National Standards for Family Planning Services

Department of Public Health
Maldives 2005

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Foreword MOH

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REPRODUCTIVE HEALTH AND FAMILY PLANNING IN MALDIVES

Reproductive health (RH) is a state of complete physical, mental and social wellbeing and not merely the absence of disease or infirmity in all matters related to the reproductive system and to its functions and processes. Reproductive health is a crucial part of overall health and is central to human development. The Government of Maldives is a signatory to the Program of Action of the International Conference on Population and Development (ICPD), which includes the concept of RH care as the constellation of methods, techniques and services that contribute to reproductive health and wellbeing by preventing and solving reproductive and sexual health problems. Table 1 and Table 2 provides a summary of key RH and family planning indicators in the country and Table 3 provides information on the availability of the various family planning methods at different facility levels within the country.

NATIONAL REPRODUCTIVE HEALTH POLICY

The Government of Maldives recognizes that reproductive health is a crucial component of general health and that developmental and intergenerational focus on RH services is a major facilitating service towards achieving the right of the individual and couples to protect their reproductive health and to take responsibility for their reproductive functions. Government of Maldives is committed to providing reproductive health services that are affordable, have equity in access and quality corresponding to the needs of each individual, encompass the principles of primary health care, ensure privacy of the individual and are sensitive and responsive to the socio-cultural circumstances of the individual. Reproductive health services should ensure confidentiality and should not discriminate against any individual on account of gender or social background. The policy recognizes the right of the individual to information and education and emphasizes access to accurate information in order that they take full, free and informed decisions and is consistent with national policies and legal provisions.

NATIONAL REPRODUCTIVE HEATH STRATEGY 2005-2007

The goal of the national reproductive health strategy 2005-2007 is ‘reproductive health and rights for all Maldivian women, men and adolescents’.

Components of Reproductive Health Strategy

The seven thematic areas of reproductive health in the National Reproductive Health Strategy 2005-2007 are:

1. Safe Motherhood and Newborn Care
2. **Family Planning**
3. Adolescent and Reproductive Health
4. Sexually Transmitted Infections and HIV/AIDS
5. Gender Based Violence
6. Partnering with Men in Sexual and Reproductive Health
7. Reproductive Morbidities (including infertility and cancers)

Family planning component of RH Strategy 2005-2007

The specific goal for family planning according to National Reproductive Health Strategy 2005-2007 is to ensure easy access to safe, affordable and effective methods of family planning and information. The family planning strategy focuses on two objectives:

1. Increase the contraceptive prevalence rate for modern methods with particular emphasis on male condoms and addressing unmet need.
2. Strengthen contraceptive procurement and logistics system.

The strategic approaches for achieving its objectives to increase contraceptive prevalence rate for modern methods with emphasis on male condoms and addressing unmet need are as follows:

- strategies for increasing demand for family planning
- strategies for improving access and quality of family planning services

The revised National Standards for Family Planning Services contributes to achieving the first objective of the family planning strategy.

The objectives of the National Standards for Family Planning Services are to:

1. Provide a basic reference document for family planning providers at all levels of health services.
2. Provide guidance for policy makers, health managers and service providers.
3. Develop training materials and job-aids for all health providers.
4. Develop appropriate material for use in the community.

While implementing the guidelines, efforts should be made to promote advocacy and behavior change communication activities. These activities are critical for increasing utilization of FP services. It is hoped that the document will be adapted for various levels of health care. The first priority is to adapt it for the primary health care services.

Table 1 Selected demographic information for Maldives

Indicators	
Total population[2] (2000)	270,101
Female (15 to 49) [2] (2000)	65,611
Male (15 to 49) [2] (2000)	64, 982
Maternal mortality ratio[3] per 100,000 live births	96
Total fertility rate (TFR)[4]	2.8
Contraceptive prevalence rate (CPR)	39%
Percentage using modern methods[1]	34%
Percentage using modern temporary methods[1]	27%
Unmet need for modern method	37%
Knowledge about modern methods of contraception[1]	91%
Knowledge about fertile period during menstrual cycle[1]	12%
Discontinuation rate[1] overall (Most common reason for discontinuation was side effects)	30%

Table 2 Current use of contraceptive methods by married men and women in 2004[1]

Method used	Percentage
Pill	13%
Injectables	3%
Condom	9%
Female sterilization	7%
Male sterilization	1%
Intra-uterine device (IUD)	2%
Norplant	<1%
Traditional methods	5%

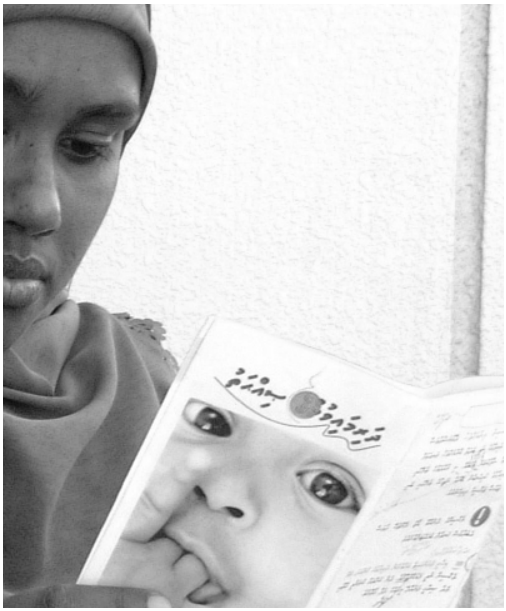
Sources for **Table 1** and **Table 2**
[1]Ministry of Health, Republic of Maldives, UNFPA, CIET International, *Reproductive Health Survey 2004*, Male', Maldives. 2004
[2]Ministry of Planning and Development, Republic of Maldives, *Statistical Year Book of Maldives* 2003.
[3] Ministry of Health, Republic of Maldives, *Vital Registration System 2004*, Maldives.
[4] Ministry of Planning and National Development, Republic of Maldives, *ICPD+10 and Beyond Progress Achievements and Challenges in the Maldives 1994-2004, Country Report,* Ministry of Planning and National Development, Male', Maldives, July 2004

Table 3 Provision of FP methods and level of health facility/level of health care

	Tertiary Hospital	Regional Hospital	Atoll Hospital	Health Centre	Health Post Cat 1	Health Post Cat 2
Counseling						
Methods						
Condoms						
COC						
POP						
Injectables (Depo-Provera)						
IUD (Cu T 380A)						
Norplant						
Female sterilization (Minilap)						
Female sterilization (laparoscopic)						
Male sterilization						
Referral						
Client follow-up as per protocol						
Home visits						

Source: Ministry of Health, Republic of Maldives, *National Reproductive Health Strategy 2005 to 2007*, Maldives 2004

01 Clients' Rights and Providers' Needs



Chapter 1: CLIENTS' RIGHTS AND PROVIDERS' NEEDS

1.1 INTRODUCTION

"Reproductive rights embrace certain human rights that are already recognized in national laws, international human rights, and other relevant consensus documents. These rights rest on the recognition of basic rights of all couples and individuals to decide freely and responsibly the number and spacing of their children and to have the information and the means to do so and the right to attain the highest standards of sexual and reproductive health" (Para 95, Beijing Platform for Action, 1995).

Reproductive and sexual health care, including family planning, aims to improve the quality of life of an individual. A rights-based approach to the provision of contraceptives assumes a holistic view of clients, which takes into account clients' needs and considering all appropriate eligibility criteria in helping clients choose and use a family planning method.

Family planning services are a part of preventative health services. Therefore, the rights of the clients of family planning services should be seen in the context of the rights of the clients of health services. The fulfilment of the rights of FP clients should be a goal for programme managers and service providers. This goal is directly related to the availability and quality of FP information and services.

A quality focus in all areas of service provision is important as the quality of the services will influence the program outcomes. To achieve the goals of client-centred services, providers' needs should be met so they can provide quality services to the clients.

1.2 CLIENTS' RIGHTS

The following are the rights of clients:

1.2.1 Right to information

Clients should be given adequate information in order to make an informed voluntary choice of a contraceptive method. Information given to clients to help them make this choice should include: understanding of the relative effectiveness of the method; correct use of the method; signs and symptoms that would necessitate a return to the clinic; information on return to fertility after discontinuing method use; and information on STI protection. They have the right to know where and how to obtain more information and services for planning their families.

1.2.2 Right to access

All clients have the right to receive services from FP programmes, regardless of their social status, economic situation, ethnic origin, geographical location or any other characteristics which may place individuals in certain groups. This means a right of access through various health care providers as well as other service delivery systems. FP programmes should take the necessary steps to ensure that services will reach all eligible individuals who need them, even those for whom the normal health services are not easily accessible.

1.2.3 Right to choose

Eligible individuals or couples have the right to decide freely whether or not to practise family planning and the choice of contraceptive method. Family planning programmes should assist people in the practice of informed free choice by providing unbiased information, education and counselling as well as an adequate range of contraceptive methods.

A client's concept of acceptability and appropriateness changes with circumstances. Therefore, the right of choice also involves the client's decisions concerning discontinuation of a method of contraception, method switching and also where practical, a right to choose where to go for FP services and the type of service provider with whom they feel most comfortable. This choice may involve a choice of physical location of service delivery, e.g. FHW, CHW, hospital, health centre or a FP clinic. Governmental, non-governmental and private sector providers should welcome the establishment of alternative service outlets.

1.2.4 Right to safety

Family planning clients have a right to safety in the practice of family planning. This implies the following:

- Although it is well recognised that the benefits to health from family planning outweigh the risks, clients have a right to protection against any possible negative effects of a contraceptive method on their physical and mental health.
- Since all pregnancies represent a risk to health, the right of the client to safety also includes the right to effective contraception.
- When receiving family planning services, clients have a right to protection against other health risks which are not related to a method of contraception, for example, protection against the possibility of acquiring an infection through the use of contaminated instruments.

Safety relates to quality of service provision, including both the adequacy of the service delivery facility itself and the technical competence of the service providers. Ensuring the client's right to safety includes:

- assisting the client in making an appropriate choice of contraceptive
- screening for contraindications
- using the appropriate techniques for providing the method if possible

- teaching the client about the proper use of the method and ensuring proper follow-up
- ensuring that the conditions in service delivery sites together with the equipment are adequate for the provision of safe services
- ensuring that any complications or major side effects receive appropriate treatment. If this treatment is not available at a particular service station/site, the client should be referred to another facility.

1.2.5 Right to privacy

When discussing his/her needs or concerns the client has a right to do this in an environment in which she/he feels confident. The client should be aware that her/his conversation with the counsellor or service provider will not be overheard by other people. When a client is undergoing a physical examination it should be carried out in an environment in which his/her right to bodily privacy is respected. The client's right to privacy also involves the following aspects related to quality of services:

- When receiving counselling or undergoing a physical examination, the client has the right to be informed about the role of each individual inside the room, besides those providing services, e.g. training students, supervisors, instructors, researchers, etc. Where the presence of individuals undergoing training is necessary, prior permission of the client should be obtained.
- A client has a right to know in advance the type of physical examination which is going to be undertaken. The client also has a right to refuse any particular type of examination if she/he does not feel comfortable with it or to request this examination to be done by another provider.
- Any case-related discussion held in the presence of the clients (particularly in a training institution) should involve and acknowledge the client and not talk over the client. It is, after all, the client's sexual and reproductive organs and functions that are under discussion.

1.2.6 Right to confidentiality

The client should be assured that any information she/he provides or any details of the services received will not be communicated to third party without his/her consent. The right to confidentiality is protected under the Hippocratic Oath. As such, family planning services should be performed in conformity with the local legal requirements and in accordance with ethical values.

A breach of confidentiality could cause the client to be shunned by the community or negatively affect the matrimonial status of the client. It may also lessen a target group's confidence and trust in the staff of a service delivery programme. In accordance with the principle of confidentiality, service providers should refrain from talking about clients by name or in the presence of other clients. Clients should not be discussed outside the service site. Clients' records should be kept closed and filed immediately after use. Similarly, access to client records should be controlled.

1.2.7 Right to dignity

Family planning clients have a right to be treated with courtesy, consideration, attentiveness and with full respect for their dignity regardless of their level of education, social status or any other characteristics which would single them out or make them vulnerable to maltreatment. In recognition of this right of clients, service providers must be able to put aside their own personal gender, marital, social and intellectual prejudices and attitudes while providing services.

1.2.8 Right to comfort

Clients have a right to feel comfortable when receiving services. This right of the client is closely related to adequacy of service delivery sites which should have proper ventilation, lighting, and seating and toilet facilities. The client should spend only a reasonable amount of time at the premises to receive the required services. The environment in which the services are provided should conform to cultural values, characteristics and demands of the community.

1.2.9 Right to continuity of care

Clients have a right to receive services and supply of contraceptives for as long as they need them, as long as there are no adverse side effects. The services provided to a particular client should not be discontinued unless this is a decision made jointly between the provider and the client. In particular, a client's access to other services should not depend on whether she/he continues or discontinues the contraceptive services. The client has a right to request transfer of her/his clinical record to another clinical facility and in response to that request the clinical record or copy of it should be sent to that facility or given to the client. The client's right to continuity of service includes referral and follow-up.

1.2.10 Right to opinion

Clients have a right to express their views on the service they receive. Clients' opinions on the quality of services, be they in the form of appreciation or complaint, together with their suggestions for changes in the service provision, should be viewed positively in a programme's ongoing effort to monitor, evaluate and improve its services.

1.3 PROVIDERS' NEEDS

The program will need to have systems and capacity in place to support the work of the providers, which include:

- information, training and skills development
- adequate supplies, equipment and infrastructure
- good quality management and supervisory support at the facility and regional levels

1.3.1 Need for information, training and skills development

Service providers should have access to competency-based training so they can acquire the knowledge, skills and confidence needed to perform family planning services – counselling, client assessment, ensuring eligibility to use family planning methods, techniques of providing the methods and follow-up care in a holistic way. They should also be trained and skilled in identifying side effects and complications and managing them effectively. Training and refresher training should emphasize both technical and communication skills.

1.3.2 Need for adequate supplies, functioning equipment and infrastructure

Service providers need to have the appropriate physical facilities and organization to provide quality services. Providers also need continuous and reliable supplies of family planning methods, expendable and non-expendable supplies (refer to Appendix 2), counselling and educational material, and appropriate job aids to enable them to provide safe and effective services.

1.3.3 Need for quality management and supervisory support, at the facility and district levels

To meet this need, supervisors (facility/clinical/area supervisors) should use the approach of facilitative supervision which emphasizes the supervisor's role in facilitating quality improvement among a team of staff. It also emphasizes mentoring, joint problem solving and two-way communication between a supervisor and those being supervised. In order to facilitate change and improvement and to encourage staff to solve problems, supervisors must have the solid technical knowledge and the skills needed to perform tasks, know how to access additional support as needed, and have time to meet with the staff they supervise. Supervisors should also ensure that providers have opportunities to refresh and update their knowledge and skills

Further reading

1. EngenderHealth. *Facilitative Supervision Handbook.* New York: EngenderHealth 2001.

2. EngenderHealth, *COPE® Handbook: A Process for Improving Quality in Health Services, Revised Edition*, EngenderHealth 2003

3. International Planned Parenthood Federation in collaboration with the World Health Organization and AVSC International: *Medical and Service Delivery Guidelines for Family Planning*: Second Edition, 1997

02 Overview of Family Planning Methods and Service Provision

Chapter 2: OVERVIEW OF FAMILY PLANNING METHODS AND SERVICE PROVISION

2.1 INTRODUCTION

A range of family planning methods are available in Maldives. Couples can choose a method that is most suitable for them. The role of the provider is to assist the client to make an informed decision and provide the chosen method.

2.2 TYPES OF FAMILY PLANNING METHODS

There are two main categories of family planning methods:

Modern methods:

- Temporary methods such as condoms, oral and injectable hormonal contraceptives, hormonal implants and intrauterine devices can be used by couples for spacing births or to delay pregnancy.
- Permanent methods such as male (vasectomy) and female (tubal occlusion) surgical sterilization can be used by couples who do not wish to have any more children.

Traditional methods:

- Fertility awareness based methods [Standard Days Method (SDM), Cervical Mucus Method, Basal Body Temperature Method (BBT), Sympto-thermal Method, Calendar Method]
- Coitus interruptus (withdrawal)

None of the contraceptive methods are perfect and side effects are seen with all methods of contraception. A brief description of modern methods, how they work, their effectiveness in preventing pregnancy and their advantages and disadvantages are given in Table 2.1.

2.3 MENSTRUAL CYCLE

The menstrual cycle prepares the woman's body for a possible pregnancy. This event occurs every month during the woman's reproductive years. The average menstrual cycle lasts 28 days (range from 26 to 32 days). The length of the menstrual cycle is counted from the first day of menstrual bleeding until the day before the first day of the next menstrual period.

The menstrual cycle is dependent on the levels of hormones of the hypothalamus, the anterior pituitary gland and the ovaries, and the consequent changes in the ovaries (ovulation), uterus (changes in the endometrium), cervix (thickening of mucus, opening of cervical os) and the basal body temperature (increase in temperature).

The menstrual cycle consists of three phases:

- Menstrual bleeding phase (usually days 1 to 5)
- Estrogen phase (usually days 6 to 14)
- Progesterone phase (usually days 15 to 28)

Table 2.1 Selected characteristics of modern family planning methods

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
Male Condom	A sheath made of latex, which when put on the erect penis during sexual intercourse and taken off carefully after intercourse prevents the ejaculate from spilling inside the woman and thus prevents pregnancy and STIs including HIV/AIDS A fresh condom is to be used with each act of intercourse.	98%	85%	Easy to use Readily reversible birth control method for men Fairly effective if used correctly and consistently Protects against STIs including HIV/AIDS (dual protection[1]) Can be used with other contraceptives where risk of STI / HIV is present Male participation in contraception (by agreeing to use the condom) No method related health risk	**Limitations** May interfere with sexual activity High level of motivation required to use a condom consistently and correctly Failure rate is high if not used correctly and consistently. Small risk of slipping, tearing and spillage of semen if not used properly Difficulty in disposing used condoms Quality of the condom can deteriorate if not stored properly **Side effects** Condom broken before or after use. Allergy to latex, experienced by

[1] Dual protection refers to preventing both STI/HIV and unwanted pregnancy. This can be achieved by the correct and consistent use of condoms alone or by simultaneous use of 2 methods, one of which is a condom.
Dual method use refers to using a barrier method for protection against STI/HIV and another method for contraception.

