIONS</td>
<td>Headaches</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-migrainous (mild or severe)</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Migraine</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without aura</td>
<td>1</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>C</td>
</tr>
<tr>
<td>Age &lt; 35</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>Age = 35</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>3</td>
<td>4</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
</tr>
<tr>
<td>With aura, at any age</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>2</td>
<td>3</td>
<td>2</td>
<td>3</td>
</tr>
<tr>
<td>Epilepsy</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>-</td>
<td>1</td>
</tr>
<tr>
<td>DEPRESSIVE DISORDERS</td>
<td>Depressive disorders</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>1*</td>
<td>-</td>
<td>1</td>
<td>1*</td>
</tr>
<tr>
<td>REPRODUCTIVE TRACT INFECTIONS AND DISORDERS</td>
<td>Vaginal bleeding patterns</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Irregular pattern without heavy bleeding</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Heavy or prolonged bleeding (including regular and irregular patterns)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Unexplained vaginal bleeding (suspicous for serious condition) before evaluation</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>I</td>
<td>C</td>
<td>I</td>
</tr>
<tr>
<td>Endometriosis</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>S</td>
</tr>
<tr>
<td>Benign ovarian tumours (including cysts)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>Severe dysmenorrhoea</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>2</td>
<td>1</td>
<td>A</td>
</tr>
<tr>
<td>Trophoblast disease</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
| Benign | 1 | 1 | 1 | 1 | 1 | 1 | - | 3 | 3 | A | (Continued)
Prophylactic antibiotics are advised before providing the method.

Category is for women without any other risk factors for stroke.

If taking anticonvulsants, refer to section on drug interactions.

Certain medications may interact with the method, making it less effective.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined Oral Contraceptives</th>
<th>Monthly Injectables</th>
<th>Combined Patch and Combined Vaginal Ring</th>
<th>Progestin-Only Pills</th>
<th>Progestin-Only Injectables</th>
<th>Implants</th>
<th>Emergency Contraceptive Pills*</th>
<th>Copper-Bearing Intrauterine Device</th>
<th>Levonorgestrel Intrauterine Device</th>
<th>Female Sterilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Malignant</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>4</td>
<td>4</td>
<td>D</td>
<td></td>
</tr>
<tr>
<td>Cervical ectropion</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Cervical intraepithelial neoplasia (CIN)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>A</td>
</tr>
<tr>
<td>Cervical cancer (awaiting treatment)</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>C, I, I, D</td>
<td></td>
</tr>
<tr>
<td>Breast disease</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td>1</td>
<td>2</td>
<td>A</td>
</tr>
<tr>
<td>Undiagnosed mass</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Benign breast disease</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Family history of cancer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>A</td>
<td></td>
</tr>
<tr>
<td>Breast cancer</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td>1</td>
<td>4</td>
<td>C</td>
</tr>
<tr>
<td>Past, no evidence of disease for at least 5 years</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>-</td>
<td>1</td>
<td>3</td>
<td>A</td>
</tr>
<tr>
<td>Endometrial cancer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>I</td>
<td>C</td>
<td>I, D</td>
</tr>
<tr>
<td>Ovarian cancer</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>3</td>
<td>2</td>
<td>3</td>
<td>2, D</td>
</tr>
<tr>
<td>Uterine fibroids</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Without distortion of the uterine cavity</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>1</td>
<td>1</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>With distortion of the uterine cavity</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
<td>4</td>
<td>4</td>
<td>C</td>
<td></td>
</tr>
<tr>
<td>Anatomical abnormalities</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Distorted uterine cavity</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>4</td>
<td>4</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Other abnormalities not distorting the uterine cavity or interfering with IUCD insertion (including cervical stenosis or lacerations)</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>-</td>
<td>2</td>
<td>2</td>
<td>-</td>
<td></td>
</tr>
<tr>
<td>Pelvic inflammatory disease (PID)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Past PID (assuming no current</td>
<td>I</td>
<td>C</td>
<td>I</td>
<td>I</td>
<td>-</td>
<td>-</td>
<td></td>
<td></td>
<td>C</td>
<td></td>
</tr>
</tbody>
</table>
### Risk Factors of Sexually Transmitted Infections (STIs)

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Without subsequent pregnancy</th>
<th>Current PID</th>
<th>Sexually transmitted infections (STIs)</th>
<th>HIV/AIDS</th>
<th>Other Infections</th>
<th>Endocrine Conditions</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1 1 1 1 1 1 1 1 1 1</td>
<td>2 2 2 2 2</td>
<td>I C I C</td>
<td>I C I C</td>
<td>I C</td>
<td>I C I C</td>
</tr>
<tr>
<td>Without subsequent pregnancy</td>
<td></td>
<td></td>
<td>Current PID</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Current PID</td>
<td>1 1 1 1 1 1 1 1 1 1</td>
<td>4 2 4 2 2</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sexually transmitted infections (STIs)</td>
<td></td>
<td></td>
<td>Current purulent cervicitis, chlamydia,</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>or gonorrhoea</td>
<td>1 1 1 1 1 1 1 2/3 2 3 2</td>
<td>D</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other STIs (excluding HIV and hepatitis)</td>
<td>1 1 1 1 1 1 2 2 2 2 2 2</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Vaginitis (including trichomonas vaginalis and bacterial vaginosis)</td>
<td>1 1 1 1 1 1 2 2 2 2 2 2</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Increased risk of STIs</td>
<td>1 1 1 1 1 1 2/3 2 2 2 2 2</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV/AIDS</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>High risk of HIV</td>
<td>1 1 1 1 1 1 2 2 2 2 2</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>HIV-infected</td>
<td>1 1 1 1 1 1 2 2 2 2 2 2</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>AIDS</td>
<td>1 1 1 1 1 1 3 2 3 2 3</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>On antiretroviral therapy</td>
<td>2 2 2 2 2 2 2 2 2 2 2 2</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Schistosomiasis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Uncomplicated</td>
<td>1 1 1 1 1 1 1 1 1 1 A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Fibrosis of liver (if severe, see cirrhosis, next page)</td>
<td>1 1 1 1 1 1 1 1 1 1 2</td>
<td>C</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Tuberculosis</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Non-pelvic</td>
<td>1 1 1 1 1 1 1 1 1 1 1 A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Known pelvic</td>
<td>1 1 1 1 1 1 2 2 2 2 3 3 S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malaria</td>
<td>1 1 1 1 1 1 1 1 1 1 1 A</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diabetes</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>History of gestational diabetes</td>
<td>1 1 1 1 1 1 2 2 2 2 2 2 2</td>
<td>A</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

(Continued)
Treat PID using appropriate antibiotics. There is usually no need to remove the IUCD if the client wishes to continue use.

The condition is category 3 if a woman has a very high individual likelihood of exposure to gonorrhoea or chlamydia.

Presence of an AIDS-related illness may require a delay in the procedure.

AIDS is category 2 for insertion for those clinically well on antiretroviral therapy; otherwise, category 3 for insertion.

If blood glucose is not well controlled, referral to a higher-level facility is recommended.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined Oral Contraceptives</th>
<th>Monthly Injectables</th>
<th>Combined Patch and Combined Vaginal Ring</th>
<th>Progestin-Only Pills</th>
<th>Progestin-Only Injectables</th>
<th>Implants</th>
<th>Emergency Contraceptive Pills*</th>
<th>Copper-Bearing Intrauterine Device</th>
<th>Levonorgestrel Intrauterine Device</th>
<th>Female Sterilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-vascular diabetes</td>
<td>Non-insulin-dependent</td>
<td>2 2 2 2 2 2 2 -</td>
<td>1 2</td>
<td>C&quot;&quot;&quot;&lt;sup&gt;D&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Insulin-dependent&lt;sup&gt;9&lt;/sup&gt;</td>
<td>2 2 2 2 2 2 2 -</td>
<td>1 2</td>
<td>C&quot;&quot;&quot;&lt;sup&gt;D&lt;/sup&gt;</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>With kidney, eye, or nerve damage&lt;sup&gt;9&lt;/sup&gt;</td>
<td>3/4&quot; 3/4&quot; 3/4&quot; 2 3 2 -</td>
<td>1 2</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td></td>
<td>Other vascular disease or diabetes of &gt;20 years’ duration&lt;sup&gt;9&lt;/sup&gt;</td>
<td>3/4&quot; 3/4&quot; 3/4&quot; 2 3 2 -</td>
<td>1 2</td>
<td>S</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**Thyroid disorders**

| Simple goitre | 1 1 1 1 1 1 - | 1 1 A |
| Hyperthyroid | 1 1 1 1 1 1 - | 1 1 S |
| Hypothyroid | 1 1 1 1 1 1 - | 1 1 C |

**GASTROINTESTINAL CONDITIONS**

**Gall bladder disease**

| Symptomatic | Treated by cholecystectomy | 2 2 2 2 2 2 - | 1 2 A |
| | Medically treated | 3 2 3 2 2 2 - | 1 2 A |
| | Current | 3 2 3 2 2 2 - | 1 2 D |
| Asymptomatic | 2 2 2 2 2 2 - | 1 2 A |

**History of cholestasis**

| Pregnancy-related | 2 2 2 1 1 1 - | 1 1 A |
| Past combined oral contraceptives-related | 3 2 3 2 2 2 - | 1 2 A |

**Viral hepatitis**

| Active | 4 3/4"<sup>x</sup> 4" 3 3 3 2 1 3 | D |
| Carrier | 1 1 1 1 1 1 - | 1 1 A |

**Cirrhosis**

| Mild (compensated) | 3 2 3 2 2 2 - | 1 2 C" |
Severe (decompensated)\(^4\) 4 3 4 3 3 3 - 1 3 S

\(^1\) Assess according to severity of condition.
\(^2\) In women with symptomatic viral hepatitis, withhold this method until liver function returns to normal or 3 months after she becomes asymptomatic, whichever is earlier.
\(^3\) Liver function should be evaluated.

<table>
<thead>
<tr>
<th>CONDITION</th>
<th>Combined Oral Contraceptives</th>
<th>Monthly Injectables</th>
<th>Combined Patch and Vaginal Ring</th>
<th>Progestin-Only Pills</th>
<th>Progestin-Only Injectables</th>
<th>Implants</th>
<th>Emergency Contraceptive Pills*</th>
<th>Copper-Bearing Intrauterine Device</th>
<th>Levonorgestrel Intrauterine Device</th>
<th>Female Sterilization*</th>
</tr>
</thead>
<tbody>
<tr>
<td>Liver tumours</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Benign (adenoma)</td>
<td>4 3 4 3 3 3 - 1 3 C(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Malignant (hepatoma)(^6)</td>
<td>4 3/4 4 3 3 3 - 1 3 C(^1)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Thalassemia</td>
<td>1 1 1 1 1 1 - 2 1 C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Sickle cell disease(^9)</td>
<td>2 2 2 1 1 1 - 2 1 C</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Iron-deficiency anaemia</td>
<td>1 1 1 1 1 1 - 2 1 D/C(^10)</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**DRUG INTERACTIONS**

**Drugs that affect liver enzymes**

| Rifampicin | 3\(^4\) 2 3\(^3\) 3\(^3\) 2 3\(^3\) - 1 1 - |
| Certain anticonvulsants (phenytoin, carbamazepine barbiturates, primidone, topiramate, oxcarbazepine) | 3\(^4\) 2 3\(^3\) 3\(^3\) 2 3\(^3\) - 1 1 - |
| Antibiotics (excluding rifampicin) | | |
| Griseofulvin | 2 1 2 2 1 2 - 1 1 - |
| Other antibiotics | 1 1 1 1 1 1 - 1 1 - |

\(^*\) For haemoglobin < 7 g/dl, delay. For haemoglobin = 7 to < 10 g/dl, caution.

**Additional conditions relating to emergency contraceptive pills**

Category 1: Repeated use; rape.
Category 2: History of severe cardiovascular complications (ischemic heart disease, cerebrovascular attack, or other thromboembolic conditions).

**Additional conditions relating to female sterilization**

**Caution:** Diaphragmatic hernia; kidney disease; severe nutritional deficiencies; previous abdominal or pelvic surgery; concurrent with elective surgery.

**Delay:** Abdominal skin infection; acute respiratory disease (bronchitis, pneumonia); systemic infection or gastroenteritis; emergency surgery (without previous counselling); surgery for an infectious condition; certain postpartum conditions (7 to 41 days after childbirth); severe pre-
eclampsia/eclampsia; prolonged rupture of membranes (24 hours or more); fever during or immediately after delivery; sepsis after delivery; severe haemorrhage; severe trauma to the genital tract; cervical or vaginal tear (at time of delivery); certain postabortion conditions (sepsis, fever, or severe haemorrhage; severe trauma to the genital tract; cervical or vaginal tear at time of abortion; acute haematometra); sub-acute bacterial endocarditis; unmanaged atrial fibrillation.

Special arrangements: Coagulation disorders; chronic asthma, bronchitis, emphysema, or lung infection; fixed uterus due to previous surgery or infection; abdominal wall or umbilical hernia; postpartum uterine rupture or perforation; postabortion uterine perforation.

Conditions relating to vasectomy
No special considerations: High risk of HIV, HIV-infected, sickle cell disease.
Caution: Young age; depressive disorders; diabetes; previous scrotal injury; hydrocele; cryptorchidism (may require referral).

Delay: Active STIs (excluding HIV and hepatitis); scrotal skin infection; balanitis; epididymitis or orchitis; systemic infection or gastroenteritis; filariasis; elephantiasis; intrascrotal mass.

Special arrangements: AIDS (AIDS-related illness may require delay); coagulation disorders; inguinal hernia.

Conditions relating to male and female condoms, spermicides, diaphragms, cervical caps, and the lactational amenorrhoea method
All other conditions listed on the previous pages that do not appear here are a category 1 or NA for male and female condoms, spermicides, diaphragms, and cervical caps and not listed in the Medical Eligibility Criteria for the lactational amenorrhoea method.

Table 4.5. Eligibility Criteria for Use of Barrier Methods, Spermicide and the Lactational Amenorrhoea Method

<table>
<thead>
<tr>
<th>Condition</th>
<th>Male and Female Condoms</th>
<th>Spermicides</th>
<th>Diaphragms</th>
<th>Cervical Caps</th>
<th>Lactational Amenorrhoea Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>REPRODUCTIVE HISTORY</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Parity</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Nulliparous (has not given birth)</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>1</td>
<td>-</td>
</tr>
<tr>
<td>Parous (has given birth)</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
<tr>
<td>&lt; 6 weeks postpartum</td>
<td>1</td>
<td>1</td>
<td>NA</td>
<td>NA</td>
<td>-</td>
</tr>
<tr>
<td>CARDIOVASCULAR DISEASE</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Complicated valvular heart disease</td>
<td>1</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>-</td>
</tr>
</tbody>
</table>

(pulmonary hypertension, risk of atrial fibrillation, history of subacute bacterial endocarditis)³

REPRODUCTIVE TRACT INFECTIONS AND DISORDERS

<table>
<thead>
<tr>
<th>Condition</th>
<th>Symptoms-Based Methods</th>
<th>Calendar-Based Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cervical intraepithelial neoplasia</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Cervical cancer</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>Anatomical abnormalities</td>
<td>1</td>
<td>NA³</td>
</tr>
<tr>
<td>HIV/AIDS⁴</td>
<td>High risk of HIV</td>
<td>1</td>
</tr>
<tr>
<td>HIV-infected</td>
<td>1</td>
<td>4</td>
</tr>
<tr>
<td>AIDS</td>
<td>1</td>
<td>2</td>
</tr>
<tr>
<td>OTHERS</td>
<td>History of toxic shock syndrome</td>
<td>1</td>
</tr>
<tr>
<td>Urinary tract infection</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Allergy to latex⁵</td>
<td>3</td>
<td>1</td>
</tr>
</tbody>
</table>

**Additional conditions relating to lactational amenorrhoea method**

**Medication used during breastfeeding:** To protect infant health, breastfeeding is not recommended for women using such drugs as anti-metabolites, bromocriptine, certain anticoagulants, corticosteroids (high doses), cyclosporine, ergotamine, lithium, mood-altering drugs, radioactive drugs, and reserpine.

**Conditions affecting the newborn that may make breastfeeding difficult:** Congenital deformities of the mouth, jaw, or palate; newborns who are small-for-date or premature and certain metabolic disorders.

### Table 4-6. Eligibility Criteria for Symptoms- and Calendar-Based Methods

<table>
<thead>
<tr>
<th>Condition</th>
<th>Symptoms-Based Methods</th>
<th>Calendar-Based Methods</th>
</tr>
</thead>
<tbody>
<tr>
<td>Age: post-menarche or perimenopause</td>
<td>C</td>
<td>C</td>
</tr>
<tr>
<td>Breastfeeding &lt; 6 weeks postpartum</td>
<td>D</td>
<td>D³³</td>
</tr>
<tr>
<td>Breastfeeding = 6 weeks postpartum</td>
<td>C³³</td>
<td>D³³</td>
</tr>
<tr>
<td>Postpartum, not breastfeeding</td>
<td>D³³</td>
<td>D³³</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Condition</th>
<th>C</th>
<th>D&lt;sup&gt;dd&lt;/sup&gt;</th>
</tr>
</thead>
<tbody>
<tr>
<td>Postabortion</td>
<td>C</td>
<td>D&lt;sup&gt;dd&lt;/sup&gt;</td>
</tr>
<tr>
<td>Irregular vaginal bleeding</td>
<td>D</td>
<td>D</td>
</tr>
<tr>
<td>Vaginal discharge</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>Taking drugs that affect cycle regularity, hormones, and/or fertility signs</td>
<td>D/C&lt;sup&gt;ee&lt;/sup&gt;</td>
<td>D/C&lt;sup&gt;ee&lt;/sup&gt;</td>
</tr>
<tr>
<td><strong>Diseases that elevate body temperature</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Acute</td>
<td>D</td>
<td>A</td>
</tr>
<tr>
<td>Chronic</td>
<td>C</td>
<td>A</td>
</tr>
</tbody>
</table>

<sup>a</sup> Delay until she has had 3 regular menstrual cycles.
<sup>b</sup> Use caution after monthly bleeding or normal secretions return (usually at least 6 weeks after childbirth).
<sup>cc</sup> Delay until monthly bleeding or normal secretions return (usually <4 weeks postpartum).
<sup>dd</sup> Delay until she has had one regular menstrual cycle.
<sup>ee</sup> Delay until the drug's effect has been determined, then use caution.
Introduction

Natural Family Planning (NFP) refers to a variety of methods used to plan or prevent pregnancy, based on identifying the woman's fertile days. For all natural methods, avoiding unprotected intercourse during the fertile days is what prevents pregnancy. Natural methods are also known as fertility awareness-based methods.

There are 6 days during the menstrual cycle when it is possible for a woman to become pregnant. This is because of the life span of the sperm, which remain viable in the woman's reproductive tract for up to 5 days, and the fact that the ovum can be fertilized for up to 24 hours following ovulation. This fertility period will move backwards or forwards, depending on when ovulation actually occurs.

The effectiveness and significant advantages of NFP address the needs of diverse populations with varied religious and ethical beliefs. They also provide an alternative for women who want to use natural methods for medical or personal reasons.

The most common natural methods used are:

- Lactatational amenorrhoea method (LAM or breastfeeding)
- Fertility awareness-based methods:
  a) Calendar-based methods:
     1) Calendar-based method
     2) Standard Days Method® (SDM)
  b) Symptoms-based methods:
     1) Ovulation method/cervical mucus method
     2) TwoDay Method®
     3) Basal body temperature (BBT) method
     4) Symptothermal method/multiple indicator method
- Withdrawal method

Policy/Standard

- Natural methods should be offered to all potential clients as a choice during counselling.
- All service providers should be well-trained in counselling and techniques of natural methods.

Lactational Amenorrhoea Method (Family Planning Method Based on Breastfeeding)
In developing nations, including Pakistan, breastfeeding plays a major role in prolonging birth intervals and thereby reducing the fertility rate. The lactational amenorrhoea method (LAM) is a temporary family planning (FP) method based on the natural effect of breastfeeding on fertility. (“Lactational” means related to breastfeeding. “Amenorrhoea” means not having monthly bleeding.)

LAM requires three conditions. All three of the following conditions must be met:

1. The mother’s monthly bleeding has not returned;
2. The baby is fully or nearly fully breastfed and is fed often, day and night; and
3. The baby is less than 6 months old.

- “Fully breastfeeding” includes both exclusive breastfeeding (the infant receives no other liquid or food, not even water, in addition to breast milk) and almost-exclusive breastfeeding (the infant receives vitamins, water, juice, or other nutrients once in a while in addition to breast milk).
- “Nearly fully breastfeeding” means that the infant receives some liquid or food in addition to breast milk, but the majority of feedings (more than three-fourths of all feeds) are breast milk.

**Mode of action**

LAM works primarily by preventing the release of eggs from the ovaries (ovulation). Frequent breastfeeding temporarily prevents the release of the natural hormones that cause ovulation.

**Effectiveness**

*Effectiveness depends on the user:* Risk of pregnancy is greatest when a woman cannot fully or nearly fully breastfeed her infant.

- When used correctly, there is less than one pregnancy per 100 women using LAM in the first 6 months after childbirth.
• As commonly used, there are about two pregnancies per 100 women using LAM in the first 6 months after childbirth. This means that 98 of every 100 women relying on LAM will not become pregnant.

*Return of fertility after LAM is stopped:* Depends on how much the woman continues to breastfeed.

*Protection against sexually transmitted infections:* None.

**Advantages**

• Effectively prevents pregnancy for at least 6 months.
• Can be used immediately after childbirth.
• No need to do anything at time of sexual intercourse.
• No direct cost for FP or for feeding the baby.
• No supplies or procedures needed to prevent pregnancy.
• No hormonal side effects.
• A breastfeeding woman can use LAM to space her next birth and as a transition to another contraceptive method.
• Breastfeeding practices required by LAM have other health benefits for baby and mother, including:
  − Provides the healthiest food for the baby.
  − Helps protect the baby from life-threatening diseases such as diarrhoea, measles, and pneumonia by passing the mother's immunities to the baby.
  − Helps develop a close relationship between mother and baby.
  − Helps early involution of uterus in mother.
  − Prevents breast engorgement.

**Limitations**

• Effectiveness after 6 months is not certain.
• Frequent breastfeeding may be inconvenient or difficult for some women, especially working mothers.
• No protection against sexually transmitted infections (STIs), including HIV/AIDS.

**Lactational amenorrhea method for women with HIV**

• Women who are infected with HIV or who have AIDS can use LAM. Breastfeeding will not make their condition worse. There is a chance, however, that mothers with HIV will transmit HIV to their infants through breastfeeding. As breastfeeding is generally practiced, 10 to 20 of every 100 infants breastfed by mothers with HIV will become infected with HIV through
breast milk, in addition to those already infected during pregnancy and delivery. HIV transmission through breast milk is more likely among mothers with advanced disease or who are newly infected.

- Women taking antiretroviral (ARV) medications can use LAM. In fact, ARV therapy during the first weeks of breastfeeding may reduce the risk of HIV transmission through breast milk.

- Replacement feeding poses no risk of HIV transmission. If—and only if—replacement feeding is acceptable, feasible, affordable, sustainable, and safe, it is recommended for the first 6 months after childbirth. If available replacement feeding cannot meet these five criteria, exclusive breastfeeding for the first 6 months is the safest way to feed the baby, and it is compatible with LAM.

- One strategy for making breastfeeding safer is expressing breast milk and heat-treating it. For women relying on LAM, expressing milk may be slightly less effective at preventing pregnancy than breastfeeding.

- Urge women with HIV to use condoms along with LAM. Used consistently and correctly, condoms help prevent transmission of HIV and other STIs.

**Client Assessment as per World Health Organization Medical Eligibility Criteria**

All breastfeeding women can safely use LAM, but a woman in the following circumstances may want to consider other contraceptive methods:

- Has HIV infection, including AIDS.

- Is using certain medications during breastfeeding (including mood-altering drugs, reserpine, ergotamine, anti-metabolites, cyclosporine, high doses of corticosteroids, bromocriptine, radioactive drugs, lithium, and certain anticoagulants).

- Her newborn has a condition that makes it difficult to breastfeed (including being small-for-date or premature and needing intensive neonatal care, being unable to digest food normally, or having deformities of the mouth, jaw, or palate).

LAM can also be used in any circumstances by women with the following characteristics or health conditions:
The only conditions that limit use of LAM are conditions that make breastfeeding difficult or that rule out breastfeeding.

**How to use the method**

**Starting Time**
Start breastfeeding as soon as possible (within 1 hour) after the baby is born.

**Technique**

- An ideal pattern is feeding on demand (that is, whenever the baby wants to be fed) and at least 10 to 12 times a day in the first few weeks after childbirth and thereafter 8 to 10 times a day, including at least once at night in the first months.

- Daytime feedings should be no more than 4 hours apart, and nighttime feedings no more than 6 hours apart.

- Some babies may not want to breastfeed 8 to 10 times a day and may want to sleep through the night. These babies may need gentle encouragement to breastfeed more often.

The mother should start giving other foods in addition to breast milk when the baby is 6 months old. At this age, breast milk can no longer fully nourish a growing baby.

**Time to start another FP method: Start another method when:**
- Menstrual periods return (bleeding in the first 56 days, or 8 weeks, after childbirth is not considered menstrual bleeding), or
- Baby is 6 months old (about the time the baby starts sitting up), or
- The woman stops fully or nearly fully breastfeeding, or
- The woman no longer wants to rely on LAM for FP.

**Follow-up visit**
Plan for the next visit while the LAM criteria still apply, so that the woman can choose another method and continue to be protected from pregnancy.

If possible, give her condoms or progestin-only pills. She can start to use them if the baby is no longer fully or nearly fully breastfeeding, if her monthly bleeding returns, or if the baby reaches 6 months of age before she can come back for another method. Emergency contraceptive pills (ECPs) are another option, particularly for unprotected sex. Plan for a follow-on method. Give her any supplies now.

**Supporting the user**

If the client reports any problems with using LAM:

- Do not dismiss the woman's concerns or take them lightly.
- Give help and advice about breastfeeding technique, and encourage continuing breastfeeding.
- If the woman is not satisfied with LAM after counselling and discussion, help her to choose another method.
<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Management</th>
</tr>
</thead>
</table>
| **Baby is not getting enough milk** | Reassure the woman that most women can produce enough breast milk to feed their babies.  \nIf the newborn is gaining more than 500 gm a month, weighs more than birth weight at 2 weeks, or urinates at least 6 times a day, reassure her that her baby is getting enough breast milk.  
Tell her to breastfeed her newborn about every 2 hours to increase milk supply.  
Recommend that she reduce any supplemental foods and/or liquids if the baby is less than 6 months of age. |
| **Sore breasts**             | If her breasts are full, tight, and painful, she may have engorged breasts. If one breast has tender lumps, she may have blocked ducts. Engorged breasts or blocked ducts may progress to red and tender, infected breasts. Treat infected breasts with antibiotics according to clinic guidelines. To aid healing, advise her to:  
  - Continue to breastfeed often.  
  - Massage her breasts before and during breastfeeding.  
  - Apply heat or a warm compress to breasts.  
  - Try different breastfeeding positions.  
  - Ensure that the infant attaches properly to the breast.  
  - Express some milk before breastfeeding. |
| **Sore or cracked nipples**   | If her nipples are cracked, she can continue breastfeeding. Assure her that they will heal over time.  
To aid healing, advise her to:  
  - Apply drops of breast milk to the nipples after breastfeeding and allow them to air dry.  
  - After feeding, use a finger to break suction first before removing the baby from the breast.  
  - Do not wait until the breast is full to breastfeed. If full, express some milk first. |
Teach the woman about proper attachment and how to check for signs that the baby is not attaching properly.

Tell her to clean her nipples with water only, once a day, and to avoid soaps and alcohol-based solutions.

Examine her nipples and the baby’s mouth and buttocks for signs of fungal infection (thrush).

Counselling for breastfeeding
Explain the benefits of breastfeeding as the source of nutrition for the baby and a natural method of contraception. Ask the client if she is having any difficulty in breastfeeding and advise her as needed.

Encourage the woman to continue breastfeeding her baby for as long as possible. She will need another method when:
- Her menstrual periods return;
- The baby becomes 6 months old; or
- The baby is not taking breast milk as frequently as before (more than 6 hours between feeding), or the baby is taking food or liquid as substitutes for breast milk feeds.

After explaining the instructions, ask the client to repeat them.

Contraception for non-lactating mothers
Most non-lactating women resume menses within 4 to 6 weeks of delivery. Ovulation generally occurs and the client can again become pregnant. Ovulation can return at any time, even before menstruation. However, this period is unpredictable, and an FP method should be used to ensure that pregnancy does not occur and the client can again become pregnant.

Suitable methods of contraception during lactation
The most appropriate methods of contraception for lactating mothers are those that do not influence the quantity and quality of breast milk, are not excreted in breast milk in amounts that make it unsafe for the infant, are effective and safe for the mother, are easily available, and are convenient to use.

Counsel the client about the methods that can be used, and assist her in making a choice. Give the following information about contraceptives that can and cannot be used during the lactation period.
• Combined oral contraceptive pills are not suitable during the first 6 months of lactation.
• The IUCD (CuT or Multiload) can be inserted 4 weeks after delivery. In facilities where there are trained providers, the CuT IUCD can be inserted within 10 minutes after delivery of the placenta or during the first 48 hours after delivery of the baby.
• Mini-pills (progestin-only) can be started after 6 weeks postpartum.
• Norplant implants can be used after 6 weeks postpartum.
• Progestin injectable contraceptives can be given after 6 weeks postpartum.
• Condoms can safely be used any time.

Tubal ligation can be performed if the client does not want any more children. It can be performed within 1 week after delivery, or at any time 6 or more weeks after delivery as an interval procedure.

**Fertility Awareness-Based Methods**

Fertility awareness means that a woman learns how to detect when the fertile time of her menstrual cycle begins and ends (ovulation days).

Women can use several ways to calculate the fertile time:
- Calendar–based methods (SDM, calendar rhythm method)

**Mode of action**

Fertility awareness helps a couple know when the woman can become pregnant. The couple avoids pregnancy by changing their sexual behaviour during fertile days. They can practice:
- **Periodic abstinence**—avoiding vaginal sex completely during the fertile time. This method is also called **Natural Family Planning (NFP)**.

**Effectiveness**

Effective or very effective when used consistently and correctly; effectiveness ranges from 1–9 percent for various methods.

Only somewhat effective as commonly used: 25 pregnancies per 100 women in the first year of use (1 in every 5).