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
					both men and women, is rare
Combined oral contraceptives (COC)	COC are tablets/pills that contain female sex hormones (estrogen and progestogen) similar to the ones naturally present in the body. COC should be taken daily. COC prevent pregnancy by suppressing the release of ovum and thickening the cervical mucus, preventing sperm from passing through. COC should be taken for 7 continuous days in order to suppress ovulation. The effect of each tablet lasts only for 48 hours.	99.7 %	92%	Very effective when used correctly and consistently Safe for most women Easy to use Non invasive Reversible (can stop the pill on her own whenever desired by the client with no loss of fertility) Not related to sexual activity Can improve menstrual problems Protects from cancers of the uterus and ovary and benign breast disease	**COC Limitations** Has to be taken every day and depends on the motivation of the user Does not protect against STIs/ HIV Not appropriate for mothers who are breastfeeding infants less than 6 months old as it may decrease the quantity of milk Effectiveness of the pill may be decreased in women who are on treatment for tuberculosis (rifampicin), convulsions (phenytoin, carbamazepine, barbiturates, primidone, topiramate and oxcarbazepine) and on certain antibiotics (griseofulvin). **COC Side Effects** Minor side effects listed below are most common during the first 3 months of use and these usually disappear with continued

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		use: • Amenorrhea • Bleeding in between periods or spotting • Nausea • Headache • High blood pressure • Weight gain • Breast tenderness Serious side effects such as heart attack or stroke are rare with low-dose pill. High risk for women who smoke and above 35 years Women, who smoke, irrespective of whether they use the pill, are at increased risk for heart attack or stroke.

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
Progestogen-only pills (POP)	POP are tablets/pills that contain female sex hormones (progestogen) similar to the one naturally present in the body. POP should be taken at the same time each day. POP provide protection against pregnancy by: • Thickening cervical mucus making it difficult for sperm to pass through. • Making the endometrial thin and thus not suitable for pregnancy. Ovulation is suppressed in about 50% of POP users. POP should be used for at least 48 hours to achieve the contraceptive effect on cervical mucus.	99.7%	92%	Very effective when used correctly and consistently Easy to use Non invasive Not related to sexual activity Can be used by breast-feeding women Does not inhibit lactation Can be used 6 weeks after delivery Reversible (can stop the pill on her own whenever desired by the client with no loss of fertility)	**POP limitations** Has to be taken same time every day and depends on the user's motivation Does not protect from STIs including HIV/AIDS Effectiveness may be decreased in women who are on treatment for tuberculosis (rifampicin), convulsions (phenytoin, carbamazepine, barbiturates, primidone) and on certain antibiotics (griseofulvin). **POP side effects** Common side effects: disruption of menstrual pattern: irregular periods, spotting or bleeding between periods and amenorrhea Less common side effects: headache and breast tenderness

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
Progestogen-only injectables (POI) (Depo Provera is the POI commonly available in Maldives)	POI contain a female sex hormone (progestogen) similar to the one in the body. Depo Provera, the POI commonly available in Maldives, should be given every 3 months, as a single injection of Depo Provera prevents pregnancy for 3 months. The injectable provides effective protection against pregnancy mainly by: • suppressing ovulation • thickening cervical mucus making it difficult for the sperm to pass through. • making the endometrium thin, which is not suitable for pregnancy POI are effective within 24 hours of receiving the injection.	99.7% effective when injections are taken regularly	97%	Very effective Reversible Effective within 24 hours of receiving the injection. Single injection of Depo Provera prevents pregnancy for 3 months Unobtrusive Not related to sexual activity Can be used by breastfeeding women No daily pill taking Health benefits include: • reduces menstrual cramps • decreases menstrual blood loss and duration, thus reduces anaemia • reduces incidence of • • PID as compared to non-users as the thick cervical secretions	**POI Limitations** Provider dependent Disruption in menstrual bleeding patterns No menses (common problem) Prolonged spotting/bleeding Delay in return to fertility Does not protect from STIs including HIV/AIDS **POI Side effects** Amenorrhea Prolonged bleeding (for more days than normal) in the first month of use Irregular bleeding or spotting Delayed return of fertility (median delay 10 months for Depo Provera) Weight gain (less common) Headaches or dizziness (less common) Breast tenderness/discomfort

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
Hormonal implants	Hormonal implant Norplant is a low dose progesterone-only method consisting of 6 capsules. Each Norplant capsule contains 36 mg levonorgestrel. At the time of initiation of Norplant all 6 capsules are inserted subdermally under local anesthesia. Acts by thickening the cervical mucus preventing sperms to pass through. Also suppress the release of the ovum. Hormonal implants are effective within 24 hours after insertion.	99.95%	99.95%	Very effective Long term contraceptive (Norplant is effective for 5 years) Reversible contraceptive Protects within 24 hours after insertion Prompt return of fertility after capsules/rods removed. Not related to sexual activity Does not require daily pill taking.	**Limitations** Provider dependent Does not protect from STIs including HIV/AIDS. Effectiveness of the implant may be decreased in women who are on treatment for tuberculosis (rifampicin), convulsions (phenytoin, carbamazepine, barbiturates, primidone) and on certain antibiotics (griseofulvin). **Implants side effects** Disruption of menstrual bleeding pattern: spotting or bleeding between monthly periods Amenorrhea Prolonged bleeding – uncommon and often decreases after first few months of use. Other less common side effects are: headache, dizziness, breast tenderness, nausea, weight gain. Most side effects stop spontaneously within the first

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
					year of use.
Intrauterine device (IUD) Copper IUD Cu T 380A is the commonly available Copper IUD in Maldives.	Cu T 380 A is a T-shaped device with copper wires on the arms and a vertical stem that when inserted into the uterus prevents pregnancy by interfering with the movement of the sperm, reducing the ability of the sperm to fertilize an egg and preventing implantation of the embryo. Effective immediately after insertion.	99.4 %	99.2%	Very effective long-term contraceptive Immediately effective after insertion Effective for 10 years Does not interfere with sexual intercourse No continued effort to use the method regularly One time insertion procedure and does not require supplies regularly Cost effective as no expenses for supplies Can be used by breastfeeding women Can be inserted post partum when menses returns which usually happens around 4-6 weeks after delivery Does not interact with any medicines the client	**Limitations** Dependent on provider Requires minor surgical procedure Removal might sometimes be painful Does not protect from STIs including HIV/AIDS. Can NOT be used by women who suffer from STIs or by women whose spouses have STI **Side effects** Common side effects: • In the first week: mild cramps, bleeding or spotting • In the first 3 months: longer and heavier periods, increased cramps during periods, bleeding or spotting between periods and expulsion of Copper T (partial or complete) Less common side effects and

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
				may be taking Can be removed when required by qualified staff as desired by the client Return of fertility immediately after removal	complications: • Continuation of side effects beyond 3 months • Anemia • Perforation of uterus • Lost Copper T thread • Infections of the genital tract due to poor infection prevention practices. • Risk of ectopic pregnancy (does not prevent ectopic pregnancy)

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
Female sterilization (Tubal occlusion)	In women, through a small cut in the lower part of the abdomen, the tube that transports ovum from the ovary to the uterus is cut so that the ovum cannot reach the uterus. In women, the tubes can also be occluded by passing a laparoscope through a small incision in the abdominal wall and applying a ring on each tube. Female sterilization is effective immediately after the procedure.	Tubal occlusion 99.5%	Tubal occlusion 99.5%	Very effective Usually safe Permanent No need to take pills daily, go for repeat injections or reinsertions No need to go for supplies No interference with sexual activity No effect on breast milk	Provider dependent Surgical procedure Even with re-connecting the tubes (re-canalization) by highly skilled doctors, the chances of conception are small Does not protect from STIs including HIV/AIDS Uncommon complications of surgery: infection or bleeding at incision, internal infection or bleeding, injury to internal organs, risk of anesthesia

Method	What it is and how it works	*Effectiveness in preventing pregnancy		Advantages	Disadvantages
		Perfect use	Typical use		
Male sterilization (Vasectomy)	In men, through a small opening on the scrotal skin, the tube that carries the sperm is cut so that sperm cannot reach the ovum. Male sterilization (vasectomy) is effective only 3 months after the procedure and during this period condoms or another effective family planning method should be used until semen analysis confirms effectiveness.	99.9%	99.85%	Very effective Permanent No need to take pills or injections, or visit clinics for supplies No interference with sex No apparent long-term health risks	Requires minor surgery Need to wait for 3 months after the procedure for procedure to be effective Need to use condoms or other effective planning method till semen analysis confirms effectiveness Even with re-connecting the tubes (re-canalization) by highly skilled doctors, the chances of conception are small. Does not protect from STIs including HIV/AIDS Minor complications post surgery: discomfort during the first 2 or 3 days post operative, pain in the scrotum, swelling or bruising Rarely bleeding or infection at the incision site or inside the wound

***Source:** Adapted from World Health Organization, *Medical Eligibility Criteria for Contraceptive Use*, 3rd edition WHO, Geneva, Switzerland. 2004. Original source: Trussell J. *Contraceptive Efficacy*. In Hatcher RA, Trussell J. Stewart F, Nelson A, Cates W, Guest F, Kowal D. *Contraceptive Technology: Eighteenth Revised Edition*. New York NY: Ardent Media, 2004.

*The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

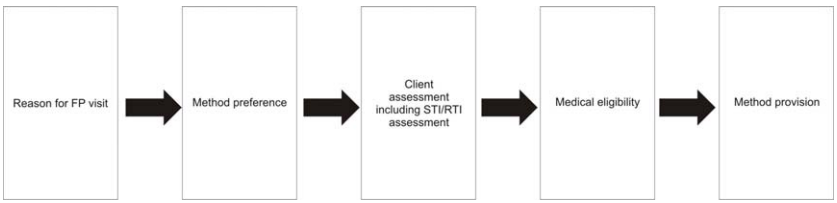
2.4 FAMILY PLANNING SERVICE PROVISION

Women attending a family planning clinic are usually interested in a method of contraception – they may have a particular method in mind – and they might have other concerns as well. Often there are other issues that need to be discussed before a client can choose and be provided a contraceptive method that meets her needs.

2.4.1 Steps in decision making at a family planning visit

Starting with the reason for the visit to the family planning clinic, a health care provider then goes through a sequence of steps to assist a client to reach a decision about a suitable family planning method and provides the method. Figure 2.1 illustrates the sequence of steps in decision making. These steps include determining the client's preferred method, clinical assessment including STI/RTI assessment, reviewing client's medical eligibility for that method and providing the chosen method. However, a provider might need to adapt the approach to meet an individual client's need. The steps used in decision making are described below.

Figure 2.1: Overview of steps in decision making at initial FP visit



Source: Adapted from World Health Organization, *Sexually Transmitted and other Reproductive Tract Infections: A guide to Essential Practice,* WHO, Geneva, Switzerland. 2005

Determine method preference by:

- asking if the client has any particular method in mind (Women who are given their preferred method use it longer and with greater satisfaction)
- assessing contraceptive needs
- assessing STI protection needs
- describing options and helping client make a choice. (For further details refer to Chapters 6 to 14)

Refer to Chapter 3 for discussion on client provider interaction and counselling.

Clinical assessment including STI/RTI assessment by:

- taking a history
- performing relevant clinical examination and laboratory tests, if indicated.

Refer to Chapters 4 and 5 for client assessment and STI assessment during routine FP visits.

Review medical eligibility by:

- evaluating suitability of the preferred method or methods.

Refer to method-specific Chapters 6 to 14 for further details.

Provide method/s by:

- performing procedure/providing contraceptive method
- instructing on method use and follow-up care.

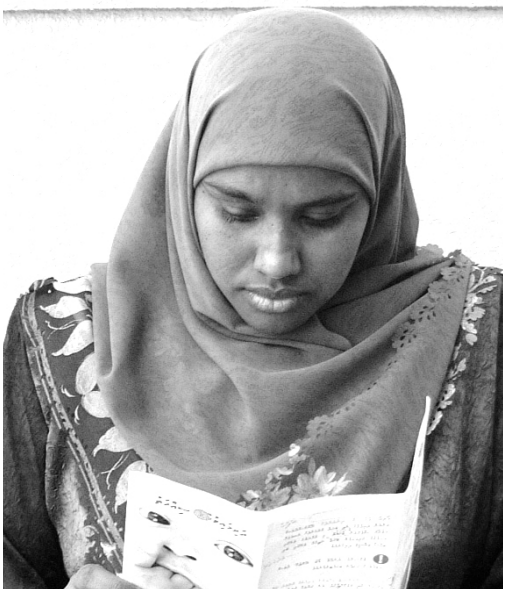
Refer to method specific Chapters 6 to 14 for further details.

Further Reading

1. WHO and INFO Project at Johns Hopkins Bloomberg School of Public Health/Center for Communication Program, *Decision making tool for family planning clients and providers,* Geneva, WHO & Baltimore, Johns Hopkins Bloomberg School of Public Health/ Center for Communication Program 2005.

2. Department of Public Health, Maldives, *Logistics Management Guidelines for Family Planning*, Male', Maldives, (In Press)

03 Counseling and Informed Choice



Chapter 3: COUNSELLING AND INFORMED CHOICE

3.1 INTRODUCTION

Counselling is a critical element of quality family planning services. Family planning counselling is the process of **two-way face to face communication** by which the counsellor assists the client to make a decision about fertility and contraceptive options. The counsellor provides accurate and complete information, addressing the client's particular reproductive health needs, concerns and goals.

Informed choice is the process by which a client makes a voluntary, well considered decision about his/her reproductive health (RH) needs. The client arrives at this decision based on accurate information in an environment of full information about available methods and resources.

3.2 OBJECTIVES OF CONTRACEPTIVE COUNSELLING

The purpose of family planning counselling is to assist individuals or couples to:

- decide whether they need and want contraception
- freely make the choice of contraception needed
- learn, understand and use the chosen method properly
- reduce anxieties, if any
- initiate the use of appropriate contraceptive method
- use the contraceptive method effectively
- switch to another method to avoid pregnancy
- prevent STIs, including HIV/ AIDS, and seek early treatment for STIs.

Confidentiality and privacy should be ensured at all counselling sessions. Wherever possible the spouse should also be counselled.

3.3 CATEGORY OF PROVIDER

Counselling can be done by any staff member with appropriate training, or a counsellor per se. General and method-specific family planning counselling can be provided by specialists (gynaecologists, surgeons) medical officers, staff nurses, community health workers (CHW), community health supervisors (CHS) and family health workers (FHW). It is important that providers have had reproductive health counselling training prior to service provision.

3.4 PRIVACY AND CONFIDENTIALITY

Privacy and confidentiality are essential for all aspects of family planning services – counselling, client assessment and method provision and follow-up care. Clients will avoid a health care facility – sometimes travelling to a distant clinic to preserve anonymity – if they feel that their privacy and confidentiality are not respected or that service providers are critical and judgemental.

Visual and auditory privacy should be ensured and family planning services should be provided in an area separate from the waiting area, so that people in the waiting area cannot see or hear the discussion and the services being provided.

3.5 CLIENT-PROVIDER INTERACTIONS

Verbal interactions and sharing of information between the provider and client during each step of a family planning procedure help alleviate client fears and concerns. When a client feels safe and is confident in the provider's skills, the client will be more cooperative. Educating the client about potential side effects and relieving concerns correlate positively with long-term use of temporary family planning methods. The following are the behaviours to be modelled by staff when interacting with clients:

- Treat the client with respect, exhibiting friendly, calm behaviour and an unrushed manner.
- Listen attentively to assist clients to discuss their family planning needs.
- Treat all clients as equals, without preferential treatment by age, gender, religion, values, economic or marital status.
- Speak in a language understood by the client and use terminology understood by the client.
- Assure confidentiality concerning the client's information.
- Use open ended questions, giving the client opportunity to give more details.
- Describe how the client can be helpful during the procedure and what to expect before, during and after the procedure.
- Provide the client an opportunity to ask questions and address concerns.
- Assure that client's modesty is maintained.
- Address doubts, fears or misconceptions held by the client.
- Minimize the client's pain and address their anxiety.

3.6 COUNSELING PROCESS

Family planning counselling is to be provided wherever family planning methods are available. The counselling session may be an individual session (client and service provider) or a couple counselling session (client with partner and service provider). If a client requests and desires it, a close friend or family member may be present in the counselling session.
Family planning counselling is provided using either the GATHER[2] approach or the REDA[3] approach. Appropriate job aids such as flip charts, samples of available FP methods etc. should be used to conduct the counselling session.

3.6.1 Choice of method

Clients should make their own choice of method. It is the counsellor's duty to assist them to make the right choice. Often the client has a particular method in mind. The counsellor could start by asking whether the client has any particular method in mind

[2] GATHER is an acronym for Greet, Ask, Tell, Help, Explain, Return visit

[3] REDA is an acronym for Rapport, Explore, Decide, Act

and what their family planning needs are, i.e. birth spacing, delaying pregnancy or limiting births.

3.6.2 Method-specific counseling

Once a client has chosen a FP method, method-specific counseling should be done as described below:

- Counsel every time a client visits: during the first visit and each subsequent visit.
- Ensure that privacy and confidentiality are maintained at all times.
- Establish rapport with the client.
- Ask the client what s/he knows about the specific method, whether s/he has heard any rumors about the method and if s/he has any past experience with the method. (Refer to Appendix 4 for common rumors.)
- Provide information as relevant and clarify doubts. If the client is new, provide the information given below (**show the contraceptive chosen while providing information**):
  - effectiveness and return to fertility
  - mechanism of action
  - advantages, disadvantages
  - clarify rumors
  - when to start using the contraceptive (in relation to menstrual period)
  - instructions on use (where relevant) emphasizing the importance of following instructions and what to do if the instructions are not followed
- If the client is still convinced about the decision to use the method, assess the client for medical eligibility as detailed in Chapters 4, 5 and 6 to 14 on specific contraceptive methods.
- Record history and findings in the client record.
- If found eligible for using the method as described in Chapters 4, 5 and 6 to 14, demonstrate the use of the contraceptive or describe the procedure as described in specific sections in Chapters 6 to 14.
- Ask the client to repeat instructions (where relevant).
- Tell the client about:
  - likely problems/side effects in the first three months and what to do in such situations
  - situations when condom use is advised (risk of pregnancy due to non-compliance, conditions that affect the effectiveness of the method or exposure to STIs)
  - if condom use is advised, how to use the condoms (ask to repeat the instructions on the use of condoms)
  - storing the contraceptive (where relevant)
  - follow up.
- Provide the method/perform the procedure:
  - Record the supply of the contraceptive or the procedure.
  - Provide a packet of condoms for use in case of situations listed above.

3.6.3 If client has not considered a particular method

- Assess the level of knowledge the client has about contraceptive or family planning methods that are available at the clinic.
- Assess what her needs are: is it for birth spacing, delaying births or to limit births?
- Explain the methods available to the client and give additional information on the method chosen by the client. The following should be included:
  - effectiveness of the method and return to fertility
  - how the method works and how it should be taken
  - health and contraceptive advantages
  - disadvantages
  - possible side-effects.
- Encourage questions to discover and address the client's specific concerns and worries about rumours she has heard about methods.
- Focus discussion on the advantages and disadvantages of the method chosen by the client.
- Specify the chosen method once the client has made up her mind, by asking a direct question: "Which method would you prefer?"
- If a client needs more time to think and decide, then reassure him/her that he/she can return at his/her convenience. Counsel him/her to use condoms in the meantime.

3.6.4 Special situations

- If the client chooses a method that is contraindicated to her health conditions then she should be assisted in choosing another method.
- If the method chosen by the client is not available at the centre or clinic, then a referral should be made to another clinic where such facilities are available. (Refer below and to Appendix 6 for details on referral.)
- Offer her/him an alternative method to be used until such time that the client can get the method desired.
- If the client wants a permanent method (surgical method) then it must be explained that it is permanent and reversal may be impossible or very expensive. One must not forget that consent should be taken.
- Age and parity specifications for sterilization should be followed. Refer to Chapter 14 on voluntary surgical sterilization.

3.7 COUNSELING A CLIENT WHO IS BEING REFERRED

- It is important to counsel a client who is being referred for problems or for a method chosen that is not available at the facility. If the client is accompanied by a husband/relative, explain the reason for referral to both client and spouse.
- Explain why the client is being referred, where the referral site is, and what the likely procedures are at the referral site.
- Give a referral letter with all the details of history and findings and the reason for referral (and/or send the client card). Request feedback from the referral site.
- Instruct the client to report back after returning from the referral site.

- If the client is reluctant about the referral, counsel for other methods of FP.
- Give a packet of condoms in case there is a delay in referral. Make sure the client knows how to use the condoms.
- Record the referral.

Refer to Appendix 6 for further details on the process of referral

3.8 COUNSELING DURING FOLLOW-UP VISIT

At each follow-up visit it is important to counsel the client to ensure the continuation of the method:

- Ask the client whether she and her spouse are satisfied with the method.
- Check if the client is still using the method and whether the method is being used correctly or not.
- Discuss any health changes that might have arisen since the client's last visit and confirm/rule out problems reported or identify any new conditions that are contraindications for use of the method. Record findings.
- Ask about any history of pelvic pain or discharge from the vagina or any history suggestive of STIs in the spouse.
- Check if she wishes to become pregnant and assist her to stop the method.
- Assist the client to choose another method if the client has developed conditions that are contraindications for the method.
- Ask about problems and reassure/resolve as required. (Refer to method-specific Chapters 6 to 14 for further information.)
- If the client is continuing with the method, ask them to repeat the instructions and what to do if problems arise.
- Provide supplies (where relevant) and record this in the Client Card.

3.9 COUNSELING A CLIENT WHO WANTS TO CHANGE OR STOP USING A METHOD

It is important to counsel a client who wants to change or stop using a method:

- If the client wants to stop the method because of wanting another child, tell them about return of fertility. Provide information on antenatal care and childbirth, and discuss postpartum FP.
- If the client is stopping the method because of dissatisfaction with the method, provide counseling (repeat the benefits and side effects for method of use). If still not convinced, counsel about other contraceptive methods.
- If the client is stopping the method due to side effects that have persisted in spite of management of the problem, counsel for other methods.
- If the client develops conditions that are contraindications for use of the method, counsel about other methods.
- Record findings, reasons for stopping the use of method/switching over to another method, and advice given.

3.10 CLIENTS WITH PROBLEMS USING THE METHOD

If the client is having problems with the method that she is currently using, then it is important to give psychological support and comfort to her. If she has to discontinue the method, she should be advised to do so, but give other options. If the client is unhappy about the method, then find out the reasons why and assist the client to choose another method.

Male involvement and participation in reproductive health is important not only for preventing pregnancy, but also for prevention of STIs including HIV/AIDS. It also promotes communication between spouses.

Box 3.1 INFORMED CONSENT

Informed consent is the client's voluntary decision to undergo a family planning procedure, in full possession and understanding of the relevant facts.

In Maldives, informed consent is taken verbally for temporary methods. Written consent should be taken for permanent methods i.e. female and male surgical sterilization. The consent form is a legal authorization for the procedure to be performed.

The consent form (refer to Appendix 5 for a sample of an informed consent form) becomes a legal document when signed/marked by the client. **A consent is valid and binding only if the client was fully informed and knowledgeable about the content of the consent before signing.**

- If a client is unable to read the consent form, staff must read or explain in detail the contents of the document in a language understood by the client.
- **Since surgical sterilization procedures are permanent, it is important that counselling is provided to both the client and spouse. It is mandatory to obtain a jointly signed consent.**
- The person executing the consent also must sign the document.
- The physician is the person ultimately responsible for ensuring that the informed consent is obtained with proper client understanding. Thus the physician's role is to see that the family planning staff have ensured that the client and spouse signed the informed consent form with full understanding.

SPOUSE'S WRITTEN CONSENT FOR SURGICAL STERILIZATION IS MANDATORY FOR SURGICAL STERILIZATION.

Below are the essential elements of voluntary surgical sterilization that the client must fully understand to obtain an informed consent:

- Temporary contraceptive methods are available.
- Voluntary sterilization is a surgical procedure.
- Risks as well as benefits are associated with the procedure, both of which must be explained.
- The procedure is permanent.
- Successful procedures result in the inability to bear any more children.
- There is a small possibility of method failure.
- The client can decide against the operation at any time (without losing the right to other medical, health, or other services or benefits).

Refer to Appendix 5 for a sample of an Informed Consent Form for surgical sterilization.

04 Client Assessment

Chapter 4: CLIENT ASSESSMENT

4.1 INTRODUCTION

Client assessment is necessary to ensure that clients are eligible for the use of the chosen method, to minimize complications and to ensure continuity of the method.

4.2 CLIENT ASSESSMENT

4.2.1 History

In the case of new clients, a history should be taken very carefully. It should include the following:

- **Personal history:**
  - Age of the client – *to help decide on the most suitable method of contraception*
- **Social history:**
  - Social habits such as smoking – *to determine eligibility for use of combined oral contraceptive (COC)*
- **Reproductive health history:**
  - Number of children ever born, number living and their sex, age of last child, desire for more children – *to help decide a method that is most appropriate*
  - If the last child is less than 6 months of age, history of breastfeeding, frequency, any supplementary feeding – *to determine eligibility for use of combined oral contraceptives and lactational amenorrhea method (LAM)*
  - Menstrual history:
    - date of last menstrual period – *for initiating use of all contraceptives*
    - regularity and bleeding in between periods – *to determine eligibility for use of oral contraceptives, injectable contraceptives, intrauterine devices (IUD) and fertility awareness based methods (FAB)*
- **Medical history:**
  - History of heart disease, stroke, hypertension, diabetes, liver disease, cancer of the breast and genital tract, convulsions, migraine and mental illness – *to determine eligibility for use of oral contraceptives and injectables*
  - History of taking antibiotics and treatment for tuberculosis and convulsions as *some of the medicines affect the effectiveness of the oral contraceptives.*
  - Any surgery: history of major surgery and prolonged immobilization is important as the risk of deep vein thrombosis is high among such people – *to determine eligibility for use of oral contraceptives and injectable contraceptives;* history of abdominal surgery will also be useful *to decide the type of female sterilization, type of anesthesia and the level of facility* where female sterilization should be performed.
- **Family history:**
  - Family history of diseases such as diabetes, hypertension, heart disease and cancers of the breast as these tend to run in families – *to determine eligibility for use of oral contraceptives and injectables.*

- **Contraceptive history:**
  - History of contraceptive use and past experience with the method – this information is important while advising on a particular contraceptive
  - History of STIs and sexual history: history of discharge from genitalia and history of husband having multiple sexual partners (more than one wife/partner) – *to determine eligibility for use of IUDs and to provide treatment for the client and spouse*. Refer to Chapter 5 on STI/RTI assessment for further details on how it can be done during routine FP visits.

Follow-up clients: In case of revisiting clients, menstrual history, exposure to/risk of STIs, and any new medical problem/treatment and other information as relevant should be asked and recorded.

4.2.2 Physical examination

(Refer to Table 4.1 for information on relevant routine clinical exam and tests before providing contraception)

1. **General and systematic examination** (e.g., pallor, jaundice, pulse, blood pressure) *to determine the eligibility for use of contraceptives such as oral contraceptives, injectables and IUD*
2. **Abdominal examination** *to rule out liver disease and pelvic inflammatory disease to determine the eligibility for use of oral contraceptives, injectables and IUDs*
3. **Pelvic examination** *to determine eligibility for use of IUDs and pre-operative assessment for female sterilization*
4. **Breast examination** – all clients should be educated on how to perform breast **self-examination** and advised to consult a doctor if any abnormality is noted. Clinical examination of the breast by the provider is recommended as good preventative health practice. It is important to counsel clients requesting hormonal contraceptives that hormonal contraceptives are contraindicated in women with current breast cancer or a history of breast cancer and it is important that clients have a breast examination done by a trained provider.

4.2.3 Laboratory examination (refer to Table 4.1)

4.3 RECORD

Findings should be recorded legibly in the client card.

4.4 RULING OUT PREGNANCY

Pregnancy should be ruled out prior to the provision of contraceptive methods – combined oral contraceptive pills (COC), progestogen-only pills (POP), progestogen-only injectable (POI), hormonal implants, IUD, surgical sterilization and emergency contraception.

Indications for a pregnancy test

A pregnancy test is indicated in all clients who have one or more of the following:

- missed period/s
- abnormal vaginal bleeding
- irregular cycles
- lactating with irregular bleeding or amenorrhea
- signs and symptoms of pregnancy such as (early morning nausea, vomiting, breast tenderness).

4.5 INTERPRETATION OF CONTRAINDICATIONS AND PRECAUTIONS

The definitions given below are more relevant for higher level facilities where specialists are available. In the case of Health Posts and Health Centers, the classification provides guidance to the health worker on conditions that need a consultation with a specialist before providing the specific method.

Contraindications

A contraindication is any condition where there is unacceptable health risk if the contraceptive method is used. In such conditions, the method should not be advised.

Precautions

A precaution is condition where the risk outweighs the advantages of the method. However, the method can be provided after consultation with a specialist and requires follow up.

Remember: Many mothers die due to complications of pregnancy and childbirth. Women should be helped to plan their families using the contraceptives of their choice. If eligible, all efforts should be made to provide the contraceptive.

Box 4.1 WHO ELIGIBILITY CRITERIA

Use of eligibility criteria is important for improving the quality of FP services. Adherence to eligibility criteria helps in proper selection of clients, contributes to reducing the chances of side effects and complications and thus continuation of the method. Eligibility criteria are applicable during initiation of a method as well as continuation of a method. Using "eligibility criteria" is not the same as screening for a specific method.

The eligibility criteria are based on evidence from studies, research and clinical experiences and are classified by WHO into four categories:

- Category 1: A condition for which there is no restriction for the use of the contraceptive.
- Category 2: A condition where the advantages of using the method outweigh the risk.
- Category 3: A condition where the theoretical or proven risks usually outweigh the advantages of using the method.
- Category 4: A condition that represents an unacceptable health risk if the contraceptive method is used.

Category 2 requires follow up. Category 3 requires clinical assessment.

The eligibility criteria for each method are discussed in Chapters 6 to 15.

Table 4.1 Routine clinical examinations and tests to be done before providing contraception

Assessment	COC	POP	POI	Implants	IUD	Condom	Traditional Methods	FS	Vasectomy
Clinical breast examination by provider*	**R**	**R**	**R**	**R**	**R**	C	C	C	NA
Pelvic/ genital examination	**R**	**R**	**R**	**R**	**M**	C	C	**M**	**M**
Cervical cancer screening	C	C	C	C	C	C	C	C	NA
Routine test for urine albumin / sugar	C	C	C	C	C	C	C	**M**	**R**
Hemoglobin test	C	C	C	C	**R**	C	C	**M**	C
STI risk assessment: medical history and physical examination	**R**	**R**	**R**	**R**	**M**	**R**	**R**	**R**	**R**
STI/ HIV screening: laboratory tests Hepatitis B	C	C	C	C	C	C	C	**R**	**R**
Blood pressure screening	**M**	**M**	**M**	**M**	**R**	C	C	**M**	**R**

NOTE: The clinical examinations and tests shown only apply to persons who are presumed to be healthy.
M = Mandatory in all circumstances for safe and effective use of the contraceptive method.
R = Recommended as it contributes to safe and effective use of the method as well as being good preventative practice.
C = Does not contribute substantially to the safe and effective use of contraceptive method. However it may be appropriate for diagnosing or assessing suspected medical conditions. It should not however be a barrier to providing the method.
NA = Not applicable
* Breast self examination: All clients should be educated on routine breast self-examination. If there are any client concerns or suspicion regarding breast lump then provider should perform breast examination and/or refer for further evaluation.

05 STI/RTI Assessment During Routine Family Planning Visit

Chapter 5: ASSESSING SEXUALLY TRANSMITTED INFECTIONS (STI) AND REPRODUCTIVE TRACT INFECTIONS (RTI) DURING ROUTINE FAMILY PLANNING VISITS

5.1 INTRODUCTION

The family planning visit is an opportunity to prevent not only unwanted pregnancies but also infection (dual protection). It is also a chance to detect some silent STI/RTI and to offer treatment to symptomatic women who may not otherwise use health services.

Many women and men with an STI/RTI do not have symptoms or have minimal symptoms and do not realize anything is wrong. In women, silent asymptomatic infections can be more serious than symptomatic ones. Syphilis, gonorrhoea and chlamydia are often asymptomatic yet have serious consequences.

Clients may visit health facilities/clinics for another reason such as family planning. Identifying and treating such clients prevents the development of complications for the individual client and helps reduce transmission in the community. Thus, quality family planning services can contribute to prevention and early diagnosis of STI/RTI by promoting recognition of symptoms and signs and managing clients with symptoms and signs during their routine visit for family planning.

Issues to keep in mind

Most women attend family planning clinics to obtain contraception and health care providers should bring up STI/RTI in a way that addresses the client's priorities. Four important points to keep in mind during client assessment are:

- All sexually active individuals are potentially at risk of contracting an STI.
- Many women are at risk of STI because of their partner's behavior, not their own, and are often not aware of their risk. They may be in a steady relationship that they believe is monogamous. Providers should be sensitive to these issues in discussing risk of infection with these women, who may need dual protection.
- Condoms used consistently and correctly are highly effective for preventing both pregnancy and STI, and are the only method that provide effective dual protection.
- Women with current STI/RTI are eligible for most contraceptive methods. However, the infection should be treated appropriately and steps taken to prevent future infection.

5.2 ASSESSING STI/RTI DURING FAMILY PLANNING VISIT

STI/RTI assessment and prevention should be mentioned at each family planning visit. The opportunities for addressing STI/RTI during the initial (choosing the method) visit and routine follow-up visits are different and should be treated separately.

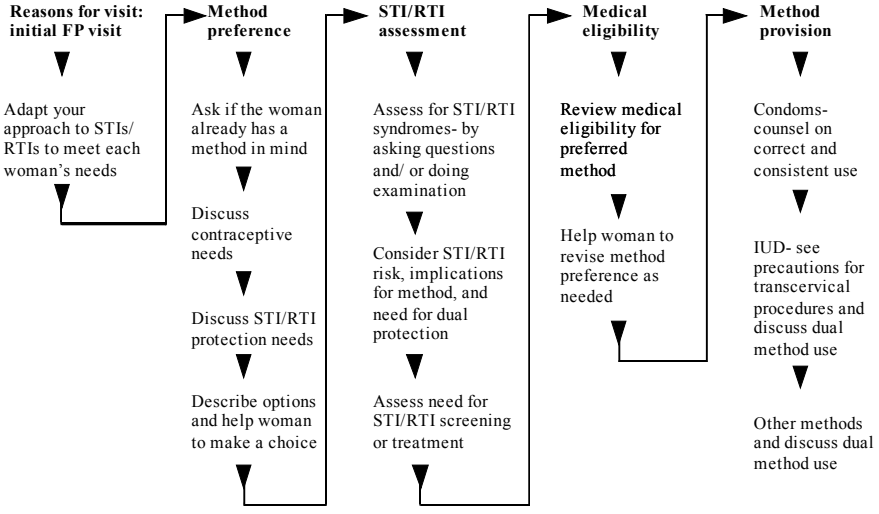
5.2.1 During the initial family planning visit

Women attending a family planning clinic for the first time are usually interested in contraception. The client's concern may or may not be about STI/RTI. However this is an opportunity to address STI/RTI.

Initiation of the discussion about STI/RTI should be timed appropriately. If STI/RTI assessment done too early, the woman might feel that her primary concern, i.e. contraception, is being overlooked. If brought up too late the choice of the method might have to be reconsidered.

The following figure illustrates how STI/RTI assessment can be done during routine FP service provision.

Figure 5.1 Steps in decision-making at initial FP visit



Source: World Health Organization, *Sexually Transmitted and other Reproductive Tract Infections: A Guide to Essential Practice,* WHO, Geneva, Switzerland. 2005

5.2.1.1 How to do STI/RTI assessment during initial FP visit

- Initiate client's STI/RTI protection during the discussion on clients preferred family planning method.

- Perform STI/RTI assessment by history taking and/or by clinical examination. The key signs and symptoms of STI/RTI are:

    - presence of vaginal discharge
    - genital ulcer
    - lower abdominal pain
    - symptoms of STI in the partner.

Clinical examination for women

- Pelvic examination (speculum examination and bimanual vaginal examination) is mandatory prior to the provision of IUD and female surgical sterilization, which provides the opportunity to check for associated STI/RTI.
- It is desirable that a pelvic examination be done on all women prior to initiating family planning as it is useful for evaluating STI/RTI concerns and also detecting some asymptomatic infections.

Clinical examination for men

- Genital examination is mandatory for all men considering vasectomy and this is an opportunity to assess for STI/RTI.

Further evaluation and laboratory tests should be done as indicated by history and clinical examination. The extent of STI/RTI diagnostic or screening work up depends on the resources available at the facility.

Management of STI/RTI
STI/RTI can be managed by either syndromic management or etiologic management**.**

Box 5.1 Syndromic and Etiologic Management

Syndromic management of STI/TI refers to the approach of treating STI/RTI symptoms and signs based on the organisms most commonly responsible for each syndrome. Syndromic management guidelines are used for syndromes such as lower abdominal pain, urethral discharge, vaginal discharge, genital ulcer and inguinal bubo. In the syndromic approach treatment is provided without laboratory tests. If the client needs further tests then this can be done by referring the client to a specialist**.**

Etiologic management involves clinical examination followed by laboratory tests (microscopy, bacteriological examinations and serological tests) and treatment is based on the results of these tests.

The existence of a current STI/RTI is not in itself a reason to deny most methods. Initiation of IUD and surgical sterilization should be delayed until the STI is cured. During the treatment period the client should be assisted to choose an alternate method.