**Advantages**
- Once learned, can be used to avoid pregnancy or to become pregnant, according to the couple’s wishes.
- No physical side effects.
- Very little or no cost.
• Can be used by most couples if they are committed to it.
• Effective if used correctly and consistently.
• Once learned, may require no further help from health care providers.
• Can be learned from trained volunteers. Contact with medical personnel is not necessary.
• Immediately reversible.
• Acceptable to some religious groups that reject or discourage use of other methods.
• No effect on breastfeeding or breast milk.
• No hormonal side effects.
• Involves men in FP.
• Educates couple about women's fertility cycles.

Limitations
• Effectiveness depends on correct usage.
• Takes the woman up to two or three cycles to learn how to identify fertile time accurately. For calendar method, a menstrual record of at least 6 months is required.
• Abstinence during fertile days may be difficult for some couples.
• Will not work without continuing cooperation and commitment of the couple.
• Can become unreliable or hard to use in condition like fever from infection, or when menstrual cycle length is short or long.
• After childbirth, may be hard to identify the fertile time until the menstrual cycle becomes regular again.
• Calendar method may not be effective for women with irregular menstrual cycles.
• Most methods require women or couples to keep careful daily records and pay close attention to body changes.
• Does not protect against STIs including HIV/AIDS.
• If client has or might get an STI, convince her to use condoms regularly. Give her condoms.

Method of use

Starting Time
Once trained, a woman or couple can begin using fertility awareness-based techniques at any time. Before starting to use the fertility awareness-based methods, a woman must record the length of her menstrual cycles for at least 6 months.

Immediately after childbirth or abortion: Once bleeding stops after delivery, cervical secretions can be used for birth spacing, but with difficulty. The calendar method and BBT method are unreliable at that stage.

Fertility awareness-based methods can be used in any circumstances by women with any of the following characteristics or health conditions
• Smoke cigarettes
• Mild high blood pressure
• Deep vein thrombosis or pulmonary embolism
• Varicose veins
• Mild or severe headaches
• Painful menstruation
• Uterine fibroids
• Endometriosis
• Ovarian cysts
• Iron deficiency anaemia
• Viral hepatitis
• Malaria

Calendar-based methods

All women can use calendar-based methods. No medical conditions prevent the use of these methods, but some conditions can make them more difficult to use effectively.

Caution means that additional or special counselling may be needed to ensure correct use of the method.

Delay means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Give the client another method to use until she can start the calendar-based method.

In the following situations, use caution with calendar-based methods:

• Menstrual cycles have just started or have become less frequent or stopped due to older age. (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.)

In the following situations, delay starting calendar-based methods:

• Recently gave birth or is breastfeeding (Delay until she has had at least three menstrual cycles and her cycles are regular again. For several months after regular cycles have returned, use with caution.)

• Recently had an abortion or miscarriage (Delay until the start of her next monthly bleeding.)

• Irregular vaginal bleeding
In the following situations, *delay* or use *caution* with calendar-based methods:

- Taking any mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic or tetracyclic), long-term use of certain antibiotics, or long-term use of any non-steroidal anti-inflammatory drug (such as aspirin or ibuprofen). These drugs may affect timing of ovulation.

**Providing Calendar-Based Methods**

**When to start**

Once trained, a woman or couple usually can begin using calendar-based methods at any time. Give clients who cannot start immediately another method to use until they can start.

**Table 5-2. When to Start Calendar-Based Methods**

<table>
<thead>
<tr>
<th>Woman’s Situation</th>
<th>When to Start</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Having regular menstrual cycles</strong></td>
<td>Any time of the month</td>
</tr>
<tr>
<td></td>
<td>No need to wait until the start of next monthly bleeding.</td>
</tr>
<tr>
<td><strong>No monthly bleeding</strong></td>
<td>Delay calendar-based methods until monthly bleeding returns.</td>
</tr>
<tr>
<td><strong>After childbirth</strong> (whether or not breastfeeding)</td>
<td>Delay the Standard Days Method until she has had three menstrual cycles and the last one was 26–32 days long. Regular cycles will return later in breastfeeding women than in women who are not breastfeeding.</td>
</tr>
<tr>
<td><strong>After miscarriage or abortion</strong></td>
<td>Delay the Standard Days Method until the start of her next monthly bleeding, when she can start if she has no bleeding due to injury to the genital tract.</td>
</tr>
<tr>
<td><strong>Switching from a hormonal method</strong></td>
<td>Delay starting the Standard Days Method until</td>
</tr>
</tbody>
</table>
the start of her next monthly bleeding. If she is switching from injectables, delay the Standard Days Method at least until her repeat injection would have been given, and then start it at the beginning of her next monthly bleeding.

| After taking emergency contraceptive pills | Delay the Standard Days Method until the start of her next monthly bleeding. |

Explaining how to use calendar-based methods

**Standard Days Method**

**IMPORTANT:** A woman can use the Standard Days Method if most of her menstrual cycles are 26 to 32 days long.

If she has more than two longer or shorter cycles within a year, the Standard Days Method will be less effective and she may want to choose another method.

Table 5-3. How to Use Calendar-Based Methods

<table>
<thead>
<tr>
<th>Basic Principles of the Method</th>
<th>How to Use the Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep track of the days of the menstrual cycle</td>
<td>A woman keeps track of the days of her menstrual cycle, counting the first day of monthly bleeding as day 1.</td>
</tr>
<tr>
<td>Avoid unprotected sex on days 8–19</td>
<td>Days 8 through 19 of every cycle are considered fertile days for all users of the Standard Days Method. The couple avoids vaginal sex or uses condoms or a diaphragm during days 8 through 19. They can also use withdrawal or spermicides, but these are less effective. The couple can have unprotected sex on all the other days of the cycle—days 1 through 7 at the beginning of the cycle and from day 20 until her next monthly bleeding begins.</td>
</tr>
</tbody>
</table>
Use memory aids if needed

The couple can use CycleBeads, a colour-coded string of beads that indicates fertile and non-fertile days of a cycle, or they can mark a calendar or use some other memory aid.

**Calendar Rhythm Method**

**Table 5-4. Using the Calendar Rhythm Method**

<table>
<thead>
<tr>
<th>Basic Principles of the Method</th>
<th>How to Use the Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Keep track of the days of the menstrual cycle</td>
<td>Before relying on this method, a woman records the number of days in each menstrual cycle for at least 6 months. The first day of monthly bleeding is always counted as day 1.</td>
</tr>
<tr>
<td>Estimate the fertile time</td>
<td>The woman subtracts 18 from the length of her shortest recorded cycle. This tells her the estimated first day of her fertile time. Then she subtracts 11 days from the length of her longest recorded cycle. This tells her the estimated last day of her fertile time.</td>
</tr>
<tr>
<td>Avoid unprotected sex during fertile time</td>
<td>The couple avoids vaginal sex, or uses condoms or a diaphragm, during the fertile time. They can also use withdrawal or spermicides, but these are less effective.</td>
</tr>
</tbody>
</table>
| Update calculations monthly                    | She updates these calculations each month, always using the 6 most recent cycles. Example:  
  - If the shortest of her last six cycles was 27 days, $27 - 18 = 9$, she starts avoiding unprotected sex on day 9.  
  - If the longest of her last six cycles was 31 days, $31 - 11 = 20$, she can have unprotected sex again on day 21.  
  - Thus, she must avoid unprotected sex from day 9 through day 20 of her cycle. |
Symptoms-based methods

All women can use symptoms-based methods. No medical conditions prevent the use of these methods, but some conditions can make them more difficult to use effectively.

Caution means that additional or special counselling may be needed to ensure correct use of the method.

Delay means that use of a particular fertility awareness method should be delayed until the condition is evaluated or corrected. Give the client another method to use until she can start the symptoms-based method.

In the following situations, use caution with symptoms-based methods:

- Recently had an abortion or miscarriage.
- Menstrual cycles have just started or have become less frequent or stopped due to older age. (Menstrual cycle irregularities are common in young women in the first several years after their first monthly bleeding and in older women who are approaching menopause. Identifying the fertile time may be difficult.)
- A chronic condition that raises her body temperature (for BBT and symptothermal methods).

In the following situations, delay starting symptoms-based methods:

- Recently gave birth or is breastfeeding. (Delay until normal secretions have returned—usually at least 6 months after childbirth for breastfeeding women and at least 4 weeks after childbirth for women who are not breastfeeding. For several months after regular cycles have returned, use with caution.)
- An acute condition that raises her body temperature (for basal body temperature and symptothermal methods).
- Irregular vaginal bleeding.
- Abnormal vaginal discharge.

In the following situations, delay or use caution with symptoms-based methods:
• Taking any mood-altering drugs such as anti-anxiety therapies (except benzodiazepines), antidepressants (selective serotonin reuptake inhibitors [SSRIs], tricyclic or tetracyclic), anti-psychotics (including chlorpromazine, thioridazine, haloperidol, risperdone, clozapine, or lithium), long-term use of certain antibiotics, any non-steroidal anti-inflammatory drug (such as aspirin or ibuprofen), or antihistamines. These drugs may affect cervical secretions, raise body temperature, or delay ovulation.

**Providing Symptoms-Based Methods**

**When to start**

Once trained, a woman or couple usually can begin using symptoms-based methods at any time. Women not using a hormonal method can practice monitoring their fertility signs before they start using symptoms-based methods. Give clients who cannot start immediately another method to use until they can start.

**Table 5-5: When to Start Symptoms-Based Methods**

<table>
<thead>
<tr>
<th>Woman’s Situation</th>
<th>When to Start</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Having regular menstrual cycles</strong></td>
<td><strong>Any time of the month</strong></td>
</tr>
<tr>
<td></td>
<td>No need to wait until the start of next monthly bleeding.</td>
</tr>
<tr>
<td><strong>No monthly bleeding</strong></td>
<td><strong>Delay symptoms-based methods until monthly bleeding returns.</strong></td>
</tr>
<tr>
<td><strong>After childbirth</strong> (whether or not breastfeeding)</td>
<td>She can start symptoms-based methods once normal secretions have returned. Normal secretions will return later in breastfeeding women than in women who are not breastfeeding.</td>
</tr>
<tr>
<td><strong>After miscarriage or abortion</strong></td>
<td>She can start symptoms-based methods immediately with special counselling and support, if she has no infection-related secretions or bleeding due to injury to the genital tract.</td>
</tr>
</tbody>
</table>
# Explaining How to Use Symptoms-Based Methods

## 1. Ovulation Method/Cervical Mucus Method

**IMPORTANT:** If a woman has a vaginal infection or another condition that changes the cervical mucus, this method may be difficult to use.

### Table 5-6. Using the Ovulation/Cervical Mucus Method

<table>
<thead>
<tr>
<th>Basic Principles of the Method</th>
<th>How to Use the Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check cervical secretions daily</td>
<td>The woman checks every day for any cervical secretions on fingers, underwear, or tissue paper or by sensation in or around the vagina.</td>
</tr>
<tr>
<td>Avoid unprotected sex on days of heavy monthly bleeding</td>
<td>Ovulation might occur early in the cycle, during the last days of monthly bleeding, and heavy bleeding could make mucus difficult to observe.</td>
</tr>
<tr>
<td>Resume unprotected sex until secretions begin</td>
<td>Between the end of monthly bleeding and the start of secretions, the couple can have unprotected sex, but not on 2 days in a row. (Avoiding sex on the second day allows time for semen to disappear and for cervical mucus to be observed.) It is recommended that they have sex in the evenings, after the woman has been in an upright position for at least a few hours and has been able to check for cervical mucus.</td>
</tr>
<tr>
<td>Avoid unprotected sex when secretions</td>
<td>As soon as she notices any secretions, she</td>
</tr>
</tbody>
</table>
begin and until 4 days after “peak day”

She considers herself fertile and avoids unprotected sex.
She continues to check her cervical secretions each day. The secretions have a “peak day”—the last day that they are clear, slippery, stretchy, and wet. She will know this has passed when, on the next day, her secretions are sticky or dry, or she has no secretions at all. She continues to consider herself fertile for 3 days after that peak day and avoids unprotected sex.

Resume unprotected sex

The couple can have unprotected sex on the fourth day after her peak day and until her next monthly bleeding begins.

Figure 5-1. Example of a Fertility Wheel to Help Women Use Natural Methods
2. Two Day Method

**IMPORTANT:** If a woman has a vaginal infection or another condition that changes cervical mucus, the Two Day Method will be difficult to use.

**Table 5-7. Using the Two Day Method**

<table>
<thead>
<tr>
<th>Basic Principles of the Method</th>
<th>How to Use the Method</th>
</tr>
</thead>
<tbody>
<tr>
<td>Check for secretions</td>
<td>The woman checks for cervical secretions every afternoon and/or evening, on fingers,</td>
</tr>
<tr>
<td></td>
<td>underwear, or tissue paper or by sensation in or around the vagina.</td>
</tr>
<tr>
<td></td>
<td>As soon as she notices any secretions of any type, color, or consistency, she</td>
</tr>
<tr>
<td></td>
<td>considers herself fertile that day and the following day.</td>
</tr>
<tr>
<td>Avoid sex or use another method on</td>
<td>The couple avoids vaginal sex or uses condoms or a diaphragm on each day with</td>
</tr>
<tr>
<td>fertile days</td>
<td>secretions and on each day following a day with secretions. They can also use</td>
</tr>
<tr>
<td></td>
<td>withdrawal or spermicides, but these are less effective.</td>
</tr>
<tr>
<td>Resume unprotected sex after 2 dry</td>
<td>The couple can have unprotected sex again after the woman has had 2 dry days (days</td>
</tr>
<tr>
<td>days</td>
<td>without secretions of any type) in a row.</td>
</tr>
</tbody>
</table>

3. Basal Body Temperature (BBT) Method

**IMPORTANT:** If a woman has a fever or other changes in body temperature, the BBT method will be difficult to use.

**Table 5-8. Using the Basal Body Temperature (BBT) Method**
Basic Principles of the Method | How to Use the Method
---|---
**Take body temperature daily** | The woman takes her body temperature at the same time each morning before she gets out of bed and before she eats anything. She records her temperature on a special graph. She watches for her temperature to rise slightly—0.2°–0.5°C (0.4°–1.0°F)—just after ovulation (usually about midway through the menstrual cycle).

**Avoid sex or use another method until 3 days after the temperature rise** | The couple avoids vaginal sex, or uses condoms or a diaphragm from the first day of monthly bleeding until 3 days after the woman’s temperature has risen above her regular temperature. They can also use withdrawal or spermicides, but these are less effective.

**Resume unprotected sex until next monthly bleeding begins** | When the woman’s temperature has risen above her regular temperature and stayed higher for 3 full days, ovulation has occurred and the fertile period has passed. The couple can have unprotected sex on the fourth day and until her next monthly bleeding begins.

### 4. Symptothermal Method (basal body temperature + cervical secretions + other fertility signs)

Table 5-9. Using the Symptothermal Method

<table>
<thead>
<tr>
<th>Basic Principles of the Method</th>
<th>How to Use the Method</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Avoid unprotected sex on fertile days</strong></td>
<td>Users identify fertile and non-fertile days by combining BBT and ovulation method instructions. Women may also identify the fertile time by other signs such as breast tenderness and ovulatory pain (lower abdominal pain or cramping around...</td>
</tr>
</tbody>
</table>
Withdrawal Method (Coitus Interruptus)

Coitus interruptus, or withdrawal, is one of the oldest forms of contraception known to man. Coitus interruptus is defined as sexual intercourse that is deliberately interrupted by withdrawal of the penis from the vagina prior to ejaculation. The withdrawal method is not particularly effective as a contraceptive method.

Mode of action
Withdrawal prior to ejaculation reduces or eliminates the introduction of sperm into the vagina.

Effectiveness
- Perfect use failure rate in first year: 4 percent
- Typical use failure rate in first year: 27 percent

Advantages
- Withdrawal as a contraceptive method is better than no method at all.
- Incurs no expenditure.
- It has relatively few medical complications, except those brought about by an unwanted pregnancy or possible transmission of STIs.
- Requires no preparation or supplies.
- No adverse effect on fertility after discontinuation of method.

Limitations
- May not be applicable for couples with sexual dysfunction such as premature ejaculation or unpredictable ejaculation.
• May reduce sexual pleasure of woman and intensity of orgasm in man.
• Requires the couple to think about what is happening during sexual intercourse.
• Relies on the male removing the penis from the vagina at a point prior to orgasm and often when he is in a high state of arousal.
• Provides no protection against STIs such as HIV/AIDS, genital herpes, or gonorrhoea.
• Over the long term, many couples find the withdrawal method frustrating and unsatisfactory.

<table>
<thead>
<tr>
<th>Medical Eligibility Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>All men can use withdrawal. No medical conditions prevent its use.</td>
</tr>
</tbody>
</table>

**Method of Use**

**Starting time:** Can begin at any time.

**Explaining How to Use (suggest take this out of table format)**

When the man feels close to ejaculating, he should withdraw his penis from the woman’s vagina and ejaculate outside the vagina, keeping his semen away from her external genitalia.

If man has ejaculated recently, he should urinate before sex and wipe the tip of his penis to remove any sperm remaining.

**Table 5-10. Advice on Use of the Withdrawal Method**

<table>
<thead>
<tr>
<th>Discussion Points on Use of Withdrawal</th>
<th>What to Advise the Man or Couple</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Learning proper use can take time</strong></td>
<td>Suggest that the couple also use another method until the man feels that he can use withdrawal correctly with every act of sex.</td>
</tr>
<tr>
<td><strong>Greater protection from pregnancy is available</strong></td>
<td>Suggest an additional or alternative family planning method. (Couples who have been using withdrawal effectively should not be discouraged from continuing.)</td>
</tr>
<tr>
<td><strong>Some men may have difficulty using withdrawal</strong></td>
<td>Explain that withdrawal is difficult for men who cannot sense consistently when ejaculation is about to occur or for men who ejaculate prematurely.</td>
</tr>
<tr>
<td><strong>Can use emergency contraceptive pills (ECPs)</strong></td>
<td>Explain ECP use in case a man ejaculates before withdrawing (see Emergency Contraceptive Pills. Give ECPs if available.</td>
</tr>
</tbody>
</table>
Introduction

Barrier methods of contraception involve the use of mechanical devices that prevent sperm from entering into the cervix. The efficacies of all barrier methods are enhanced with the use of spermicides. Barrier and protective methods include vaginal methods and male and female condoms. These are available over the counter and are inexpensive.

Policy

The available barrier and protective methods are to be offered to the client along with other contraceptives so that the client may choose the method she or he wants. Condoms are to be sold at government prescribed rates.

Standards

- The client must be provided full information on the use and disposal of condoms.
- The client should be informed that condoms prevent sexually transmitted infections (STIs).
- The client must be informed of the rare occurrence of allergic manifestations with the use of condoms.

Male Condoms

A condom is a sheath or covering made of thin latex rubber that fits over a man's erect penis. Condoms are known by many different brand names and are of different sizes, shapes, colours, and textures.

Mode of action

A condom works by creating a barrier that keeps sperm out of the vagina, thus preventing pregnancy. It also prevents infections present in the semen, on the penis, or in the vagina from infecting the other partner.

Effectiveness

When used correctly with every act of sex, about two pregnancies per 100 women occur over the first year of use. As commonly used, about 15 pregnancies per 100 women occur over the first year.

Advantages

- Prevent STIs, including HIV/AIDS, and pregnancy, when used correctly with every act of sexual intercourse. Consistent condom use reduces risks of HIV transmission by approximately 10 fold.
- Help protect against conditions caused by STIs, pelvic inflammatory disease (PID), chronic
pain, and possibly cervical cancer in women and infertility in both men and women.

- Can be used to prevent STIs during pregnancy.
  
  Can be used soon after childbirth.
- Are safe and have no hormonal side effects.
- Help prevent ectopic pregnancies.
- User-controlled—can be stopped any time.
- Offer occasional contraception with no daily upkeep.
- Easy to keep on hand in case sex occurs unexpectedly.
- Can be used by men of any age.
- Can be used without seeing a health care provider.
- Usually easy to obtain and are sold in many places.
- Enable a man to take responsibility for preventing pregnancy and disease.
- Increase sexual enjoyment because no need to worry about pregnancy or STIs.
- Often help prevent premature ejaculation (help the man last longer during sex).
- If the woman/partner puts the condom on, it may add to sexual pleasure.
- Male involvement is encouraged and is essential.
- Availability of wide selection of condom types and designs can add variety.

**Limitations**

- Latex condoms may cause itching in a few people who are allergic to latex.
- Some people may be allergic to the lubricant on some brands of condoms.
- Either member of a couple may have latex allergy or reaction to spermicide (polyurethane condom is the appropriate alternative).
- May decrease sensation, making sex less enjoyable for either partner.
- The couple must take the time to put the condom on the erect penis before sex.
- The supply of condoms must be ready even if the woman or man is not expecting to have sex.
- There is a small possibility that the condom will slip off or break during sex.
- Condoms can weaken if stored too long or in too much heat, sunlight, or humidity, or if used with oil-based lubricants, and then may break during use.
- A man's cooperation is needed for a woman to protect herself from pregnancy and disease.
- May have a bad reputation because many people connect condoms with immoral sex, sex outside marriage, or sex with prostitutes.
- May embarrass some people to buy, ask partner to use, put on, take off, or throw away condoms.
- Use may interrupt or be perceived as interrupting lovemaking. Require discipline to resist impulse to progress to intercourse after erection.
- May cause man to lose erection.
- Plain condoms may decrease lubrication and provide less stimulation for woman.
- Require prompt withdrawal after ejaculation, which may decrease pleasure (especially the woman's pleasure).
- Make sex messy for the man (getting rid of condom).
• Require education/experience for successful use.
• .
• Couples may be embarrassed to purchase or to put on condoms due to taboos about touching genitalia, or stigma or concern about STIs, including HIV/AIDS.

**Medical Eligibility Criteria**
In general, anyone can use condoms safely and effectively. Only one medical condition prevents the use of condoms, i.e., severe allergy (severe redness, itching, and swelling after use). The client can be asked about this allergy and no tests are indicated. If the client is at risk of STIs including HIV/AIDS, s/he may use the condoms despite the allergy.

**Method of use**
Male condom use can be started at any time. Care should be taken to use it for all sexual acts. Just one unprotected act of sexual intercourse can lead to pregnancy or an STI.

**Technique of Use**
• Make sure condoms are stored properly and obtained from a good source.
• Check manufacturing or expiry date on package.
• Remove condom from package.
• Do not use teeth or sharp object to open condom package.
• Unroll condom slightly to make sure it unrolls properly.
• Place condom on the tip of the erect penis.
• Squeeze air out of tip of condom.
• Unroll condom down the penis.
• If condom is initially placed on the penis backwards, do not turn it around, throw it away and start with a new one.
• Smooth out air bubbles.
• Start the sex act with condom on.
• After ejaculation, hold on to the condom at the base of penis while withdrawing it.
• Withdraw while still erect.
• Take off the condom carefully, without spilling semen.
• Tie the upper edge of the condom to prevent spills or leaks.
• Dispose of the condom safely.

**Side effects and management**
If the client reports any problems with condoms: Do not dismiss the client's concerns or take them lightly. If the client is not satisfied, help him in choosing another contraceptive.
## Table 6-1. Male Condoms: Side Effects and Their Management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
</table>
| Itching or rash on genitals             | • If itching continues, check for infection. Treat or refer for treatment as appropriate.  
• Recommend a dry condom if client had been using a lubricated condom.  
• If problem continues, help client to choose another method if client is not at risk of STIs.  
• For clients at risk of STIs, urge continued use of condom despite discomfort. |
| Man cannot maintain an erection while using condom | • This is often due to embarrassment.  
• Discuss how to make condom use enjoyable by having partner put it on. With counselling and experience, the problem may be solved.  
• Suggest a small amount of water or lubricant on the penis and extra lubricant on the outside. This may increase sensation and help the man maintain an erection. |

### Counselling

Couples desiring to use condoms often benefit from specific instructions. Use a model and actual condom. Counsel new users about:

- Options among condom types
- Storage for safety and ready access
- How to negotiate condom use with partner and when to place condom
- How to use the condom correctly

If a condom breaks:

- Immediately insert a spermicide into the vagina
- Clients must use emergency contraceptives to prevent pregnancy.

Provide the following information on care for condoms:

- Store condoms in a cool, dark place, if possible. Heat, light, and humidity damage condoms.
- If possible, use lubricated condoms that come in square wrappers and are packaged so that light does not reach them. Lubrication may help prevent tears.
- Handle condoms carefully. Fingernails and rings can tear them.
- Do not unroll condoms before use. This may weaken them. Also, an unrolled condom is difficult to put on.

Always use a different (second) condom if the first condom:

- Has torn or damaged packaging.
- Has a manufacturing date on the package that is more than 5 years past.
- Is uneven or changed in colour.
- Feels brittle, dried out, or very sticky.

Explain specific reasons to see a health care provider if either partner:
- Has symptoms of STIs such as sores on the genitals, pain when urinating, or a discharge drip.
- Has an allergic reaction to condoms (itching, rash, irritation).
- Other specific reasons to return: need more condoms, dissatisfied with condoms for any reason, have any questions or problems.

**Follow-up**

At any return visit:
- Ask if the client has any questions or anything to discuss.
- Ask the client about his or her experience with condoms, whether the client is satisfied, and whether the client has any problems. Give any information and advice that the client needs.
- If client is satisfied: Give client plenty of condoms. Give each client a 3-month supply of condoms, if possible, or more. How often people have sex varies, but for most clients, 40 condoms probably will last for at least 3 months.
- If the client has problems that cannot be resolved, help the client choose another method.
- Emphasize to clients at risk for STIs including HIV/AIDS to keep using condoms despite any dissatisfaction. Explain that only condoms protect against STIs during sex.

**Female Condoms**

The female condom is a sheath, or lining, that fits loosely inside a woman's vagina; it is made of thin, transparent, soft plastic film, with a flexible ring at both ends:
- One ring at the closed end helps to insert the condom.
- The ring at the open end holds part of the condom outside the vagina.

**Mode of action**

The mode of action of the female condom is the same as that of the male condom.

**Effectiveness**

When used correctly with every act of sex, about 5 pregnancies per 100 women occur over the first year of use. As commonly used, about 21 pregnancies per 100 women occur over the first year.

**Advantages**
- Cause a 97 percent reduction in incidence of HIV infection.
- Do not require male partner's erection for use.
- Are controlled by the woman.
• Are designed to prevent both STIs and pregnancy.
• No medical conditions appear to limit use.
• No apparent side effects, no allergic reactions.
• Intercourse may be more pleasurable because fear of pregnancy and STIs is decreased.
• If woman inserts the condom, she can be sure she is somewhat protected.
• Make sex less messy for the woman after removal of the condom.
• No medical visit required to start use.
• Immediately effective after placement.
• Provide an option to women whose partners cannot or will not use the male condom. May circumvent some concerns men have with male condoms.
• Can be safely used by people with latex allergies or sensitivities.
• Opportunity for women to share the responsibility for the condoms with their partners.
• Polyurethane, the material from which female condoms are made, is less likely to cause an allergic reaction than male latex condoms. With both types, the likelihood of breakage is very small if the condoms are used correctly.
• The female condom will protect against most STIs and pregnancy if used correctly.
• The polyurethane is thin and conducts heat well, so sensation is preserved.
• The female condom can be used with oil-based lubricants.
• There are no special storage requirements because polyurethane is not affected by changes in temperature and dampness. The expiry date for female condoms is 5 years from the date of manufacture.

Limitations
• Are expensive.
• Ring is visible outside the vagina.
• Can make noises during intercourse.
• Only somewhat effective as commonly used.
• Usually need partner’s consent and cooperation.
• Regular supply is required.
• Woman must touch her genitals.
• Some women find the female condom hard to insert and remove.
• Have a higher failure rate in preventing pregnancy than non-barrier methods such as the oral contraceptive pill.
• It is recommended that a female condom be only used once.

Medical Eligibility Criteria (MEC)
All women can use the plastic female condom. No medical condition prevents the use of this method.

Method of use
A woman can begin using female condoms any time during her monthly cycle and soon after childbirth, abortion, or miscarriage.
**Technique of use**

- Open packaging carefully. Avoid scissors or sharp objects that could cut or tear the condom.
- The client should rest comfortably in a squatting or lithotomy position.
- Compress the inner ring of the device and introduce the condom into the vagina much like a diaphragm. Use the inner ring to guide the sheath high into the vagina until the outer ring rests against the vulva. Rotate the inner ring to stabilize the device in the vault. Avoid tearing the condom with fingernails or jewellery. See package instructions for details and drawings illustrating insertion.
- Either the man or woman should manually place the penis into the sheath for intercourse and should take care to avoid penile contact outside the female condom.
- The man should monitor for any friction between penis and condom, which can cause breakage or inversion of the device.
- Remove the condom immediately after intercourse and then discard it.
- If there is any dislocation of the female condom during intercourse or any breakage or spillage of the ejaculate into the genitalia, have the client start emergency contraceptive pills (ECPs) as soon as possible. If she is at risk for STIs when the condom fails, seek medical care.

**Caution:** When a latex male condom is used with a polyurethane female condom, there can be an increased risk of breakage of either or both condoms. The oil-based lubricant of the female condom can cause breakage of the male condom. Friction could cause breakage of either.

**Table 6-2. Female Condoms: Side Effects and Their Management**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Difficulty in inserting condom</td>
<td>• Reinstruct the client.</td>
</tr>
<tr>
<td>Problem with removal</td>
<td>• Recommend relaxation techniques or suggest that the partner may remove it.</td>
</tr>
<tr>
<td>Condom dislodgement or penis inserted outside condom</td>
<td>• Insert a new condom prior to continuing intercourse.</td>
</tr>
<tr>
<td></td>
<td>• Use ECPs if any spill suspected.</td>
</tr>
<tr>
<td></td>
<td>• If at risk for STIs, seek medical care.</td>
</tr>
<tr>
<td>Allergy to condom</td>
<td>• Occurs very rarely.</td>
</tr>
</tbody>
</table>

**Follow-up**

**Return Visit**

At any return visit, ask:
- Did the client have any problems using the female condom?
- If the client had intercourse, did she have intercourse even once without using a condom?
- Does the client know how to use ECPs? Does she need more ECPs?
- Does the client plan to have children? Or plan to have more children? When?
- Ask if the client has any questions or anything to discuss.
- Ask the client about her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return again at any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.
- Ask if she has had any health problems since her last visit.

**Other Vaginal Methods**

Vaginal methods are the contraceptives, involving either physical or chemical barriers, that a woman places in the vagina shortly before sex. There are several methods:

- **Diaphragm:** It is a soft latex rubber cup that covers the cervix. It is available in different sizes.
- **Cervical cap:** It is a soft, deep latex or plastic rubber cap that snugly covers the cervix.