5.2.2 During family planning follow-up visits

There are various reasons for which a client returns to a family planning clinic. These reasons can include:

- routine follow-up visit related to contraceptive methods
- side-effects and concerns
- symptoms of STI/RTI.

Irrespective of the reason, a follow-up visit is an opportunity to assess his/her needs and concerns especially those related to the family planning method being used, his/her STI/RTI protection needs and any current STI/RTI symptoms. These return visits are also an opportunity to promote STI/RTI prevention through education and counseling.

5.3 FAMILY PLANNING METHODS AND STI/RTI

Most family planning methods do not protect against STI/RTI. Some contraceptive methods might increase the risk of non-sexually transmitted RTI or their complications and clients may abandon a method and risk pregnancy if they think it is causing a problem. Yeast infection, for example, is more common in women using oral contraceptives. Providers should be aware of method-related problems and counsel clients about their management or assist clients to choose another method if the current method is unacceptable.

DUAL PROTECTION[4]

Condoms should be used correctly and consistently to provide reliable protection against STIs and prevent pregnancy.

[4] Dual protection refers to preventing both STI/HIV and unwanted pregnancy. This can be achieved by the correct and consistent use of condoms alone or by simultaneous use of 2 methods, one of which is a condom.
Dual method use refers to using a barrier method for protection against STI/HIV and another method for contraception.

Table 2 Family planning methods: protection from pregnancy and STI

Method	Effectiveness* in pregnancy prevention	Protection against STIs
Male Condom	85-98%	Protects against most STI, including HIV. Protection unproven against infections transmitted by skin-to-skin contact (HSV, HPV).
Female Condom	79-95%	Lab studies show protection against STI/HIV. More human studies needed.
Spermicides	71-85%	Possible protection against bacterial STI, no protection against viral STI and HIV. May increase risk of HIV infection.
Oral Contraceptives (COC & POP)	92-99.7%	No protection against lower genital tract infection. Reduced risk of symptomatic PID. No protection against viral STI and HIV. (RTI such as yeast infection is more common among COC users.)
Progestogen-Only Injectable (POI)	97-99.7%	No protection against lower genital tract infection. Reduced risk of symptomatic PID. No protection against viral STI and HIV.
Hormonal Implants (Norplant)	99.95%	No protection against bacterial or viral STI and HIV.
IUD	99.2-99.4%	No protection against bacterial or viral STI and HIV. Associated with PID in first month after insertion.
Surgical Sterilization (tubal occlusion and vasectomy)	>99%	No protection against lower genital tract infections. Reduced risk of symptomatic PID. No protection against viral STI and HIV.

* Effectiveness range between typical and perfect use.

Source: Adapted from World Health Organization, *Sexually Transmitted and other Reproductive Tract Infections: A Guide to Essential Practice,* WHO, Geneva, Switzerland. 2005

Box 3 WHAT ARE STI/RTI?

Reproductive tract infection (RTI) refers to infections of the genital tract. They affect both men and women. RTI are caused in several ways. RTI caused by overgrowth of organisms normally present in the reproductive tract are referred to as endogenous RTI – commonly seen in women. RTI can be introduced from the outside into the reproductive tract during sexual contact – sexually transmitted infections (STI) – or by clinical procedures/interventions especially if infection prevention practices are not adhered (iatrogenic RTI). In men, STI are much more common than endogenous or iatrogenic RTI.

Terminology
Reproductive tract infection is a broad term that includes infections that are sexually transmitted as well as other infections of the reproductive tract that are not transmitted through sexual intercourse. Not all sexually transmitted infections (STI) are reproductive tract infections; and not all reproductive tract infections are sexually transmitted. STI refers to the way of transmission whereas RTI refers to the site where infection develops.
Internationally the term STI/RTI is used to highlight the importance of STI within reproductive tract infections.

Types of STI/RTI
Endogenous RTIs: *yeast infection (candidiasis), bacterial vaginosis***.**
STI: *gonorrhoea, chlamydia, syphilis, chancroid, trichomoniasis, genital herpes, genital warts, HIV, Hepatitis B infection, granuloma inguinale, lymphogranuloma venereum.*

Source: World Health Organization, *Sexually Transmitted and other Reproductive Tract Infections: A Guide to Essential Practice,* WHO, Geneva, Switzerland. 2005

5.4 KEY POINTS IN STI/RTI ASSESSMENT DURING FAMILY PLANNING VISITS

- Discuss STI/RTI prevention and concerns with all family planning clients at each visit. Promote dual protection (against pregnancy and STI/RTI) at every opportunity.
- Counsel clients that condoms can provide highly effective dual protection if used correctly and consistently and are the only method currently available for dual protection.
- IUD use should not be recommended for those with high individual likelihood of exposure to gonorrhea or chlamydia infection.
- Women with high individual risk of acquiring HIV infection, or those already infected with HIV, should not use spermicides.
- Ask about symptoms in the partner. Women with symptomatic partners should be treated, and the treatment of partner arranged.
- Screen for STI/RTI whenever warranted. A blood test and a careful speculum examination can identify many silent STIs/RTIs.

- Risk assessment may help identify some women who need special attention with regard to STI, but a negative risk assessment does not mean that a woman is not at risk.

Further Reading

1. World Health Organization, *Sexually Transmitted and other Reproductive Tract Infections: A Guide to Essential Practice,* WHO, Geneva, Switzerland. 2005

06 Low Dose Combined Oral Contraceptive Pills (COC)

Chapter 6: LOW DOSE COMBINED ORAL CONTRACEPTIVES (COC)

6.1 INTRODUCTION

Combined oral contraceptive pills are preparations of synthetic estrogens and progestogens and this form of contraception is highly effective in preventing pregnancy**.** The discussion in this chapter is mainly on monophasic low dose COC containing ethinyl estradiol 0.03 mg and levonorgestrel 0.15 mg.

6.2 TYPES OF COMBINED ORAL CONTRACEPTIVE PILLS (COC)

In Maldives, the combined oral contraceptive pills that are widely and commonly available are low dose monophasic pills (fixed concentration of estrogen and progesterone in each of the hormone containing pills throughout the menstrual cycle) and are available as 28 day pills. COC are also available as 21 day pills. COCs are usually supplied in packs, each pack containing 3 'cards' – one card for each month.

With 28 day pills, one pill containing hormones (active pill) is taken every day for 21 days, followed by the 7 placebo (inactive, non hormonal) pills which are taken one pill each day for the last 7 days. With 21 day pills, all the pills are active (contain hormones) and one pill is taken every day for 21 days, then there is a break/interval from pill-taking for 7 days before starting a new pill card

The following 2 low dose COCs are commonly available in Maldives:

1. Microgynon ED contains ethinyl estradiol 0.03 mg and levonorgestrel 0.15 mg. (28 day pills). The seven non hormonal pills contain ferrous fumarate 75 mg.
2. Rigevidon (28 day pills) contains ethinyl estradiol 0.03 mg and levonorgestrel 0.15 mg. Each card contains 7 dummy pills i.e. pills without hormones.

Low dose COCs containing 20 microgram or less ethinyl estradiol might be available in Maldives. In addition, multiphasic COCs with two (biphasic[5]) or three (triphasic[6]) dose variations of estrogens and /or progestogens throughout the menstrual cycle might also be available in Maldives.

For information on brand names and the composition of oral contraceptives available around the world, refer to International Planned Parenthood Federation's *Directory of Hormonal Contraception*.

[5] Biphasic pills typically contain 2 different progesterone doses. The progesterone dose is increased about halfway through the cycle.
[6] Triphasic pills gradually increase the dose of estrogens through the cycle (some pills also increase the dose of progestogen). Three different increasing pill doses are contained in each cycle.

The discussion in this chapter is mainly on monophasic low dose COC containing 0.03 mg and levonorgestrel 0.15 mg.

Combined low dose oral contraceptive pills (COC) - do not protect against STI/HIV. If there is a risk of STI/HIV (including the post partum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

6.3 EFFECTIVENESS AND RETURN TO FERTILITY

Effectiveness

Among COC perfect users (users who miss no pills and follow instructions consistently and correctly) it is highly effective* (99.7%). Among COC typical users, it is only about 92% effective*. Pregnancy rates during COC typical use are determined by the extent and type of imperfect use.

Return to fertility

When the woman stops taking the COC, her fertility returns to normal soon after stopping. Use of the pill does not alter a woman's capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the COC, a specific cause other than pill use should be sought.

6.4 CATEGORY OF PROVIDERS

COC pill can be provided by any health worker who has been trained to explain pill use, manage minor side effects and explain alternative methods of contraception. The following providers can provide COC: family health worker (FHW), community health worker (CHW), community health supervisor (CHS), staff nurse, medical officer and gynecologist.

6.5 ELIGIBILITY

Combined oral contraceptive pills (COCs) should be provided to any woman who requests COC, receives appropriate counselling, makes an informed decision and who does not have any contraindications for its use.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

6.5.1 Indications

Combined oral contraceptive pills are appropriate for women in the reproductive age group requesting highly effective contraception and:

- are motivated and willing to use a method which requires action daily and will be able to obtain supplies on a continuous basis
- are NOT breast feeding and >21days post partum
- desire contraception immediately after a miscarriage
- have menstrual problems such as heavy cramps, heavy bleeding with or without anemia, or irregular cycles and have been evaluated by a gynaecologist (COC decreases such problems)
- have a previous history of ectopic pregnancy[7]
- have a family history of ovarian, uterine cancer or cysts of the ovary as pill is protective
- have uterine fibroids
- have varicose veins
- have simple goitre
- have hyperthyroidism or hypothyroidism
- have thalassaemia

6.5.2 Health workers should consult a doctor before prescribing the pill in the following conditions:

- woman over 40 years, as the risk of heart disease increases with age and the pill may increase this risk
- adequately controlled hypertension where BP can be evaluated
- thyroid disorders such as goitre, hyperthyroidism and hypothyroidism
- thalassaemia
- diabetes.

6.5.3 Contraindications

- Pregnancy
- Breastfeeding mother less than 6 months post partum
- Active or severe liver disease, cirrhosis, liver tumours, gall bladder disease, history of jaundice in the previous 6 months, recurrent jaundice during pregnancy
- Breast cancer (current or past with no current evidence of disease)
- Smoking and over age 35: client should use another contraceptive method (e.g. IUD or progestogen-only method). Women 35 years or older who smoke (especially heavy smokers ≥15 cigarettes per day) are at increased risk of heart attack, stroke and other clotting problems if they use COCs and so COC is not recommended.

[7] Past ectopic pregnancy: The risk of future ectopic pregnancy is increased among women who have had an ectopic pregnancy in the past. COC provides protection against pregnancy in general, including ectopic pregnancy.

- Severe headache or migraine (recurrent vascular migraine with focal neurologic symptoms): client should be advised to use another non-estrogen method.
- High blood pressure with or without vascular problems
- Thromboembolic disorders (blood clots in the legs, lungs or eyes): current or past
- History of cerebrovascular accidents/stroke
- Major surgery which involves immobilization: COC should be discontinued at least 4 weeks in advance of planned major surgery which involves immobilization as COC increases blood coagulation.
- Diabetes with nephropathy, retinopathy, neuropathy, and diabetes of >20 years duration
- History of heart disease (ischaemic heart disease, angina, cardiac failure, valvular heart disease) and multiple risk factors for arterial cardio vascular disease (older age, smoking, diabetes and hypertension)
- Complicated valvular heart disease (pulmonary hypertension, risk of atrial fibrillation, history of sub acute bacterial endocarditis)
- Clients on the following medications:
    - Rifampicin (treatment for tuberculosis)
    - Anti convulsant drugs (medication used for patients with epilepsy/seizure disorder – phenytoin, carbamazepine, barbiturates, primidone, topiramate and oxcarbazepine)
    - Griseofulvin

  These drugs interact with COC as they cause liver to metabolize estrogens and progestogens very quickly and hence COC may be less effective.

6.6 COUNSELLING AND INFORMED CHOICE

All COC clients must receive appropriate counselling for selecting and using the method. Encourage clients to ask all their questions so that any uncertainties, misunderstandings and rumours can be cleared up. Counsel clients that COC does not protect against STI or HIV/AIDS.

Method specific counseling

- Effectiveness, the need to use correctly and consistently, and the return to fertility (a woman who stops COC can become pregnant soon after stopping)
- Mechanism of action, disadvantages and advantages
- Alternative methods of family planning
- Rumors about oral contraceptive pills (refer to Appendix 4)
- How to take the pill consistently and correctly (provide written instructions as well); not to stop COC when husband is away
- How to take the pill based on the type of packaging, i.e. 28 day package or 21 day package.
- What to do if she misses pills or has vomiting and diarrhea
- Side effects: minor side effects are most common in the first three months of use of the pill. These disappear with continued use of the pill.

- The client should use condoms in addition if she thinks there is any chance that she or her partner are at risk for exposure to STI, including HIV/AIDS.
- Counsel clients that breast self examination should be done regularly and that hormonal contraceptives are contraindicated in women with breast cancer.

For more detailed information refer to Chapter 3: Counselling and Informed Choice.

6.7 CLIENT ASSESSMENT

The purpose of the health assessment is to determine the client's suitability for the use of the method. Pregnancy should be ruled out prior to the provision of contraception. A pregnancy test should be done if there is any suspicion of pregnancy. Refer to Chapter 4: Client Assessment for indications for performing a pregnancy test.

It is also an opportunity to assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI and to offer other available sexual and reproductive health services as appropriate. Refer to Chapter 5 for further details on STI/RTI assessment during routine FP visit.

The following checklist can be used for history taking:

Table 6.1 History-taking checklist for use of oral contraceptive pills

Ask the client the following:	
1. Age	Age above 35 years: Yes No
2. Whether smokes	Yes No If yes, how many cigarettes per day
3. Date of last menstrual period Suspected pregnancy	 Yes No
4. Date of last child birth and if less than 6 months, whether breastfeeding	Date: Yes No
5. History of stroke or deep vein thrombosis	Yes No
6. History of heart attack or heart disease (severe chest pain or unusual shortness of breath)	Yes No
7. History of high blood pressure	Yes No
8. History of frequent severe headaches	Yes No
9. History of cancer of the breast or undiagnosed lump in the breast	Yes No
10. History of jaundice now or in the last 6 months or history of liver disease or tumors	Yes No
11. History of diabetes and years with the disease	Yes No
12. History of major surgery with staying in bed for long (immobilization)	Yes No
13. Whether on treatment for tuberculosis	Yes No
14. Whether on treatment for convulsions	Yes No
15. Whether on Griseofulvin	Yes No

The following are mandatory and recommended clinical examination and tests to be done prior to initiating COC:

Mandatory

- Blood pressure should be checked and eligibility ascertained prior to starting COC.
- All FP clients can be educated and shown how to perform a breast self exam and to report if there are any abnormalities noted.

Recommended[8]

The following examinations are recommended in all women requesting COC:

- Breast examination by provider*
- Pelvic examination*
- STI risk assessment (Refer to Chapter 5 for further details on STI assessment).

Checking baseline body weight and recording it in the Client Clinic Card can be useful information for subsequent follow up visits.

6.8 PROVISION OF COC

6.8.1 Timing of initiation

- COC should be initiated only after ruling out pregnancy. A pregnancy test should be done if there is any suspicion of pregnancy.
- COC should be initiated between the first and fifth day of a client's menstrual cycle. There is no need for back up contraception such as condoms when COC is started within the first 5 days of her menstrual cycle.
- Post miscarriage: COC can be started immediately or within the first 7 days after a spontaneous miscarriage, if contraception is desired by the client. There is no need for back up contraception such as condoms if COC started within first 7 days post miscarriage.
- Switching from POI (DMPA or NET-EN): COC can be started at the time the repeat injection was due. There is no need for back up in this situation.

COC should be discontinued at least 4 weeks in advance of planned major surgery which involves immobilization as COC increases blood coagulation.

[8] Recommended examinations contribute to safe and effective use of the method as well as being good preventive practice.

* Health workers can advise clients to visit a facility and see a doctor or nurse for a breast and pelvic exam.

6.8.2 Missed COC[9]

It is important that all clients on COC should be counselled and provided with written/ printed instructions on what should be done if they missed pills

Missed COC containing 30- 35 microgram ethinyl estradiol

- Missed 1 or 2 active (hormonal) pills or is if she starts a new pill card 1 or 2 days late (COC containing 30- 35 microgram ethinyl estradiol)
    - Take an active pill as soon as she remembers/ possible, even if it means taking two pills on one day. She should then continue taking pills daily, one each day. She does not need any additional contraception/ i.e. back up contraception.
- Missed 3 or more active (hormonal) pills or if she starts a new pill card 3 or more days late. (COC containing 30- 35 microgram ethinyl estradiol)
    - She should take an active pill as soon as possible and then continue taking pills daily, one each day. In addition she should either abstain from sex or use back up method of contraception (e.g. condom) until she has taken active (hormonal) pills for 7 consecutive days.
    - If she missed the pills in the 3rd week, she should finish the active (hormonal) pills in her current pill card and start a new pill card soon after completing the active pills in the current pill card. She should not take the 7 inactive pills (non hormonal pills/ dummy pills) in the current pill card.
    - If she missed in the first week and had unprotected sexual intercourse consider using emergency contraceptive pills.
- Missed any inactive (non hormonal) pills
    - She should discard the missed inactive pill/s and then continue taking the rest of the pills daily, one each day and start a new card immediately after completing the current pill card.

Missed COC containing 20 microgram or less ethinyl estradiol

- If the woman misses 1 active (hormonal) pill or starts a card 1 day late when using COC with 20 microgram or less ethinyl estradiol, she should follow the guidance as above for missed 1 or 2 active pills of COC containing 30-35 microgram ethinyl estradiol.
- If the woman misses 2 or more active hormonal pills or if she starts a pack 2 or more days late, she should follow the guidance as for missed 3 or more active (hormonal) pills or if she starts a pack 3 or more days late.

[9] Seven days of continous COC use is deemed necessary to reliably prevent ovulation. Women who frequently miss pills should consider an alternative contraceptive method. The risk of pregnancy is greatest when active (hormonal) pills are missed at the beginning or at the end of the active pills, ie when the hormone–free interval is extended.

6.8.3 Vomiting or diarrhoea while using COC

It is important that all clients on COC should be counselled and provided with written/ printed instructions on what should be done if she has vomiting or diarrhoea.