**Spermicide:** This is a sperm-killing substance inserted deep in the vagina before sex. Spermicides are available in the form of creams, jellies, foams, foaming tablets, melting films, and suppositories, and can be used with diaphragms and cervical caps, or alone.

**Mode of action**
- Diaphragms and cervical caps block sperm from entering the uterus and tubes, where sperm could meet an egg.
- Spermicides kill the sperm or make them unable to progress towards the uterine cavity and eventually meet the egg.

**Effectiveness**

As commonly used, about XX pregnancies occur per 100 women using them over the first year. When correctly used with every act of sex, about XX pregnancies occur per 100 women over the first year.

**Advantages**
- Safe, woman-controlled methods that almost every woman can use.
- Help prevent some STIs and conditions caused by STIs such as PID, infertility, ectopic pregnancy, and possibly cervical cancer.
- Offer contraception just when needed, even immediately after childbirth.
- Prevent pregnancy effectively if used correctly with every act of sexual intercourse (except cervical cap, which protects up to 48 hours after insertion).
- No effect on breast milk.
- Can be stopped at any time.
• Easy to use with a little practice.
• In case of spermicides:
  - No need to see a health care provider before use.
  - May increase vaginal lubrication.
• Spermicide can be inserted 1 hour before sex, whereas the diaphragm or cervical cap may be inserted 6 hour before sex to avoid interrupting sex.

Limitations
• Cause few side effects:
  - Spermicide may cause local allergic reaction/irritation in the woman or her partner, especially if used very frequently.
  - May cause urinary tract infections.
  - Require expertise.
• Require woman or her partner to put fingers or inserter into her vagina. (They should wash their hands first.)
• Spermicide may be messy.
• May be hard to conceal from partner.
• In case of spermicide:
  - Because it can melt, it must be placed in the vagina at least 10 minutes before a man ejaculates but not more than 1 hour before.
  - Irritation caused by using several times a day may increase the risk of STIs/HIV.
• For diaphragm and cervical cap:
  - A woman requires a health care provider’s help initially to learn the proper technique of insertion and removal.
  - Women may find it difficult to interrupt sex to insert a vaginal method.
• Women may need a different size of diaphragm after childbirth.
• The diaphragm or cap should be washed with mild soap and clean water after each use.
• The diaphragm needs careful storage to avoid developing holes.

Client Assessment as per World Health Organization Medical Eligibility Criteria

<table>
<thead>
<tr>
<th>Medical Eligibility Criteria (MEC)</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Vaginal methods</strong></td>
</tr>
<tr>
<td>Ask the client the questions below. If the answers is “no” to all of the questions, then she can use vaginal methods if she desires. If the answer is “yes” to a question below, follow the instructions.</td>
</tr>
</tbody>
</table>

1. *Did the client recently have a full-term delivery or second-trimester spontaneous or induced abortion? If yes, when?*

Diaphragm and cervical cap generally should not be fitted until 6 to 12 weeks after childbirth or second-trimester abortion, depending on when the uterus and cervix return to normal. The client can use spermicides alone or other backup methods.
2. Is the client allergic to latex?
Client should not use a latex diaphragm or cap. She can use a plastic diaphragm.

3. Has the client ever been told that her vagina, cervix, or uterus has an unusual shape or position?
May be impossible or ineffective for her to use a diaphragm or cap. A pelvic exam may be necessary to determine whether diaphragm or cap can be correctly placed and will stay in place.

4. Does the client have a medical condition that makes pregnancy dangerous?
Women may want a more effective method. The client may use vaginal methods, however, if she makes an informed choice and receives proper instruction on effective use.

5. Has the client ever had toxic shock syndrome? (This is extremely rare.)
Generally she should not use diaphragm or cervical cap but can use spermicides alone or another method. Be sure to explain the health benefits and risks and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable, if relevant to the client’s situation.

Method of use

Starting Time
- A woman can begin using a vaginal method at any time during her monthly cycle, and
- Soon after childbirth, abortion, or miscarriage.
- The diaphragm and cervical cap generally do not fit well in the first 6 to 12 weeks after full-term delivery or second-trimester spontaneous or induced abortion. She can use these methods, depending on when her uterus and cervix return to their normal sizes. If needed, a woman can use spermicide alone or with condoms until then.

Technique of Use
Inserting the diaphragm
Once the client has consulted the health care provider for the recommended proper size of diaphragm, she can insert and remove it herself when needed.

The woman inserts the diaphragm with spermicide in the proper position in the vagina before having sexual intercourse. The woman:
- Holds the diaphragm with the dome down (like a cup).
- Squeezes about a tablespoon of spermicidal cream or jelly into the cup of the diaphragm and around the rim.
- Presses opposite sides of the rim together and, with the dome side toward the palm of her hand, pushes the diaphragm into the vagina as far as it goes.
• Touches the diaphragm with a finger, to make sure that it covers the cervix. Through the dome of the diaphragm, the cervix feels like the tip of the nose.
• Does not remove the diaphragm, but uses an applicator to insert additional spermicide for each additional act of intercourse.

Removing the diaphragm
The woman:
• Leaves the diaphragm in place for at least 6 hours after the man's last ejaculation. She should not leave the diaphragm in for more than 24 hours. Doing so might increase the risk of toxic shock syndrome.
• Inserts a finger into the vagina until she feels the rim of the diaphragm.
• Gently slides a finger under the rim and pulls the diaphragm down and out. She is careful not to tear the diaphragm with a fingernail.
• Washes the diaphragm with mild soap and clean water after each use. She checks for holes by filling it with water or by holding it up to the light.
• Dries the diaphragm and stores it in a clean, dark, cool place, if possible.

Inserting the cervical cap
The woman inserts the cervical cap with spermicide in the proper position in the vagina before having sexual intercourse. The woman:
• Fills the dome of the cap one-third full with spermicidal cream or jelly.
• Squeezes the rim of the cap between her thumb and index finger, and, with the dome side toward the palm of the hand, slides the cap into the vagina as far as it goes.
• Uses a finger to locate the cervix, which feels like the tip of the nose.
• Presses the rim of the cap around the cervix until it is completely covered, and sweeps a finger around the cap rim to be sure the cervix is covered.
• Does not need additional spermicide for additional acts of intercourse that occur within 48 hours after insertion, as long as she keeps the cap in place.

Removing the cervical cap
The woman:
• Leaves the cap in for at least 6 hours after her partner's last ejaculation. She does not leave the cap in for more than 48 hours. Doing so may increase the risk of toxic shock syndrome.
• Inserts a finger into the vagina until she feels the rim of the cap.
• Presses on the cap rim until the seal against the cervix is broken, and then she tilts the cap off the cervix.
• Hooks a finger around the rim and pulls it sideways out of the vagina.
• Washes the cap with mild soap and clean water after each use and checks for holes by filling it with water or by holding it up to the light.
• Dries the cap and stores it in a clean, dark, cool place if possible.

Inserting spermicide
The woman:
- Inserts the spermicide in the vagina any time within 1 hour of each act of sexual intercourse.
- Inserts more spermicide before each act of sexual intercourse.
- Does not douche for at least 6 hours after sex.

Table 6-3. Vaginal Methods (Diaphragms, Cervical Caps, and Spermicides): Side Effects and Their Management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
</table>
| Allergic reaction or sensitivity to spermicide, burning or itching | • Check for signs of infection, e.g., abnormal vaginal discharge, redness and/or swelling of the vagina, and itching of the vulva.  
• Treat or refer as appropriate.  
• If no infection, suggest a different type or brand of spermicide.  
• In case of infection, treat with antibiotics such as Ampicillin or Trimethoprim plus Sulfamethoxazole or Urixin for 10 to 14 days. |
| Urinary tract infection                         | • Suggest that the woman urinate soon after sex to help prevent future infections.  
• Suggest that she drink plenty of fluids, urinate often, and eat food containing vitamin C, such as oranges, grapefruit, and limes, if possible.  
• If infection is frequent or recurrent, check that the diaphragm is not too tight. (You should be able to fit a gloved finger in front of the rim.) Also consider the possibility of STIs.  
• Consistent use of the diaphragm is usually not recommended for a woman who has chronic or recurrent urinary tract infection that does not respond to treatment. |
| Pain from pressure on bladder or rectum with diaphragm use | • Check diaphragm fit and look for vaginal lacerations.  
• If diaphragm is too large, replace with smaller size. |
| Difficulty inserting diaphragm or cap            | • Give additional advice on insertion.  
• Have her try insertion in the clinic and then check placement.  
• Her sex partner sometimes can help with insertion. |
| Sudden high fever, body rash, vomiting, diarrhoea, dizziness, | • The woman should be taken immediately to the nearest health centre. She may have toxic shock |
and muscle aches (very rare) syndrome.
- Treatment with antibiotics and intravenous fluids is very effective and should be given right away.

Vaginal lesion
- Suggest that she use another method temporarily and give her supplies.
- Check diaphragm fit and how the client removes her diaphragm.

Counselling
A client who chooses a vaginal method will benefit from good counselling, a friendly provider who listens to her concerns, answers her questions, and gives clear, practical information, especially about the importance of consistent use. Good counselling, including the points below, will help clients use vaginal methods with success and satisfaction:
- Give the client plenty of spermicide, up to a year's supply, if possible.
- Explain how to use vaginal methods, including insertion and, for diaphragm and cervical cap, removal.
- If the client chooses a diaphragm or cap, arrange for proper fitting and placement with a specifically trained provider. Refer if necessary.
- Plan a return visit when the client will need to get more spermicide if she does not prefer to get it elsewhere.
- Invite the client to come back any time she has questions or problems, or wants another method.

Follow-up
A scheduled return visit is not necessary. At any time convenient for the client, she can return for more spermicide or for advice on diaphragm or cap use and proper placement.
Advise the client to return for any of these reasons:
- For more spermicide.
- When a diaphragm or cap wears out, gets thin, develops holes, or becomes stiff. It needs to be replaced.
- After delivery or abortion to check the size of the diaphragm or cervical cap to fit.
The client or her partner has an allergic reaction (itching, rash, irritation). Advise the client to stop using the method.
- If the client had intercourse without using the method, or if the diaphragm or cervical cap was displaced or torn during use, she may need ECPs
- The client has any questions or problems or wants another method.

Record keeping
Maintain the following record for follow-up of the client:
- Daily register
- Client record card
- Client card, to be given to the client with information such as:
- Name, age, and registration number
- Type of method given
- Date for follow-up visit

Update records at each visit including details of complaints, side effects, and treatment given.
Introduction

Oral contraceptive pills (OCPs) have been available since the 1960s. The early preparations contained 50 mcg of oestrogen, but modern preparations contain 20–35 mcg and are called “low-dose” OCPs. Most preparations contain a combination of an oestrogen (usually ethinyl estradiol, in a low dose of 20 to 35 mcg) and a progestin (Norethindrone, norgestrel, Desogestrel, or Norgestimate). These are called combined oral contraceptive pills (COCs). There are two types of COC pill packets. Some packets have 28 pills. These contain 21 “active” pills, which contain hormones, followed by seven “reminder” pills of a different colour, which do not contain hormones, but only iron or lactose. Other packets usually have 21 “active” pills. Women who use oral contraceptives swallow a pill each day to prevent pregnancy.

Progestin-only pills (POPs) are also available, and are useful for women who cannot take oestrogen or are lactating. These are called mini-pills.

Policy

- OCPs are advised as a method of spacing pregnancy rather than as a method for long-term or permanent use.
- OCPs are not to be given to a woman who is pregnant or is suspected to be pregnant.
- COCs are not to be given to a lactating mother until the child is 6 months of age.
- POPs are to be given to a lactating mother only after 6 weeks postpartum.
- OCPs are not to be recommended approximately 4 weeks before and 6 weeks after major surgery that requires long-term immobilization.

Standards

The following standards will be observed:
- The client should be given full information about the use, risks, advantages, and possible side effects before OCPs are prescribed for her.
- Pills should be given only to those who meet the Medical Eligibility Criteria (MEC).

Combined Oral Contraceptive Pills

Mode of action
The combined pills contain both oestrogen and progestin. They act in the following ways:
- Inhibit ovulation.
- Thicken cervical mucus.
• Make the endometrium less suitable for implantation.

There is no evidence of a harmful effect if an unsuspecting pregnant woman inadvertently uses OCPs; nevertheless, a woman should be given OCPs only when it is reasonably certain she is not pregnant.

Effectiveness

Effectiveness Depends on the User
• Risk of pregnancy is greatest when a woman starts a new pill pack after the prescribed time, or misses three or more pills.
• As commonly used, about eight pregnancies occur per 100 women using COCs over the first year. This means that 92 of every 100 women using COCs will not become pregnant.
• When pills are taken regularly, less than one pregnancy occurs per 100 women using COCs over the first year.

Advantages
• Very effective when used correctly.
• No need to do anything at the time of sexual intercourse.
• Increased sexual enjoyment because no need to worry about pregnancy.
• Monthly periods are regular with lighter monthly bleeding and fewer days of bleeding.
• Can be used as long as a woman wants to prevent pregnancy.
• No rest period needed.
• Can be used at any age from adolescence to menopause.
• Can be used by women who have children and nulliparous women.
• User can stop taking pills at any time.
• Fertility returns soon after stopping.
• Can be used as an emergency contraceptive after unprotected sex.
• Can prevent or decrease iron deficiency anaemia.
• Help prevent: ectopic pregnancies, endometrial cancer, ovarian cancer, ovarian cysts, pelvic inflammatory disease (PID), and benign breast disease.
• Reduce:
  – Menstrual cramps
  – Menstrual bleeding problems
  – Ovulation pain
  – Symptoms of polycystic ovarian syndrome (irregular bleeding, acne, excess hair on face or body)
  – Symptoms of endometriosis (pelvic pain, irregular bleeding)

Limitations
Common side effects (not signs of sickness):
• Nausea (most common in first 3 months).
• Spotting or bleeding between menstrual periods, especially if a woman forgets to take her
pills or takes them late (most common in first 3 months).

- Mild headaches.
- Breast tenderness.
- Slight weight gain.
- Amenorrhoea (some women see amenorrhoea as an advantage).
- Not highly effective unless taken every day. Difficult for some women to remember every day.
- New packet of pills must be at hand every 28 days.
- In a few women, may cause mood changes including depression and less interest in sex.
- Very rarely can cause stroke, blood clots in deep veins of the legs, or heart attack. Those at highest risk are women with high blood pressure and women who are age 35 or older and at the same time smoke 15 or more cigarettes per day.
- Do not protect against sexually transmitted infections (STIs) including HIV.

### Client Assessment as per World Health Organization Medical Eligibility Criteria

#### Medical Eligibility Criteria (MEC)
Ask the client the following questions about known medical conditions. Examinations and tests are not necessary. If she answers “no” to all of the questions, then she can start COCs if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still start COCs. These questions also apply for the combined patch and the combined vaginal ring.

1. **Is the client breastfeeding a baby younger than 6 months old?**
   - If fully or nearly fully breastfeeding: Give her COCs and tell her to start taking them 6 months after giving birth or when breast milk is no longer the baby’s main food—whichever comes first.
   - If partially breastfeeding: She can start COCs as soon as 6 weeks after childbirth.

2. **Has the client had a baby in the last 3 weeks but she is not breastfeeding?**
   - Give her COCs now and tell her to start taking them 3 weeks after childbirth.

3. **Does the client smoke cigarettes?**
   - If she is 35 years of age or older and smokes, do not provide COCs. Convince her to stop smoking and help her choose another method.

4. **Does the client have cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [Signs of jaundice]) Has she ever had jaundice when using COCs?**
   - If she reports serious active liver disease (jaundice, active hepatitis, mild or severe cirrhosis, liver tumours) or ever had jaundice while using COCs, do not provide COCs. Help her choose a method without hormones.

5. **Does the client have high blood pressure?**
If blood pressure cannot be checked and she reports a history of high blood pressure or if she is being treated for high blood pressure, do not provide COCs. Refer her for a blood pressure check if possible or help her choose a method without oestrogen. Check blood pressure if possible: If her blood pressure is below 140/90 mm Hg, provide COCs. If her systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide COCs. Help her choose a method without oestrogen, but not progestin-only injectables if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher. (One blood pressure reading in the range of 140–159/90-99 mm Hg is not enough to diagnose high blood pressure. Give her a backup method to use until she can return for another blood pressure check, or help her choose another method now if she prefers. If her blood pressure at next check is below 140/90, she can use COCs.)

6. Has the client had diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes?
Do not provide COCs. Help her choose a method without oestrogen but not progestin-only injectables.

7. Does the client have gallbladder disease now or is she taking medication for gallbladder disease?
Do not provide COCs. Help her choose another method, but not the combined patch or combined vaginal ring.

8. Has the client ever had a stroke, blood clot in her legs or lungs, heart attack, or other serious heart problems?
If she reports heart attack, heart disease, or stroke, do not provide COCs. Help her choose a method without oestrogen, but not progestin-only injectables. If she reports a current blood clot in the deep veins of the legs or lungs (not superficial clots), help her choose a method without hormones.

9. Does the client have or has she ever had breast cancer?
Do not provide COCs. Help her choose a method without hormones.

10. Does the client sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Does she get throbbing, severe headaches, and often on one side of the head, which can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)? Such headaches are often made worse by light, noise, or moving about.
If she has migraine aura or migraine headaches without aura and is age 35 or older, do not provide COCs. Help these clients choose a method without oestrogen. If she is under 35 and has migraine headaches without aura, she can use COCs.

11. Is the client taking medications for seizures or taking rifampicin for tuberculosis or other medicine?
If she is taking barbiturates, carbamazepine, oxcarbazepine, phenytoin, primidone, topiramate, or rifampicin, do not provide COCs. They can make COCs less effective. Help her choose another method, but not progestin-only pills or implants.

12. Is the client planning major surgery that will keep her from walking for 1 week or more? If so, she can start COCs 2 weeks after the surgery. Until she can start COCs, she should use a backup method.

13. Does the client have conditions that could increase her chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes? Do not provide COCs. Help her choose a method without oestrogen but not progestin-only injectables.

Indications

- Have or have not had children
- Are fat or thin
- Are any age, including adolescents and over 40 (except clients who smoke and are above 35 years age)
- Smoke cigarettes but are below 35 years of age
- Have just had an abortion or miscarriage
- Heavy, painful menstrual periods or iron deficiency anaemia (condition may improve)
- Irregular menstrual periods
- Benign breast disease
- Diabetes without vascular, kidney, eye, or nerve disease
- Mild headaches
- Varicose veins
- Malaria
- Thyroid disease
- Pelvic inflammatory disease
- Endometriosis
- Benign ovarian tumours
- Uterine fibroids
- Past ectopic pregnancy
- Tuberculosis (unless taking rifampicin)

Method of use

**Starting Time**

- Any of the first 5 days after menstrual bleeding starts, if she has a normal cycle. The first day of menstrual bleeding may be easiest to remember.
- Any other time it is reasonably certain that she is not pregnant. If more than 5 days since
menstrual bleeding started, she can begin COCs but should avoid sex or also use condoms or spermicide for the next 7 days. Her usual bleeding pattern may change temporarily.

- When switching from injectables or implants, she can start COCs immediately if it is reasonably certain she is not pregnant. No need to wait for a first period after using injectables or implants.
- After she stops breastfeeding or 6 months after childbirth, whichever comes first.
- Three to 6 weeks after childbirth if she is not breastfeeding. No need to wait for menstrual periods to return to be certain that she is not pregnant.
- Six weeks or more after childbirth if she is partially breastfeeding, or any time it is reasonably certain that she is not pregnant. If not reasonably certain, she should avoid sex or use condoms or spermicide until her first period starts, and then begin COCs.
- In the first 7 days after first or second trimester miscarriage or abortion. Later, any time it is reasonably certain that she is not pregnant.

Technique

28 pills packet (containing 21 white and seven brown):
- Start the white pills within the first 5 days of the menstrual cycle.
- If not menstruating, start the pills on the same day and keep taking one pill every day until finishing all of the white pills, but use a backup method for the first 7 days of taking the pills.
- Start the brown pills immediately after finishing the white pills and continue taking one pill every day for 7 days.
- Menses usually start 2 to 3 days after starting the brown pills.
- After finishing the seven brown pills, start the new packet of 28 pills (it does not matter if bleeding continues).

21 pills packet (containing 21 white pills):
- Start the pills within the first 5 days of the menstrual cycle.
- If not menstruating, start taking the pill and keep taking one pill every day until finishing all of the pills, but use a backup method for the first 7 days of taking the pills.
- After finishing the pills, do not take any pill for the next 7 days.
- Menses usually start 2 to 3 days after the pills are finished.
- After a 7-day period of no pills, start the new packet of 21 pills.

Missed Pills

Instructions If a Woman Forgets to Take a Pill or Pills
- Take a missed hormonal pill (white) as soon as possible.
- Keep taking pills as usual, one each day. (She may take two pills at the same time or on the same day.)

Missed one or two pills? Started a new pack 1 or 2 days late?
- Take a hormonal pill as soon as possible.
- There is little or no risk of pregnancy.
**Missed three or more pills in the first or second week? Started a new pack 3 or more days late?**
- Take a hormonal pill as soon as possible.
- Use a backup method for the next 7 days.
- Also, if she had sex in the past 7 days, she should consider using emergency contraceptive pills (ECPs).

**Missed three or more pills in the third week?**
- Take a hormonal pill as soon as possible.
- Finish all hormonal pills in the pack. Throw away the seven non-hormonal pills in a 28-pill pack.
- Start a new pack the next day.
- Use a backup method for the next 7 days.
- Also, if she had sex in the past 5 days, she should consider using ECPs.

**Missed any non-hormonal pills (brown pills)? (Last seven pills in 28-pill pack)**
- Discard the missed non-hormonal pill(s).
- Keep taking COCs, one each day, and start the new pack as usual.

**Severe vomiting or diarrhoea?**
- If she vomits within 2 hours after taking a pill, she should take another pill from her pack as soon as possible, and then keep taking pills as usual.
- If she has vomiting or diarrhoea for more than 2 days, follow instructions for one or two missed pills, above.

**Side Effects and Management**
Most women tolerate COCs very well. However, a number of women may have side effects, especially in the first few months of taking the pill.

**Table 7-1. Combined Oral Contraceptive Pills: Side Effects and Their Management**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dizziness or nausea</td>
<td>• Make sure she is taking the pill at bed time.</td>
</tr>
<tr>
<td></td>
<td>• She should take the pill with meals and not on an empty stomach.</td>
</tr>
<tr>
<td></td>
<td>• Check for pregnancy; if no cause is found, reassure the client.</td>
</tr>
<tr>
<td>Vomiting</td>
<td>• If she vomits within 2 hours of taking the pill, ask her to take an extra pill from another packet.</td>
</tr>
<tr>
<td></td>
<td>• Make sure she is taking the pill just before going to bed and with food.</td>
</tr>
<tr>
<td></td>
<td>• Pills should be stopped; inform her that withdrawal bleeding will occur. Change over to another suitable contraceptive method of her choice.</td>
</tr>
<tr>
<td>Severe diarrhoea</td>
<td>• Diarrhoea for more than 2 days, follow instructions for</td>
</tr>
</tbody>
</table>
missed pills as mentioned above.

- More than 24 hours of tenderness or fullness of the breast
  - Follow the instructions for missed pills.
  - Examine breasts for lump.
  - If none, reassure the client.
  - Prescribe a mild analgesic (paracetamol), if necessary.

**Weight gain**

- Less than 2 kg in months
  - Ask if her appetite has increased, and if so, ask her to decrease food intake, especially of fats and sweets.
- More than 2 kg in 3 months
  - Stop pills; provide another suitable contraceptive method.

**Spotting or irregular bleeding**

- If due to STI or PID
  - Continue treatment and COCs.
- Within 3 months of starting the pills
  - Reassure the client that it is transitory.
  - Ask if she has been forgetting to take pills. If so, ask her to be regular and take the pill at the same time each day.
  - For temporary relief, give:
    - Tab. Ibuprofen 800 mg TDS (max) after meals for 5 days,
    - or
    - Tab. Ponstan, 2xTDS, beginning when irregular bleeding starts.
- After 3 months of starting the pills
  - If this persists despite the client being regular in taking pills, then stop pills and give a backup method and watch/investigate. If no problem, reassure and provide another suitable contraceptive method.

**Amenorrhoea**

- Check for pregnancy.
- If negative, reassure and give oral pills with higher dose of hormones.
- If amenorrhoea persists (after changing pills) for more than 3 months, stop pills and give another suitable contraceptive method.

**Rise in BP (above 140/90)**

- Advise her to come to the clinic for a regular check of BP on three visits, 1 week apart. If high BP persists, stop pills and give another suitable method and refer.

**Severe migraine**

- If it develops while using COCs, stop the pills. Give her another suitable contraceptive method.
<table>
<thead>
<tr>
<th>Rare side effects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Acne</td>
</tr>
<tr>
<td>• Mild acne</td>
</tr>
<tr>
<td>• Avoid use of creams containing lanolin.</td>
</tr>
<tr>
<td>• Ask her to keep the skin clean.</td>
</tr>
<tr>
<td>• Avoid fatty food.</td>
</tr>
<tr>
<td>• Severe acne</td>
</tr>
<tr>
<td>Stop pills. Give another suitable contraceptive method.</td>
</tr>
<tr>
<td>Pigmentation of skin</td>
</tr>
<tr>
<td>(especially of face)</td>
</tr>
<tr>
<td>Stop pills.</td>
</tr>
<tr>
<td>Give another suitable contraceptive method.</td>
</tr>
<tr>
<td>Generalized loss of hair</td>
</tr>
<tr>
<td>Avoid use of creams containing mercury.</td>
</tr>
<tr>
<td>Ask if this followed after the start of pills; if so, stop pills and give another suitable contraceptive method.</td>
</tr>
<tr>
<td>Depression or irritability</td>
</tr>
<tr>
<td>If confirmed to have happened after starting the pills, stop pills, and give another suitable contraceptive method.</td>
</tr>
<tr>
<td>Loss of sexual desire</td>
</tr>
<tr>
<td>If confirmed to have happened after starting pills:</td>
</tr>
<tr>
<td>• Rule out local infections as a cause.</td>
</tr>
<tr>
<td>• Stop pills, and give another suitable contraceptive method.</td>
</tr>
</tbody>
</table>

**Counselling**

A woman who chooses low-dose COCs can benefit from good counselling. A friendly provider who listens to a woman's concerns, answers her questions, and gives clear, practical information about side effects and advice about their proper use will help the woman use COCs with success and satisfaction.

The health care provider should follow these steps to provide COCs:

- Show her which kind of pill packet you are giving her, 21 pills or 28 pills.
- Tell her about the advantages and limitations.
- Inform her about the common side effects and what to do.
- Give her a sufficient number of pill packets, depending on her need. Running out of pills is a major reason for unintended pregnancies.
- Explain how to use COCs and what to do if she misses pills.
- If possible, give her condoms or spermicide to use:
  - Until she can start taking her pills (if needed).
  - If she starts a packet of pills late, if she forgets several pills in a row, or if she stops taking oral contraceptives for any reason.
  - If she or her spouse are at risk of HIV/AIDS or any other STI, show her how to use condoms.
- Plan a return visit in time to give her more pills before her supply runs out.
- Invite the client to come back at any time to the clinic if she has questions, problems, or wants another method.
- Ask her to repeat the most important instructions and, using the pill packet, show how she
will take her pills.

- Ask her if she has any questions, fears, or concerns, and answer her concerns respectfully and caringly.
- For any unscheduled visit, ask her to bring the packet in use with her.

**Follow-up**
The follow-up care and support of the client is very important for continued use of OCPs. The health care provider has a responsibility to keep the client satisfied, in case she has side effects, by providing correct information and reassurance.

**Explain Specific Reasons to See a Trained Health Care Provider**
- Describe the symptoms of problems that require medical attention.
- Serious complications of pill use are rare. Still, a client should see a doctor or return to the clinic if she has questions or problems for any possible symptoms of a serious problems or warning signs.

**Warning Signs**
COCs may or may not cause these problems. But if any of the following occur, the client should immediately contact a trained provider:
- A - Abdominal pain (severe)
- C - Chest pain (severe) with cough and shortness of breath
- H - Headache (severe) with dizziness and shortness of breath
- E - Eye problems (vision loss, blurring, or flashes of light)
- S - Severe leg pain (calf or thigh)

**Helping Clients at Any Return Visit**
At any return visit, ask the client:
- If she has any questions or anything to discuss.
- About her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return again any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.
- If she has had any health problems since her last visit, and assess the following:
  - Check blood pressure once a year if possible.
  - Ask if she has developed high blood pressure, heart disease due to blocked arteries, stroke, breast cancer, active liver disease, or gallbladder disease, or she is taking medicines for seizures, rifampicin, or griseofulvin. If appropriate, help her choose another method.
  - Ask if she has developed very bad headaches. If appropriate, help her choose another suitable method.

**Plan for Her Next Visit**
If she has not developed any condition, that means she can use COCs; provide more supplies if needed. Plan for her next visit before she needs more pills.

**Minimum Record**
Maintain the following record for follow-up of the client:
- Daily register.
- Client record card.
- Client card, to be given to the client with information such as:
  - Name, age, and registration number
  - Type of COCs given
  - Date for follow-up visit
- Update records at each visit including details of complaints, side effects, and treatment given.

**Progestin-Only Pills**

**Effectiveness**
- Effectiveness depends on the user. For women who have monthly bleeding, risk of pregnancy is greatest if pills are taken late or missed completely.

For breastfeeding women:
- As commonly used, about one pregnancy per 100 women using POPs over the first year. This means that 99 of every 100 women will not become pregnant.
- When pills are taken every day, less than one pregnancy per 100 women using POPs over the first year (3 per 1,000 women).

For women not breastfeeding, they are less effective:
- As commonly used, about three to 10 pregnancies occur per 100 women using POPs over the first year. This means that 90 to 97 of every 100 women will not become pregnant.
- When pills are taken every day at the same time, less than 1 pregnancy occurs per 100 women using POPs over the first year (9 per 1,000 women).

**Advantages**
- Protect against pregnancy.
- Very effective when used correctly.
- No need to do anything at the time of sexual intercourse.
- Increased sexual enjoyment because no need to worry about pregnancy.
- Monthly periods are regular; lighter monthly bleeding and fewer days of bleeding; milder and fewer menstrual cramps.
- Can be used as long as a woman wants to prevent pregnancy.
- No rest period needed.
- Can be used at any age from adolescence to menopause.
- User can stop taking pills at any time.
• Fertility returns soon after stopping.
• Can be used as an emergency contraceptive after unprotected sex.
• Can be used by nursing mothers starting 6 weeks after childbirth.
• Do not affect quantity and quality of breast milk.
• No estrogen related side effects. Do not increase risk of estrogen-related complications such as heart attack or stroke.
• Women take one pill every day with no break. Easier to understand than taking 21-day combined pills.
• Can be very effective during breastfeeding.