- **Vomiting or severe diarrhoea while using COC**
    - Vomiting for any reason within 2 hours of taking COC, client should take another pill.
- **Severe vomiting or diarrhoea for more than 24 hours.**
    - Client to continue taking the pills despite her discomfort.
- **If severe diarrhoea or vomiting continues for 2 or more days she should follow the procedure for missed pills.**

6.8.4 Guidelines for Instructing on Use of COCs

- Show the packet of COC to the client as instructions are being given.
- Explain that the first day of menstruation is the day when bleeding/spotting starts.
- Show the client where to start the pill (where it is marked START) and advise to follow the arrow to decide which pill to take next and follow the arrow till the last pill.
- Show how to take out the pill from the packet.
- Emphasize the importance of taking 'the pill' everyday even during her periods and even when no sexual intercourse.
- Emphasize the importance of avoiding sex or using condoms in case of pills missed for more than 2 days.
- Ask the client to repeat the instructions.
- Provide 3 months supply of the pill and ask the client to return after 3 months for re-supply/ follow up or earlier if problems develop. Ask the client to bring the used packets (even the empty ones) to make sure that the pills are being taken regularly.
- Provide a packet of condoms in case of missed pills or develop the conditions where condom used is advisable. Demonstrate how to use the condom if the client does not know how to use it.

Client instructions

- Take one pill each day, preferably at the same time of day.
- In 28 day pills, start with the pill in the top left hand corner of the pill card and continue taking the next pill one each day until all the white pills (active/hormone containing pills) have been taken (for 21 days). After finishing the active/hormone containing pills (white pills) start the brown pills (non-hormonal pills) taking one brown pill each day for the next 7 days until all pills have been taken. When the 28-day pack is empty, start taking pills from a new pill card the next day. During the 7 days on the brown pills, the client might have some withdrawal bleeding. Even if there is bleeding after finishing the pills start the new pill card the next day. There is no pill free period when taking a 28 day pills. (Give verbal and written instructions.)

- For 21 day pills, start with the pill in the top left hand corner of the 'pill card' and continue taking the next pill one each day until all the pills are gone (for 21 days). This is followed by a pill free week. Start a new 'pill card' immediately after the pill free week. (Give verbal and written instructions.)
- Clients should NOT stop and start pills when their partner is away for a short period of time. COCs are not effective if not taken consistently.
- Provide verbal and written instructions on what should be done if she misses pills.
- When the client begins to take the COCs, she may have some bleeding between menstrual periods. The light bleeding is not her menstrual period, is not dangerous and will likely go away after the first 3 months. She should continue taking the pill each day.
- The client may have some nausea or dizziness or headaches because her body is adjusting to the pill. These discomforts usually disappear after one or two packs of pills. She should try taking the pill at bedtime or with the evening meal. If discomfort persists, she should come back to the clinic.
- Acute vomiting and/or diarrhoea interfere with the effectiveness of COCs. Client should continue taking the pills despite her discomfort. Vomiting for any reason within 2 hours of taking an active (hormonal) pill: client should take another active pill. If severe diarrhoea or vomiting continues for 2 or more days she should follow the procedure for missed pills.
- The client should use condoms in addition to COCs if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/ Acquired Immunodeficiency Syndrome (AIDS).
- She should contact the doctor/nurse immediately if she develops any of the warning signs (refer to Box 6.1) as these are life threatening conditions. (Give verbal and written instructions.)
- Contact the health worker for advice if started on treatment for tuberculosis, convulsions or on long term treatment for infections as these drugs reduce the effectiveness of the pill.
- Keep the pill in a cool, dry place, out of reach of children.
- Give follow-up instructions: where and when (verbal and written).

The client should also be provided with WRITTEN/PRINTED instructions on missed pills and warning signs as well as routine follow-up schedules – where and when.

Box 6.1 WARNING SIGNS

See doctor promptly in the event of:

1. Severe abdominal pain
2. Possible pregnancy
3. Severe vaginal bleeding
4. Severe chest pain, breathlessness
5. Severe headache, dizziness, numbness
6. Eye problems, speech problems
7. Severe pain in calf or thigh.

6.9 ROUTINE FOLLOW-UP CARE

All clients initiated on combined oral contraceptive pills are advised:

- First follow up at 3 months for assessment and supplies.
- Subsequently 3 monthly follow-up visits
    - Replenish supplies every 3rd month
    - Routine FU assessment and replenish supplies every 6th month
- Return to facility earlier if she has any concerns, side-effects or if she wants to change the method.
- Contact doctor immediately if she has any of the warning signs in Box 6.1.

Clients with specific medical conditions may need more frequent follow up visits.

At routine follow-up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects and, if so, record them in the client clinical card/record.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history, measure blood pressure and body weight, and perform any examination indicated by the history.
- Provide appropriate counselling and/or treatment as required.
- Refer client to an appropriate referral facility/specialty if any serious problems or side effects cannot be managed at the facility were client has attended for follow up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- Replenish supplies for clients continuing oral contraceptives.
- Provide date for next follow-up.
-

Refer to Chapter 3 on Counselling and Informed choice for detailed information on counselling at follow-up visit.

Supplying combined oral contraceptive pills
All clients on COC should be provided with a 3 month supply. If a client requests for more supplies a maximum of 6 months supply can be provided.

6.10 SIDE EFFECTS AND MANAGEMENT

Clients should be routinely counselled about common side effects and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counselled and managed appropriately. Refer to Chapter 3 for details on counselling clients with problems using a contraceptive method.

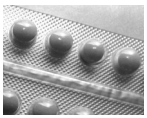
Table 6.2 Management of side effects and health problems

Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding)	Ask how she has been taking her pills. Has she missed any pills in the cycle? Has she stopped taking pills? Rule out pregnancy. Perform pregnancy test.	If the client is taking COCs correctly, reassure her. Explain that absent menses is most likely due to lack of build-up of uterine lining; there is no menstrual blood building up within her. Advise client to return to clinic if amenorrhoea continues to be a concern. If client is NOT taking COCs *correctly*, review instructions for use. If intrauterine pregnancy is confirmed, stop COCs and assure her that the small dose of estrogen and progestin in the COCs to which she was exposed will have no harmful effect on the foetus.
Spotting or bleeding (common during the first three months after starting the pills).	Has client recently begun COCs?	If yes, reassure. Advise that spotting and bleeding are common during the first 3 months of COCs use and decrease markedly in most women by the fourth month of use. Refer to specialist if problem persists for more than 3 months.
	Ask if she has missed one or more pills, or if she takes pills at a different time every day.	If yes, give instructions about what to do for missed pills and stress the importance of taking the pill at the same time every day. If she continues to miss pills, she may need to switch to another method to minimize risk of pregnancy.
	As appropriate: exclude gynaecological problems (e.g. uterine tumours, pregnancy, abortion, PID).	If gynaecological problems are present, refer to a doctor if possible, or manage according to clinic practice.
	Is client taking rifampin or epilepsy medication?	Counsel client to switch to another method until she discontinues rifampin or epilepsy medication.

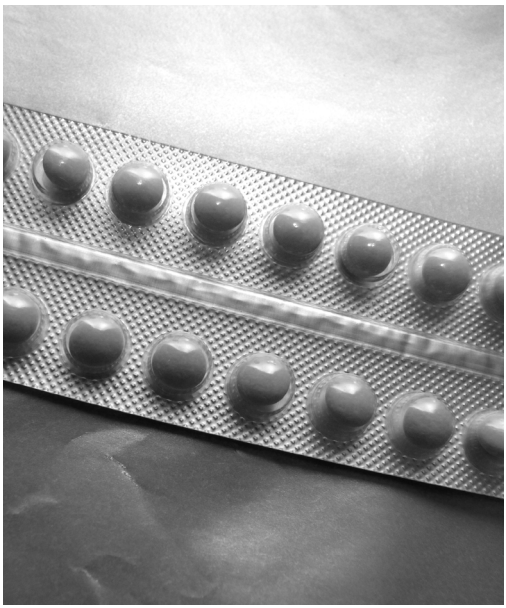
High blood pressure	Recheck BP after 15 minutes rest. Find out if rise in BP is after starting the pill.	If blood pressure persists to be over >140/90, refer to a specialist for further evaluation. Repeat warning signs (severe headache, blurred vision, chest pain). If COCs are discontinued, help client make an informed choice of a non-hormonal method.
Headache	Assess if new headache or marked changes in headache.	Refer for evaluation if headache is new or there are marked changes.
Breast fullness or tenderness	Find out whether the pill is being taken correctly and consistently. Rule out pregnancy. Rule out breast lumps, ulcer and infection of the breast	If pregnant, advise as above. If not pregnant and no breast lumps, counsel. Refer to specialist in case of breast lumps or ulcer.
Weight gain	Check if the weight gain is after the pill. Assess food intake. If no reason found, rule out pregnancy by checking symptoms.	If pregnant, advise as above. If not pregnant, counsel.
Nausea/dizziness/nervousness (usually improves during first 3 months)	Find out if pills are taken in morning or on an empty stomach.	Take with evening meal or before bedtime.
	As appropriate: exclude pregnancy.	If pregnant, manage as above (see Amenorrhoea).
	Rule out other causes of nausea (gall bladder disease, hepatitis).	Evaluate for disease (gall bladder disease, hepatitis, gastroenteritis). Counsel that it will probably decrease with time, or counsel client to switch to a progestogen-only method if problem is intolerable.

6.11. RECORD KEEPING AND REPORTING

The provider should legibly record information in the Client Clinic Card and Family Planning Register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.



07 Progestogen-Only Pills (POP)



Chapter 7: PROGESTOGEN-ONLY PILLS (POP)

7.1 INTRODUCTION

Progestogen-only pills (POPs) are oestrogen-free oral contraceptives containing a low dose of progesterone. Progestogen-only pills are also referred to as 'minipills'. POP are good for breastfeeding women and can also be taken by non-breastfeeding women.

Progestogen-only pills (POP) do not protect against STI/HIV. If there is a risk of STI/HIV (including the post partum period) the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

7.2 TYPES OF PROGESTOGEN-ONLY PILLS (POP)

Progestogen-only pills commonly available in Maldives are Micronar (28 day). Each pill contains Norethisterone 350 microgram.

For information on brand names and the composition of oral contraceptives available around the world, refer to International Planned Parenthood Federation's *Directory of Hormonal Contraception*.

7.3 EFFECTIVENESS AND RETURN TO FERTILITY

Effectiveness

Among perfect users (users who miss no pills and follow instructions consistently and correctly), POP is highly effective* (99.7%). Among POP typical users, it is only about 92% effective*. Pregnancy rates during POP typical use are determined by the extent and type of imperfect use.

The effectiveness rates for perfect use and typical use are similar for COC and POP. However, woman will be at risk of pregnancy sooner after missing a POP than a COC.

Return to Fertility

When the woman stops taking the POP, her fertility returns to normal soon after stopping. Use of the pill does not alter a woman's capacity for normal fertile cycles. If a woman does not resume normal cycles after stopping the POP, a specific cause other than pill use should be sought.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

7.4 CATEGORY OF PROVIDERS

Progestogen-only pills can be provided by any health worker who has been trained to explain pill use, manage minor side effects, and explain alternative methods of contraception. The following providers can provide POP and perform follow up care: family health worker (FHW), community health worker (CHW), community health supervisor (CHS), staff nurse, medical officer and gynecologist.

7.5 ELIGIBILITY

7.5.1 Indication

POP should be provided to any women in the reproductive age who requests POP, after appropriate counselling and reaching an informed decision, and who does not have any contraindication for its use.

POP are appropriate for women who:

- cannot or will not use combined oral contraceptives
- are breastfeeding and are more than 6 weeks post partum
- are not breastfeeding post partum
- have had a miscarriage and desire contraception
- have a history of ectopic pregnancy[10]
- have gynecological disorders (evaluated) such as endometriosis, benign ovarian tumours, severe dysmenorrhoea
- have an STI excluding HIV and Hepatitis B
- have diabetes
- smoke
- are obese
- have adequately controlled hypertension
- have a history of high BP during pregnancy where the current pressure is normal
- have varicose veins
- have non-migraine headache
- have other oestrogen-related complications
- have valvular heart disease (complicated and uncomplicated), pulmonary hypertension, irregular heart rhythm (fibrillation) or a history of subacute bacterial endocarditis (SBE) (progestins do not contribute to blood clotting and embolism)
- have thyroid disorders (simple goitre, hyperthyroidism, hypothyroidism)

[10] POP have a higher absolute rate of ectopic pregnancy compared with other progestogen only contraceptives, but still less than using no method

7.5.2 Health workers should consult a doctor when women with the following conditions request POP

- History of ectopic pregnancy[11]
- Thyroid disorders (such as goitre, hyperthyroidism and hypothyroidism)
- Raised BP >140/90
- Valvular heart disease (complicated or uncomplicated)
- Superficial thrombophlebitis
- Diabetes
- History of past ectopic pregnancy.

7.5.3 Contraindication

- Pregnancy
- Current deep vein thrombosis or pulmonary embolism
- Hypertension not controlled
- Severe headache or migraine with focal neurological symptoms
- Current and history of breast cancer
- Liver disease: active viral hepatitis, cirrhosis, liver tumours
- Unexplained vaginal bleeding before evaluation
- Drug interactions
    - Rifampicin (treatment for tuberculosis)
    - Anti-convulsant (medication used for patients with epilepsy/seizure disorder), e.g. phenytoin, carbamazepine, barbiturates, primidone, topiramate and oxcarbazepine
    - Griseofulvin

These drugs interact with POP as they cause the liver to metabolize estrogens and progestogens very quickly and hence POP may be less effective.

7.6 COUNSELLING AND INFORMED CHOICE

All POP clients must receive appropriate counselling for selecting and using the methods. Encourage clients to ask all their questions so that any uncertainties and misunderstandings can be cleared up. It is important to counsel clients that POP does not protect against STIs or HIV/AIDS.

Method Specific Counseling for POP

- Effectiveness and the need to use correctly and consistently
- Return to fertility (a woman who stops POP can become pregnant soon after stopping)
- Mechanism of action, advantages and disadvantages
- Suitability for women who cannot take estrogen as it contains only progestogen

[11] POP have a higher absolute rate of ectopic pregnancy compared with other progestogen only contraceptives, but still less than using no method

- Alternate methods of FP
- Rumours about oral contraceptive pills (refer to Appendix 4)
- How to take the pill and the importance of taking the pill at the same time each day
- No wait or pill free period between cards; all pills are active (they all contain hormones)
- Should be taken without a break between cycles regardless of the bleeding pattern through the cycle
- Very effective when breastfeeding
- Does not affect quality or amount of breast milk

The client should use condoms in addition if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/AIDS. Counsel clients that breast self examination should be done regularly and that hormonal contraceptives are contraindicated in women with breast cancer.

For more detailed information on counselling refer to Chapter 2 Overview of FP and Chapter 3 Counselling and Informed Choice.

7.7. CLINICAL ASSESSMENT

The purpose of the health assessment is to determine the client's suitability for the use of the method. Pregnancy should be ruled out prior to the provision of contraception. A pregnancy test should be done if there is any suspicion of pregnancy. Refer to Chapter 4 for indications for performing a pregnancy test.

It is also an opportunity to assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI and to offer other available sexual and reproductive health services as appropriate. Refer to Chapter 5 for further details on STI/RTI assessment.

The following are mandatory and recommended practices.

Mandatory

- Blood pressure should be checked and eligibility ascertained prior to starting POP.
- All FP clients can be educated and shown how to perform a breast self exam and to report if there are any abnormalities noted.

Recommended[12]

The following examinations are recommended in all women requesting POP

- Breast examination by a provider*
- Pelvic examination*
- STI risk assessment (Refer to Chapter 5 for further details on STI assessment)

Checking baseline body weight and recording it in the Client Clinic Card can be useful information for subsequent follow up visits.

7.8. PROVISION OF POP

7.8.1 Timing of initiation

- POP should be initiated only after ruling out pregnancy. A pregnancy test should be done if there is any suspicion of pregnancy.
- POP should be initiated only between the first and fifth day of a client's menstrual cycle. There is no need for back up contraception such as condoms when POP is started within the first 5 days of her menstrual cycle.
- Post miscarriage: POP can be started immediately or within the first 7 days after a spontaneous miscarriage, if the client desires contraception. There is no need for back up contraception such as condoms if POP provided as above.
- Switching from POI (DMPA or NET-EN) to POP can be started at the time the repeat injection was due. There is no need for back up in this situation

7.8.2 Missed POP

Clients should be provided with written/printed instructions on what to do for missed pills as well as about warning signs and follow up.

Women having menstrual cycles (including those who are breast feeding) AND who missed one or more pills by **more than 3 hours** should do the following:

- Take one pill as soon as possible.
- Continue taking the remaining pills, one each day.
- Abstain from sex or use back up contraception for the next 2 days.
- Consider the use of emergency contraceptive pills if appropriate.

It is important that all clients on POP should be counselled and provided written instructions on what should be done if she misses POP

[12] Recommended examinations contribute to safe and effective use of the method as well as being good preventive practice.
* Health workers can advise clients to visit a facility and see a doctor or nurse for a breast and pelvic exam.

7.8.3 Vomiting or diarrhoea while using POP

Clients should be provided with written/printed instructions on what to do if she has vomiting or diarrhoea.

- **Vomiting or severe diarrhoea while using POP**
  - If she vomits for any reason within 2 hours of taking POP, the client should take another pill.
- **Severe vomiting or diarrhoea for more than 24 hours.**
  - Client should continue taking the pills despite her discomfort.
- **If severe diarrhoea or vomiting continues for 2 or more days she should follow the procedure for missed pills.**

7.8.4 Guidelines for instructing on use of POPs

- Show the packet of POP to the client as instructions are being given.
- Explain that the first day of menstruation is the day when bleeding/spotting starts.
- Show the client where to start the pill (where it is marked START) and advise to follow the arrow to decide which pill to take next and follow the arrow till the last pill.
- Show how to take out the pill from the packet.
- Emphasize the importance of taking 'the pill' at the same time every day, even during her periods and even when there is no sexual intercourse.
- Emphasize the importance of avoiding sex or using condoms if she misses taking pills for 1 or more days by more than 3 hours.
- Ask the client to repeat the instructions.
- Provide 3 months supply of the pill and ask the client to return after 3 months for re-supply/follow-up or earlier if problems develop. Ask the client to bring the used packets (even the empty ones) to make sure that the pills are being taken regularly.
- Provide a packet of condoms in case of missed pills or develop the conditions where condom use is advisable. Demonstrate how to use the condom if the client does not know how to use it.

Client instructions

- Instructions on taking POP: Start the pill on the first day of the period. Continue to take one pill at the same time each day even during the period.
- As soon as one card is completed, begin the next card. Start the next card even if there is bleeding or you have not started a period. Continue taking one pill at the same time each day. (Verbal and written instructions should be provided.)
- Clients should NOT stop and start pills when their partner is away for a short period of time. POPs are not effective if not taken consistently.
- Client should be counseled on what to do if she misses pills and on what to do if she has vomiting or diarrhoea (refer above) Written/printed instructions should also be provided.
- Recap on side effects.