Limitations
Some users report the following:
• Changes in bleeding patterns, including:
  − For breastfeeding women, longer delay in return of monthly bleeding after childbirth (lengthened postpartum amenorrhoea)
  − Irregular menstrual bleeding
  − Amenorrhoea
• Headaches
• Dizziness
• Mood changes
• Breast tenderness
• Abdominal pain
• Nausea
• For women not breastfeeding, enlarged ovarian follicles

Client Assessment as per World Health Organization Medical Eligibility Criteria

Medical Eligibility Criteria (MEC)

1. *Does the client have or has she ever had breast cancer?*
   Do not provide POPs. Help her choose a method without hormones.

2. *Does the client have jaundice, severe cirrhosis of the liver, a liver infection, or tumour?*
   Perform physical exam or refer. If she has serious active liver disease (jaundice, painful or enlarged liver, active viral hepatitis, liver tumour), do not provide POPs. Refer for care. Help her choose a method without hormones.

3. *Is the client breastfeeding a baby younger than 6 weeks old?*
   Can give her POPs now, with instructions on when to start—when the baby is 6 weeks old.

4. *Does the client have serious problems with her blood vessels? If so, what problems?*
   Do not provide POPs if she reports blood clots (except superficial clots). Help her choose another effective method.
5. *Is the client taking medicine for seizures? Taking rifampicin or griseofulvin?*
If she is taking phenytoin, carbamezapine, barbiturates, or primidone for seizures or rifampicin or griseofulvin, provide condoms or spermicide or another contraceptive. If she prefers, or if she is on long-term treatment, help her choose another effective method.

6. *Does the client think she is pregnant?*
Assess whether pregnant. If she might be pregnant, give her condoms or spermicide to use until reasonably sure that she is not pregnant. Then she can start POPs.

**Method of use**

**Starting Time**
POPss may be given to breastfeeding women:
- As early as 6 weeks after childbirth and at any time after confirmation that she is not pregnant.
- If menstrual periods have returned, she can start POPs any time it is reasonably certain that she is not pregnant.

POPss may be given to non-breastfeeding women:
- Within 3 weeks of childbirth.

**Technique**
The client should always take one pill each day at approximately the same time for maximum efficacy, until the pill packet is finished. The more pills she misses, the greater her risk of becoming pregnant.
- When she finishes one pack, she should take the first pill from the next pack on the very next day.
- It is very important to start the next pack on time. Starting a pack late risks pregnancy.

**Missed Pills**

*Instructions If a Woman Forgets to Take a Pill or Pills*
It is easy to forget a pill or to be late in taking it. POP users should know what to do if they forget to take pills.

If a woman is 3 or more hours late in taking a pill or misses one completely, she should follow the instructions below:
For breastfeeding women, whether missing a pill places her at risk of pregnancy depends on whether or not her monthly bleeding has returned.
- Take a missed pill as soon as possible.
- Keep taking pills as usual, one each day. (She may take 2 pills at the same time or on the same day.)
If the client has regular monthly bleeding:
- Use a backup method for the next 2 days.
- Also, if she had sex in the past 5 days, she can consider taking ECPs.

If she vomits within 2 hours after taking a pill:
- Take another pill from her pack as soon as possible, and keep taking pills as usual.
- If vomiting or diarrhoea continues, follow the instructions above for making up missed pills.

Table 7-2. Progestin-Only Pills: Side Effects and Their Management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Nausea or dizziness</td>
<td>Take POPs at bedtime and with food.</td>
</tr>
</tbody>
</table>
| Breast tenderness    | • Advise her to wear a supportive bra (including during strenuous activity and sleep).  
                          • Use hot or cold compresses.  
                          • Give her:  
                            - Tab. aspirin (325–650 mg), SOS and not more than three times a day  
                            - Tab. ibuprofen (200–400 mg), 1BD  
                            - Tab. paracetamol (325–1,000 mg), 1TDS  
                          The number of tabs will depend on the formulation. The dosage can vary with the severity of the problem. |
| Amenorrhoea          | Breastfeeding women: Reassure her that this is normal during breastfeeding. It is not harmful.  
                          Women not breastfeeding: Reassure her that it is not harmful; in fact, lack of menstruation will help improve her anaemia. |
| Irregular bleeding   | • Reassure her that it is not harmful.  
                          • Breastfeeding itself may cause irregular bleeding.  
                          • Many women using POPs experience irregular bleeding, whether breastfeeding or not:  
                            - Vomiting or diarrhoea might cause irregular bleeding.  
                            - Taking anticonvulsants or rifampicin might cause irregular bleeding.  
                          To reduce irregular bleeding:  
                            • Tell her to make up for missed pills properly, including after vomiting or diarrhoea.  
                            • For temporary relief:  
                              - Tab. ibuprofen 800 mg TDS after meals for 5 days, or  
                              - Tab. Ponstan 2TDS, beginning when irregular bleeding starts.  
                            • If even after taking medication condition does not improve, counsel her for another method. |
| If irregular bleeding continues | • Consider underlying conditions unrelated to method |
or starts after several months of normal or no monthly bleeding, or you suspect that something may be wrong for other reasons

<table>
<thead>
<tr>
<th>Heavy or prolonged bleeding (twice as much as usual or longer than 8 days)</th>
<th>Reassure her that it is not harmful and usually lessens or stops after a few months.</th>
</tr>
</thead>
<tbody>
<tr>
<td>For temporary relief:</td>
<td></td>
</tr>
<tr>
<td>- Tab. ibuprofen 800 mg (max) TDS after meals for 5 days, or</td>
<td></td>
</tr>
<tr>
<td>- Tab. Ponstan 2TDS, beginning when irregular bleeding starts.</td>
<td></td>
</tr>
<tr>
<td>- Iron Tab. 1 TDS and eat foods containing iron.</td>
<td></td>
</tr>
<tr>
<td>Consider underlying conditions unrelated to method use. Refer if necessary.</td>
<td></td>
</tr>
<tr>
<td>Counsel for another suitable method if needed.</td>
<td></td>
</tr>
</tbody>
</table>

| If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding | Consider underlying conditions unrelated to method use. |

<table>
<thead>
<tr>
<th>Headache</th>
<th>Give her:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Tab. aspirin (325–650 mg), 1TDS</td>
<td></td>
</tr>
<tr>
<td>- Tab. ibuprofen (200–400 mg), 1BD</td>
<td></td>
</tr>
<tr>
<td>- Tab. paracetamol (325–1,000 mg), 1TDS</td>
<td></td>
</tr>
<tr>
<td>The number of tabs will depend on the formulation. Dosage will vary according to the severity of the headache.</td>
<td></td>
</tr>
</tbody>
</table>

| Headaches that get worse or occur more often | Counsel her for another suitable contraceptive method. |

| Depression or irritability | If confirmed to have happened after starting the pills, stop pills; give another suitable contraceptive method. |

<table>
<thead>
<tr>
<th>Loss of sexual desire</th>
<th>Rule out local infections as a cause.</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Stop pills, and give another suitable contraceptive method.</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Severe pain in lower abdomen</th>
<th>Many conditions can cause severe abdominal pain. Check for signs and symptoms of ectopic pregnancy, which are:</th>
</tr>
</thead>
<tbody>
<tr>
<td>- Unusual abdominal pain or tenderness</td>
<td></td>
</tr>
<tr>
<td>- Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from her usual bleeding pattern</td>
<td></td>
</tr>
<tr>
<td>- Light-headedness or dizziness</td>
<td></td>
</tr>
<tr>
<td>- Fainting</td>
<td></td>
</tr>
<tr>
<td>If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care.</td>
<td></td>
</tr>
</tbody>
</table>
Warning signs

- If the client comes with any of the warning signs
  - Stop pills.
  - Refer to the doctor/hospital immediately.

Counselling

A client who chooses POPs can benefit from good counselling. A friendly provider who listens to a client’s concerns, answers her questions, and gives clear, practical information helps the woman use POPs with success and satisfaction. Thorough counselling about bleeding changes and other side effects is an important part of providing the method. Counselling about menstrual changes may be the most important help a client needs to keep using the method.

The health care provider should follow these steps to provide POPs:
- Show the client the POP packet that she will use, even if she will be getting her pills elsewhere later.
- Explain that all pills in POP packets are the same white colour and all are active hormonal pills.
- Tell her about the advantages and limitations.
- Inform her about the common side effects and what to do.
- Give her a sufficient number of pills packets, depending on her need. Running out of pills is a major reason for unintended pregnancies.
- Explain how to use POPs and what to do if she misses pills.
- If possible, give her condoms or spermicide to use:
  - Until she can start taking her pills (if needed).
  - If she starts a packet of pills late, if she forgets several pills in a row, or if she stops taking oral contraceptives for any reason.
  - If she or her spouse are at risk of HIV/AIDS or any other STI, show her how to use condoms.
- Plan a return visit in time to give her more pills before her supply runs out.
- Invite the client to come back at any time to the clinic if she has questions, problems, or wants another method.
- Ask her to repeat the most important instructions and, using the pill packet, show her how she will take her pills.
- Ask her if she has any questions, fears, or concerns, and answer her concerns respectfully and caringly.
- For any unscheduled visit, ask her to bring the packet in use with her.

Follow-up

The follow-up care and support of the client is very important for continued use of OCPs. The health care provider has a responsibility to keep the client satisfied, in case she has side effects, by providing correct information and reassurance.

Explain specific reasons to see a trained health care provider
Assure the client that she is welcome to come back any time, especially if:
• She has problems, questions, or wants another method.
• She has a major change in health status.
• She thinks she might be pregnant.
• She has stopped breastfeeding and wants to switch to another method.
• She took a pill more than 3 hours late or missed one completely, and also had sex during this time; she may wish to consider ECPs.

She should immediately see a health care provider if she has any of the following warning signs.

**Warning signs**
- A Abnormal heavy bleeding
- S Stroke and heart disease (Chest pain with dyspnea)
- H Headache (severe)
- Y Yellow colour of eyes (jaundice)

**Helping clients at any return visit**
• Ask if the client has any questions or anything to discuss.
• Ask the client about her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return again any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another suitable contraceptive method.

**Plan for her next visit**
• Encourage her to come back for more pills before she uses up her supply of pills.

**Minimum record**
Maintain the following record for follow-up of the client.
• Daily register
• Client record card
• Client card, to be given to the client with information such as:
  - Name, age and registration number
  - Type of POP given
  - Date for follow-up visit
• Update records at each visit including details of complaints, side effects, and treatment given.
Injectable contraceptives contain female hormones. These hormones are slowly released in a woman’s body and provide protection against pregnancy. Two types of injectable contraceptives are available in Pakistan. These are:

- Progestin-only injectable contraceptives (PICs), which contain only progestin.
- Combined injectable contraceptives (CICs), which contain oestrogen as well as progesterone.

Policy

- Injectables will not be given to:
  - A woman who is pregnant or suspected to be pregnant.
  - Postpartum women before 6 weeks after childbirth if breastfeeding for Depo-Provera/Megestron and Norigest, and 6 months postpartum for Mesigyna.
- Injectables can be given to women immediately after abortion on their request.

Standards

The following standards must be maintained:

- Complete asepsis must be ensured while the injection is given.
- Use of disposable syringes should be made compulsory.
- All health care providers must be trained in the technique of administering injectables.

Progestin-Only Injectables

The injectable contraceptives DMPA (depot medroxyprogesterone acetate) and NET-EN (norethindrone enanthate) each contain synthetic progestin like the natural hormone progesterone that is in a woman’s body.

**DMPA:**
This progestin injectable contraceptive (PIC) contains depot medroxyprogesterone acetate and is prepared as a micro-crystalline suspension. A dose of 150 mg in 1 ml of the suspension is given by deep intramuscular injection at regular, 12-week intervals to protect the client from unwanted pregnancy. DMPA, the most widely used PIC, is also known as “the shot”, “the jab”, Depo, Depo-Provera, and Megestron.

**NET-EN:**
This PIC contains norethindrone enanthate and is prepared in an oily solution. A dose of 200
mg in 1 ml of oily solution is given by deep intramuscular injection regularly at 8-week intervals to protect the client from unwanted pregnancy.

Mode of action
The progestin in the injectables acts as a contraceptive by:

- Inhibiting ovulation most of the time.
- Thickening cervical mucus to form a plug, which inhibits the transport of sperm.
- Making the endometrium less suitable for implantation of the fertilized ovum.

Effectiveness

- When women have injections on time, less than 1 pregnancy/100 women.
- As commonly used, about 3 pregnancies/100 women.

Pregnancy rates may be higher for women who are late for an injection or who miss an injection, or if providers run out of supplies.

Advantages

- Very effective.
- Privacy—No one else can tell that a woman is using it.
- One injection prevents pregnancy for 2–3 months.
- Is reversible.
- Does not interfere with sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No daily pill-taking.
- Allows some flexibility in return visit; client can return for next injection up to 4 weeks late for DMPA and 2 weeks late for NET-EN.
- Does not affect the quantity and quality of breast milk.
- Can be used by nursing mothers as soon as 6 weeks after childbirth.
- No oestrogen-related side effects.
- Helps prevent endometrial cancer.
- Helps prevent uterine fibroids.
- May help prevent ovarian cancer.
- Special advantages for some women:
  - May help prevent iron-deficiency anaemia.
  - Makes sickle cell crises less frequent and less painful.
- Reduces symptoms of endometriosis (pelvic pain, irregular bleeding).
- Protects against symptomatic pelvic inflammatory disease (PID).
- Women who are infected with HIV, have AIDS, or are on antiretroviral (ARV) therapy can safely use progestin-only injectables.

Limitations

- Menstrual changes like spotting and irregular bleeding are common in the first few months
of use with both Norigest and Depo-Provera/Megestron.

- Amenorrhoea after prolonged use may occur.
- The return to fertility can be delayed—an average of 10 months longer for DMPA and 6 months longer for NET-EN.
- There is some delay in return of fertility after stopping the injection.
- Cannot be easily discontinued or removed from the body if complications develop or if pregnancy is desired.
- Do not protect against sexually transmitted infections (STIs), including HIV/AIDS.

Client Assessment as per World Health Organization Medical Eligibility Criteria

### Medical Eligibility Criteria (MEC)

Ask the client the questions given below. If the answer is "no" to all of the questions, then the client can use injectables. If the answer is "yes" to a question, follow the instructions.

1. **Is the client breastfeeding a baby younger than 6 weeks old?**
   Start using injectables 6 weeks after childbirth. If fully or almost fully breastfeeding, she is protected from pregnancy for 6 months after childbirth or until her menstrual period returns. The client must begin contraception at once to avoid pregnancy. Encourage her to continue breastfeeding.

2. **Does the client have problems with her heart or blood vessels? Has she ever had such problems? If so, what problems?**
   Do not provide injectables if the client reports heart attack, heart disease due to blocked arteries, stroke, blood clots (except superficial clots), severe chest pain with unusual shortness of breath, severe high blood pressure, diabetes for more than 20 years, or damage to vision, kidneys, or nervous system caused by diabetes. Help the client choose another effective method except combined hormonal contraceptives.

3. **Does the client have high blood pressure?**
   If the client reports high blood pressure, check BP immediately. If systolic BP is over 160 or diastolic BP over 100, do not provide the injection. Help the client choose another method except COCs/CICs.

4. **Does the client have or has she ever had breast cancer?**
   Do not provide the injection. Help the client choose a method without hormones.

5. **Does the client have severe cirrhosis of the liver, a liver infection or tumour? (Are the client's eyes or skin unusually yellow?)**
   Perform physical examination or refer. If the client has serious active liver disease (jaundice, painful or enlarged liver, viral hepatitis, or liver tumour) do not provide injection. Refer for care. Help the client choose a method without hormones.
6. **Does the client think she is pregnant?**
Assess whether pregnant. Give condoms to use until reasonably sure that pregnancy is excluded. Then the injection can be given.

7. **Does the client have vaginal bleeding that is unusual for her?**
If the client has unexplained vaginal bleeding that suggests an underlying medical condition, do not provide the injection. (PICs could make diagnosis and monitoring of any treatment difficult.) Assess and treat any underlying condition as appropriate, or refer. Help her to choose a suitable method while being evaluated and treated. After treatment, reevaluate for use of PICs. Be sure to explain the health benefits, risks, and the side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable.

**Method of use**
- Any time it is reasonably certain that the client is not pregnant. If she is not at risk of pregnancy (for example, has not had sex since her last menstrual period), she may start injections any time she wants.
- During the first 7 days after menstrual bleeding begins, no backup method is needed for extra protection.
- If she is starting on or after day eight of her menstrual period, she should use condoms or avoid sex for the next 7 days. If possible, give her condoms or spermicides.
- If a woman is breastfeeding, she may start PICs as early as 6 weeks after childbirth.
- If she is switching from any other hormonal method, injectables can be given immediately.
- If switching from non-hormonal contraceptive, and she is not menstruating at present, she should use a condom or avoid sex for the next 7 days. In the case of switching in the first 7 days of the menstrual period, no backup method is required.

**Equipment and supplies needed for injection**
- One of the injectables
- Antiseptic and cotton wool
- 2- or 5-ml disposable syringe with disposable needle

**Technique for giving injection**
1. Wash hands with soap and water.
2. If injection site is dirty, clean it with a wet swab.
3. Shake vial gently for DMPA. No need to do it for NET-EN.
4. If vial is cold, warm to skin temperature before giving injection. Now fill syringe with full dose.
5. Insert sterile needle deep into the upper arm (deltoid muscle) or into buttocks (gluteal muscle, upper outer portion). Inject the contents of the syringe.
6. Do not massage the injection site, as it causes the medicine to be absorbed too fast.
7. Maintain the record of injections.

**Figure 8-1. Injection Sites for Progestin-Only Injectables**

![Injection Sites Diagram]

**Table 8-1. Progestin-Only Injectables: Side Effects and Their Management**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
</table>
| Amenorrhoea (no monthly bleeding period)         | • Is normal among injection users (especially DMPA) and not harmful. The client is not pregnant. Menstrual blood is not building up inside her. Instead, her body is not producing blood.  
• Explain that this can improve her health. It helps to prevent anaemia.  
• If not having monthly bleeding is bothering her, she may want to switch to monthly injectables, if available.  
• Spotting or bleeding between periods is normal and very common during the first few months of injection use. It is not harmful.  
• If spotting or bleeding persists or follows a period of amenorrhoea, rule out gynaecological problems.  
• If a gynaecological problem is found, treat or refer.  
• If irregular bleeding is caused by STI or PID, continue injections. Treat the cause or refer.  
• For modest, short-term relief, take 800 mg (max) ibuprofen three times daily or 500 mg mfenamic acid two times daily after meals for 5 days, beginning when irregular bleeding starts.  
• If irregular bleeding continues, or starts after several months of normal or no monthly bleeding, or if it is suspected that something may be wrong for another reason, consider underlying conditions unrelated to method use. |
| Spotting or bleeding between monthly periods      |                                                                                                                                                  |
| **Heavy or prolonged bleeding** (more than 8 days long or twice as much as her usual menstrual period) | **Reassure her.**  
- For modest, short-term relief, a client can take:  
  - Combined oral contraceptive (COCs), taking one pill daily for 21 days, beginning when heavy bleeding starts.  
  - 50 mcg of ethinyl estradiol daily for 21 days, beginning when heavy bleeding starts.  
  - If bleeding becomes a health threat or if the woman wants to switch methods, help her choose another method.  
  - To prevent anaemia, suggest iron tablets and tell the woman it is important to eat foods that contain iron, such as meat, poultry, fish, green leafy vegetables, and legumes.  
If heavy or prolonged bleeding continues or starts after several months of normal or no monthly bleeding, consider underlying conditions unrelated to method use. |
| Unexplained abnormal vaginal bleeding that suggests pregnancy or an underlying medical condition | **Refer or evaluate by history and pelvic examination. Diagnose and treat as appropriate.**  
- If no cause of bleeding can be found, consider stopping PICs to make diagnosis easier. Provide another method of her choice.  
If bleeding is caused by STIs or PID, she can continue using PICs during treatment. |
| **Ordinary headaches** | **Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1,000 mg), or another pain reliever.**  
**Any headaches that get worse or occur more often should be evaluated.** |
| **Migraine headaches** | **If a woman has migraine headaches without aura, she can continue to use the method if she desires.**  
**If she has migraine with aura, do not give the injection. Help her choose a method without hormones.** |
| **Mood changes** | **Ask about changes in her life that could affect her mood, including her relationship with her partner. Give support as appropriate.**  
**Refer clients who have serious mood changes such as major depression.** |

**Method-specific counselling**
Pre-Procedure Counselling
After greeting the client and making her comfortable, ask questions to confirm that she needs a contraceptive for long-term use.
Give the following information:
• Tell the client that there are two types of injectables.
• Show the client the injection ampoule and disposable syringe.
• Explain how the injection acts as a contraceptive.Explain its method of use.
• Tell the client about advantages and limitations.
• Discuss doubts and fears that the client may have and help dispel these by providing adequate information.
• Answer any questions the client asks.

Post-Procedure Counselling
Give information to the client regarding the schedule for follow-up, possible side-effects, and their management.

Schedule for next injection
Give the following information to the clients:
• Acceptors of injection NET ENt should report for the next injection after exactly 8 weeks. However, it can be given within 2 weeks earlier or later.
• Acceptors of injection DMPA should report for the next injection after exactly 12 weeks. However, it can be given 4 weeks earlier or later.
• The client can come at any time in case of any problem.

Combined Injectable Contraceptives
Combined injectable contraceptives (CICs) are also called monthly injectables. They contain two hormones—a progestin and an oestrogen. In contrast, PICs contain progestin only. These differences result in more regular bleeding and fewer bleeding disturbances than with PICs.

Mesigyna: This CIC contains both norethindrone enanthate (NET-EN) 50 mg and estradiol valerate 5 mg in 1 ml of oily solution, and provides protection for 4 weeks.

Mode of action
Works primarily by inhibiting ovulation.

Effectiveness
Effectiveness depends on the client’s returning on time: Risk of pregnancy is greatest when a woman is late for an injection or misses an injection.
• When women have injections on time, less than 1 pregnancy per 100 women using monthly injectables over the first year (5 per 10,000 women).
• As commonly used, about 3 pregnancies per 100 women using monthly injectables over the first year. This means that 97 of every 100 women using monthly injectables will not become pregnant.
Advantages

- Most of the advantages are same as PIC.
- Return of fertility may be delayed, but the delay is less than with PICs. Women can become pregnant on average 5 months after their last injection.

Limitations

Long-term studies of monthly injectables are limited, but researchers expect that their health risks are similar to those of COCs.

Some user reports the following:

- Changes in bleeding patterns including infrequent bleeding, amenorrhoea, or prolonged bleeding
- Breast tenderness
- Headache, dizziness
- Weight gain
- CICs require frequent clinic visits after 4 weeks
- There is less flexibility in case of late injection (1 week only)
- Cannot be used by breastfeeding mothers before 6 months postpartum

Client Assessment as per World Health Organization Medical Eligibility Criteria

<table>
<thead>
<tr>
<th>Medical Eligibility Criteria (MEC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the client the questions given below about any known medical conditions. If she answers &quot;no&quot; to all of the questions, then she can start monthly injectables if she wants. If she answers &quot;yes&quot; to a question, follow the instructions. In some cases she can still start monthly injectables.</td>
</tr>
</tbody>
</table>

1. **Is she breastfeeding a baby younger than 6 months old?**
   - If fully or nearly fully breastfeeding: She can start 6 months after giving birth or when breast milk is no longer the baby’s main food—whichever comes first.
   - If partially breastfeeding: She can start monthly injectables as soon as 6 weeks after giving birth.

2. **Has she had a baby in the last 3 weeks and is not breastfeeding?**
   She can start monthly injectables as soon as 3 weeks after childbirth.

3. **Does she smoke 15 or more cigarettes a day?**
   If she is 35 years of age or older and smokes more than 15 cigarettes a day, do not provide monthly injectables. Urge her to stop smoking and help her choose another method.
4. Does she have severe cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice])

If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumour), do not provide monthly injectables. Help her choose a method without hormones. (If she has mild cirrhosis or gall bladder disease, she can use monthly injectables.)

5. Does she have high blood pressure?

If you cannot check her blood pressure and she reports a history of high blood pressure, or if she is being treated for high blood pressure, do not provide monthly injectables. Refer her for a blood pressure check if possible or help her choose another method without oestrogen.

Check her blood pressure if possible:

- If blood pressure is below 140/90 mm Hg, provide monthly injectables.
- If systolic blood pressure is 140 mm Hg or higher or diastolic blood pressure is 90 or higher, do not provide monthly injectables. Help her choose a method without oestrogen, but not PICs if systolic blood pressure is 160 or higher or diastolic pressure is 100 or higher.

(One blood pressure reading in the range of 140–159/90–99 mm Hg is not enough to diagnose high blood pressure. Provide a backup method to use until she can return for another blood pressure check, or help her choose another method now if she prefers. If blood pressure at next check is below 140/90, she can use monthly injectables.)

6. Has she had diabetes for more than 20 years or damage to her arteries, vision, kidneys, or nervous system caused by diabetes?

Do not provide monthly injectables. Help her choose a method without oestrogen but not progestin-only injectables.

7. Has she ever had a stroke, blood clot in her legs or lungs, heart attack, or other serious heart problems?

If she reports heart attack, heart disease due to blocked or narrowed arteries, or stroke, do not provide monthly injectables. Help her choose a method without oestrogen, but not PICs. If she reports a current blood clot in the deep veins of the leg or in the lung (not superficial clots), help her choose a method without hormones.

8. Does she have or has she ever had breast cancer?

Do not provide monthly injectables. Help her choose a method without hormones.

9. Does she sometimes see a bright area of lost vision in the eye before a very bad headache (migraine aura)? Does she get throbbing, severe head pain, often on one side of the head, that can last from a few hours to several days and can cause nausea or vomiting (migraine headaches)?

If she has migraine aura at any age, do not provide monthly injectables. If she has migraine
headaches without aura and is age 35 or older, do not provide monthly injectables. Help these women choose a method without oestrogen. If she is under 35 and has migraine headaches without aura, she can use monthly injectables.

10. Is she planning major surgery that will keep her from walking for 1 week or more?

If so, she can start monthly injectables 2 weeks after the surgery. Until she can start monthly injectables, she should use a backup method.

11. Does she have several conditions that could increase her chances of heart disease (coronary artery disease) or stroke, such as older age, smoking, high blood pressure, or diabetes?

Do not provide monthly injectables. Help her choose a method without oestrogen, but not PICs.

Method of use

Same as PICs, except:

- If a woman is fully or nearly fully breastfeeding, then she may start the method after 6 months postpartum or when breast milk is no longer the baby’s main food—whichever comes first.
- If more than 6 months postpartum and she does not have monthly bleeding, she can start injectables at any time it is reasonably certain that she is not pregnant. She will need a backup method for the first 7 days after the injection.
- If she is partially breastfeeding, the first injection should be delayed until 6 weeks postpartum.
- Non-breastfeeding mothers can start CICs at any time on days 21–28 postpartum. No need for a backup method.
- If she is more than 4 weeks postpartum with no monthly bleeding, she can start CICs at any time if it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after the injection.
- After miscarriage or abortion, a woman can start CICs immediately or within 7 days after first or second trimester abortion. No need for backup method.
- If more than 7 days postabortion, she can start injection any time after pregnancy is excluded, but will need a backup method for the first 7 days after the injection.
- After taking emergency contraceptive pills (ECPs), she can start a CIC on the same day. There is no need to wait for the next monthly bleeding. She will need a backup method for the first 7 days after the injection.

Managing late injection:

- If the client is less than 7 days late for a repeat injection, she can receive her next injection. There is no need for tests, evaluation, or a backup method.
• A client who is more than 7 days late can receive her next injection if:
  – She has not had sex since 7 days after she should have had her last injection,
  or
  – She has used a backup method or has taken ECPs after any unprotected sex
    since 7 days after she should have had her last injection.

She will need a backup method for the first 7 days after the injection.

• If the client is more than 7 days late and does not meet these criteria, additional steps
  can be taken to be reasonably certain she is not pregnant.

• Discuss why the client was late and ways to avoid this happening again. If coming back
  on time is often a problem, discuss using a backup method when she is late for her next
  injection, taking ECPs, or choosing another method.

Technique for Giving Injection
The technique for giving the injection is the same as that for NET-EN except it can be given
deep into the anterior outer thigh as well:

Figure 8-2. Injection Sites for Combined Injectable Contraceptives

Table 8-2. Combined (Monthly) Injectables: Side Effects and Their Management:

<table>
<thead>
<tr>
<th>Side Effects</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Irregular bleeding</td>
<td>Same as PIC</td>
</tr>
<tr>
<td>Prolonged bleeding</td>
<td>Same as PIC</td>
</tr>
<tr>
<td>No monthly bleeding</td>
<td>Same as PIC</td>
</tr>
<tr>
<td>Headache</td>
<td>Same as PIC</td>
</tr>
<tr>
<td>Dizziness</td>
<td>Same as PIC</td>
</tr>
<tr>
<td>Weight gain</td>
<td>Same as PIC</td>
</tr>
</tbody>
</table>
| Breast tenderness        | • Advise the client to wear supportive bra (including during strenuous activity and sleep)
                              • Give pain killer(aspirin, paracetamol or ibuprofen) |

Method-specific counselling
Pre-Procedure Counselling
After greeting the client and making her comfortable, ask questions to confirm that she needs a contraceptive for long-term use.
Give the following information:
• Show the client the injection ampoule and disposable syringe.
• Explain how the injection acts as a contraceptive.
• Explain its method of use.
• Tell the client about advantages and limitations.
• Discuss doubts and fears that the client may have and help dispel these by providing adequate information.
• Answer any questions the client asks.

Post-Procedure Counselling
Give information to the client regarding the schedule for follow-up, possible side-effects, and their management.

Schedule for Next Injection
She should report for the next injection after 4 weeks. However, she can receive her injection 7 days earlier or later.

Follow-up
Ask the following questions at any return visit:
Ask if the client if she has any questions or anything to discuss.
1. Ask the client about her experience with the method, whether she is satisfied, and whether she has any problems. Give her any information or help that she needs and invite her to return any time she has questions or concerns. If she has problems that cannot be resolved, help her choose another method.
2. Ask about her bleeding patterns.
3. Ask if she has had any health problems since her last visit:
   • If the client has developed heart disease due to blocked arteries, stroke, blood clots (except superficial clots), breast cancer, severe high blood pressure, migraine or active liver disease, help her choose a method without hormones.