- The client should use condoms in addition to POPs if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/AIDS.
- She should contact the doctor immediately if she develops any of the warning signs (refer to Box 7.1) as these are life threatening conditions. (Give verbal and written instructions.)
- She should contact the health worker for advice if she starts treatment for tuberculosis, convulsions or long-term treatment for infections as these drugs reduce the effectiveness of the pill.
- Keep the pill in a cool, dry place, out of reach of children.
- Routine follow up instructions: where and when. Verbal and written.

7.9 ROUTINE FOLLOW-UP CARE

All clients initiated on progestogen-only pills are advised:

- First routine follow up at 3 months for assessment and supplies.
- Subsequent routine follow up
    - Every 3 months to replenish supplies.
    - Every 6 months visits for routine follow-up assessment and replenish supplies.
- Return to facility earlier if she has any concerns, side-effects or if she wants to change the method.
- Contact a doctor immediately if she has any of the warning signs in Box 7.1.

At routine follow up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects and, if so, record them in the client clinical card/record.
- Assess for any STI/RTI-related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history; measure blood pressure and body weight, and perform any examination indicated by the history.
- Provide appropriate counselling and/or treatment as required.
- Refer client to an appropriate referral facility/speciality if any serious problems or side effects cannot be managed at the facility where the client has attended for follow up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- Replenish supplies for clients continuing on POP.
- Provide date for next follow up.

Refer to Chapter 3 on Counselling and Informed choice for detailed information on counselling at follow up visit.

Supplying progestogen-only pills
All clients on POP should be provided with a 3 month supply. If a client requests more supplies, a maximum of 6 months' supply can be provided.

Box 7.1 WARNING SIGNS

See doctor promptly in the event of:

- severe lower abdominal pain
- possible pregnancy
- unusually heavy or long bleeding
- chest pain or shortness of breath
- very bad headaches
- severe leg or arm pain or numbness
- eye problems such as blurred vision
- yellow skin or eyes

7.10 SIDE EFFECTS AND MANAGEMENT

Clients should be routinely counselled about common side effects and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counselled and managed appropriately. Refer to Chapter 3 for details on counselling clients with problems using a contraceptive method.

Table 7.1 Side effects and their management for the use of progestogen-only pills

Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding or spotting)	Rule out pregnancy by checking symptoms; perform a pelvic exam (speculum and bimanual) and pregnancy test.	Periods of amenorrhoea can occur among women taking POP. If pregnancy has been ruled out, there is no need for any medical treatment for the amenorrhoea. Counseling is sufficient. If amenorrhoea is unacceptable to the client, discontinue POP and help her choose another method. If intrauterine pregnancy is confirmed, counsel client and refer for appropriate care. Discontinue POP and assure her that the small dose of progesterone to which she was exposed will have no harmful effect on the foetus. If ectopic pregnancy[13] is suspected, refer promptly for complete evaluation.
Bleeding/Spotting (prolonged spotting or moderate bleeding) Prolonged spotting: >8 days Moderate bleeding: same as normal menses	Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to another cause (e.g., genital tract lesion such as vaginitis, cervicitis, cervical polyps or uterine fibroids). If pregnancy (intrauterine or ectopic) or incomplete abortion is suspected, examine and perform a pregnancy test.	Light bleeding or spotting between periods, irregular periods, is common especially in non breastfeeding women while using POP. Counsel that skipping pills may make bleeding side-effects worse and risks pregnancy. In women with persistent spotting or bleeding after a period of amenorrhoea, exclude gynaecological problems when clinically warranted. If a gynaecological problem has been identified, treat the condition or refer for care. If haemoglobin less than 9 g/dl, hematocrit less than 27 or conjunctival pallor significant, give iron or iron folate (1 tablet daily for 1 to 3 months) and nutritional counselling. If anaemia persists, or client requests, discontinue POP and help client choose another method.

[13] POP have a higher absolute rate of ectopic pregnancy compared with other progestogen only contraceptives, but still less than using no method

Side Effect	Assessment	Management
		If no gynaecological problems are found and she finds the bleeding unacceptable, discontinue the POP. Help her choose another method. If pregnancy is confirmed, see Amenorrhoea section in this table for management of pregnancy related conditions.
Lower abdominal pain	Rule out pregnancy by checking symptoms, perform abdominal and pelvic exams (speculum and bimanual) and a pregnancy test.	If ectopic pregnancy is suspected refer promptly for complete evaluation.
Weight gain	Check if the weight gain occurred while on POP. Assess food intake. If no reason is found, rule out pregnancy (as under amenorrhoea in this table).	If pregnant, advise as discussed under amenorrhoea in this table. If not pregnant, counsel.
Nausea	Find out whether the POP is being taken regularly every day at the same time. Rule out pregnancy (as above)	If pregnant, advise as in amenorrhoea in this table. If not pregnant, if the POP is being taken regularly at the same time every day, counsel. Refer to specialist, if nausea continues, to rule out other causes.
Headache	Assess if the headache is new or there are marked changes in headache.	Refer for evaluation if headache is new or there are marked changes in headache.

7.11 RECORD KEEPING AND REPORTING

The provider should legibly record information in the Client Clinic Card and Family Planning Register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.

08 Progestogen-Only Injectables (POI)

Chapter 8: PROGESTOGEN-ONLY INJECTABLE CONTRACEPTIVES (POI)

8.1 INTRODUCTION

The progestogen-only injectable contraceptives (POI) are synthetic steroid hormones resembling the female hormone progesterone. The injectable hormone is released slowly into the bloodstream from the site of the injection.

Progestogen-only injectables (POI) do not protect against STI/HIV. If there is a risk of STI/HIV (including the post partum period) the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

8.2 TYPES OF PROGESTOGEN-ONLY INJECTABLE (POI)

Currently depot-medroxyprogesterone acetate (DMPA) known as Depo-Provera® is the injectable contraceptive widely available in Maldives. Each dose of DMPA/Depo-Provera contains 150 mg of medroxyprogesterone acetate and is given every 3 months (12 weeks) as deep intramuscular injection.

Another type of progestogen-only injectables is norethisterone enantate (NET-EN) and each dose of NET-EN contains 200 mg and is given every 2 months (8 weeks).

8.3 EFFECTIVENESS AND RETURN TO FERTILITY

Effectiveness

Progestogen-only injectables i.e. DMPA/Depo-Provera are effective reversible contraceptive methods. DMPA/Depo-Provera (150 mg) given every 3 months has an effectiveness* of 99.7% if taken consistently and on time. Typical use effectiveness* of POI is 97%.

Return to Fertility

When a client stops taking progestogen-only injectables, it may take several months for fertility to return. The median delay in return to fertility with DMPA/ Depo-Provera is 10 months and for NET-EN is 6 months from the date of the last injection regardless of the duration of use.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

8.4 CATEGORY OF PROVIDERS

Hormonal injectables can be provided by a trained family health worker (FHW), community health worker (CHW), community health supervisor (CHS), staff nurse, medical officer and gynecologist.

8.5 ELIGIBILITY

DMPA / Depo-Provera should be provided to any women who requests it after appropriate counselling and reaching an informed decision, and who does not have any contraindication for its use.

8.5.1 Indications

DMPA/Depo-Provera can be provided to women who:

- prefer a method that does not require taking contraceptive action every day or before having intercourse, or want long-term birth spacing or have the number of children they want but do not want or cannot have a permanent method (voluntary surgical sterilization) at this time
- are aged 18 to 45 years
- are parous (have one or more children)
- are breastfeeding (AFTER 6 weeks postpartum) and need a contraceptive
- are not breastfeeding post partum
- have had miscarriage, if so desired by the client
- have a history of past ectopic pregnancy
- cannot use estrogen containing contraception i.e. COC, or have developed estrogen-related complications taking COCs
- have endometriosis
- have severe dysmenorrhoea evaluated by a gynaecologist
- have PID currently or in the past
- have STI infections excluding HIV and Hepatitis B
- have a history of high blood pressure during pregnancy where current blood pressure is measurable and normal
- smoke
- are obese
- have thyroid disorders such as goitre, hyperthyroidism and hypothyroidism
- have thalassaemia
- have varicose veins or superficial thrombophlebitis
- have valvular heart disease (complicated and uncomplicated), pulmonary hypertension, irregular heart rhythm (fibrillation) or a history of subacute bacterial endocarditis (SBE).

8.5.2 Health workers should consult a doctor when women with the following conditions request POI

- Thyroid disorders such as goitre, hyperthyroidism and hypothyroidism.
- BP ≥140/90 mmHg

- Valvular heart disease, complicated or uncomplicated
- Superficial thrombophlebitis
- Thalassaemia
- Diabetes
- Migraine

8.5.3 Contraindication

- Pregnancy
- Nulliparous[14]
- Breastfeeding and less than 6 weeks post partum
- Elevated BP (≥160/100 mm of Hg)
- Migraine with focal neurological symptoms
- Active liver disease or jaundice in the previous 6 months; benign or malignant liver tumours
- Current deep vein thrombosis or pulmonary embolism
- Current and history of ischaemic heart disease and stroke
- Diabetes long standing (>20 years) or diabetes with nephropathy, retinopathy, neuropathy
- Breast cancer (current or past with no current disease for 5 years)
- Multiple risk factors for arterial cardiovascular disease (such as older age, smoking, diabetes and hypertension)
- Unexplained vaginal bleeding

8.6 COUNSELLING AND INFORMED CHOICE

All clients must receive appropriate counselling for selecting and using the method. Encourage clients to ask all their questions so that any uncertainties and misunderstandings can be cleared up. Counsel clients that hormonal injectables do not protect against STIs or HIV/AIDS. For selecting the method, counsel about:

- effectiveness and the delay to return to fertility
- advantages and disadvantages
- alternative family planning methods
- rumors about the method (see Appendix 4)
- timing of injection

Ensure that the client has understood the importance of regular injections and how often they should be. Make sure that the woman understands about the side effects such as amenorrhea, bleeding/spotting and delayed return of fertility. The client should use condoms in addition if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/AIDS. Counsel clients that breast self examination should be done regularly and that hormonal contraceptives are contraindicated in women with breast cancer.

[14] Nulliparity is a contra indication for POI due to the long delay for return to fertility following the use of POI.

For more detailed information refer to Chapter 2 Overview of FP and Chapter 3: Counselling and Informed Choice.

8.7 CLINICAL ASSESSMENT

The purpose of the health assessment is to determine the client's suitability for the use of the method. Pregnancy should be ruled out prior to the provision of contraception. A pregnancy test should be done if there is any suspicion of pregnancy. Refer to Chapter 4 for indications for performing a pregnancy test.

It is also an opportunity to assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI and to offer other available sexual and reproductive health services as appropriate. Refer to chapter 5 for further details on client assessment.
The following are mandatory and recommended practices.

Mandatory

- Blood pressure should be checked and eligibility ascertained prior to starting POI.
- All FP clients should be educated and shown how to perform a breast self exam and to report if there are any abnormalities noted.

Recommended[15]

The following examinations are recommended in all women requesting POI:

- Breast examination by a provider*
- Pelvic examination* - a pelvic examination prior to starting POI is useful to rule out any pelvic lesions
- STI risk assessment (refer to chapter 5 for STI/RTI assessment)

Checking baseline body weight and recording it in the Client Clinic Card can be useful information for subsequent follow up visits.

[15] Recommended examinations contribute to safe and effective use of the method as well as a good preventive practice.
* Health workers can advise clients to visit a facility and see a doctor or nurse for a breast and pelvic exam.

8.8 PROVISION OF PROGESTOGEN-ONLY INJECTABLES

8.8.1 Starting POI

- POI should be initiated only after ruling out pregnancy. A pregnancy test should be done if there is any suspicion of pregnancy.
- POI should be initiated any day between the **first (day 1) and seventh day (day 7)** of the client's menstrual cycle. There is no need for back up contraception such as condoms when POI is started within the first 7 days of her menstrual cycle.
- Post miscarriage: POI can be started **immediately up to the first 7** days after a complete spontaneous miscarriage, if the client desires contraception. There is no need for back up contraception such as condoms if POI provided as above.
- If her previous method was another injectable, she should have the new POI when the repeat injection of the first POI would have been given. No other contraceptive protection is needed
- **Switching from an IUD:** The first injection can be given within 7 days after the start of her menstrual bleeding. No additional contraceptive protection is needed. IUD can be removed at the same visit.

8.8.2 Repeating progestogen-only injectables

Repeat injections of DMPA/Depo-Provera should be provided every 3 months (12 weeks). Repeat injections of NET-EN should be provided every 2 months (8 weeks). Compliance with regular injection intervals should be encouraged.

- **Early for an injection:** The repeat injection of DMPA/Depo-Provera and NET-EN can be given up to 2 weeks early.`
- **Late for an injection:** The repeat injection for DMPA/Depo-Provera and NET-EN can be given up to 2 weeks late without requiring additional contraceptive protection. If she is more than 2 weeks late for DMPA/Depo-Provera or NET-EN repeat injection, she can be given the repeat injection if pregnancy has been ruled out. Provide additional contraception as back up for the next 7 days. If appropriate use emergency contraception.
- **Unknown previous injectable type and/or timing of injection:** Provide available injectable if pregnancy has been ruled out. Provide back up contraception such as condoms for the next 7 days.

Switching between DMPA/Depo-Provera and NET-EN injection interchangeably is NOT recommended. If it becomes necessary to switch from one to the other, the switch should be made at the time the repeat injection would have been given

8.8.3 Possible emergency and management

Anaphylactoid reactions may occur immediately following DMPA/Depo-Provera injection. Fortunately, severe anaphylactic reactions are rare. Clients are encouraged to stay in the area for 20 minutes following an injection.

8.8.4 Client instructions

The injectable is a very effective and safe method of contraception if taken regularly.

- When to take the next dose of Depo-Provera:
  3 months after the last injection
- What to do if you miss taking the injection:
- If missed more than two weeks of the expected date of injection, take the injection, but **abstain from sex or use another contraceptive for next 7 days.**
- You may experience prolonged bleeding or spotting. This is not dangerous but is an effect of the injection.
- Explain about the injection.

Post-Injection Counseling

- Repeat the advice about when to return for a repeat injection and if she has any concerns (verbal and written).
- Advise about warning signs and where to go (written and verbal).
- Repeat the side effects and advise to return anytime to the provider.
- Advise her to report if she experiences marked changes or new headaches.
- Give routine follow up instructions: where and when(written and verbal).

Box 8.1 WARNING SIGNS]

See a doctor promptly in the event of:

- severe lower abdominal pain
- possible pregnancy
- severe headaches
- unusually heavy or long bleeding
- severe leg pain
- yellow skin or eyes

8.9 ROUTINE FOLLOW-UP CARE

All clients initiated on progestogen-only injectables are advised to:

- make regular follow up visits every three months (12 weeks) for clients on DMPA and every 2 months (8 weeks) for clients on NET-EN
- return to the facility earlier if she has any concerns, side-effects or if she wants to change the method.
- contact a doctor immediately if she has any of the warning signs in Box 8.1.

At follow-up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects and if so, record them in the client clinical card/record. Check if the client is experiencing any new headaches or marked changes in headaches.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history; measure blood pressure and perform any examination indicated by the history.
- Provide appropriate counselling and/or treatment as required.
- Refer the client to an appropriate referral facility/speciality if any serious problems or side effects cannot be managed at the facility where the client has attended for follow up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- Provide date for next follow up visits for repeat injection.

8.10 SIDE EFFECTS AND MANAGEMENT

Clients should be routinely counselled about common side effects and what to do if certain problems occur. When a client presents with side effects or complications, they should be assessed, counselled and managed appropriately. Refer to Chapter 3 for details on counselling clients with problems using a contraceptive method.

Table 8.1 Side effects and their management for the use of DMPA/Depo-Provera

Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding or spotting)	Rule out pregnancy by checking symptoms; perform a pelvic exam (speculum and bimanual) and a pregnancy test.	Periods of amenorrhoea are common with Depo-Provera users (80%). If pregnancy has been ruled out, there is no need for any medical treatment for the amenorrhoea. Counseling is sufficient. If amenorrhoea is unacceptable to the client, discontinue the injectable and help her choose another method. If **intrauterine pregnancy** is confirmed,

Side Effect	Assessment	Management
		counsel client and refer for appropriate care. Discontinue injections and assure her that the small dose of progesterone to which she was exposed will have no harmful effect on the foetus. If **ectopic pregnancy** is suspected, refer immediately for complete evaluation.
Bleeding/Spotting (prolonged spotting or moderate bleeding) Prolonged spotting: >8 days Moderate bleeding: same as normal menses	Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to another cause (e.g., genital tract lesion such as vaginitis, cervicitis, cervical polyps, cervical cancer or uterine fibroids). If pregnancy (intrauterine or ectopic) or incomplete abortion is suspected, examine and perform pregnancy test.	Light bleeding or spotting is common during POI particularly in the first injection cycle and is not harmful and usually does not require treatment. Reassure her that light intermenstrual bleeding or spotting occurs in a large percentage of women using POI (15–20%). In women with persistent spotting or bleeding after a period of amenorrhoea, exclude gynaecological problems when clinically warranted. If a gynaecological problem has been identified treat the condition or refer for care. If haemoglobin less than 9 g/dl, hematocrit less than 27 or conjunctival pallor significant, give iron or iron folate (1 tablet daily for 1 to 3 months) and nutritional counselling. If anaemia persists, or client requests, discontinue DMPA/Depo-Provera and help client choose another method. If a STI or PID is diagnosed, she can continue her injection while receiving treatment for STI and be counselled on condom use. If no gynaecological problems are found and she finds the bleeding unacceptable, discontinue the injectable. Help her choose another method. If not satisfied after counselling and reassurance, but wants to continue using DMPA/Depo-Provera, give: • A cycle of COCs (30 mcg estrogen) or • Ibuprofen (800 mg three times daily for

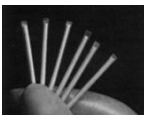
Side Effect	Assessment	Management
		5 days) If pregnancy is confirmed, see **Amenorrhoea** section in this table for management of pregnancy related conditions.
Heavy or prolonged bleeding (more than 8 days or twice as much as her usual menstrual period)	Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to another cause (e.g., genital tract lesion such as vaginitis, cervicitis, cervical polyps or uterine fibroids). If a pregnancy complication such as incomplete abortion is suspected, examine and perform pregnancy test.	If a pregnancy complication or gynaecological problem has been identified, refer for further management. If a pregnancy complication and gynaecological problems have been ruled out, explain to the client that heavy or prolonged bleeding is common in the first injection cycle. If heavy or prolonged bleeding persists and if the bleeding is unacceptable to the client or is a threat to her health, discontinue the injectable and help her choose another method. In the interim, short term treatment a cycle of COCs (30 ethinyl estradiol) may be helpful. Provide iron supplementation.
Lower abdominal pain	Rule out pregnancy by checking symptoms, pelvic exam (speculum and bimanual) and pregnancy test.	If ectopic pregnancy is suspected refer promptly for complete evaluation.
Weight gain	Check if the weight gain occurred while on the injectable. Assess food intake. If no reason found, rule out pregnancy (as above).	If pregnant, advise as described under amenorrhoea in this table. If not pregnant, counsel.
Nausea	Find out whether the injectable is being taken regularly as instructed. Rule out pregnancy (as under amenorrhoea in this table).	If pregnant, advise as under amenorrhoea in this table. If not pregnant and the injectable is being taken regularly, counsel. Refer to specialist if nausea continues to rule out other causes.
Headache	Assess if the headache is	Refer for evaluation if headache is new or

Side Effect	Assessment	Management
	new or there are marked changes in headache.	there are marked changes in headache.
Breast fullness /tenderness	Find out whether the injection is being taken regularly as instructed. Rule out pregnancy (as under amenorrhoea in this table). Rule out breast lumps and ulcer and infection of the breast (if breastfeeding).	If pregnant, advise as under amenorrhoea in this table. If not pregnant and no breast lumps, counsel. Refer to specialist in case of breast lumps or ulcer.

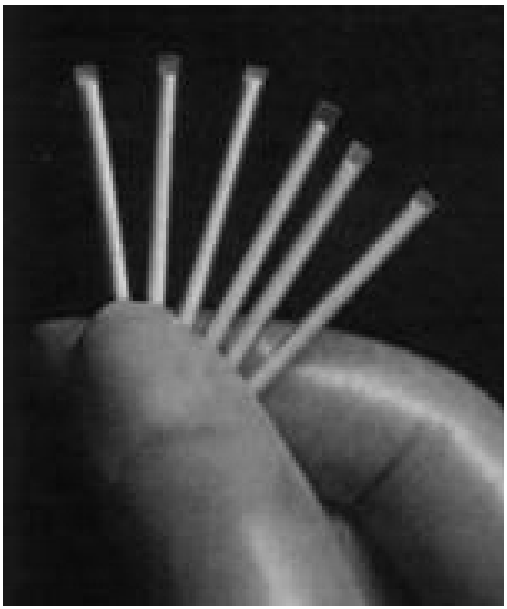
Note: Abortion is illegal in Maldives. A client needs counselling should an unplanned or unwanted pregnancy occur. Unplanned pregnancy may be followed by many conflicting emotions such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

8.11 RECORD KEEPING AND REPORTING

The provider should legibly record information in the Client Clinic Card and Family Planning Register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.



09 Hormonal Implants



Chapter 9: HORMONAL IMPLANTS

9.1 INTRODUCTION

Hormonal implants are a long acting reversible low-dose progestin only method inserted sub-dermally, preferably in the inner side of the upper arm. The discussion in this chapter is mainly on the hormonal implant Norplant.

Hormonal implants do not protect against STI/HIV. If there is a risk of STI/HIV (including the post partum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

9.2 TYPES OF HORMONAL IMPLANTS

Norplant® is the hormonal implant available in Maldives and consists of six capsules. Each capsule with an outer sheath made of silicone is 2.4 mm in diameter and 34 mm in length and contains 36 mg of levonogestrel (total 216 mg). It protects from pregnancy for up to 5 years.

Two other types of hormonal implants are available internationally:

- Norplant 2 / Jadelle® has two rods with outer sheaths made of silicon. Each rod measures 2.5 mm in diameter and 43 mm in length and contains 75 mg of levonorgestrel (total 150 mg). Protection from pregnancy is provided within 24 hours when inserted during the first 7 days of a woman's menstrual cycle. Jadelle can be left in place for up to 5 completed years. Effectiveness of Jadelle is reduced after 4 completed years in women weighing 80 kg or more.
- Implanon® has a single non biodegradable rod. It measures 2 mm in diameter and 40 mm in length and contains 68 mg of Etonogestrel with a release rate of 40 microgram per day. Implanon can be left in place for up to 3 completed years.

The discussion in this chapter is on Norplant.

9.3 EFFECTIVENESS AND RETURN TO FERTILITY

Effectiveness

Norplant implants are one of the most effective reversible long term methods, with effectiveness of 99.95%*. Contraceptive effectiveness of Norplant decreases substantially after year 4 for women weighing 80 kg or more at insertion. Hence, women weighing 80 kg or more should have their implants removed after 4 years of use.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

Return to fertility

When the capsules are removed, the return of fertility is immediate. If the client does not want another pregnancy and does not want to use implants any longer, she should begin using another contraceptive method right away.

9.4 CATEGORY OF PROVIDER

Insertion and removal of hormonal implants can be performed by trained and competent staff nurse, medical officer or gynecologist.

9.5 ELIGIBILITY

9.5.1 Indications for hormonal implants

Hormonal implants should be provided to any women in the reproductive age who requests them after appropriate counselling and reaching an informed decision, and who does not have any contraindication for its use.

Hormonal implants are appropriate for women who:

- prefer a method that does not require taking contraceptive action every day or before having intercourse
- want long-term birth spacing or have the number of children they want but do not want or cannot have a permanent method (voluntary sterilization) at this time
- are breastfeeding (≥6 weeks postpartum) and need a contraceptive
- are post partum but not breastfeeding
- desire contraception after a miscarriage
- have a history of ectopic pregnancy
- smoke
- are obese[16]
- do NOT want or can NOT use estrogen-containing contraceptives, or have developed estrogen-related complications while taking combined oral contraceptives (COCs)
- have endometriosis
- have severe dysmenorrhoea evaluated by a gynaecologist
- have uterine fibroids
- have past or current PID
- have STI infections excluding HIV and Hepatitis B
- have adequately controlled hypertension
- have thalassaemia
- have a history of high blood pressure during pregnancy where current blood pressure is measurable and normal
- have varicose veins and superficial thrombophlebtis
- have thyroid disorders such as goitre, hyperthyroidism and hypothyroidism

[16] Contraceptive effectiveness of Norplant decreases after year 4 for women weighing 70 kg or more at insertion and decreases substantially for women weighing 80 kg or more at insertion. Women weighing 80 kg or more should have their implants removed after 4 years of use.

- have valvular heart disease (complicated and uncomplicated), pulmonary hypertension, irregular heart rhythm (fibrillation) or history of subacute bacterial endocarditis (SBE) (as progestins do not contribute to blood clotting and embolism).

9.5.2 Health workers should consult a doctor when women with the following conditions request hormonal implants

- Thyroid disorders such as goitre, hyperthyroidism and hypothyroidism.
- BP ≥140/90 mmHg
- Valvular heart disease (complicated or uncomplicated)
- Superficial thrombophlebitis
- Thalassaemia
- Diabetes
- Migraine

9.5.3 Contraindications for hormonal implants

- Pregnancy
- Breastfeeding and less than 6 weeks post partum
- Deep vein thrombosis/pulmonary embolism
- Ischaemic heart disease or stroke
- Migraine with aura, at any age
- Unexplained vaginal bleeding
- Active liver disease: viral hepatitis, cirrhosis, liver tumours (benign and malignant)
- Current or past history of breast cancer
- Client on medications such as rifampicin and anti-convulsants such as phenytoin, carbamazepine, barbiturates, primidone, topiramate, oxcarbazepine.

9.6 COUNSELLING AND INFORMED CHOICE

All hormonal implant clients must receive appropriate counselling for selecting and using the method. Encourage and give the client an opportunity to ask all of their questions so that any uncertainties and misunderstandings can be cleared up. Counsel the client that hormonal implants do not protect against STIs or HIV/AIDS

Clearly discuss the following points for selecting the method:

- effectiveness and return to fertility
- mechanism of action, advantages and disadvantages
- alternative family planning methods
- physical characteristic of the implants; how they are inserted and in which part of the body; how they should feel under the skin
- when implant should be removed; importance of removal or replacement at the end of 5 years; follow-up requirements
- possible changes in the menstrual bleeding pattern
- side effects and complications

The client should use condoms in addition if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/AIDS. Counsel clients that breast self examination should be done regularly and that hormonal contraceptives are contraindicated in women with breast cancer.

For more detail information refer to Chapter 2 Overview of FP and Chapter 3 Counselling and Informed Choice.

9.7 CLIENT ASSESSMENT

The purpose of the health assessment is to determine the client's suitability for the use of the method. Pregnancy should be ruled out prior to the provision of contraception. A pregnancy test should be done if there is any suspicion of pregnancy. Refer to Chapter 4 for indications for performing a pregnancy test.

It is also an opportunity to assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI and to offer other available sexual and reproductive health services as appropriate. Refer to Chapter 5 for further details on STI/RTI assessment. The following are mandatory and recommended practices:

Mandatory

- Blood pressure should be checked and eligibility ascertained prior to starting hormonal implants.
- Check body weight prior to insertion and at each follow-up visit.
- All FP clients should be educated and shown how to perform a breast self exam and to report if there are any abnormalities noted.

Recommended[17]

The following examinations are recommended in all women requesting hormonal implants:

- Breast examination by provider*
- Pelvic examination*
- STI risk assessment (refer to Chapter 5 for further information)

Checking baseline body weight and recording it in the Client Clinic Card can be useful information for subsequent follow up visits and deciding on the timing of Norplant removal.

[17] Recommended examinations contribute to safe and effective use of the method as well as being good preventative practice

* Health workers can advise clients to visit a facility and see a doctor or nurse for a breast and pelvic exam.

9.8 PROVISION OF HORMONAL IMPLANTS

9.8.1 Timing of insertion

- Hormonal implants should be inserted only after ruling out pregnancy. A pregnancy test should be done if there is any suspicion of pregnancy.
- Hormonal implants should be inserted any day between the **first (day 1) and seventh day (day 7)** of the client's menstrual cycle. There is no need for back up contraception such as condoms when the implant is inserted within the first 7 days of her menstrual cycle.
- **Post miscarriage**: Hormonal implants can be started any day **within the first 7** days after a complete spontaneous miscarriage, if desired by the client. There is no need for back up contraception such as condoms.
- **Switching from an injectable**: If her previous method was an injectable, she should have the hormonal implant inserted when the repeat injection of the POI would have been given. No other contraceptive protection is needed.
- **Switching from an IUD:** The first injection can be given within 7 days after the **start** of her menstrual bleeding. No additional contraceptive protection is needed. IUD can be removed at the same visit.

9.8.2 Procedure for inserting hormonal implant

Insertion of Norplant is a minor surgical procedure requiring aseptic technique, as well as good surgical technique. Norplant is inserted sub-dermally on the upper inner arm or forearm, under local anesthesia. Norplant should not be inserted deep as this makes removal very difficult.

9.8.3 Removal of hormonal implant

Norplant capsules can be left in place for 5 completed years when it should be removed.
However, as contraceptive effectiveness of Norplant decreases substantially after year 4 for women weighing 80 kg or more at insertion, women weighing 80 kg or more should have their implants removed after 4 years of use.

9.8.4 Client instructions following insertion of hormonal implant

Wound care
The following instructions should be given to the client regarding wound care:

- Keep the area dry and clean for at least 3 days. The incision could become infected if the area gets wet while bathing or washing clothes.
- There may be bruising, swelling or tenderness at the insertion site for a few days. This is normal.
- Routine work can be done immediately, but do not put unusual pressure on the area for a few days.
- Leave the gauze pressure bandage in place for 3 to 5 days to avoid having people touch the area while it is still tender.

- If signs of infection occur, such as fever, inflammation (redness with heat) at the site, or if there is persistent pain for several days, return immediately to the clinic/ hospital.

Advise on side effects, warning signs and where to go. Give routine follow-up instructions – where and when.

Box 9.1 WARNING SIGNS

See doctor promptly in the case of:

- severe lower abdominal pain
- possible pregnancy
- unusually heavy or long bleeding
- very bad headaches
- severe leg pain
- yellow skin or eyes

9.9. ROUTINE FOLLOW-UP CARE

All clients provided hormonal implants are advised:

- have routine yearly follow-up
- return to facility earlier if she has any concerns, side-effects or if she wants to change the method
- contact a doctor immediately if she has any of the warning signs in Box 9.1
- return to the facility when it is time to have hormonal implant removed.

At follow up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects and, if so, record them in the client clinical card/record. Check if client has new or marked changes in headaches.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history; measure blood pressure and perform any examination indicated by the history.
- Check body weight. As contraceptive effectiveness of Norplant decreases substantially after year 4 for women weighing 80 kg or more at insertion, women weighing 80 kg or more should have their implants removed after 4 years of use.
- Provide appropriate counselling and/or treatment as required.
- Refer client to an appropriate referral facility/speciality if any serious problems or side effects cannot be managed at the facility were client has attended for follow up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- Provide a date for the next routine follow-up visit.

9.10 SIDE EFFECTS AND MANAGEMENT

Clients should be routinely counselled about common side effects and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counselled and managed appropriately. Refer to Chapter 3 for details on counselling clients with problems using a contraceptive method.

Table 9.1 Management of side effects for the use of hormonal implants

Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding or spotting)	Rule out pregnancy by checking symptoms, perform a pelvic exam (speculum and bimanual) and a pregnancy test	Amenorrhoea in the absence of pregnancy does not require any management/medical treatment. Counseling is sufficient as amenhorrhoea occurs in about 70% of Norplant implants users. If client finds amenorrhoea unacceptable, the implants should be removed and client should be assisted to choose another contraceptive method. If intrauterine pregnancy is confirmed, counsel and refer for appropriate care. Remove all capsules and assure her that the small dose of hormone (levonorgestrel) to which she was exposed will have no harmful effect on the foetus. If ectopic pregnancy is suspected, refer promptly for complete evaluation.
Bleeding/Spotting (Prolonged spotting or moderate bleeding) Prolonged spotting: more than 8 days Moderate bleeding: same as normal menses	As appropriate: Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to other cause (e.g., genital tract lesion such as vaginitis, cervicitis, cervical polyps or uterine fibroids). If pregnancy (intrauterine or ectopic) or miscarriage is suspected, examine and perform pregnancy test if indicated and	If no abnormality on examination, reassure her that light intermenstrual bleeding or spotting occurs in a large percentage of women using Norplant implants (50–80%) during the first year of use. It is not serious and usually does not require treatment. Most women can expect their bleeding pattern to become more regular after 6–12 months. If client at any time feels that the side effects are unacceptable the implants should be removed and she should be assisted to choose another method of contraception. If abnormality of the genital tract is found, treat the problem if possible or refer for treatment. Do not discontinue Norplant implants. Advise client to return for

Side Effect	Assessment	Management
	available. Check Hb if clinically indicated	additional counselling after management of problem If a STI or PID is diagnosed, she can continue using implant while receiving treatment and be counselled on condom use. If haemoglobin less than 9 g/dl, hematocrit less than 27 or conjunctival pallor significant, give iron or iron folate (1 tablet daily for 1 to 3 months) and nutritional counselling. If anaemia persists, or client requests, discontinue Norplant implants and help client choose another method. If not satisfied after counselling and reassurance, but wants to continue using implants, give: • Hormonal (if medically eligible) : low dose COCs (A cycle of COCs (30 mcg ethinyl estradiol) • Non hormonal: Non steroidal anti-inflammatory drugs (NSAID) eg Ibuprofen (800 mg 3 times daily for 3 days) If pregnancy is confirmed, see Amenorrhoea section above for management of pregnancy related conditions.
Heavy or prolonged bleeding (more than 8 days or twice as much as her usual menstrual period)	Perform a pelvic exam (speculum and bimanual) to be sure bleeding is not due to other gynaecological causes. Check her haemoglobin (Hb)	If no gynaecological problem and she desires treatment, treat with non hormonal or hormonal method as given above. If haemoglobin less than 9 g/dl, hematocrit less than 27 or conjunctival pallor significant, give iron or iron folate (1 tablet daily for 1 to 3 months) and nutritional counselling. If anaemia persists, or client requests, discontinue Norplant implants and help client choose another method. If she does not desire treatment, or the treatment is not effective and the bleeding becomes a threat to her health, or the

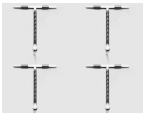
Side Effect	Assessment	Management
		method is not acceptable to her , the implant should be removed and client counseld and assisted to choose another method of contraception.
Lower abdominal pain	Rule out pregnancy by checking symptoms, pelvic exam (speculum and bimanual) and pregnancy test	If ectopic pregnancy is suspected, refer promptly for complete evaluation.
Headache	Assess if headache is new or if there are marked changes in headache.	If headache is new or there are marked changes refer for further evaluation.
Capsule / Rod Expulsion	Check for partial or complete expulsion of capsules/ rod.	Remove partially expelled capsule(s). If an area of insertion is not infected (no pain, heat and redness) replace with new capsules. If area of insertion is infected, see "Infection" below.
Infection at site of insertion	Check area of insertion for infection (pain, heat and redness), pus or abscess.	If infection (not abscess): • Do not remove capsules, and instruct client not to attempt to remove the capsules. • Cleanse with (soap and water or antiseptic). • Give appropriate oral antibiotic for 7 days. • Ask client to return after 1 week. If no improvement, remove capsules and insert a new set in the other arm or help client choose another method. Continue to treat infection with 7 additional days of antibiotics.
Weight gain	• Check if the weight gain is while on the implant • Assess food intake • If no reason found, rule out pregnancy (as above)	• If pregnant, advise as above • If not pregnant, counsel
Nausea	• Rule out	• If pregnant, advise as above

Side Effect	Assessment	Management
	pregnancy (as above)	• Refer to specialist if nausea continues to rule out other causes.
Breast fullness /tenderness	• Rule out pregnancy (as above) • Rule out breast lumps /ulcer and infection of the breast (if breastfeeding)	• If pregnant, advise as above • If not pregnant and no breast lumps, counsel • Refer to specialist in case of breast lumps or ulcer.

Note: Abortion is illegal in Maldives. A client needs counselling should an unplanned or unwanted pregnancy occur. Unplanned pregnancy may be followed by many conflicting emotions such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

9.11. RECORD KEEPING AND REPORTING

The provider should legibly record information in the Client Clinic Card and Family Planning Register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.



10 Intrauterine Device

Chapter 10: INTRAUTERINE DEVICES (IUD)

10.1 INTRODUCTION

Intra uterine devices (IUD), also referred to as intra uterine contraceptive devices (IUCD), are small flexible devices made of metal or plastic that are inserted into the uterus through the vagina. The IUD is a safe effective long term reversible method of contraception. The IUD discussed in this chapter is Copper T 380A/TCu-380A.

Intra uterine devices do not protect against STI/HIV. If there is a risk of STI/HIV (including the post partum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

10.2 TYPES OF IUD AVAILABABLE

The IUD currently available in Maldives is the Copper T 380A/TCu-380A. The Copper T 380A is shaped like a T and has copper on the stem and the arms, with a total exposed copper area of 380 square mm. It has a white string at its base, which extends through the cervix so that the IUD can be removed easily.