Record keeping
Maintain the following minimum information for proper follow-up of the client:
• Daily client register.
• Client record card: record information about age, parity, menstrual history, and findings of physical examination.
• Injection diary especially prepared and supplied for the purpose. Note the client's name, address, date of first injection, and also due date for the next injection.
• Client card: give this card to the client after entering on it her name, address, registration number, particulars of the contraceptive given, and the follow-up date.

Update all records after each follow-up visit, including details of complaints or side effects and treatment given, as per policy.
IINTRAUTERINE CONTRACEPTIVE DEVICE (IUCD)

Introduction

Intrauterine contraceptive devices (also referred to as IUCDs) have been used by women in Pakistan since 1965, when the Government-sponsored family planning (FP) program was launched. The IUCD is suitable and convenient for birth spacing. Once inserted, it is effective for 5 to 12 years.

The types now most widely used are copper-bearing IUCDs made of plastic with copper sleeves/copper wire on the plastic, for example, the CuT-380A and Multiload Cu-375; and hormone-containing IUCDs, such as the levonorgestrel intrauterine system (LNG-IUS).

<table>
<thead>
<tr>
<th>Copper-Bearing IUCD</th>
<th>Hormone-Containing IUCD</th>
</tr>
</thead>
<tbody>
<tr>
<td>• CuT-380A</td>
<td>Levonorgestrel</td>
</tr>
<tr>
<td>• MLCu-375</td>
<td>intrauterine system</td>
</tr>
<tr>
<td></td>
<td>(LNG-IUS)</td>
</tr>
</tbody>
</table>

Policy

- The IUCD will be inserted by a medical or paramedical health care provider who is trained in its insertion technique.
- IUCD insertion will be performed in a facility that has acceptable standards of asepsis and infection control.

Standards

The following standards should be maintained:
- The client seeking the IUCD should be provided with all necessary information regarding advantages, effectiveness, limitations, side effects, and warning signs of the IUCD. The procedure for its insertion and removal must be fully explained.
- The health care provider must refer the client to a doctor if:
  - Perforation is suspected.
  - Pregnancy occurs with the IUCD in place.
  - There are symptoms or signs of pelvic inflammatory disease (PID).

Copper-Bearing IUCD

Mode of action
• Prevents fertilization, primarily by interfering with the ability of sperm to survive and to ascend to the fallopian tubes where fertilization occurs.
• Alters or inhibits sperm migration, ovum transport, and fertilization.
• Creates a sterile foreign-body reaction in the endometrium, which is potentiated by copper ions.

**Effectiveness**

The CuT-380A is effective for 12 years and the MLCu-375 is effective for 5 years. The copper IUCD is one of the most effective and long-lasting methods of contraception. Less than 1 pregnancy per 100 women using an IUCD occurs over the first year (6 to 8 per 1,000 women). This means that 992 to 994 of every 1,000 women using IUCDs will not become pregnant. A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the IUCD. Over 10 years of IUCD use, there would be about two pregnancies per 100 women.

**Advantages**

• A single decision leads to effective, long-term prevention of pregnancy.
• Very effective.
• No interference with sex.
• Increased sexual enjoyment because no need to worry about pregnancy.
• Immediately reversible. After removal, pregnancy can occur as quickly as in women who have not used IUCDs.
• Has no effect on lactation. Can be inserted immediately after childbirth or after abortions (if no evidence of infection).
• Can be used through menopause (1 year or so after last menstrual period).
• No interactions with any medicines.
• Reduces the risk of ectopic pregnancy (less risk of ectopic pregnancy than in women not using any FP method).
• May help to protect against endometrial cancer.

**Limitations**

• Changes in bleeding pattern, especially in the first 3 to 6 months but likely to lessen after 3 months of use:
  - Longer and heavier menstrual periods
  - Irregular bleeding or spotting between periods
  - More cramps or pain during periods
  - May contribute to anaemia, if the woman has low iron blood stores before insertion and IUCD causes heavier monthly bleeding
• Perforation of the wall of the uterus (very rare, if IUCD properly inserted)
• Does not protect against sexually transmitted infections (STIs) including HIV/AIDS. Client cannot stop IUCD use on her own. A trained health care provider is required for removal.
• May come out of the uterus, without the woman’s knowledge.

Client Assessment as per World Health Organization Medical Eligibility Criteria

<table>
<thead>
<tr>
<th>Medical Eligibility Criteria (MEC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask the client the questions below. If she answers &quot;no&quot; to all of the questions, then the IUCD can be inserted if she wants. If she answers &quot;yes&quot; to a question below, follow the instructions:</td>
</tr>
</tbody>
</table>

1. **Does the client think she is pregnant?**
   Assess whether pregnant. Do not insert the IUCD. Give her condoms or spermicide to use until reasonably sure that she is not pregnant.

2. **Does the client have vaginal bleeding that is unusual for her?**
   If she has unexplained vaginal bleeding that suggests pregnancy or an underlying medical condition, use of an IUCD could make diagnosis and monitoring of any treatment more difficult.
   Help her choose a method to use while being evaluated and treated (but not a hormonal IUCD, progestin-only injectables, or implants). After treatment, re-evaluate for IUCD use.

3. **Did the client give birth more than 48 hours but less than 4 weeks ago?**
   Delay inserting an IUCD until 4 or more weeks after childbirth. If needed, give her condoms.

   **Does she have an infection following childbirth or abortion?**
   If she currently has infection of the reproductive organs during the first 6 weeks after childbirth (puerperal sepsis) or she just had an abortion-related infection in the uterus (septic abortion), do not insert the IUCD. Treat or refer her if she is not already receiving care. Help her choose another method or offer a backup method. After treatment, re-evaluate for IUCD use.

   **Note:** Assure confidentiality before asking the remaining questions.

   4. **Has the client had a sexually transmitted infection (STI) or pelvic inflammatory disease (PID) in the last 3 months?** Does she have an STI, PID, or any other infection in the female organs now? (Signs and symptoms of PID: severe pelvic infection with pain in lower abdomen and possibly abnormal vaginal discharge, fever, or frequent urination with burning.) If she has no tenderness in the abdomen or when the cervix is moved, however, she probably does not have pelvic infection.

   Women who have a very high individual likelihood of exposure to gonorrhoea or chlamydia should not have an IUCD inserted. Do not insert the IUCD now. Advise her to use condoms for STI protection. Treat or refer the client and her spouse. The IUCD can be inserted 3 months after cure unless re-infection is likely.

   **Does the client have AIDS?**
   Do not insert an IUCD if she has AIDS unless she is clinically well on antiretroviral therapy. If
she is infected with HIV but does not have AIDS, she can use an IUCD. If a woman who has an IUCD in place develops AIDS, she can keep the IUCD. Whatever method she chooses, advise condom use. Give her condoms.

4. **Does she think that she might get an STI in the future? Does she or her spouse have more than one sex partner?**
A woman who has a very high individual likelihood of STIs should not have an IUCD inserted. Advise her to use condoms and help her chose another method.

5. **Does she have cancer or tuberculosis of the female reproductive organs?**
In case of known cervical, endometrial, or ovarian cancer; benign or malignant trophoblast disease; or pelvic tuberculosis: Do not insert an IUCD. Treat or refer her for care as appropriate. Help her choose another effective method.

Be sure to explain the health benefits, risks, and side effects of the method that the client will use. Also, point out any conditions that would make the method inadvisable for the client.

Characteristics and conditions listed below are in World Health Organization (WHO) Eligibility Criteria category 1. Women with characteristics and conditions in WHO category 2 also can use this method. With proper counselling, women of any age or any number of children can use the IUCD. (Age under 20 and having no children are characteristics in WHO Eligibility Criteria category 2.)

The IUCD can be used in any circumstances by women with any of the following characteristics or health conditions:
- Smoke cigarettes
- Have just had an abortion or miscarriage (if no evidence of infection or risk of infection)
- Take antibiotics or anticonvulsants
- Are fat or thin
- Are breastfeeding
- Benign breast disease
- Breast cancer
- Headaches
- High blood pressure
- Irregular vaginal bleeding (after evaluation)
- Blood clotting problems
- Varicose veins
- Heart disease (disease involving heart valves may require treatment with antibiotics before IUCD insertion)
- History of stroke
• Diabetes
• Liver or gallbladder disease
• Malaria
• Thyroid disease
• Epilepsy
• Non-pelvic tuberculosis
• Past ectopic pregnancy
• Past pelvic surgery

Correcting misperceptions
Intrauterine devices:
• Are not directly associated with PID.
• Do not increase the risk of contracting STIs, including HIV.
  Do not increase the risk of miscarriage when a woman becomes pregnant after the IUCD is removed.
• Do not make women infertile.
• Do not cause birth defects.
• Do not cause cancer.
• Do not move to the heart or brain.
• Do not cause discomfort or pain for the woman during sex.
• Substantially reduce the risk of ectopic pregnancy.

Screening questions for pelvic examination before IUCD insertion
When performing the pelvic examination, the questions below help check for signs of conditions that would rule out IUCD insertion. If the answer to all of the questions is “no,” then the client can have an IUCD inserted. If the answer to any question is “yes,” do not insert an IUCD.

For questions 1 through 5, if the answer is “yes,” refer for diagnosis and treatment as appropriate. Help the woman choose another method and counsel her about condom use if she faces any risk of STIs. Give her condoms, if possible. If STI or PID is confirmed and she still wants an IUCD, it may be inserted as soon as she finishes treatment, if she is not at risk for re-infection before insertion.

1. Is there any type of ulcer on the vulva, vagina, or cervix? Possible STI.
2. Does the client feel pain in her lower abdomen when you move the cervix? Possible PID.
3. Is there tenderness in the uterus, ovaries, or fallopian tubes (adnexal tenderness)? Possible PID.
4. Is there a purulent cervical discharge? Possible STI or PID.
5. Does the cervix bleed easily when touched? Possible STI or cervical cancer.
6. Is there an anatomical abnormality of the uterine cavity that will prevent correct IUCD insertion? If an anatomical abnormality distorts the uterine cavity, proper IUCD placement may not be possible. Help the woman choose another method.
7. Were you unable to determine the size and/or position of the uterus?
Determining the size and position of the uterus before IUCD insertion is essential to ensure high placement of the IUCD and to minimize risk of perforation. If size and position cannot be determined, do not insert an IUCD. Help the woman choose another method.

When to start

**IMPORTANT:** In many cases, a woman can start the IUCD at any time it is reasonably certain she is not pregnant.

*Having Menstrual Cycles/Any Time of the Month*

If she is starting within 12 days after the start of her monthly bleeding, there is no need for a backup method. If it is more than 12 days after the start of her monthly bleeding, she can have the IUCD inserted at any time it is reasonably certain she is not pregnant; there is no need for a backup method.

*Switching from Another Method*

The client can switch from another method immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. There is no need to wait for her next monthly bleeding and no need for a backup method.

If she is switching from injectables, she can have the IUCD inserted when the next injection would have been given; there is no need for a backup method.

*Soon after Childbirth*

She can have an IUCD inserted at any time within 48 hours after giving birth (requires a provider with specific training in postpartum insertion). If it is more than 48 hours after the woman gave birth, delay IUCD insertion until 4 weeks or more after childbirth.

*Fully or Nearly Fully Breastfeeding*

Less than 6 months after giving birth if her monthly bleeding has not returned, she can have the IUCD inserted at any time between 4 weeks and 6 months after giving birth. There is no need for a backup method. If her monthly bleeding has returned, she can have the IUCD inserted as advised for women having menstrual cycles (see above).

More than 6 months after giving birth, if her monthly bleeding has not returned, she can have the IUCD inserted at any time it is reasonably certain she is not pregnant. There is no need for a backup method. If her monthly bleeding has returned, she can have the IUCD inserted as advised for women having menstrual cycles (see above).

*Partially Breastfeeding or Not Breastfeeding*

More than 4 weeks after giving birth, If her monthly bleeding has not returned, she can have the IUCD inserted *if it can be determined that she is not pregnant*. No need for a backup method. If her
monthly bleeding has returned, she can have the IUCD inserted as advised for women having menstrual cycles.

**No Monthly Bleeding** (not related to childbirth or breastfeeding)
She can have an IUCD inserted at any time *if it can be determined that she is not pregnant*. No need for a backup method.

**After Miscarriage or Abortion**
She can have an IUCD inserted immediately, if within 12 days after first- or second-trimester abortion or miscarriage and if no infection is present. There is no need for a backup method. If it is more than 12 days after first- or second-trimester miscarriage or abortion and no infection is present, she can have the IUCD inserted at any time it is reasonably certain she is not pregnant. There is no need for a backup method. If infection is present, treat or refer and help the client choose another method. If she still wants the IUCD, it can be inserted after the infection has completely cleared up. IUCD insertion after second-trimester abortion or miscarriage requires specific training. If not specifically trained, delay insertion until at least 4 weeks after miscarriage or abortion.

**When to Start for Emergency Contraception**
Start it within 5 days after unprotected sex. When the time of ovulation can be estimated, the woman can have an IUCD inserted up to 5 days after ovulation. Sometimes this may be more than 5 days after unprotected sex.

**After Taking Emergency Contraceptive Pills (ECPs)**
The IUCD can be inserted on the same day that she takes the ECPs; there is no need for a backup method.

**Instruments and equipment required for IUCD insertion and removal**
Following is the list of equipment and instruments required for IUCD insertion. All of the instruments must be either sterilized or high-level disinfected before use:

**Table 9-1. Instruments and Equipment Required for IUCD Insertion and Removal**

<table>
<thead>
<tr>
<th>Instruments/Equipment</th>
<th>Quantity</th>
<th>Instruments/Equipment</th>
<th>Quantity</th>
</tr>
</thead>
<tbody>
<tr>
<td>Cheatle forceps</td>
<td>1</td>
<td>Container for cheatle forceps</td>
<td>1</td>
</tr>
<tr>
<td>Sponge forceps</td>
<td>1</td>
<td>Covered tray for sterilized instruments</td>
<td>1</td>
</tr>
<tr>
<td>Tenecalum</td>
<td>1</td>
<td>Covered jar for cotton swabs</td>
<td>1</td>
</tr>
<tr>
<td>Bivalve speculum</td>
<td>1</td>
<td>Bowl for antiseptic solution</td>
<td>1</td>
</tr>
<tr>
<td>Uterine sound</td>
<td>1</td>
<td>Kidney tray for used instruments</td>
<td>1</td>
</tr>
<tr>
<td>Artery forceps</td>
<td>1</td>
<td>Autoclave or boiler for sterilization or high-level disinfection of instruments</td>
<td>1</td>
</tr>
</tbody>
</table>
IUCD insertion technique
A woman who has chosen the IUCD needs to know what will happen during insertion. The following description can help explain the procedure to her. Learning IUCD insertion requires training and practice under direct supervision. Therefore, the steps below are only a summary of the process and should not be considered detailed instructions for insertion:

1. The provider conducts a pelvic examination to assess eligibility (see “Screening Questions for Pelvic Examination before IUCD Insertion” above). The provider first performs the bimanual examination and then inserts a speculum into the vagina to inspect the cervix.

2. The provider cleans the cervix and vagina with appropriate antiseptic.

3. The provider slowly inserts the tenaculum through the speculum and closes the tenaculum just enough to gently hold the cervix and uterus steady.

4. The provider slowly and gently passes the uterine sound through the cervix to measure the depth and position of the uterus.

5. The provider loads the IUCD into the inserter using the no-touch technique.

6. Using the no-touch technique, the provider slowly and gently inserts the IUCD and removes the inserter. The provider cuts the strings of the IUCD, leaving about 3 cm hanging out of the cervix.

7. After the insertion, the woman rests. She remains on the examination table until she feels ready to get dressed.

Postpartum Insertion
Only providers who have special training should insert IUCDs after childbirth. Proper insertion technique is important to reduce the risk of expulsion. An IUCD can be inserted immediately
after delivery or up to 48 hours after childbirth.

**IUCD removal technique**
Removing an IUCD is usually simple. It can be done at any time throughout the menstrual cycle. Removal may be somewhat easier during menstruation, when the cervix is dilated. The provider must ensure that proper infection prevention procedures are followed. To remove the IUCD:

- The health care provider pulls the IUCD strings slowly and gently with forceps.
- If removal is not easy, the provider may dilate the cervix using a uterine sound or alligator forceps or refer the client to a specially trained provider.

**Side effects and management**
After IUCD insertion, some clients may have side effects (as mentioned in the section on Post-Procedure Counselling); these are not very serious and usually are resolved within 1 to 3 months. Most of the time, clients need only reassurance and simple treatment. However, if the symptoms become severe and persistent, the client may need immediate medical attention, and the IUCD may have to be removed.

**Table 9-2. IUCDs: Side Effects and Their Management**

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td>Changes in menstrual cycle</td>
<td>• Reassure her that many women using IUCDs experience heavy or prolonged bleeding. It is generally not harmful and usually lessens or stops after the first several months of use.</td>
</tr>
<tr>
<td>With in 3 months of IUCD insertion</td>
<td>• For modest, short-term relief she can try (one at a time):</td>
</tr>
<tr>
<td>Heavy or prolonged bleeding</td>
<td>- Tranexamic acid (1,500 mg) three times daily for 3 days, then 1,000 mg once daily for 2 days, beginning when heavy bleeding starts.</td>
</tr>
<tr>
<td></td>
<td>- Nonsteroidal anti-inflammatory drugs (NSAIDs) such as ibuprofen (400 mg) or indomethacin (25 mg) two times daily after meals for 5 days, beginning when heavy bleeding starts. Other NSAIDs—except aspirin—also may provide some relief of heavy or prolonged bleeding.</td>
</tr>
</tbody>
</table>
Provide iron tablets if possible and tell her it is important for her to eat foods containing iron. If heavy or prolonged bleeding continues or starts after several months of normal bleeding or long after the IUCD was inserted, or if you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use.

<table>
<thead>
<tr>
<th>Irregular bleeding (bleeding at unexpected times that bothers the client)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Reassure her that many women using IUCDs experience irregular bleeding. It is not harmful and usually lessens or stops after the first several months of use.</td>
</tr>
<tr>
<td>• For modest, short-term relief she can try NSAIDs such as ibuprofen (400 mg) or indomethacin (25 mg) two times daily after meals for 5 days, beginning when irregular bleeding starts.</td>
</tr>
<tr>
<td>• If irregular bleeding continues or starts after several months of normal bleeding, or you suspect that something may be wrong for other reasons, consider underlying conditions unrelated to method use (see “Unexplained vaginal bleeding” below).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Cramping and pain</th>
</tr>
</thead>
<tbody>
<tr>
<td>• She can expect some cramping and pain for the first day or two after IUCD insertion.</td>
</tr>
<tr>
<td>• Explain that cramping also is common in the first 3 to 6 months of IUCD use, particularly during monthly bleeding. Generally, this is not harmful and usually decreases over time.</td>
</tr>
<tr>
<td>• Suggest aspirin (325–650 mg), ibuprofen (200–400 mg), paracetamol (325–1,000 mg), or other pain reliever. If she also has heavy or prolonged bleeding, aspirin should not be used because it may increase bleeding.</td>
</tr>
<tr>
<td>If cramping continues and occurs outside of monthly bleeding, consult a medical professional.</td>
</tr>
</tbody>
</table>
bleeding:
- Evaluate for underlying health conditions and treat or refer.
- If no underlying condition is found and cramping is severe, discuss removing the IUCD.
  - If the removed IUCD looks distorted, or if difficulties during removal suggest that the IUCD was out of proper position, explain to the client that she can have a new IUCD that may cause less cramping.

Possible anaemia
- The copper-bearing IUCD may contribute to anaemia if a woman already has low iron blood stores before insertion and the IUCD causes heavier monthly bleeding.
- Pay special attention to IUCD users with any of the following signs and symptoms:
  - Inside of eyelids or underneath fingernails looks pale, pale skin, fatigue or weakness, dizziness, irritability, headache, ringing in the ears, sore tongue, and brittle nails.
  - If blood testing is available, haemoglobin less than 9 g/dl or haematocrit less than 30.
- Provide iron tablets if possible.
- Tell her it is important to eat foods containing iron, such as meat and poultry (especially beef and chicken liver), fish, green leafy vegetables, and legumes (beans, bean curd, lentils, and peas).

Partner can feel IUCD strings during sex
- Explain that this happens sometimes when strings are cut too short.
- If partner finds the strings bothersome, describe available options:
  - Strings can be cut even shorter so they are not coming out of the cervical canal. Her partner will not feel the strings, but
the woman will no longer be able to check her IUCD strings.
- If the woman wants to be able to check her IUCD strings, the IUCD can be removed and a new one inserted. (To avoid discomfort, the strings should be cut so that 3 cm hang out of the cervix.)

<table>
<thead>
<tr>
<th>Severe pain in lower abdomen (suspected PID)</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Some common signs and symptoms of PID often also occur with other abdominal conditions, such as ectopic pregnancy. If ectopic pregnancy is ruled out, assess for PID.</td>
</tr>
<tr>
<td>• If possible, do abdominal and pelvic examinations (see signs and symptoms of serious health conditions below).</td>
</tr>
<tr>
<td>• If a pelvic examination is not possible, and she has a combination of the following signs and symptoms in addition to lower abdominal pain, suspect PID:</td>
</tr>
<tr>
<td>- Unusual vaginal discharge</td>
</tr>
<tr>
<td>- Fever or chills</td>
</tr>
<tr>
<td>- Pain during sex or urination</td>
</tr>
<tr>
<td>- Bleeding after sex or between monthly bleeding</td>
</tr>
<tr>
<td>- Nausea and vomiting</td>
</tr>
<tr>
<td>- A tender pelvic mass</td>
</tr>
<tr>
<td>- Pain when the abdomen is gently pressed (direct abdominal tenderness) or when gently pressed and then suddenly released (rebound abdominal tenderness)</td>
</tr>
<tr>
<td>• Treat PID or immediately refer for treatment.</td>
</tr>
</tbody>
</table>

Because of the serious consequences of PID, health care providers should treat all suspected cases, based on the signs and symptoms:
• Treatment should be started as soon as possible.
### Severe pain in lower abdomen
(suspected ectopic pregnancy)

Many conditions can cause severe abdominal pain. Be particularly alert for additional signs or symptoms of ectopic pregnancy, which is rare but can be life-threatening.

In the early stages of ectopic pregnancy, symptoms may be absent or mild, but eventually they will become severe. A combination of these signs or symptoms should increase suspicion of ectopic pregnancy:

- Unusual abdominal pain or tenderness
- Abnormal vaginal bleeding or no monthly bleeding, especially if this is a change from her usual bleeding pattern
- Light-headedness or dizziness
- Fainting

If ectopic pregnancy or other serious health condition is suspected, refer at once for immediate diagnosis and care. If the client does not have these additional symptoms or signs, assess for PID.

### Suspected uterine puncturing
(perforation)

If puncturing is suspected at the time of insertion or sounding of the uterus, stop the procedure immediately (and remove the IUCD if inserted). Observe the client in the clinic carefully:

- For the first hour, keep the woman at bed rest and check her vital signs (blood pressure, pulse, respiration, and temperature) every 5 to 10
If the woman remains stable after 1 hour, check for signs of intra-abdominal bleeding, such as low haematocrit or haemoglobin, if possible, and her vital signs. Observe for several more hours. If she has no signs or symptoms, she can be sent home, but she should avoid sex for 2 weeks. Help her choose another method.

- If she has a rapid pulse and falling blood pressure, or new pain or increasing pain around the uterus, refer her to a higher level of care.
- If uterine perforation is suspected within 6 weeks after insertion or if it is suspected later and is causing symptoms, refer the client for evaluation to a clinician experienced at removing such IUCDs.

<table>
<thead>
<tr>
<th>IUCD partially comes out (partial expulsion)</th>
<th>If the IUCD partially comes out, remove the IUCD. Discuss with the client whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted at any time it is reasonably certain she is not pregnant. If the client does not want to continue using an IUCD, help her choose another method.</th>
</tr>
</thead>
<tbody>
<tr>
<td>IUCD completely comes out (complete expulsion)</td>
<td>If the client reports that the IUCD came out, discuss with her whether she wants another IUCD or a different method. If she wants another IUCD, she can have one inserted at any time it is reasonably certain she is not pregnant. If complete expulsion is suspected and the client does not know whether the IUCD came out, refer for x-ray or ultrasound to assess whether the IUCD might have moved to the abdominal cavity. Give her a backup method to use in the meantime.</td>
</tr>
</tbody>
</table>
| Missing strings (suggesting possible pregnancy, uterine) | Ask the client:
- Whether and when she saw the IUCD come out |
perforation, or expulsion) • When she last felt the strings
• When she had her last monthly bleeding
• If she has any symptoms of pregnancy
• If she has used a backup method since she noticed the strings were missing

Always start with minor and safe procedures and be gentle. Check for the strings in the folds of the cervical canal with forceps. About half of missing IUCD strings can be found in the cervical canal.

If strings cannot be located in the cervical canal, either they have gone up into the uterus or the IUCD has been expelled unnoticed. Rule out pregnancy before attempting more invasive procedures. Refer for evaluation. Give her a backup method to use in the meantime, in case the IUCD came out.

| New problems that may require switching methods |  |
| May or may not be due to the method |  |
| **Unexplained vaginal bleeding** (that suggests a medical condition not related to the method) | Refer or evaluate by history or pelvic examination. Diagnose and treat as appropriate. She can continue using the IUCD while her condition is being evaluated. If bleeding is caused by STI or PID, she can continue using the IUCD during treatment. |
| **Suspected pregnancy** | Assess for pregnancy, including ectopic pregnancy. Explain that an IUCD in the uterus during pregnancy increases the risk of preterm delivery or miscarriage, including infected (septic) miscarriage during the first or |

| 121 |  |
second trimester, which can be life-threatening. If she continues the pregnancy:

- Advise her that it is best to remove the IUCD.
- Explain the risks of pregnancy with an IUCD in place.

Early removal of the IUCD reduces these risks, although the removal procedure itself involves a small risk of miscarriage.

If she agrees to removal, gently remove the IUCD or refer for removal.

Explain that she should return at once if she develops any signs of miscarriage or septic miscarriage (vaginal bleeding, cramping, pain, abnormal vaginal discharge, or fever).

If she chooses to keep the IUCD, her pregnancy should be followed closely by a nurse or doctor. She should see a nurse or doctor at once if she develops any signs of septic miscarriage.

If the IUCD strings cannot be found in the cervical canal and the IUCD cannot be safely retrieved, refer for ultrasound, if possible, to determine whether the IUCD is still in the uterus. If it is, or if ultrasound is not available, her pregnancy should be followed closely. She should seek care at once if she develops any signs of septic miscarriage.

Counselling
If the Client Chooses an IUCD:

1. Screen the client carefully to make sure there is no medical condition that would be a problem.

2. Explain potential side effects and make sure that each is fully understood. Stress that most can be managed and make sure she knows how to contact you if she has problems.

Pre-insertion Counseling (Examination/Procedure Area)

3. Inform the client about required physical and pelvic examinations.

4. Describe the insertion procedure and what she should expect during the insertion and afterward.

Postinsertion Education

5. Remind the client what type of IUCD she has and for how long this is effective.

6. Provide a client followup card and inform the client when to return for the followup visit.

7. Remind the client of warning signs: **PAINS** (Period late or heavy, Abdominal pain, signs of Infection, Not feeling well, String changes or problems).

8. Review common side effects (menstrual changes) or problems and what to do if they occur.

9. Remind client of need to use condoms in addition if she is at risk of sexually transmitted infections.

10. Assure the client she can return to the same clinic to receive advice or medical attention and, if desired, to have the IUCD removed.

11. Ask the client to repeat the instructions.

12. Answer the client’s questions.
13. Observe the client for at least 15 to 20 minutes and ask how she feels before sending her home.

COUNSELING (REMOVAL)

1. Greet the client respectfully and with kindness.

2. Establish the purpose of visit and answer any questions.

3. Ask the client her reason for removal and answer any questions.

4. Ask client about her reproductive goals (Does she want to continue spacing or limiting births?) and need for protection against GTIs and other STIs.

5. Describe the removal procedure and what she should expect during the removal and afterward.

6. Discuss what to do if the client experiences any problems (e.g., prolonged bleeding or abdominal or pelvic pain).

7. Ask the client to repeat instructions.

8. Answer any questions.

9. If the client wants to continue spacing or limiting births using another method, review general and method-specific information about family planning methods that she is interested in.

10. Help client obtain new contraceptive method or provide temporary (barrier) method until method of choice can be started.

11. Observe client for at least 15 to 20 minutes and ask how she feels before sending her home.

Rarely, allergic skin reaction may develop in a woman using the copper IUCD. In such a case, she should go to a doctor, who may advise removal of the IUCD, and will help her choose
another contraceptive method.

**Follow-Up**
Follow-up care and support of the client's decision to use an IUCD is very important to keep her satisfied and reassured, especially during the first 3 months when side effects are more common. Explain the follow-up schedule:

- The client can come after her first menses, but not later than 3 months, for her first check-up.
- If no complaints subsequently, she can come to clinic whenever any problem arises.

During the first follow-up visit:

- Ask the client if she has any complaints.
- Check for anaemia if she complains of excessive or prolonged bleeding.
- Do a pelvic examination to check if:
  - IUCD threads are visible.
  - There are any signs of infection.

**Record Keeping**
The minimum record list below should be maintained for proper follow-up of IUCD clients:

- Daily clinic register to register the client.
- Client record card (CRC) to record relevant information about the client e.g., age, parity, menstrual history, and findings of physical and pelvic examination. Keep a follow-up record on the reverse side of CRC.
- A client card, to be given to the client after particulars about the contraceptive are given and the follow-up date are recorded.

**Hormone-Containing Intrauterine Contraceptive Devices**

**Levonorgestrel Intrauterine System (Mirena™)**

Levonorgestrel-containing IUCDs have been available in more than 50 countries for over 10 years. Approximately 2 million women have used levonorgestrel-containing IUCDs. In December 2000, the U.S. Food and Drug Administration approved the use of Mirena.

The Levonorgestrel Intrauterine System (LNG-IUS or LNG-IUCD) is a T-shaped polyethylene device. The frame is 32 mm in both the horizontal and the vertical directions. The cylindrical reservoir around the vertical stem contains a mixture of silicone and 52 mg of levonorgestrel, a progestin widely used in implants, oral contraceptives, and vaginal rings. Twenty-five mcg of levonorgestrel are released every day. A monofilament removal thread is attached to a loop at the end of the vertical stem. Mirena is packaged within a newly designed inserter, which is discarded after use. Mirena has an effective life of 5 years. Like other copper-bearing IUCDs, Mirena can be inserted within the first 7 days of onset of menstruation or if pregnancy can be
ruled out.

Mode of action
Levonorgestrel is responsible for the contraceptive effect of this IUCD. It has the following three mechanisms of action, which enable it to be highly effective for contraception:

• Thins the uterine lining
• Thickens the cervical mucus
• Inhibits sperm mobility

Effectiveness
It is very effective for 5 years.

It is one of the most effective and long-lasting methods:
There is less than one pregnancy per 100 women using an LNG-IUCD over the first year (two per 1,000 women). This means that 998 of every 1,000 women using LNG-IUCDs will not become pregnant.

A small risk of pregnancy remains beyond the first year of use and continues as long as the woman is using the LNG-IUCD. Over 5 years of LNG-IUCD use, there is less than one pregnancy per 100 women (five to eight per 1,000 women). It is approved for up to 5 years of use.

Return of fertility after the LNG-IUCD is removed: No delay

Protection against sexually transmitted infections (STIs): None

Advantages and limitations
With few exceptions, the mechanism of action, indications, precautions, side effects, complications, and time of insertion are the same as for copper IUCDs.

Advantages
Mirena has many advantages over copper IUCDs:

• It is highly effective, having a first-year failure rate of 0.1 percent and 5-year cumulative failure rate of 0.7 percent.
• There is a marked reduction in menstrual blood loss and the systemic level of hormone is very low compared to the other progesterone-only methods.
• Once inserted, it is effective for 5 years and fertility returns rapidly on discontinuation. Eighty percent of the women intending to get pregnant will become pregnant within 12 months of discontinuing Mirena.
• Mirena has many non-contraceptive benefits. It has a beneficial effect on menorrhagia and dysmenorrhoea and reduces the risk of PID. It also reduces the risk of endometrial cancer by 50 percent.
• Other possible side effects are almost the same as those of Copper T 380 A or Multiload.
Limitations
- Women’s access to this type of IUCD may be limited.
- The cost of having the device inserted may deter some women from obtaining it.

Who Can Use It?
Nearly all women can use the LNG-IUCD safely and effectively.

Medical Eligibility Criteria for Levonorgestrel IUCDs

Ask the client the Medical Eligibility Criteria questions for copper-bearing IUCDs. Also ask the questions below about known medical conditions. If she answers “no” to all of the questions here and for the copper-bearing IUCD, then she can have an LNG-IUCD inserted if she wants. If she answers “yes” to a question, follow the instructions. In some cases she can still have an LNG-IUCD inserted.

1. Did you give birth less than 4 weeks ago?
If no, She can have the LNG-IUCD inserted as soon as 4 weeks after childbirth

2. Do you now have a blood clot in the deep veins of your legs or lungs?
If she reports current blood clot (except superficial clots), help her choose a method without hormones.

3. Do you have severe cirrhosis of the liver, a liver infection, or liver tumour? (Are her eyes or skin unusually yellow? [signs of jaundice])
If she reports serious active liver disease (jaundice, active hepatitis, severe cirrhosis, liver tumour), do not provide the LNG-IUCD. Help her choose a method without hormones.

4. Do you have or have you ever had breast cancer?
Do not insert the LNG-IUCD. Help her choose a method without hormones.

Side Effects and Management

Side effects
Some users report the following:
- Changes in bleeding patterns, including:
  - Lighter bleeding and fewer days of bleeding
  - Infrequent bleeding
  - Irregular bleeding
  - No monthly bleeding
  - Prolonged bleeding
• Acne
• Headaches
• Breast tenderness or pain
• Nausea
• Weight gain
• Dizziness
• Mood changes
• Other possible physical changes:
  - Ovarian cysts

**Complications**
Rare: Puncturing (perforation) of the wall of the uterus by the LNG-IUCD or an instrument used for insertion. Usually heals without treatment.
Very rare: Miscarriage, preterm birth, or infection in the very rare case that the woman becomes pregnant with the LNG-IUCD in place.

**When to start**
**IMPORTANT:** In many cases a woman can start the LNG-IUCD at any time it is reasonably certain she is not pregnant.

**Woman Having Menstrual Cycles or Switching from a Non-Hormonal Method at Any Time of the Month**
If she is starting within 7 days after the start of her monthly bleeding, there is no need for a backup method.
If it is more than 7 days after the start of her monthly bleeding, she can have the LNG-IUCD inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
- Backup methods include abstinence, male and female condoms, spermicides, and withdrawal. Tell her that spermicides and withdrawal are the least effective contraceptive methods. If possible, give her condoms.

**Switching from a Hormonal Method**
She can switch immediately, if she has been using the method consistently and correctly or if it is otherwise reasonably certain she is not pregnant. No need to wait for her next monthly bleeding. No need for a backup method.

If she is switching from injectables, she can have the LNG-IUCD inserted when the repeat injection would have been given. She will need a backup method for the first 7 days after insertion.
**Fully or Nearly Fully Breastfeeding**
If it is less than 6 months after she gave birth: If she gave birth less than 4 weeks ago, delay insertion until at least 4 weeks after giving birth. If her monthly bleeding has not returned, she can have the LNG-IUCD inserted any time between 4 weeks and 6 months. There is no need for a backup method.
If her monthly bleeding has returned, she can have the LNG-IUCD inserted as advised for women having menstrual cycles.

If it is more than 6 months since she gave birth: If her monthly bleeding has not returned, she can have the LNG-IUCD inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
If her monthly bleeding has returned, she can have the LNG-IUCD inserted as advised for women having menstrual cycles.

**Partially Breastfeeding or Not Breastfeeding**
If it is less than 4 weeks since the woman gave birth, delay LNG-IUCD insertion until at least 4 weeks after giving birth.

If it is more than 4 weeks after giving birth, and if her monthly bleeding has not returned, she can have the LNG-IUCD inserted at any time if it can be determined that she is not pregnant. She will need a backup method for the first 7 days after insertion. If her monthly bleeding has returned, she can have the LNG-IUCD inserted as advised for women having menstrual cycles.

**No Monthly bleeding** (not related to childbirth or breastfeeding)
It can be inserted at any time if it can be determined that she is not pregnant. She will need a backup method for the first 7 days after insertion.

**After Miscarriage or Abortion**
It can be inserted immediately, if within 7 days after first- or second-trimester abortion or miscarriage and if no infection is present. There is no need for a backup method.
If it is more than 7 days after first- or second-trimester miscarriage or abortion and no infection is present, she can have the LNG-IUCD inserted at any time it is reasonably certain she is not pregnant. She will need a backup method for the first 7 days after insertion.
If infection is present, treat or refer and help the client choose another method. If she still wants the LNG-IUCD, it can be inserted after the infection has completely cleared up.
LNG-IUCD insertion after second-trimester abortion or miscarriage requires specific training.
If a specifically trained provider is not available, delay insertion until at least 4 weeks after miscarriage or abortion.

After Taking Emergency Contraceptive Pills (ECPs)
The LNG-IUCD can be inserted within 7 days after the start of her next monthly bleeding or at any other time it is reasonably certain she is not pregnant. Give her a backup method, or oral contraceptives to start the day after she finishes taking the ECPs, to use until the LNG-IUCD is inserted.

Giving advice on side effects
IMPORTANT: Thorough counselling about bleeding changes must come before IUCD insertion. Counselling about bleeding changes may be the most important help a woman needs to keep using the method.

Describe the Most Common Side Effects
Changes in bleeding patterns: No monthly bleeding, lighter bleeding, fewer days of bleeding, infrequent or irregular bleeding.
Acne, headaches, breast tenderness and pain, and possibly other side effects.

Explain about These Side Effects
Bleeding changes usually are not signs of illness.
They usually lessen after the first several months after insertion.
The client can come back for help if side effects bother her.
Introduction

Voluntary surgical contraception (VSC) is one of the best methods of contraception when the desired family size has been achieved. It is also desirable for women or couples for whom another pregnancy might be detrimental to their health.

VSC is the most effective form of contraception and is a one-time procedure intended to be permanent for both man and woman. It includes tubal ligation (TL) in the female and vasectomy in the male.

Both TL and vasectomy are usually performed under local anaesthesia. The client is sent home after a few hours, and hospital admission is not required. TL can be performed within one week of delivery or within 48 hours of an abortion or as an interval procedure. Vasectomy is easier, safer, simpler, and less expensive than TL.

Policy

- Surgical contraception will be purely voluntary.
- There will be no element of coercion while offering contraceptive surgery to clients.
- Informed consent of the couple and written consent of both husband and wife will be obtained in every case.
- Clients having two living children, are eligible for contraceptive surgery, provided the age of the younger child is more than 1 year.
- VSC should not be denied to any client, regardless of age, who wants to undergo the procedure.
- Contraceptive surgical procedures will be performed only by trained and certified medical personnel.
- The staff assisting the surgeon during the surgical procedure must also be trained.
- VSC will be performed by a medical doctor in a properly equipped facility that has acceptable standards of asepsis and infection control.
- Minilaparotomy will be the preferred surgical technique for TL, as compared to laparoscopy.
- No-scalpel vasectomy (NSV) will be the preferred technique for vasectomy.
- To promote vasectomy, more stress should be placed on information, education, and counselling for men.

Standards

The following standards must be maintained:

- Adequate facilities for carrying out the procedure must be available. This includes equipment and drugs to handle life-threatening situations and other emergencies.
- The surgeon and staff must be trained and skilled in the techniques they are using and in
the use of appropriate and safe anaesthesia.

- All instruments and equipment must be in optimum working order.
- Strict asepsis must be maintained.
- A back-up or a referral system must be ensured.
- Proper counselling, informed choice, and accurate information regarding reversal of VSC should be provided to all potential clients.

**For female sterilization (tubal ligation/minilaparotomy)**

- The surgeon must be skilled in the management of emergencies related to the minilaparotomy procedure.
- A backup facility for the management of any complications that may arise must be available.
- Follow-up after 7 days must be ensured for all acceptors.

**For male sterilization (vasectomy)**

- No-scalpel vasectomy (NSV) would be the standard technique for vasectomy. However, where surgeons trained in NSV are not available, the conventional technique would be acceptable.
- All vasectomy clients must be advised to use condoms, or their wives can use a temporary method like pills or injection or abstain from sexual contact for 3 months after having the vasectomy.
- All vasectomy clients must be advised to get their semen analysis done 3 months after the procedure to make sure that the operation was successful.

**Female Sterilization**

- Female sterilization provides permanent contraception for women when the desired family size has been achieved.
- It is a safe and simple surgical procedure. It can usually be done with just local anaesthesia and light sedation. Proper infection prevention procedures are required.
- The two most common approaches are minilaparotomy and laparoscopy.

**Mode of action**

The doctor makes a small incision in the woman's abdomen and blocks off or cuts the two fallopian tubes. These tubes carry eggs/ovum from the ovaries to the uterus. When the tubes are blocked, the woman's ovum cannot be fertilized by the sperm but she continues to have menstrual periods.

**Effectiveness**

Female sterilization is very effective and permanent. In the first year after the procedure, 0.5 pregnancies occur per 100 women (1 in every 200 women).

Within 10 years after the procedure, 1.8 pregnancies occur per 100 women (1 in every 55
women). Effectiveness depends partly on how the tubes are blocked, but all pregnancy rates are low.

Advantages
- Very effective.
- Permanent: A single procedure leads to life-long, safe, effective family planning.
- Nothing to remember, no supplies needed, and no repeated clinic visits required.
- No interference with sex; does not affect a woman’s ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No effect on breast milk.
- No known long-term side effects or health risks.
- Can be performed just after a woman gives birth.
- May help protect against ovarian cancer.

Limitations
- Requires minor surgery by a specially trained provider.
- Compared with vasectomy, female sterilization is:
  - Slightly more risky
  - Often more expensive
- Reversal surgery is difficult, expensive, and not available in most areas.
- Successful reversal is not guaranteed.
- No protection against sexually transmitted infections (STIs), including HIV/AIDS.

Client Assessment as per World Health Organization Medical Eligibility Criteria

<table>
<thead>
<tr>
<th>Medical Eligibility Criteria (MEC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>The questions on the following pages check whether the client has any known medical conditions that limit when, where, or how female sterilization should be performed.</td>
</tr>
</tbody>
</table>

The checklist should be used after the client has decided not to have more children, and has chosen female sterilization. It is not meant to replace counselling.

The questions on the checklist refer to known conditions. Generally, the health care provider can learn about these conditions by asking the client. The health care provider does not usually have to perform special laboratory tests to rule out these conditions.

No medical condition prevents a client from having sterilization. Some conditions and circumstances call for delay, referral, or caution, however. These conditions are noted in the checklist.

Delay means delay female sterilization. These conditions must be treated and resolved before female sterilization can be done. Temporary methods should be provided in the meantime.
**Refer** means refer client to a centre where an experienced surgeon and staff can perform the procedure in a setting equipped with general anaesthesia and other medical support. Temporary methods should be provided.

**Caution** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.

If no conditions require delay or referral, female sterilization can be performed in these routine settings:

**Minilaparotomy** can be done in RHS-A and RHS-B Centres where surgery can be performed. These include both static and mobile camp facilities that can refer clients for special care if needed.

**Laparoscopy** requires a well-equipped centre, with highly trained staff, one where laparoscopy is performed regularly and an anaesthetist is available.

Ask the client the questions below. If the client answers "no" to all of the questions, then the female sterilization procedure can be performed in a routine setting without delay. If the answer is "yes" to a question below, follow the instructions.

1. *Does the client have any gynaecological/obstetric conditions or problems (female conditions), such as pregnancy, infection, or cancer?* **DELAY** female sterilization and treat if appropriate or refer in case of:
   - Pregnancy
   - Postpartum or after second-trimester abortion (7–42 days)
     - Serious postpartum or postabortion complications (such as infection or haemorrhage) except uterine rupture or perforation (see below)
   - Unexplained vaginal bleeding that suggests a serious condition
   - Pre-eclampsia/eclampsia
   - Pelvic inflammatory disease (PID) within the past 3 months
   - Current STIs
   - Pelvic cancers
   - Malignant trophoblastic disease

**REFER** her to a centre with experienced staff and equipment that can handle potential problems:
   - Fixed uterus due to previous surgery or infection
   - Endometriosis
   - Hernia (umbilical or abdominal wall)
• Postpartum uterine rupture or perforation or postabortion uterine perforation

**CAUTION:**
• Past PID since last pregnancy
• Current breast cancer
• Uterine fibroids
• Previous abdominal or pelvic surgery

2. *Does the client have any cardiovascular conditions, such as heart problems, stroke, high blood pressure, or diabetes?*

---

**DELAY** female sterilization:
• Acute heart disease. Deep vein thrombosis or pulmonary embolism.

**REFER** to a centre with experienced staff and equipment that can handle potential problems:
• Moderate or severe high blood pressure (160/100 mm or higher)
• Vascular disease
• Complicated valvular heart disease

**CAUTION:**
• Mild high blood pressure (140/90 mm Hg–159/99 mm Hg)
• History of high blood pressure that can be evaluated and adequately controlled.
• Past stroke or heart disease

3. *Does the client have any lingering, chronic diseases or any other conditions? Which ones?*

**DELAY** female sterilization in case of:
• Gallbladder disease with symptoms
• Active viral hepatitis
• Severe iron deficiency anaemia (haemoglobin less than 7 g/dl)
• Acute lung disease (bronchitis or pneumonia)
• Systemic infection or significant gastroenteritis
• Abdominal skin infection
• Abdominal surgery due to acute abdomen
• Immobilization due to major surgery
• Post surgical wound infection
• Current AIDS-related acute illness

**REFER** her to a centre with experienced staff and equipment that can handle potential problems:
• Severe cirrhosis of the liver
• Diabetes for more than 20 years
• Hyperthyroidism
• Bleeding disorders
• Chronic lung disease
• Pelvic tuberculosis

CAUTION:
• Epilepsy or taking medicine for seizures (phenytoin, carbamezapine, barbiturates, primidone)
• Taking the antibiotics rifampicin or griseofulvin
• Diabetes without vascular disease

• Hypothyroidism
• Mild cirrhosis of the liver, liver tumours, or schistosomiasis with liver fibrosis
• Moderate iron deficiency anaemia (haemoglobin 7–10 g/dl)
• Sickle cell disease
• Inherited anaemia (thalassemia)
• Kidney disease
• Diaphragmatic hernia
• Severe malnutrition
• Obesity
• Elective abdominal surgery at time sterilization is desired
• Young age
• Mental disorder

Be sure to explain the health benefits and risks and side effects of the method that the client will use. Also point out any conditions that would make the method inadvisable.

In general, most clients who want sterilization can have safe and effective procedures in routine settings. With proper counselling and informed consent, sterilization can be used in any circumstances by women clients who:
• Just gave birth (within 7 days)
• Are breastfeeding

Also, clients with the following conditions can have sterilization in a routine setting in any circumstances:
• Mild pre-eclampsia
• Past ectopic pregnancy
• Benign ovarian tumours
• Irregular or heavy vaginal bleeding patterns, painful menstruation
• Vaginitis without purulent cervicitis
• Varicose veins
• HIV-positive or high risk of HIV or other STIs
• Uncomplicated schistosomiasis
Before the procedure, the client should:

- Not eat or drink anything for 8 hours before surgery, except for clear liquids, which the client can take until 3 hours before surgery.
- Not take any medication for 24 hours before surgery. The morning dose of medicine for hypertensive or diabetes can be taken with doctor’s advice.
- Bathe thoroughly, especially belly, genital area, and upper legs.
- Wear clean, loose-fitting clothing.
- Not wear nail polish or jewellery.
- Bring a friend or relative to accompany her/him home afterwards.

Method of use
The client can have a female sterilization procedure at any time when the desired family size is achieved:

- If it is certain that she is not pregnant.
- Immediately after childbirth, ideally within 48 hours postpartum but allowable within 7 days after delivery (minilaparotomy procedure only).
- At any time 6 weeks or more after childbirth if it is reasonably certain she is not pregnant.
- Within 48 hours of an uncomplicated abortion, if she has made a voluntary, informed choice to be sterilized and there is no infection or genital trauma.
- Any other time, but not between 7 days and 6 weeks postpartum.

Techniques of female sterilization
To perform female sterilization, training and practice under direct supervision are required. All health care providers should understand these procedures and be able to discuss them with clients.

The minilaparotomy procedure
Below is a description of the interval procedure, used more than 6 weeks after childbirth. The postpartum procedure, used less than 7 days after childbirth, is slightly different.

1. Use proper infection prevention procedures.
2. Ask questions about the client’s past and current health, and perform a physical examination and a pelvic examination.
3. Give light sedation to relax the client.
4. Infiltrate local anaesthetic into the incision site just above the pubic hair line.
5. Make a small incision (2–5 cm) in the anaesthetized area and expose the abdominal cavity.
6. Raise and turn the uterus with the uterine elevator to bring
each of the two fallopian tubes under the incision.
7. Tie and cut each tube.
8. Close the incision with stitches and cover with adhesive bandages.

The laparoscopy procedure
1. Use proper infection prevention procedures.
2. Ask questions about the client's past and current health, and perform a physical examination and a pelvic examination.
3. Give the client light sedation.
4. Infiltrate the local anaesthetic into the incision site just under the navel.
5. Insert a special needle into the abdomen and, through the needle, introduced gas to inflate the abdomen. This raises the wall of the abdomen away from the organs inside.
6. Make a small incision (about 2 cm) under the navel and insert the trocar.
7. Insert the laparoscope or laprocator through the trocar.
8. Apply the fallope ring or clip using the laprocator to close off the tubes. Each tube is closed with a clip or a ring.
9. After the tubes are closed, remove the trocar and laparoscope. Let the gas out of the abdomen.
10. Close the incision with stitches and cover it with adhesive bandages.

Anaesthesia
Local anaesthesia, used with or without mild sedation:
• Is safer than general, spinal, or epidural anaesthesia.
• Minimizes the length of the client’s stay at the hospital.
• May involve use of many different anaesthetics and sedatives.

May need to use additional sedation and/or analgesia. This should be adjusted according to the clients body weight.

For situations in which clients need general anaesthesia, see section on Medical Eligibility Criteria for medical conditions requiring referral to a centre that can provide general anaesthesia.

After the Procedure
The client should:
• Rest for 2 or 3 days and avoid lifting heavy objects for 7 days.
• Keep the incision clean and dry for 2 or 3 days.
• Not rub or irritate the incision for 1 week.
• Take paracetamol or another safe, locally available pain relief medicine, if needed.
• Not have sex for at least 1 week.

Side effects and management
• Some discomfort is common after the operative procedure. This discomfort can be relieved
with analgesics.

- In laparoscopic ligation, chest and shoulder pain may occur for 1 or 2 days because of trapped gas remaining in the abdominal cavity. This pain can be relieved with analgesics.
- Some women complain of heavy or irregular periods after TL. These are not related to the procedure. If the complaint is troublesome, the client should be referred to a gynaecologist.

**Complications of minilaparotomy**

TL using minilaparotomy is a safe procedure, and complications are few. There may, however, be short-term (immediate) or long-term (delayed) complications as listed below.

(a) Possible short-term (immediate) complications are:
- Drug reaction
- Bleeding from the wound
- Uterine perforation with the uterine elevator
- Injury to mesosalpinx and broad ligament
- Bladder or intestinal injury
- Anaesthesia problems
- Tears/transaction of the tubes

(b) Possible long-term (delayed) complications are:
- Wound infection
- Haematoma or abscess formation
- Menstrual disorders
- Ectopic pregnancy
- Failure of sterilization (which is rare)

**Complications of laparoscopic ligation**

- Bleeding
- Visceral injuries
- Infection
- Gas insufflation such as gas embolism, subcutaneous emphysema, and respiratory or cardiac arrest
- Lacerations of large blood vessels or abdominal organs by trocar

**Resuscitation and emergency management**

**Anaesthesia Problems**

There is a small but definite risk of problems with the use of parenteral sedation and/or analgesia. Emergency drugs should be ready in case a reaction occurs. Adequate monitoring will lead to early recognition and prompt management of:

- Allergy to the local anaesthetic agent
- Reaction to pre-medication
**Haemorrhage during Surgery and Early Post-Operative Period**

Haemorrhage may occur with both minilaparotomy and laparoscopic ligation, and may be detected by closely monitoring the vital signs of the client during the pre- and post-operative periods. If haemorrhage occurs, do the following:

- Establish an intravenous line, preferably with a large needle or branula.
- Introduce intravenous fluids or plasma expanders, if necessary.
- Send blood for grouping and cross-matching and transfuse blood, if necessary, after you receive the laboratory clearance for hepatitis and HIV.
- Take the client into the theatre for emergency surgery. Ensure that a sterile emergency laparotomy kit is available at all times (to meet such emergencies).
- In case of bladder and bowel injury, call a surgeon.

**Uterine Perforation**

If perforation occurs during minilaparotomy:

- Change the position of the elevator and observe the client.
- If bleeding occurs, apply pressure with a hot-water sponge and use spongostan.
- Apply mattress stitches and, if bleeding does not stop, call a surgeon.

**Post-Operative Complications and Management**

**Infection**

TL may be followed by pelvic infection. The chances of infection increase if there is a history of previous sepsis after surgery, or if undiagnosed infection was present before surgery. Immediately refer to the doctor (preferably to the operating surgeon) any client complaining of fever, severe lower abdominal pain, or vaginal discharge. Wound infection may occur, but is usually not serious. The wound should be dressed daily, and if the discharge persists for more than 2 days, refer the client to a doctor.

**Menstrual changes**

In some cases, menstrual changes have been reported. Studies have shown that these changes could be due to a decline in the level of serum progesterone.

**Other problems**

- Subsequent regret
- Psychological problems

**Failure of tubal ligation**

All tubal occlusion methods have a failure rate, however slight, and the pregnancy that results carries a higher risk of being ectopic. Pregnancy after TL may occur when:

- The woman may have become pregnant in the same menstrual cycle in which the operation was carried out, i.e., she was already pregnant at the time of surgery.
- Structures other than the tubes were ligated.
- The fallope ring was not situated properly.
- The cut ends of the tubes reconnected spontaneously.
• The uterine end of the tube developed a fistula with the peritoneal cavity, which may permit the sperms to pass.

If the client complains of amenorrhoea, send her for a pregnancy test. Be alert to the possibility of an ectopic pregnancy if the client complains of amenorrhoea, irregular vaginal bleeding, or lower abdominal pain, and refer her immediately to an appropriate medical facility for diagnosis and treatment.

Post-operative danger signs
• Fever (greater than 100.4°F or 39°C)
• Dizziness with fainting
• Abdominal pain that is persistent or increasing
• Bleeding or fluid oozing from the incision
• Signs of tetanus: Twitching of facial muscles, lockjaw, opisthotonos, etc.
• Abdominal distension associated with vomiting and failure to pass gas

Patients with these danger signs should be referred to the doctor immediately.

Counselling
Greet the client, ask her to sit down and make sure that she is comfortable. Now ask her some questions to confirm whether she needs permanent contraception.

Ask the client following questions:
• Do you want to have any more children in the future?
• If not, do you think you could change your mind later? What might change your mind? Suppose one of your children dies?
• Suppose you lose your spouse, and you marry again?
• Have you discussed sterilization with your spouse?
• Does your spouse want more children in the future?
• Do you think your spouse might change his or her mind later? Clients who cannot answer these questions may need encouragement to think further about their decisions regarding sterilization.

Special care
In general, people most likely to regret sterilization have these characteristics:
• Young
• Few or no children
• Have not talked with their spouse about sterilization
• Spouse opposes sterilization
• Not married
• Have problems in their marriage

Also, for a woman, just after delivery or abortion is a convenient and safe time for voluntary
sterilization, but women sterilized at this time are more likely to regret it later. Thorough counselling during pregnancy, and ensuring that the woman made her decision well before labour and delivery began, help avoid regrets.

A client should return to the clinic for any of these reasons:
- For a follow-up visit, within 7 days to have stitches removed.
- The client has questions or problems of any kind.
- Return at once if:
  - High fever (greater than 38°C) in the first week
  - Pus or bleeding from the wound
  - Pain, swelling, or redness of the wound
  - Abdominal pain, cramping, or tenderness
  - Fainting or dizziness
- The client suspects pregnancy.
- The client should come to the clinic at once if she has any of the following signs:
  - Lower abdominal pain or tenderness on one side
  - Abnormal or unusual vaginal bleeding
  - Faintness (indicating shock)

Note: Pregnancies among users of voluntary sterilization are rare. But when pregnancy occurs, it is more likely to be ectopic than the normal pregnancy. Ectopic pregnancy is life-threatening. It requires immediate treatment.

Vasectomy

Vasectomy provides permanent contraception for clients who decide that their desired family size has been achieved. It is a safe, simple, quick surgical procedure and can be performed in a clinic. It is not castration, does not affect the testes, and does not affect sexual ability.

Mode of action
The surgeon makes a small opening in the scrotum and closes off both tubes that carry sperm
from the testicles. The semen becomes devoid of sperm and, therefore, pregnancy cannot occur.

Effectiveness
Vasectomy is very effective and permanent when correctly done. Two to three pregnancies occur per 100 women in the first year after their husbands have the procedure.

Correctly done means that condoms were used consistently for at least 3 months after the procedure. Semen analysis 3 months after the procedure should be performed to make sure that the vasectomy was successful.

Advantages
- Very effective.
- Permanent. A single, quick procedure leads to life-long, safe and very effective family planning.
- No interference with sex. Does not affect the ability to have sex.
- Increased sexual enjoyment because no need to worry about pregnancy.
- No supplies to obtain and no repeated clinic visits required.
- No apparent long-term health risks.
- Compared with voluntary female sterilization, vasectomy is:
  - A non-invasive procedure
  - Slightly more effective
  - Slightly safer
  - Easier to perform
- Effectiveness can be checked any time.
- If pregnancy occurs due to failure of vasectomy, it is less likely to be ectopic than a pregnancy in a woman who has been sterilized.

Limitations
- Requires minor surgery by a specially trained provider.
- Not immediately effective. The couple must use another contraceptive method for at least the first 3 months.
- Semen analysis has to be done to make sure that there are no sperm in it and the procedure is successful.
- Reversal surgery is difficult, expensive, and not available in most areas.
- Success cannot be guaranteed.
- No protection against STIs including HIV/AIDS.

Client Selection as per World Health Organization Medical Eligibility Criteria

<table>
<thead>
<tr>
<th>Medical Eligibility Criteria (MEC)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All clients who wish to can have a vasectomy. No medical conditions prevent a client from having vasectomy. This checklist asks the client about known medical conditions that may...</td>
</tr>
</tbody>
</table>
limit the vasectomy procedure. Ask the client the questions below. If the answer is “no” to all of the questions, then the vasectomy procedure can be performed in a routine setting without delay. If the answer is “yes” to a question given below, follow the instructions, which recommend caution, delay, or special arrangements.

In the checklist below:

**Caution** means the procedure can be performed in a routine setting but with extra preparation and precautions, depending on the condition.

**Delay** means postpone vasectomy. These conditions must be treated and resolved before vasectomy can be performed. Give the client another method to use until the procedure can be performed.

**Special** means special arrangements should be made to perform the procedure in a setting with an experienced surgeon and staff, equipment to provide general anaesthesia is needed as well as other backup medical support. For these conditions, the capacity to decide on the most appropriate procedure and anaesthesia regimen also is needed. Give the client a backup method to use until the procedure can be performed.

1. **Does the client have any problems with his genitals, such as infections, swelling, injuries, or lumps on his penis or scrotum?**

   If client has any of the following, use caution:
   • Previous scrotal injury
   • Swollen scrotum due to swollen veins or membranes in the spermatic cord or testes (large varicocele or hydrocele)
   • Undescended testicle, one side only (Vasectomy is performed only on the normal side. Then, if any sperm are present in a semen sample after 3 months, the other side must be done, too.)

2. **Does the client have any other conditions or infections? If so, what?**

   If client has any of the following, delay vasectomy:
   • Active STI
   • Swollen, tender (inflamed) tip of the penis, sperm ducts (epididymis), or testicles
   • Scrotal skin infection or a mass in the scrotum

   If client has any of the following, make special arrangements:
   • Hernia in the groin
   • Undescended testicles
If client has the following, use caution:

- Diabetes
- Depression
- Young age

*Delay* vasectomy if client has:

- Systemic infection or gastroenteritis
- Filariasis or elephantiasis

Make *special* arrangements if:

- Client has AIDS (see vasectomy for men with HIV, below)
- Client has blood that fails to clot (coagulation disorders)

### Vasectomy for men with HIV

- Clients who are infected with HIV, have AIDS, or are on antiretroviral therapy (ART) can safely have a vasectomy, but special arrangements are needed.
- Vasectomy does not prevent transmission of HIV.
- Advise the client to use condoms correctly and consistently for 3 months post-operatively.
- Coercion or force for getting a vasectomy should be avoided.

### Method of use

Any time client decides that the desired family size is achieved.

### Technique of vasectomy

- Use proper infection prevention procedures at all times.
- Inject local anaesthetic in the scrotum.
- Feel the two vas deferens under the skin in the scrotum.
- Make a puncture or incision in the skin:
  - Using the no-scalpel vasectomy technique, grasp the vas deferens with specially designed, sharp surgical forceps and make a tiny puncture in the skin at the midline of the scrotum. OR
  - Using the conventional procedure, make one or two small incisions in the skin with a scalpel.
- Lift out a small loop of each vas from the puncture or incision.
- Cut each vas and tie one or both cut ends with thread.
- Cover the puncture with an adhesive bandage.

### Side effects and management

If a client experiences pain, swelling or redness at or around the incision, check for clots, pus, infection, or abscess and refer accordingly.

**Table 11-1. Vasectomy: Side Effects and Their Management**
## Side Effect Management

<table>
<thead>
<tr>
<th>Side Effect</th>
<th>Management</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Pain</strong></td>
<td></td>
</tr>
</tbody>
</table>
| Check for blood clots in the scrotum: | • Small, uninfected blood clots require rest and pain relief medication such as paracetamol.  
• Large blood clots may need to be surgically removed.  
• Infected blood clots require antibiotics and hospitalization. |
| **Infection (pus, heat, pain, or redness)** | • Clean site with soap and water or antiseptic.  
• Give 7- to 10-day course of oral antibiotics. |
| **Abscess (a pocket of pus under the skin)** | • Clean site with antiseptic.  
• Incise and drain the abscess.  
• Perform wound care.  
• If significant skin infection involved, give 7- to 10-day course of oral antibiotics. |
| **Fear of impotence** | Vasectomy does not physically change sexual desire, functioning, or pleasure. |

## Method-Specific Counselling

**Pre-procedure counselling**
For all clients requesting VSC, follow the steps given below:
- Give them information about temporary methods of contraception.
- Ask the couple what they know about VSC.
- Inform them that VSC is a surgical procedure that it is permanent, and involves cutting and tying of the tubes in the female and of the vas in the male.
- Make sure that the client understands the information correctly and has no misconceptions.
- Explain to the client about the steps of the minilaparotomy or vasectomy procedures.
- Encourage questions.
- Answer questions clearly in terms that the client(s) understand; dispel misconceptions.
- Explain the effectiveness of the procedure, and its failure rate.
- Give written information as well.
- Ensure that the client is not making a decision because of pressure from any person, policy, or incentive to avoid later regrets.

If the client is undecided about accepting VSC:
- Give him/her time to think things over.
- Help him/her choose another method of contraception.
- Ask him/her to come back when he/she has reached a decision.
If VSC is not acceptable:
• Advise a long-term contraceptive such as an IUCD or implant.

When a client is ready to accept VSC:
• Give him/her additional information about the nature of the anaesthesia and surgery, operating theatre routine, post-operative care, side effects, etc., and refer him/her to a VSC facility after you fill out a referral form.
• If TL is the method of choice, give information about the time in relation to menstrual cycle, delivery, and abortion.

If you are counselling a pregnant client, inform her that TL can be performed:
• Within 1 week of delivery, or with 48 hours after abortion (early surgery has the advantage of avoiding re-admission to hospital).
• As an interval procedure at any time after 6 weeks postpartum.

At the VSC centre, the client will be given a consent form to sign in which he/she will again be asked about informed choice, and it will be made clear that he/she is still free to change his/her mind, even though the consent form has been signed.

A separate consent form for males should be available for vasectomy.

**Post-procedure counselling**
After the VSC procedure is over, take the following steps:
• Reassure the client that the procedure will not affect him/her adversely.
• Give instructions, both verbally and in writing, on post-operative care and follow-up.
• Explain how he/she should take the required medication.
• Advise the clients to rest until that evening.
• Tell the client that in case of any problems, he/she should return to the VSC facility. If the procedure is performed in an Extension Service Camp, tell the client to contact the nearest referral centre or hospital, the name of which is entered on the client card.
• Inform the client about warning signs.
• In the case of TL, remind the client to revisit the centre for removal of stitches 1 week after the procedure. (Write down the date on the client card.)
• In the case of TL, if the client is unable to come to the centre, arrange for a trained paramedic to visit the client at home and remove the stitches.
• Advise the client that sexual intercourse can be resumed after 1 week. This applies to female acceptors undergoing interval ligation, as well as to male acceptors, but warn male acceptors to use condoms for 3 months, and have a semen analysis to ensure the semen is sperm-free. If the surgeon advises, use scrotal support and avoid cycling for 1 week in case of NSV.
Informed consent
The client must understand the following points:
• Temporary contraceptives are also available to the client.
• Voluntary sterilization is a surgical procedure.
• There are certain risks involved in the procedure.
• If successful, the operation will prevent the client from having any more children.
• The procedure is considered permanent for all practical reasons.
• The client can decide against the procedure at any time before it takes place.

Follow-Up

After tubal ligation
There should be a follow-up visit within 7 days after the procedure. During the visit, take the following steps:
• Ask the client if there are any complaints. If so, carry out any required examination or, if necessary, refer for an examination and/or treatment.
• Check the operative site for infection.
• Remove the stitches.
• Again reassure the client, and clear up any doubts or misconceptions.
• If all is well, inform the client that she can resume sexual activity.
• If necessary, plan another follow-up visit.

Complete all entries after the follow-up examination.

After NSV
Vasectomy acceptors should also have at least one follow-up examination, preferably after 1 week. During this visit, take the following steps:
• Check the operative site and perform any other relevant examination if indicated.
• Remind the client to use condoms or abstain from sex for 3 months for successful contraception and, after this, have a semen analysis performed to ensure that the semen is sperm-free.

Reversal of Tubal Ligation and Vasectomy

Reversal surgery is difficult, expensive, and not available in most areas of the world. Success cannot be guaranteed. In certain conditions such as death of spouse, death of children due to natural or accidental causes, divorce, or second marriage after divorce, when reversal becomes necessary, refer the client to a properly equipped and well-trained surgical team of a teaching hospital, preferably to a gynaecologist/urologist trained in microsurgery.
Record Keeping

Maintain the following records:

- The signed consent form.
- Client record card. Complete the information on the client's personal and medical history and investigations.
- After the procedure, notes on the anaesthesia operative procedure, the immediate post-operative period and treatment.
- The client card with information about follow-up visits and whom to contact in case of problems.
- Printed post-operative care instructions.
Annex I: Standard Facilities for a Reproductive Health Service Centre

Physical Facilities
- Running or potable water
- Electricity and other light source
- Toilet facilities
- Reception/registration/counsellor’s area
- Examination room
- Space for laboratory tests
- Operating room with screened windows

Room/Area for:
- Auxiliary facilities such as autoclave/sterilization equipment
- Scrub facility/area pre-operative room/area
- Post-operative room

If a room is used for several activities, it is important that clients’ privacy be assured.
### Annex II: Staff Requirement

#### Vasectomy

<table>
<thead>
<tr>
<th>Staff</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained doctor</td>
<td>1</td>
</tr>
<tr>
<td>Assistant</td>
<td>1</td>
</tr>
<tr>
<td>Theatre technician</td>
<td>1</td>
</tr>
<tr>
<td>Counsellor/Paramedic</td>
<td>1</td>
</tr>
<tr>
<td>Clinic helper</td>
<td>1</td>
</tr>
</tbody>
</table>

#### Tubal Ligation

<table>
<thead>
<tr>
<th>Staff</th>
<th>No.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Trained doctor</td>
<td>1</td>
</tr>
<tr>
<td>Trained theatre nurse</td>
<td>1</td>
</tr>
<tr>
<td>Theatre technician</td>
<td>1</td>
</tr>
<tr>
<td>Counsellor</td>
<td>1</td>
</tr>
<tr>
<td>Assistant</td>
<td>2</td>
</tr>
<tr>
<td>Helper</td>
<td>1</td>
</tr>
<tr>
<td>Clerk</td>
<td>1</td>
</tr>
<tr>
<td>Driver</td>
<td>1</td>
</tr>
<tr>
<td>Sweeper</td>
<td>1</td>
</tr>
</tbody>
</table>
Annex III: Other Material and Medicine Required for Minilaparotomy

Suture Material and Other Items

- Black silk or black thread
- Chromic catgut No.1
- Sterile gauze squares (4" x 4")
- Sterile cotton balls

Linen for One Operation

<table>
<thead>
<tr>
<th>Number</th>
<th>Item</th>
</tr>
</thead>
<tbody>
<tr>
<td>6</td>
<td>Drape, towel with eyehole</td>
</tr>
<tr>
<td>4</td>
<td>Gowns</td>
</tr>
<tr>
<td>4</td>
<td>Masks</td>
</tr>
<tr>
<td>4</td>
<td>Caps</td>
</tr>
<tr>
<td>6</td>
<td>Pairs of gloves size 6, 6.5, 7 and 7.5 with glove powder</td>
</tr>
<tr>
<td>2</td>
<td>Packing towels</td>
</tr>
<tr>
<td>1</td>
<td>Soap</td>
</tr>
<tr>
<td>3</td>
<td>Surgical nail brush (nylon)</td>
</tr>
</tbody>
</table>

Medicines

- Prep solution: Betadine
- Methylated spirit
- Sedatives/tranquilizers:
  - Local anaesthetic: Xylocaine 1%
- Adhesive plaster
- Analgesics (12 tablets/patient):
  - Tab. Paracetamol or Panadol 1 TDS
- Antibiotics (when required): 20 capsules per client:
  - Cap. Tetracycline 250 mg, or
  - Cap. Amoxicillin 250 mg 6 hourly x 5 days
- Iron sulphate tablets

Emergency and Resuscitation Equipment

- Ora-pharyngeal airways—2 sizes
- Ambu bag
- Laryngoscope and endotracheal tubes
- Suction machine with tubing and two traps
- Oxygen tank with reducing valve, flow meter, tubing, and mask
- Intravenous administration sets with large-calibre needles
- I.V. fluids, dextrose-saline/dextrose 5%
- Emergency drugs and antidotes to anaesthetic or other drugs
- Venisection set
• Standard laparotomy set

Note: The tray containing drugs and equipment should be kept in an accessible place in good working order and the staff should be familiar with its location and proper use.
Annex IV: Medical History Record Card for Tubal Ligation/Vasectomy

Name and address of the RH Centre ___________________________ Client Reg. No. □□□□

A. History

Name of the client _____________________________________________
Husband's/Father's name_______________________________________
Complete address _____________________________________________
Referred by ___________________________________________________

Age of the client (Years) □□ Age of husband/wife (Years) □□

Occupation of husband ______________________ Occupation of wife _____________

Education of wife  1. Illiterate  3. Middle

2. Primary  4. High school or above

Education of husband  1. Illiterate  3. Middle

2. Primary  4. High school or above

Duration of marriage: (Years) □□

Total number of children born: □□

Number of children alive: Boys □□ Girls □□

Age of the last living child: □□ Months

Total Number of:
Stillbirths □□ Spontaneous Abortions □□ Induced Abortions □□
Outcome of the last pregnancy
1. Live birth
2. Stillbirth
3. Abortion

Previous use of contraceptives:
0. None
1. Oral Pill
2. IUCD
3. Foam/Jelly/Diaphragm
4. Rhythm/Withdrawal
5. Condom
6. Injectable
7. Combination of above methods

Menstrual History
24 25 26 27 28 29
Date of LMP
Day Month Year
1. Regular
2. Irregular
1. Scanty
2. Normal
3. Heavy

Past History
1. Diabetes
2. Hypertension
3. Peritonitis
4. Hernia
5. Lung infection
6. Jaundice
7. Heart disease
8. History of drug allergy
9. Any abdominal operation
10. None

Laboratory Investigation
Urine
1. Diabetes
2. Albumin positive
3. Sugar positive
4. Sugar + Albumin positive

Blood Hb%
1. Less than 50%
2. 50% to 60%
3. 60% and above

Examination
1. Normal
2. Not normal
General examination:

<table>
<thead>
<tr>
<th>Weight</th>
<th>Kgs</th>
<th>B.P.</th>
<th>Temp.</th>
<th>C.V.S</th>
</tr>
</thead>
<tbody>
<tr>
<td>________</td>
<td></td>
<td>________</td>
<td></td>
<td>________</td>
</tr>
</tbody>
</table>

Resp. System | Abdomen | ________ | ________ |

Pelvic examination
(Findings) 1. Normal 2. Not normal

P/S examination (Findings) 1. Normal 2. Not normal

Remarks of doctor: ______________________________________________________

B. Pre-Operative Medication

<table>
<thead>
<tr>
<th>Drug</th>
<th>Dose</th>
<th>Route</th>
</tr>
</thead>
<tbody>
<tr>
<td>1</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

C. Operative Procedure and Medication

Date □ □ - □ □ - □ □

Name of surgeon: ______________________________________________________

Assisted by (name of doctor) ____________________________________________

Operative procedure: Minilap/Laparoscopy/Other (specify): ______________________

Type of local anaesthesia _________________________________________________

Vital sign monitoring during surgery ______________________________________

B.P. ________ Pulse ________ Respiration ________ Duration of surgery _________

Name and Signature of Doctor
D. Operative Procedure and Medication

Complication of operative procedure (specify)

Management of these complications (state briefly)

Date of discharge of client

Condition discharge: B.P. _________ Pulse _________ Temp. _________

General conditions

Post-operative instructions including medicines given:

Name and Signature of Doctor
Date: __________________

E. Follow-up

Date ________________

1. Satisfactory

2. Not Satisfactory
   a. General condition of client
Introduction

Many new contraceptive methods have been developed in recent years. Some of these have been approved by the U.S. Food and Drug Administration. All of these methods can be grouped under five categories:

- Barrier methods
- Combined hormonal contraceptives
- Intrauterine devices
- Implants
- Female sterilization

Policy

- Provide better options and choices for contraception.
- Introduce new contraceptives after trial under local conditions and obtaining conclusive evidence of efficacy and safety of methods.
- Inform the respondents about the trial, obtain their consent for participation, and reassure them about privacy and confidentiality.
- Disseminate the information to stakeholders and formally launch the methods after approval by the Ministry of Population Welfare.

Standards

New contraceptives will be used only after successful clinical trials have been conducted in Pakistan.

All of the concerned health care providers will be trained in the procedure and in management of side effects before introducing any new contraceptives into the programme.

Services meeting high standards of quality will be made available in the clinics/centres for providing the new contraceptives and dealing with their side effects.

Barrier Methods

Cervical barrier: Lea’s Shield®

Features
Lea’s Shield was approved by the U.S. Food and Drug Administration in March 2002. It is a reusable cervical barrier made of medical grade silicone rubber. Lea’s Shield has the same shape as the cervical cap and it also contains a valve in the centre and a loop at the anterior end to facilitate removal.

**Mode of Action**
It acts by preventing sperm from entering the cervix.

**Effectiveness**
The first year failure rate is 9–14 percent. The failure rate varies by parity and concurrent use of spermicides.

Women choosing Lea’s Shield as a contraceptive method require a clinician’s assistance and instructions during the first use; it is therefore available by prescription only.

For maximum effectiveness, Lea’s Shield should be inserted in the vagina anytime before intercourse and should be left in for 8 hours after intercourse.

The shield should never be left in the vagina for more than 48 hours.

It should be properly cleaned and stored for future use.

Fitting this device is quite simple. The user needs guidance from a clinician to understand how to use it. The woman inserts Lea’s Shield after listening to the clinician’s instructions. The clinician then checks to see if the cervix is covered, the loop fits behind the symphysis, and the woman is comfortable. Once the client is comfortable and is able to insert the device correctly, she can continue using it independently.

**Combined Hormonal Contraceptives**

**Types**
The combined hormonal contraceptive methods introduced recently include:
- Yasmin®: a combined oral contraceptive pill (COC) with a newer progestin, drospirenone
- NuvaRing®: a contraceptive vaginal ring
- Ortho Evra®: a transdermal contraceptive patch
- Seasonale®: an oral contraceptive pill taken in a 12-week regimen

All of these methods contain both oestrogen and progesterone, with daily dosage either less than or the same as in COCs. The mechanism of action, advantages, limitations, indications, usage, side effects, complications, and the time for starting these methods are similar to COCs, with a few exceptions.
Yasmin pill

Features
Yasmin, a COC, is available in a 28-pill package and was approved by the U.S. Food and Drug Administration in May 2001. Each active tablet contains a newer progestin, drospirenone 3 mg, and oestrogen-ethinyl estradiol, 30 mcg.

Effectiveness
Over 1 million women have used Yasmin to date, with a failure rate of 1–5 percent.

Advantages and Limitations
Apart from being highly effective, safe, and well-tolerated:
- Yasmin provides excellent cycle control with low incidence of breakthrough bleeding and spotting, particularly after the third cycle.
- Blood pressure, lipids, glucose, electrolytes, and haematology values stayed within the normal ranges in the majority of women during the clinical trials. The other advantages of Yasmin are the same as those for currently available COCs.
- Women having hepatic dysfunction, renal insufficiency, or adrenal insufficiency should not take Yasmin.
- Women taking non-steroidal anti-inflammatory agents, other drugs such as naproxen, potassium-sparing diuretics (spironolactone), acetyl cholinesterase inhibitors, angiotensin II receptor antagonists, and heparin should not take Yasmin. The counselling guidelines and instructions for use of Yasmin and the adverse reactions are same as for other COCs.

Vaginal ring (NuvaRing)

Features
In October 2001, the U.S. Food and Drug Administration approved NuvaRing, a vaginal contraceptive ring. NuvaRing is a non-biodegradable, flexible, colourless ring made of a polymer of ethylene vinyl acetate and magnesium stearate.

The outer diameter of the ring is 54 mm and the cross-sectional diameter is 4 mm. The ring contains 11.7 mg of etonogestrel and 2.7 mg of ethinyl estradiol. It releases 120 mcg of etonogestrel and 15 mcg of ethinyl estradiol every day.

How to Use
The ring is left in place for 3 weeks, followed by 1 ring-free week. The ring can be inserted any time during the first 5 days of the menstrual cycle. The ring should be placed in the vagina even if the woman has not finished bleeding, and she should use a backup contraceptive method for 7 days. A new ring should be inserted each month. If the ring comes out during the first 3 weeks
of use, it should be washed with lukewarm water and placed again. If the ring-free interval is more than 3 hours, a backup contraceptive method should be used for 7 days. The ring should never be left in the vagina for more than 4 weeks. If left in for more than 4 weeks, pregnancy should be ruled out before inserting a new ring, and the woman should use a backup contraceptive method for 7 days after inserting a new ring.

**Advantages and Limitations**

- NuvaRing has many advantages. Some are common to COCs and some are unique to the ring.
- Vaginal rings are highly effective as they result in complete suppression of ovulation.
- The steady release of hormones provides exceptional cycle control.
- It is easily inserted and removed by the woman herself.
- Rapid return of fertility on discontinuation makes it a highly acceptable method for the woman and her spouse.
- Because the hormones are absorbed directly into the blood through the vaginal mucosa, the hepatic first pass metabolism of progestin is prevented.
- The ring delivers the lowest dose of ethinyl estradiol as compared to other combined hormonal contraceptives.
- The NuvaRing does not protect against STIs and HIV/AIDS.

**Transdermal patch (Ortho Evra®)**

The U.S. Food and Drug Administration approved a contraceptive patch in November 2001. The patch is applied on the skin through which the hormones are absorbed. The patch is marketed with the brand name Ortho Evra.

The patch is 4.5 square cm in size and has three layers: the inner release liner, which should be removed before application, a layer containing hormones, and an outer polyester protective layer. The patch contains 6 mg of progestin, norelgestromin (also called 17-acetylnorgestimate) and 0.75 mg of ethinyle estradiol. The patch releases 120 mcg of norelgestromin and 20 mcg of ethinyl estradiol every day.

**Advantages and Limitations**

The patch has many advantages over combined oral contraceptive pills.

**Mode of Action**

It provides a steady release of hormones resulting in complete suppression of ovulation.

**Effectiveness**

It is highly effective, with a first year failure rate of 1–2 percent.
It can be easily applied on the skin and has been found to be a highly acceptable method among clients.
The patch is very simple and easy to use and women do not require any assistance.
Women weighing more than 198 pounds should not use the patch, as the effectiveness of
the patch is reduced in these women.
The user can easily verify the presence of patch, which can reassure her of continued protection.

**Method of Use**
The patch is applied to clean, dry, intact healthy skin on the buttocks, abdomen, outer arm, or
upper torso, but not to the breasts.

The first patch should be applied within the first 5 days of the menstrual cycle and backup
contraception should be used for 7 days. A new patch should be applied every week for 3
weeks followed by 1 patch-free week.

If the patch falls off for any reason, a new patch should be applied as soon as possible but
within 48 hours. No backup contraception is required. The patch does not fall off easily. Heat,
humidity, and exercise do not affect adhesion. The patch may detach completely in up to 2–6
percent of all patches used.

Under no circumstances should the patch-free interval go beyond 7 days between cycles. If this
happens, pregnancy should be ruled out before applying a new patch, and a backup method
used for 7 days or the option of emergency contraceptive pills should be considered.

In case of skin irritation, the patch should be removed and a new patch applied at a different
location until the next change day.

1. **Seasonale**
   Seasonale is the continuous birth control pill. It is taken just like the regular
active/hormonal pill, continuously for 3 months, and then with inactive pills for 1 week
after that. The client will have periods four times in a year.

**Advantages**
- Fewer periods.
- Lighter periods with less blood flow.
- Some women with menstrual migraines or headaches benefit because they have fewer
  or less intense periods.

**Limitations**
- It must be taken daily.
• It does not protect against sexually transmitted infections (STIs).
• There are more chances of having spotting and breakthrough bleeding (light to fairly heavy bleeding between periods) than with a 28-day pill.
• It can be difficult to be sure you are not pregnant without a monthly period.
• There are some health risks similar to those with all birth control pills:
  – Blood clots, stroke, and heart attack.
  – Cigarette smoking increases the risk of serious side effects.

How to Use

• Like traditional birth control pills, the series of pills contains synthetic hormones, oestrogen and progestin, that are taken daily to prevent the client from ovulating (releasing an egg to be fertilized). Instead of a true menstrual period that occurs 2 weeks after ovulation, the client will get a "pill period" that may be lighter than a regular period.
• Unlike traditional birth control pills that require 21 days of active pills followed by 7 days of inactive pills, Seasonale allows the woman to take "active" pills continuously for 3 months. During this time, Seasonale prevents the uterine lining from thickening enough to produce a full menstrual period. Every 3 months, the client will take 1 week of inactive pills to produce a "pill period" that may be lighter than a regular period.
• When the clients takes continuous birth control pills, she should expect to have four menstrual periods per year (bleeding when she is taking the seven white pills). However, she will have more bleeding and spotting between menstrual periods than if she were taking a traditional birth control pill with a 28-day treatment cycle.
• For most effective use, the client should take the pill at the same time each day.

Intrauterine Contraceptive Devices

Yuangong IUCD

Features
The Yangong IUCD is an intrauterine contraceptive device. It is made with high-quality stainless steel and highly pure copper. This IUCD has been designed to suit the shape and dynamics of the uterus, and the content of the material assures safe, long-term use without degeneration. Each of the IUCDs (220 IUCD, 300 IUCD, and 365 IUCD) is available in three different sizes—large, medium, and small—and is impregnated with indomethacin, a non-steroidal anti-inflammatory drug (NSAID).

Characteristics of Yangong IUCD
• Made of stainless steel wire, which is easily compatible with the human body.
• Capable of placement in the uterus for over 20 years without aging and degeneration.
• Possesses moderate elasticity.
• Pure copper is released inside.
• Thread-less.
• No effect on sexual life.
• Easy insertion and removal.
• With impregnation of indomethacin, pain/bleeding and other side effects are reduced.

**Advantages**
• It springs to the uterine fundus when inserted.
• It cannot be easily displaced or expelled.
• It returns to its original shape when the uterus relaxes.

**Limitations**
• Uterine cramps and/or abdominal pain may occur.
• Nulliparous women are more prone to syncope, bradycardia, and other neurovascular episodes during or immediately after insertion or removal of this IUCD.
• Breakthrough bleeding and/or spotting often occurs during the first cycle and may recur for several subsequent cycles.
• Increased duration of menstruation and an increase in menstrual blood loss may occur, especially during the first few cycles.
• Dysmenorrhea may occur or be aggravated.
• Does not protect against HIV infection or any of the STIs.

**Contraindications**
• In pregnancy or when there is a possibility of pregnancy
• Inflammation of the genitalia, such as acute and chronic pelvis infection, vaginitis, acute cervicitis, and severe cervical erosion
• Heavy or irregular uterine bleeding
• Endometriosis
• Uterine cavity is less than 5.5 cm
• Severe dysmenorrhea, tumour of the female genitalia tract, and severe uterine deformity
• In patients with untreated STls or those who have not yet recovered from the infection
• In patients with history of ectopic pregnancy, women with severe vagus reflex, or who fainted during uterine operation

**Implants**

**Types**

**Jadelle®**
Jadelle is an implant system that provides effective, long-acting, reversible contraception for women. Two thin, flexible rods made of silicone tubing and filled with levonorgestrel, a synthetic progestin, are inserted just under the skin of a woman's upper, inner arm in a minor surgical procedure. Jadelle has two rods
Female Sterilization

Essure™
Essure is a new method of female sterilization that uses the trans-cervical approach. It was approved by the U.S. Food and Drug Administration in November 2002.

The Essure micro-insert consists of a stainless steel inner coil, a nitinol super-elastic outer coil, and polyethylene (PET) fibres. The coil is placed into the uterine end of the fallopian tube using hysteroscopy technique. The micro-insert is 4 cm in length and 0.8 mm in diameter in its wound-down configuration. When released, the outer coil expands to 1.5 to 2.0 mm in diameter to anchor the micro-insert in the varied diameters and shapes of the fallopian tube.

Effectiveness
In clinical trials, Essure was 99.8 percent effective after 2 years of follow-up. Women were back to their regular activities typically in 1–2 days post-procedure.

Mode of Action
The micro-insert remains anchored in the fallopian tube and results in tubal occlusion eliciting a tissue in-growth. The PET fibre mesh and the micro-insert acts as scaffolding into which the tissue grows, anchoring the micro-insert within the fallopian tube and occluding the tube. The remaining parts of the tubes are normal. The larger diameter of the micro-insert at the uterine end prevents its migration towards the peritoneal cavity.

Advantages and Limitations
• Essure requires a trained provider to perform the procedure in a special setting.
• Most of the side effects and complications are related to poor insertion techniques.
• Failure to correctly place the micro-inserts in the fallopian tubes may result in expulsion.

How to Use
Essure comes with a disposable delivery system. The system consists of a single-handed ergonomic handle containing the delivery wire, release catheter, delivery catheter, and micro-inserts. Essure can be inserted in a hospital or outpatient setting. Using Essure does not require any incision on the abdominal skin, and so there is no scar. The micro-inserts are inserted into the uterine cavity during hysteroscopy, and no general anaesthesia is required for the procedure. The procedure is completed in 30 minutes, and the client can go home 45 minutes after the procedure.

It takes up to 12 weeks for the tissue in-growth to completely occlude the fallopian tubes. Clients need to use a backup contraceptive method for 3 months. To confirm the tubal occlusion on
both sides, a hysterosalpingogram should be done at the end of 12 weeks.

Male Methods

Male hormonal methods
Many methods that act by inhibiting spermatogenesis are currently under development. For example:
- Exogenous progestin or gonadotropin-releasing hormone (GnRH) antagonist to suppress follicle-stimulating hormone (FSH) and luteinizing hormone (LH), thereby decreasing spermatogenesis.
- Exogenous testosterone (injectable, patch, or implant) combined with a slow-release progestin implant.

Non-hormonal methods
- Anti-sperm compounds, e.g., gossypol from cottonseed oil and triptolide.
- Immuno-contraception methods based on interference of the reproductive process by products of an immune reaction.
- Temporary sterilization by injecting the vas deferens with a polymer to block sperm transport.
Introduction

This chapter deals with minimizing the risk of spreading reproductive tract infections (RTIs), sexually transmitted infections (STIs), HIV/AIDS, and hepatitis B. To minimize this risk and effective management of the clients, the health care provider should be knowledgeable about these diseases and their management.

The health provider can play a pivotal role in the prevention of spread and treatment of the clients suffering from STIs/RTIs, HIV/AIDS, and hepatitis. It is therefore important that they be able to identify these cases, give advice on preventive measures and suggest how they can be managed.

Reproductive Tract Infections (RTIs)

Reproductive Tract Infection is a group of infections affecting the reproductive system. These infections can lead to diseases affecting the reproductive tract (e.g., pelvic inflammatory disease) that have both immediate (e.g., tubo-ovarian abscess) and long term consequences (infertility).

They include STIs, non-sexually transmitted infections like endogenous infections caused by the overgrowth of the organisms normally present in the reproductive tract, and iatrogenic infections caused by medical procedures when infection control is poor.

Sexually Transmitted Infections (STIs)

STIs are infections that are spread from one person to another by sexual contact. STIs can lead to both acute and long term consequences.

Policy

After incorporating the recommendation of ICPD (International Conference on Population Development, Cairo, 1994), in the ninth Five Year Plan. A package of comprehensive Reproductive Health Services was prepared and to be offered in the service outlets of all health and population welfare programmes as well as private facilities. Facilities for screening and managing RTIs/STIs will be made available to all clients and preventive health education will be offered.

Standards
• Clients requiring RTIs/STIs information and treatment will be provided comprehensive counselling, treatment, and referral, if required.
• All health and family planning (FP) facilities should have information, education and communication (IEC) materials available along with preventive and curative facilities for the common RTIs/STIs.
• No client will be denied treatment on the basis of his/her HIV status.

Classification of RTIs/STIs
Several types of organisms cause STIs. Those caused by organisms such as bacteria generally can be treated with successfully treated with the correct antibiotic regimen. STIs caused by viruses are not responsive to antibiotics but can be prevented in some cases through vaccination (Hepatitis B) or its symptoms relieved by medications.

Table 14-1. Classification of Reproductive Tract and Sexually Transmitted Infections

<table>
<thead>
<tr>
<th>Sexually Transmitted Infection</th>
<th>Type</th>
<th>Organism</th>
<th>Sexual Transmission</th>
<th>Non-Sexual Transmission</th>
<th>Treatable</th>
</tr>
</thead>
<tbody>
<tr>
<td>Chancroid</td>
<td>Bacterial</td>
<td>Haemophilus ducreyi</td>
<td>Vaginal, anal, and oral sex</td>
<td>None</td>
<td>Yes</td>
</tr>
<tr>
<td>Chlamydia</td>
<td>Bacterial</td>
<td>Chlamydia trachomatis</td>
<td>Vaginal and anal sex, rarely from genitals to mouth</td>
<td>From mother to child during pregnancy</td>
<td>Yes</td>
</tr>
<tr>
<td>Gonorrhoea</td>
<td>Bacterial</td>
<td>Neisseria gonorrhoea</td>
<td>Vaginal and anal sex, or contact between mouth and genitals</td>
<td>From mother to child during delivery</td>
<td>Yes</td>
</tr>
<tr>
<td>Hepatitis B</td>
<td>Viral</td>
<td>HBV</td>
<td>Vaginal and anal sex, or from penis to mouth</td>
<td>In blood, from mother to child during delivery; No, But can be prevented by vaccination</td>
<td></td>
</tr>
<tr>
<td>Herpes</td>
<td>Viral</td>
<td>Herpes simplex virus type-II</td>
<td>Genital or oral contact with an ulcer, including vaginal and anal sex; also genital contact in area without ulcer</td>
<td>From mother to child during pregnancy or delivery</td>
<td>No</td>
</tr>
<tr>
<td>HIV</td>
<td>Viral</td>
<td>Human immuno-deficiency virus</td>
<td>Vaginal and anal sex, very rarely oral sex</td>
<td>In blood, from mother to child during pregnancy or delivery or in breast milk</td>
<td>No</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Human</td>
<td>Skin-to-skin and</td>
<td></td>
<td>Yes</td>
</tr>
<tr>
<td>Disorder</td>
<td>Type</td>
<td>Pathogen</td>
<td>Manifestation</td>
<td>Transmission</td>
<td>Prevention/Management</td>
</tr>
<tr>
<td>--------------------------------------</td>
<td>---------</td>
<td>-------------------------------</td>
<td>---------------------------------------------------</td>
<td>-----------------------</td>
<td>-----------------------</td>
</tr>
<tr>
<td>Genital warts</td>
<td>Viral</td>
<td>papillomavirus (HPV)</td>
<td>Genital contact or mouth and genitals contact</td>
<td>From mother to child during delivery</td>
<td>Some of the manifestations of genital warts can be treated by medical or surgical means;</td>
</tr>
<tr>
<td>Syphilis</td>
<td>Bacterial</td>
<td>Treponema pallidum</td>
<td>Genital or oral contact with an ulcer, including vaginal and anal sex</td>
<td>From mother to child during pregnancy or delivery</td>
<td>Yes</td>
</tr>
<tr>
<td>Trichomoniasis</td>
<td>Parasite</td>
<td>Trichomonas vaginalis</td>
<td>Vaginal, anal, and oral sex</td>
<td>From mother to child during delivery</td>
<td>Yes</td>
</tr>
<tr>
<td>Candidiasis</td>
<td>Fungal</td>
<td>Candida albicans</td>
<td>Vaginal, anal, and oral sex</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Bacterial vaginosis</td>
<td>Bacterial</td>
<td>Mycoplasma hominis</td>
<td>Vaginal, anal, and oral sex</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Granuloma inguinale</td>
<td>Bacterial</td>
<td>C. granulomatis</td>
<td>Vaginal, anal, and oral sex</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Lymphogranuloma venereum (LGV)</td>
<td>Bacterial</td>
<td>C. trachomatis</td>
<td>Vaginal, anal, and oral sex</td>
<td>No</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**Strategies**

Strategies for RTI/STI control as recommended by the World Health Organization (WHO) are as follow:

**Strategy 1: Use male or female condom correctly with every act of sex.**
- One method that helps protect against the pregnancy and STIs, including HIV.

**Strategy 2: Use condoms consistently and correctly, plus another FP method.**
- Adds extra protection from pregnancy in case a condom is not used or is used incorrectly.
- May be a good choice for women who want to be sure to avoid pregnancy but cannot always count on their partners to use condoms.

**Strategy 3: If both partners know they are not infected, use any FP method to prevent pregnancy and stay in a mutually faithful relationship.**
- Many FP clients will fall into this group and thus are protected from STIs, including HIV.
- Depends on communication and trust between partners.
Role of Health Care Provider

- STIs are common, and cause much suffering and disability. All health care providers have a responsibility to do what they can to prevent and treat STIs.

The providers should recognize signs of STIs and either promptly treat or refer for treatment. Women who currently have an STI indicative of gonococcal, or chalmydial in origin or are likely to be at higher risks for these infections should not use IUCDs. Providers should diagnose and treat STIs before inserting an IUCD. During the treatment period, the couple should be provided with an option to use alternative contraceptive methods.

Men and women who have several sex partners have more chances of getting STIs. Sex workers and the clients of sex workers are most likely to get STIs. Female sex workers also usually want to avoid pregnancy, and so they may come to health care providers for contraceptives.

Protocol for treatment

- History taking
- Examination
- Counselling
- Management and follow-up

History taking

During history taking and examination for RTIs / STIs, it is important to win the client’s trust to obtain all necessary information. The session should be conducted in privacy and in a non-judgmental manner. Four sets of information are needed:

- General history
- Medical history
- Present illness
- Sexual history

The Five Ps of Sexual History

1. Partner (Spouse)
2. Prevention of Pregnancy
3. Protection from RTIs/STIs
4. Practices
5. Past history of RTIs/STIs

1. Partner (Spouse)

When assessing sexual risk, it is important to determine the number of sexual contacts a client has had. If the client has had multiple contacts, there is a need to explore for specific
risk factors such as other contacts, injecting drug use, history of STIs, and drug use with sex. If the client has no partner other than her/his spouse, the health care provider should ask about the length of the relationship and the spouse’s risk, such as other contacts and injecting drug use.

2. Prevention of pregnancy
   Based on the information about a male partner (see above), the health care provider can determine if the spouse is at risk of becoming pregnant. If this is the case, the health care provider should determine if the pregnancy is desired.

3. Protection from RTIs/STIs
   Through discussion, the health care provider should explore different issues such as condom use, monogamy/polygamy, client self-perception of risk, and perception of spouse’s risk.

4. Practices
   If the client has had more than one spouse in the past year, the health care provider may want to further explore the client’s sexual practices and condom usage. Asking about other sex practices will guide risk reduction strategies and help in identifying anatomical sites from which to collect specimens for STIs testing.

5. Past history
   A history of gonorrhoea or chlamydia increases a person's risk of repeated infection.

   STIs in the recent past indicate higher risk behaviour.

Examination

It includes pelvic examination in females; examination of vulva, anus, and perineum; and palpation of inguinal region for enlarged lymph nodes. In males, genital, inguinal and peri anal region are examined.

Counselling

People who seek treatment for a suspected STI constitute a very important target group for education and counselling for prevention of RTI/STI. Those who are actually diagnosed to have an RTI/STI may be more receptive to advice. They now have proof that “it can happen to me,” not only to others. This is a valuable opportunity to communicate with them about the risk of HIV/AIDS infection and how to avoid future RTIs/STIs.

Preventing STIs

People can avoid STIs by changing their sexual behaviour. They can follow any of the ABCD: Abstain, Be mutually faithful, Consistently Use Condoms (and Do not share needles).

Abstain from sex.
Or
Be mutually faithful.
Or
Consistently use condoms.
And
Do not share needles/blades/razors.

The four basic health education message (4 Cs)
In syndromic management of RTI/STI, the following are a must for counselling the patients and/or their partner(s).
- Compliance with treatment
- Practice safe sex behaviour
- Use condoms for both prevention of pregnancy and STIs.
- Manage Partner.

There is no standard order in which these messages should be delivered. However, patients tend to be most responsive to messages related to their own cure, followed by the treatment of those close to them, for instance a spouse. There is often a lack of interest in discussing the long-term consequences of STIs, especially the risk of acquiring or transmitting HIV and the behavioural changes required for preventing its spread.

Good RTI/STI counselling should include the “WELL” method of communication to make RTI/STI clients comfortable and let them know that we want to help them:
‘WELL’

<table>
<thead>
<tr>
<th>W</th>
<th>Welcome the Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Greet the clients warmly and offer them a seat. Sit close enough to them so that they can talk comfortably and privately. Have a welcoming tone in the voice.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>E</th>
<th>Encourage the Clients to Talk</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Encourage clients to talk by looking at them as they speak, by asking questions, by nodding as they speak, by saying “Mmm, Hmmm” or “Tell me more about that”, etc.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>L</th>
<th>Look at the Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Looking at the clients as they speak helps them to talk comfortably. Make sure the provider has a warm and friendly facial expression.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>L</th>
<th>Listen to the Clients</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Listen carefully to what the clients have to say.</td>
</tr>
</tbody>
</table>

In counselling a person who thinks that she/he may have an STI, tell person to do the following:
- Get diagnosed and treated immediately. Many STIs can be treated and cured, especially in their early stages. Some, such as HIV and herpes, cannot be cured, but sometimes their effects can be stopped for a time.
- Take all of the medicine according to the instructions, even if symptoms go away. Inform the client that the medicines can cause some side effects such as vomiting, diarrhoea, or a
rash. If any of these side effects occur and are severe, the person must return to the clinic that provided the medicine.

- Avoid sex with anyone until 3 days after treatment is finished and all symptoms are gone to prevent spread.
- Get treatment for his/her spouse also so that both can get treated. Unless all sex partners are treated at the same time, they will infect each other again and again. It is especially important that a man informs his female partner. This is because many women do not have symptoms until the STI has reached a more serious stage.

Pregnant woman should visit an antenatal clinic within the first 3 months of pregnancy for a physical exam and syphilis test to protect the unborn child.

**Management**

**SYNDROMIC APPROACH**

Ideally each of the case of RTI/STI should be properly diagnosed and appropriate treatment should be given according to the diagnosis. But this may not be possible in most of the areas of the world.

The WHO endorsed simple and effective regimes and tools to be used in the situations where standard laboratory tests to identify RTIs/STIs are expensive and require equipment that is generally unavailable to clinics in those areas/countries.

The primary screening approach developed, syndromic management, diagnoses infection based on the presence of symptom of the disease rather than on laboratory tests.

A syndrome is a collection or a group of symptoms that the patient complains of and the signs observed by the health care provider while examining the patient. Depending on the signs the health care provider manage the patient by using the simple flowchart or algorithm. It is acceptable, feasible, and-cost effective in most settings.

Mentioned below are the management of the symptoms of RTIs/STIs based on the “syndromic approach”.

Figure 14-1. Flowchart for Syndromic Management of Urethral Discharge

Treatment options for gonorrhoea
- Ciprofloxacin, 500 mg orally, as a single dose
  OR
- Ceftriaxone, 125 mg by intramuscular injection, as a single dose
  OR
- Cefixime, 400 mg orally, as a single dose
  OR
- Spectinomycin, 2 g by intramuscular injection, as a single dose

Note
- Ciprofloxacin is contraindicated in pregnancy, and is not recommended for use in children and adolescents.
- There are variations in the anti-gonococcal activity of individual quinolones, and it is important to use only the most active.

Treatment options for chlamydia
• Doxycycline, 100 mg orally, twice daily for 7 days
  OR
• Azithromycin, 1 g orally, in a single dose

**Alternative regimen**
• Amoxicillin, 500 mg orally, three times a day for 7 days
  OR
• Erythromycin, 500 mg orally, four times a day for 7 days
  OR
• Ofloxacin, 300 mg orally, twice a day for 7 days
  OR
• Tetracycline, 500 mg orally, four times a day for 7 days

**Note**
• Doxycycline and other tetracyclines are contraindicated during pregnancy and lactation.
• Current evidence indicates that 1 g single-dose therapy of Azithromycin is efficacious for chlamydial infection.
• There is evidence that extending the duration of treatment beyond 7 days does not improve the cure rate in uncomplicated chlamydial infection.
• Erythromycin should not be taken on an empty stomach.

**Note**
• WHO recommends that, where possible, single-dose therapy be used.
Figure 14-2. Flowchart for Syndromic Management of Vaginal Discharge

- Patient complains of vaginal discharge, vulval itching or burning
  - Take history and examine
  - Assess risk

- Abnormal discharge or vulval erythema?
  - No
    - Any other genital disease?
      - No
        - Use appropriate flowchart
      - Yes
        - Use flowchart for lower abdominal pain
     - Yes
       - Lower abdominal tenderness?
         - No
           - TREAT FOR BACTERIAL VAGINOSIS AND TRICHOMONAS VAGINALIS
         - Yes
           - High GC/CT prevalence setting or risk assessment positive?
             - No
               - TREAT FOR BACTERIAL VAGINOSIS AND TRICHOMONAS VAGINALIS
             - Yes
               - High GC/CT prevalence setting or risk assessment positive?
                 - No
                   - TREAT FOR CANDIDA ALBICANS
                 - Yes
                   - TREAT FOR GONOCOCCAL INFECTION, CHLAMYDIA TRACHOMATIS, BACTERIAL VAGINOSIS AND TRICHOMONAS VAGINALIS

Treatment Options for Cervical Infection
- Therapy for uncomplicated gonorrhoea (refer to urethral discharge)
  - PLUS
  - Therapy for chlamydia (refer to urethral discharge)

Treatment options for vaginal infection
*Trichomoniasis*
• Metronidazole, 2 g orally, in a single dose
  OR
• Tinidazole, 2 g orally, in a single dose

**Note**
The reported cure rate in women ranges from 82 percent to 88 percent, but may be increased to 95 percent if sexual partners are treated simultaneously.

**Alternative regimen**
• Metronidazole, 400 mg or 500 mg orally, twice daily for 7 days
  OR
• Tinidazole, 500 mg orally, twice daily for 5 days

**Note**
• Other 5-nitroimidazoles are also effective, both in single- and in multiple-dose regimen.
• Patients taking metronidazole or other imidazoles should be cautioned not to consume alcohol while they are taking the drug, and for up to 24 hours after taking the last dose.
• Metronidazole is generally not recommended for use in the first trimester of pregnancy.
• Asymptomatic women with trichomoniasis should be treated with the same regimen as symptomatic women.

**Bacterial Vaginosis**
• Metronidazole, 400 mg or 500 mg orally, twice daily for 7 days.

**Alternative regimen**
• Metronidazole, 2 g orally, as a single dose
  OR
• Clindamycin 2 percent vaginal cream, intravaginally, at bedtime for 7 days

**Pregnant women**
• Metronidazole, 200 or 250 mg orally, three times daily for 7 days, after first trimester
• Metronidazole 2 g orally, as a single dose, if treatment is imperative during the first trimester of pregnancy

**Candidiasis**
• Miconazole or Clotrimazole, 200 mg intravaginally, daily for 3 days
  OR
• Clotrimazole, 500 mg intravaginally, as a single dose
  OR
• Fluconazole, 150 mg orally, as a single dose

**Alternative regimen**
Nystatin, 100,000 IU intravaginally, daily for 14 days
Figure 14-3. Flowchart for Syndromic Management of Genital Ulcers

1. Indications for syphilis treatment:
   - RPR positive; and
   - Patient has not been treated for syphilis recently.
2. Treat for HSV where prevalence is 30% or higher, or adapt to local conditions.

Drug Options for Syphilis
• Benzathine Benzylpenicillin<sup>3</sup> 2.4 million IU by intramuscular injection, at a single session. Because of the volume involved, this dose is usually given as two injections at separate sites.

**Alternative regimen**
Procaine benzylpenicillin<sup>4</sup> 1.2 million IU by intramuscular injection, daily for 10 consecutive days.

**Alternative regimen for penicillin-allergic, non-pregnant patients**
• Doxycycline, 100 mg orally, twice daily for 14 days
  
  OR

• Tetracycline, 500 mg orally, four times daily for 14 days

**Alternative regimen for penicillin-allergic, pregnant patients**
• Erythromycin, 500 mg orally, four times daily for 14 days

**Drug Options for chancroid**
• Ciprofloxacin, 500 mg orally, twice daily for 3 days
  
  OR

• Erythromycin base, 500 mg orally, four times daily for 7 days
  
  OR

• Azithromycin, 1 g orally, as a single dose

**Alternative regimen**
• Ceftriaxone, 250 mg by intramuscular injection, as a single dose

**Drug options for granuloma inguinale**
• Azithromycin, 1 g orally on first day, then 500 mg orally, once a day
  
  OR

• Doxycycline, 100 mg orally, twice daily

**Alternative regimen**
• Erythromycin, 500 mg orally, four times daily
  
  OR

• Tetracycline, 500 mg orally, four times daily
  
  OR

• Trimethoprim 80 mg/sulfamethoxazole 400 mg, two tablets orally, twice daily for a minimum of 14 days

---

<sup>3</sup> Benzathine benzylpenicillin synonyms: Benzathine penicillin G; benzylpenicillin Benzathine; Benzathine penicillin.

<sup>4</sup> Procaine benzylpenicillin synonyms: procaine penicillin G.
Note
• Treatment should be continued until all lesions are epithelialized.

Drug Options for lymphogranuloma venereum (LGV)
• Doxycycline, 100 mg orally, twice daily for 14 days
  OR
• Erythromycin, 500 mg orally, four times daily for 14 days

Alternative regimen
• Tetracycline, 500 mg orally, four times daily for 14 days

Note
• Tetracyclines are contraindicated in pregnancy.
• Fluctuant lymph nodes should be aspirated through healthy skin. Incision and drainage or excision of nodes may delay healing. Some patients with advanced disease may require treatment for longer than 14 days, and sequelae such as strictures and/or fistulae may require surgery.

Drug options for genital herpes
• Acyclovir, 200 mg orally, five times daily for 7 days
  OR
• Acyclovir, 400 mg orally, three times daily for 7 days
  OR
• Valaciclovir, 1 g orally, twice daily for 7 days
  OR
• Famciclovir, 250 mg orally, three times daily for 7 days

Note
• The decision to treat for chancroid, granuloma inguinale, or LGV depends on the local epidemiology of the infections.
• Specific treatment for herpes genitalis is recommended as it offers clinical benefits to most symptomatic patients. Health education and counselling regarding the recurrent nature of genital herpes lesions, the natural history, sexual transmission, probable perinatal transmission of the infection, and available methods to reduce transmission, are an integral part of genital herpes management.
Figure 14-4. Flowchart for Syndromic Management of Lower Abdominal Pain

Patient complains of lower abdominal pain

Take history (including gynaecological and examine (abdominal and vaginal)

Any of the following present?
- Missed/overdue period
- Recent delivery-abortion/miscarriage
- Abdominal guarding and/or rebound tenderness
- Abnormal vaginal bleeding

Yes

Refer patient for surgical or gynaecological opinion and assessment
Before referral set up an IV line and apply resuscitative measures if necessary

No

Is there cervical excitation tenderness, or lower abdominal tenderness and vaginal discharge?

Yes

Manage for PID
Review in 3 days

No

Any other illness found?

Yes

Manage appropriately

No

Patient has improved?

Yes

Continue treatment until completed
- Educate and counsel
- Promote condom use and provide condoms
- Offer HIV counselling and testing if both facilities are available
- Ask patient to return if necessary

No

Refer

Recommended syndromic treatment

- Single-dose therapy for uncomplicated gonorrhoea
  
  **Plus**
  
  Doxycycline, 100 mg orally, twice daily, or tetracycline, 500 mg orally, four times daily for 14 days
  
  **Plus**
  
  Metronidazole, 400–500 mg orally, twice daily for 14 days
Note

- Patients taking Metronidazole should be cautioned to avoid alcohol.
- Tetracyclines are contraindicated in pregnancy.

Figure 14-5. Flowchart for Syndromic Management of Scrotal Swelling

Recommended syndromic treatment

- Therapy for uncomplicated gonorrhoea (refer to urethral discharge)
  PLUS
- Therapy for chlamydia (refer to urethral discharge)
Figure 14-6. Flowchart for Syndromic Management of Inguinal Bubo

Patient complains of inguinal swelling

Take history and examine

Inguinal/femoral Bubo(s) present?

Yes

Use appropriate flowchart

No

Any other genital disease?

Yes

Use genital ulcer flowchart

No

Ulcer(s) present?

Yes

TREAT FOR LYMPHOGRAULOMA VENEREUM AND CHANCROID

- Educate and counsel
- Promote condom use and provide condoms
- Offer HIV counselling and testing if both facilities are available

No

Recommended syndromic treatment

- Ciprofloxacin; 500 mg orally, twice daily for 3 days
  AND
- Doxycycline, 100 mg orally, twice daily for 14 days
  OR
- Erythromycin, 500 mg orally, four times daily for 14 days

Note

- Some cases may require longer treatment than the 14 days recommended above. Fluctuant lymph nodes should be aspirated through healthy skin. Incision and drainage or excision of nodes may delay healing and should not be attempted. Where there is doubt and/or treatment failure, referral for diagnostic biopsy is advisable.
Figure 14-7. Flowchart for Syndromic Management of Neonatal Conjunctivitis

Recommended syndromic treatment
- Ceftriaxone, 50 mg/kg by intramuscular injection, as a single dose, to a maximum of 125 mg
- Alternative regimen where Ceftriaxone is not available
  - Kanamycin, 25 mg/kg by intramuscular injection, as a single dose, to a maximum of 75 mg
  - OR
  - Spectinomycin, 25 mg/kg by intramuscular injection, as a single dose, to a maximum of 75 mg
Note
- Single-dose Ceftriaxone and Kanamycin are of proven efficacy. The addition of Tetracycline eye ointment to these regimens is of no documented benefit.

HIV/AIDS

Acquired immuno-deficiency syndrome (AIDS) is an infectious disease, caused by the human immuno-deficiency virus (HIV), in which the body's defense system is destroyed, resulting in the failure of the body to fight infections. The disease in its final stage is known as AIDS.

AIDS is a very serious STI with no vaccine presently available; primary prevention is the only tool to control HIV/AIDS. Hence it is very important to know the mode of spread and the preventive measures and to identify and detect early, to counsel and refer patients for treatment and management.

Stages of HIV/AIDS infection
- **Initial Stage:** In this stage of the disease most (60 percent) of the patients remain asymptomatic. But in few cases the patient may develop flu-like symptoms after 1 to 3 weeks. The fever in these cases may continue from 1 to 3 weeks.
- **Window Period:** The HIV/AIDS virus takes about 3 to 6 months for antibodies to become detectable in the blood, from the time of entering the body. This period is called the window period.
- **Asymptomatic HIV/AIDS Infection:** In some cases, the person may remain in the carrier stage for up to 15 years without developing any signs/symptoms.
- **Symptomatic Stage - AIDS:** Of the HIV/AIDS carriers, about 50 percent after 8 years and 60 percent after 15 years develop full-blown AIDS.

Clinical features
AIDS is suspected if two of the major and one of the minor signs are present.

**Major Signs**
- Weight loss (10 percent of body weight)
- Recurrent/prolonged fever lasting more than 1 month
- Chronic diarrhoea lasting more than 1 month
- Painful genital ulcer

**Minor Signs**
- Persistent cough lasting more than 1 month
- Purplish blue skin rash that does not disappear
- Thrush in mouth or throat
- Swollen lymph nodes
- Deteriorating blisters and ulcers from herpes spreading beyond the lips and genitals
Transmission of HIV/AIDS infection
HIV is spread when blood, semen, and vaginal fluids of an infected person come in contact with the blood or body fluid, through a breach in the mucous membrane or the skin, of another person.

Modes of Transmission
• Through sexual intercourse, the virus can pass from men to women or vice versa in heterosexuals, and from men to men in homosexuals, or through any other form of sex where a breach of the mucous membrane or the skin occurs.
• Contaminated blood transfusion or infected blood or blood products can transmit the virus in 90 percent of cases.
• Contaminated needles, sharps, razors, and other skin-piercing instruments can pass the virus in 5–10 out of 1,000 cases. Therefore, drug addicts who share needles are at risk.
• Vertical transmission from an infected mother to her baby can occur during pregnancy or during delivery, or even after birth while nursing. Almost 10 percent of the HIV/AIDS cases in the world are children, most of whom acquired the infection from their infected mothers.
• Although HIV can be transmitted through breast milk, WHO still encourages breastfeeding in the developing world, because a baby’s chances of dying from malnutrition outweigh those of dying from HIV/AIDS infection.

High-risk behaviour
• Having sex with more than one partner or with a spouse who has other partners (commercial sex workers), without using condoms
• Taking infected blood or blood products
• In childbirth, when the virus passes from an infected mother to the child
• Sharing contaminated needles and syringes

Behaviour through which HIV does not spread
• Talking, sneezing, coughing, or through air
• Insect bite
• Shaking hands with or embracing an infected person
• Sharing a toilet or swimming pool with an infected person
• Playing or eating together
• Sharing towels or clothes
• Living together with or taking care of a person with HIV/AIDS, or going to the same school as an infected person
• Having sex with a mutually faithful person who does not have AIDS
• Correct and consistent use of condom

Treatment
Antiretroviral (ARV) drugs inhibit the replication of HIV. When antiretroviral drugs are given in combination, HIV replication and immune determination can be delayed, and survival and quality of life improved. Symptomatic treatment can be given to ease the symptoms.

Prevention of HIV/AIDS

Through the Acronym AIDS
A: Avoiding unprotected sex with more than one partner
I: Information or education
D: Drug abuse—avoid
S: Safe blood transfusion

Promoting Safe Medical Practices
- Processing (decontamination, cleaning, and sterilization) of all needles, syringes, and surgical instruments
- Strict application of infection prevention measures
- Destruction of all disposable supplies
- Performing blood transfusion only when necessary

Protecting Health Care Providers
- Wearing gloves for all procedures requiring contact with blood or body fluids
- Wearing gloves while processing surgical instruments; using sterilized or after high-level disinfection (HLD) of instruments
- Proper laundering of soiled linen

Hepatitis

Hepatitis is an inflammation of the liver, which stops it from proper functioning. Several different viruses cause hepatitis. They are named the hepatitis A, B, C, D, and E viruses.

All of these viruses can cause acute, or short-term, viral hepatitis. The hepatitis B, C, and D viruses can also cause chronic hepatitis, in which the infection is prolonged, sometimes lifelong and in some can lead to chronic cirrhosis and liver cancer

Hepatitis B
Liver disease caused by hepatitis B virus (HBV).

Mode of Transmission
- Having contact with an infected person’s blood, semen, or other body fluids.
- Having sex with an infected person without using a condom.
• Sharing drug needles.
• Getting a tattoo or body piercing with dirty tools that were used on someone else.
• Getting pricked with a needle that has infected blood on it.
• Sharing a toothbrush or razor with an infected person.
• In the case of an infected mother, transmission to child during birth or breastfeeding.

**Hepatitis B does not spread by**

• Shaking hands with an infected person.
• Hugging an infected person.
• Sitting next to an infected person.

**Prevention**

A person can get vaccinated against hepatitis B.

Hepatitis B vaccine is given through three shots. All babies should get the vaccine. Infants get the first shot within 12 hours after birth. They get the second shot at age 1 to 2 months, and the third shot between the ages of 6 and 18 months.

Older children and adults can get the vaccine, too. They get three shots over 6 months. Children who have not had the vaccine should get it. A person needs all of the shots to be protected from hepatitis B. If a person misses one (or two) of the three shots, s/he should go to the doctor or clinic right away to set up a new appointment.

One can also protect oneself and others from hepatitis B by:

• Using a condom at time of sexual intercourse.
• Not sharing drug needles with anyone.
• Wearing gloves if one has to touch anyone's blood.
• Not using an infected person's toothbrush, razor, or anything else that could have blood on it.
• Tattooing or body piercing only with clean tools.

**Hepatitis C**

An infection of the liver caused by the hepatitis C virus (HCV), which is found in the blood of persons who have the disease.

**Mode of Transmission**

Hepatitis C is spread by:

• Having contact with an infected person's blood.
• Sharing drug needles.
• Getting pricked with a needle that has infected blood on it.
• Being born to a mother with hepatitis C.
• Getting a tattoo or body piercing with unsterilized, dirty tools.
• Blood transfusion with infected blood or organ transplant without screening for hepatitis C.
• Having sex with an infected person, especially if he/she or his/her partner has other STIs.

Hepatitis C does not spread by:
• Shaking hands with an infected person.
• Hugging an infected person.
• Kissing an infected person.
• Sitting next to an infected person.

Contraceptives for Clients with STIs, HIV/AIDS

People with STIs or HIV/AIDS or who on antiretroviral therapy (ART) can start and continue to use most contraceptive methods safely. There are a few limitations. However, in general, contraceptives and ARV medications do not interfere with each other. It is not certain whether some ARV medications make low-dose hormonal contraceptives less effective. Even if they do, condom use can make up for that.

Condoms
When used consistently and correctly, condoms provide almost 100 percent protection against STIs, HIV, and AIDS.

Intrauterine contraceptive devices (Copper-Bearing or Hormonal IUCDs)
Do not insert an IUCD in a woman who is at very high individual risk for gonorrhoea and chlamydia, or who currently has gonorrhoea, chlamydia, purulent cervicitis, or PID. (A current IUCD user who becomes infected with gonorrhoea or chlamydia or develops PID can safely continue using an IUCD during and after treatment.) A woman with HIV can have an IUCD inserted. A woman with AIDS should not have an IUCD inserted unless she is clinically well on ART. (A woman who develops AIDS while using an IUCD can safely continue using the IUCD.) Do not insert an IUCD if the client is not clinically well.

Female sterilization
If a client has gonorrhoea, chlamydia, purulent cervicitis, or PID, delay sterilization until the condition is treated and cured. Women who are infected with HIV, have AIDS, or are on ART, can safely undergo female sterilization. Special arrangements are needed to perform female sterilization on a woman with AIDS. Delay the procedure if she is currently ill with AIDS-related illness.

Vasectomy
If a client has scrotal skin infection, an active STI, or swollen, tender tip of penis, sperm ducts, or testicles, delay sterilization until the condition is treated and cured. Men who are infected with HIV, have AIDS, or are on ART can safely undergo vasectomy. Special arrangements are needed to perform vasectomy on a man with AIDS. Delay the procedure if he is currently ill with
AIDS-related illness.

**Oral pills, injectables, and implants**
STI clients can safely use contraceptive pills, injections, and implants. These do not affect the course of disease and are without any harmful effects or interaction with the medicines being taken.