Multiload 375 (ML Cu 375) is another copper IUD that might be available in Maldives. Multiload 375 is effective for 5 years.

Levonorgestrel-releasing IUD (Mirena®/LNG IUD) is a newer IUD available in many countries. Each levonorgestrel IUD contains 52 mg of levonorgestrel (releasing 20 microgram per 24 hours) and is effective for 5 years. The perfect use and typical use effectiveness for the levonorgestrel-releasing IUD is 99.9%*.

10.3 EFFECTIVENESS AND RETURN OF FERTILITY

Effectiveness

The TCu-380A is the most cost-effective reversible contraceptive on the market today, with effectiveness* of 99.4% with perfect use and the typical use effectiveness of 99.2%. After insertion, the effective contraceptive action lasts 10 years. Note that an IUD inserted into a client just before the shelf life of the packaging expires is still effective for up to 10 years.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use. Source WHO, Medical Eligibility Criteria, 3 rd edition, 2004

Return to fertility

Fertility returns immediately after the removal of IUD.

10.4 CATEGORY OF PROVIDER: INSERTION AND REMOVAL OF IUD

IUD insertion can be performed by trained and competent gynecologists, medical officers and staff nurses. IUD removal with visible strings can be performed by trained and competent staff nurses, medical officers and gynecologists. IUD removal with missing strings should be done only by trained and competent gynecologists.

10.5 ELIGIBILITY

10.5.1 Indications

IUD should be provided to any woman who requests it after appropriate counselling and reaching an informed decision, and who does not have any contraindication to its use.

IUD is appropriate for those who:

- prefer a method that provides highly effective, long-term contraception, but do not want a permanent method such as voluntary sterilization
- prefer a method that does not require taking contraceptive action daily or before sexual intercourse
- prefer not to use a hormonal contraceptive method such as combined oral contraceptive pills or have contra indications for its use
- have one or more children
- are breastfeeding and need a contraceptive
- have successfully used an IUD in the past
- are at least 4 weeks post partum and menses has returned, breastfeeding or not breastfeeding, including after Caesarean section
- have had a miscarriage in the absence of sepsis
- smoke
- are obese
- have hypertension
- have a history of DVT
- have a history of migraine
- have a history of breast disease including current or past breast cancer
- have difficulty obtaining contraceptives on a regular basis.

Note:
IUD can be provided to women at low risk of contracting STIs (i.e. women in a mutually faithful sexual relationship).

10.5.2 Health workers should consult a doctor when women with the following conditions request hormonal implants

- anaemia
- thalassaemia
- past ectopic pregnancy[18]
- valvular heart disease[19]
- history of PID
- HIV infection

10.5.3 Contraindications

The contraindications for the use of IUD are:

- pregnancy
- post partum <4 weeks
- immediate post septic abortion
- excessive, unexplained or irregular vaginal bleeding
- increased risk of STI, both self and spouse
- current pelvic inflammatory disease
- STI currently or within the last 3 months (current purulent cervicitis, chlamydial or gonococcal infection)
- AIDS
- known pelvic tuberculosis
- cervical cancer, endometrial cancer, ovarian cancer
- known to have distorted uterine cavity (due to congenital uterine abnormalities, uterine fibroids) as it will be difficult to insert IUD, and the chances of expulsion/ perforation are high
- malignant trophoblastic disease as management of this disease can require multiple uterine curettages.

10.6 COUNSELLING AND INFORMED CHOICE

All IUD clients must receive appropriate counselling for selecting and using the method. Review the woman's history to determine the possibility of existing contraindications to the method, such as the risk of STIs, and take this into account when providing counselling. Encourage clients to ask all of their questions so that any uncertainties and misunderstandings can be cleared up. It is important to counsel clients that IUD do not protect against STI/HIV. If STI/HIV/AIDS protection is needed condoms should be used in conjunction with IUD.

[18] The absolute risk of ectopic pregnancy is extremely low due to the high effectiveness of IUDs. However, when a woman becomes pregnant during IUD use, the relative likelihood of ectopic pregnancy is greatly increased.

[19] Women with health conditions, e.g. cardiac valve disorders, that warrant antibiotic prophylaxis for invasive procedures will need antibiotic prophylaxis for Cu bearing IUD insertion.

For more detailed information refer to Chapter 3 Counselling and Informed Choice and Chapter 5 on STI assessment.

10.6.1 IUD method specific counseling

Specific points to be noted while counselling for IUD:

- Show the client a sample IUD (type to be inserted) and let them feel the IUD.
- Explain that TCu-380A is effective immediately after insertion.
- Describe the mechanism of action, advantages and disadvantages.
- Talk about rumours and clarify as needed. (See Appendix 4)
- Explain the timing and procedure of insertion.
- Explain that during the insertion, the client might feel some pain.
- Describe likely problems and complications.
- Emphasise the importance of checking the threads.
- Highlight the importance of follow-up.
- Describe side effects and warning signs.
- Advise use of condom if at risk for STI, HIV/AIDS.

10.7 CLIENT ASSESSMENT

The purpose of the health assessment is to determine the client's suitability for the use of the method. It is also an opportunity to offer other available sexual and reproductive health services as appropriate. All FP clients should be educated and shown how to perform a breast self exam and to report if there are any abnormalities noted.

Pregnancy should be ruled out prior to the provision of IUD. A pregnancy test should be done if there is any suspicion of pregnancy. Refer to Chapter 4 for indications for performing a pregnancy test.

Medical/social/gynaecological/obstetric history:

History taking should be done as detailed in Chapter 4. It is mandatory to do STI risk assessment by medical history (history of STIs, including HIV and PID, and risk factors for STI such as multiple sexual partners) and physical examination.

Physical examination

Mandatory:

1. Abdominal examination (especially lower abdominal tenderness, or masses)
2. Pelvic examination – speculum visualization of cervix and bimanual pelvic examination. Bimanual vaginal examination is done to identify the position of the uterus (anteverted or retroverted) and to rule out pregnancy, PID, other pathology of the uterine cavity and overt malignancies.
3. Other examination can be done as indicated by the medical history.

Recommended:
The following are recommended as good preventative health measures.

1. Blood pressure check
2. Breast examination by provider*

Laboratory tests are not routinely required for the use of an IUD except when indicated by medical history and physical examination. Haemoglobin testing is recommended prior to provision of an IUD to have a baseline result.

10.8 PROVISION OF IUD

Infection prevention must be strictly followed for safe insertion and removal procedures. For more detail information, refer to Appendix 3 Infection Prevention

10.8.1 Timing of insertion of the IUD

- IUD should be inserted only after ruling out pregnancy. A pregnancy test should be done if there is any suspicion of pregnancy.
- IUD should be inserted any day between first (day 1) and seventh day (day 7) of the client's menstrual cycle. There is no need for back up contraception such as condoms when IUD is inserted within the first 7 days of her menstrual cycle.
- Post miscarriage in the absence of sepsis/pelvic infection: IUD can be inserted immediately up to the first 7 days after a complete spontaneous miscarriage, if so desired by the client. There is no need for back up contraception such as condoms.
- Switching from POI: IUD can be inserted when the repeat injection of the POI would have been given. No other contraceptive protection is needed.

10.8.2 Technique of IUD insertion

Provision of IUD should be done using aseptic precautions, as well as good surgical technique. A careful pelvic examination is mandatory prior to insertion of the IUD. The uterus is sounded to determine the length of the uterus. 'No touch' technique is used to load the IUD into the inserter. After introducing the loaded IUD into the uterine cavity, the final placement of the TCu-380A is done using the withdrawal technique.

10.8.3 Role of prophylactic antibiotics for IUD insertion

Routine prophylactic antibiotics are not required for insertion of IUD in healthy women.

* Health workers can advise clients to visit a facility and see a doctor or nurse for a breast and pelvic exam.

Note: Women with health conditions e.g. cardiac valve disorders that warrant antibiotic prophylaxis for invasive procedures will need antibiotic prophylaxis for Cu bearing IUD insertion.

Box 10.1 IUD AND PREGNANCY

Suspected pregnancy or confirmed pregnancy

IUD should NOT be inserted if pregnancy is suspected or confirmed.

If a woman using Copper IUD is found to be pregnant

- Exclude ectopic pregnancy.
- Explain that she is at an increased risk of first and second trimester miscarriages (including septic miscarriage that may be life threatening) and of pre-term delivery if the IUD is left in place. The removal of the copper bearing IUD reduces this risk, although the procedure itself entails a small risk of miscarriage. Advise the client to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.

Copper IUD strings are visible or can be retrieved safely from the cervical canal

- Advise the client it is best to remove the IUD.
- If the Cu IUD is to be removed, then remove by gently pulling on the strings.
- Explain that she should return promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.
- If she chooses to keep the Cu IUD, advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.

Copper IUD strings are NOT visible or cannot be safely retrieved

- If ultrasound is available, it may be useful in determining the location of the Copper IUD. If the Copper IUD is not located, this may suggest that it might have been expelled.
- If ultrasound is not available or if the Copper IUD is determined by ultrasound to be inside the uterus, make clear the risks and advise her to seek care promptly if she has heavy bleeding, cramping, pain, abnormal vaginal discharge or fever.

Note:
Abortion is illegal in Maldives. A client needs counselling should an unplanned or unwanted pregnancy occur. Unplanned pregnancy may be followed by many conflicting emotions such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

10.8.4 Removal of IUD

Removal of IUD is a simple procedure. A speculum examination is done, IUD thread is grasped close to the cervix with sponge holding forceps/artery forceps and gently pulled out using steady gentle traction. If the removal requires more than a gentle traction, the client should be referred to a specialist.

Indications for removal and/or re-insertion of IUD

An IUD may be removed for medical or personal reasons:

- 10 years after of insertion of TCu-380A – this should be done preferably during menstrual period. A new IUD can be re-inserted at the same time if the client desires. Use a new TCu-380A for re-insertion.
- Wants another child
- Desires removal
- Severe bleeding
- Severe abdominal pain
- Pelvic infection not responding to treatment
- Pregnancy
- Menopause (cessation of periods for one year)
- Evidence of IUD displacement

If an IUD is being re-inserted, make sure that the client is not pregnant.

If there is difficulty with removal, including breaking of the string, excessive pain or a question of perforation or embedding of the IUD, the client should be referred to a gynaecologist and removal be done in a fully-equipped facility

10.8.5 Management of possible problems during insertion and removal

Table 10.1 Management of problems DURING insertion or removal of IUD

Problem	Assessment	Management
Fainting (syncope); slow heart rate (bradycardia) or vasovagal episode during IUD insertion or removal	Is woman extremely anxious? Does she have a small uterus or cervical stenosis? (These characteristics increase risk for fainting and/or vasovagal reaction.)	• Every step of IUD insertion and removal should be done slowly and very gently, with an explanation of each step to the client. • If available, aspirin, acetaminophen or ibuprofen may reduce pain associated with IUD insertion or removal. Provide 30 minutes prior to procedure and for 24 hours afterwards. • Maintain a calm, relaxed, unhurried atmosphere and a gently reassuring approach to the client. • At the earliest sign of fainting, stop the insertion. Resume the procedure once the episode has passed and client desires.

Problem	Assessment	Management
IUD sterile package damaged	Inspect package before use. Be alert for break in seal or plastic cover.	• Discard and use another IUD from a sterile package.
Suspected uterine perforation (during uterine sounding or IUD insertion)	Client complains of suddenly significant pain during procedure. There is feeling of giving way Sound measures more than 9 centimeters	• Stop the procedure (and remove IUD if inserted). • Check pulse and BP. • If the pulse is rapid, the blood pressure is low or the pain is severe around the uterus, hospitalize, start IV fluids and refer the client to a specialist. • If the pulse and blood pressure are normal, make the client lie down and check the pulse and blood pressure every 15 minutes for an hour. • **If the client is stable**, make her sit up and walk around and observe her for another hour. **If stable**, send her home with instructions to avoid intercourse for a week. Counsel for another FP method.

10.8.6 Client instructions post IUD insertion

Instruct clients on following points:

Checking strings

The client will need to check for the strings of the IUD to be sure it is in place. During the first month after insertion, she should check the strings several times. After that, she needs to check them after each menstrual period only. Provide verbal and written instructions.

Steps for checking IUD strings:

- Wash hands.
- Sit in a squatting position or put one foot up on a step or a ledge.
- Insert either second or middle finder into the vagina to find the opening to the uterus (the cervix). She will know it because it feels firm, like the tip of her nose.
- Feel for the strings. If she feels the strings, it means that the IUD is correctly in place. She must never pull on the strings. This could cause the IUD to come out and could damage the cervix.
- If she cannot feel the strings, if they feel longer or shorter than normal, or if she feels the stem of the IUD protruding from the cervix, she should return to the clinic for a check-up. She should not have intercourse until the IUD is replaced unless she uses another contraceptive method.

- Since most expulsions occur during menstruation, the IUD user should check menstrual cloths, pads or tampons, as well as the toilet or latrine, during menstrual periods. If the device is expelled accidentally, she should return to where she received her IUD for possible insertion of another IUD. She should use another contraceptive method until her IUD is replaced.

Changes in the client's menstrual periods
For most women the first few periods will be heavier, last longer and may have more cramping. There might also be inter-menstrual bleeding or spotting. This is not harmful. However, if the bleeding lasts twice as long as usual or if she uses twice as many pads, cloths or tampons, she should see a health care provider.

Special concerns for return visits
A woman should get medical help as soon as possible if she has any of the warning signs. Provide verbal and written instructions on warning signs and where to go. (Refer to Box 10.2)

In addition, if either the women or her husband begins having sexual relations with other partners without using condoms, this increases her risk of getting a sexually transmitted disease because IUDs do not protect against them.

Routine follow-up visit
Give verbal and written instructions on where and when.

Box 10.2 WARNING SIGNS

See doctor promptly in the case of:

- Severe lower abdominal pain
- Missed period, possible pregnancy
- Severe vaginal bleeding
- Infection exposure (such as gonorrhea), abnormal discharge
- Fever and/or chills, especially if accompanied by lower abdominal pain
- Strings missing, shorter or longer then usual, or the tip of the IUD can be felt when she is checking for the strings.

10.9 ROUTINE FOLLOW-UP CARE

- Routine follow-up after the first menses to check if IUD is in place and to rule out any infection.
- Routine subsequent follow up every 6 months.
- Advise the client to return to the facility earlier if she has any concerns or if she wants to change the method.
- Advise the client to contact doctor immediately if she has any of the warning signs in Box 10.2.
- She should return to the facility for IUD removal. TCu-380A lasts for 10 years.

At follow-up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects and, if so, record them in the client clinical card/record.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history.
- Perform clinical examination. Pelvic examination (speculum examination and bimanual vaginal examination) is mandatory to check for IUD strings or any signs of STI/RTI.
- Perform other clinical examinations indicated by the history or findings.
- Provide appropriate counselling and/or treatment as required.
- Refer the client to an appropriate referral facility/specialty if any serious problems or side effects cannot be managed at the facility were she has attended for follow-up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- Provide a date for the next follow-up.

10.10 SIDE EFFECTS AND MANAGEMENT

Clients should be routinely counselled about common side effects and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counselled and managed appropriately. Refer to Chapter 3 for details on counselling clients with problems using a contraceptive method.

Box 10.3 IUD AND PELVIC INFLAMMATORY DISEASE (PID)

Women using IUD diagnosed with PID

- Treat PID using appropriate antibiotics.
- There is no need to remove IUD if she wishes to continue its use.
- If she does not want to keep IUD, remove it AFTER antibiotic treatment has been started.
- If the infection does not improve, remove IUD and continue antibiotics.
- Provide comprehensive management for STI, including partner management and counselling about condom use.

Table 10.2 Management of side effects of IUD

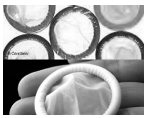
Side Effect	Assessment	Management
Amenorrhoea (absence of vaginal bleeding or spotting)	Ask client: • when she had her last menstrual period • when she last felt the IUD strings • if she has symptoms of pregnancy Rule out pregnancy (intrauterine or ectopic) by checking symptoms, and performing a pelvic exam (speculum and bimanual) and a pregnancy test	If pregnancy is ruled out, no treatment is required except counselling and reassurance. Explain that blood does not build up in the uterus. Advise the client to return to the IUD provider for further evaluation if amenorrhoea remains a concern. If the client is over 48 years, amenorrhoea could be due to menopause. Refer to Box 10.1 for management of a client with IUD found to be pregnant.
Irregular bleeding with or without symptoms of pregnancy	Perform abdominal and pelvic (speculum and bimanual vaginal) examination to check for infection, pelvic pain or tenderness, palpable adnexal mass or enlarged uterus (consistent with pregnancy).	**Ectopic pregnancy** must be suspected in clients with irregular bleeding and/or abdominal pain. Refer promptly to an appropriate facility for complete evaluation if ectopic suspected. If other gynaecological problems are identified, refer for further management. If less than 3 months and no evidence of pregnancy or pathology, counsel client that spotting or bleeding is common during the first 3 to 6 months after insertion of Copper IUD and decreases over time. If she desires treatment, a short course of NSAID may be given during the days of the bleeding. If there are no other gynaecological problems and if the client finds bleeding unacceptable, remove the IUD and assist her to choose another method.

Bleeding (heavy/prolonged) Amount: more than normal period Duration: more than 8 days	Perform pelvic examination (speculum and bimanual) to be sure that client does not have: • intrauterine or ectopic pregnancy • incomplete abortion • vaginal, cervical or pelvic infection Check for clinical signs of anaemia: Check Hb	If client has had IUD less than 3 months: • If exam is normal, reassure and give iron tablets (1 tablet daily for 1–3 months). Ask client to return in 3 months for another check. Use NSIAD, such as ibuprofen, during bleeding episodes, if available, to decrease bleeding (800 mg 3 times daily for 1 week). NOTE : ASPIRIN SHOULD NOT BE USED AS TREATMENT FOR BLEEDING • If bimanual examination shows enlarged or irregular uterus due to fibroids, tell client of the problem and refer for evaluation. • Remove the IUD if bleeding worsens and client is anaemic or requests removal, and help her to select another method. • Provide iron supplement and/or encourage foods containing iron.
Missing strings	Ask the client whether she knows if the IUD has come out/been expelled. If client does not know if IUD was expelled, check if she is pregnant by history, physical, abdominal and pelvic examination and a pregnancy test. If she returns while menstruating and strings are not visible, rule out lost IUD or perforation. If she returns with delayed (more than 4 weeks) menses, check for pregnancy (pelvic exam, Pregnancy test).	If IUD expelled and there is no evidence of pregnancy or infection counsel for reinsertion. If an ectopic pregnancy (lower abdominal pain, spotting, cramping) is suspected, refer promptly to an appropriate facility for complete evaluation. If examination/test reveals intra uterine pregnancy, refer to Box 10.1 IUD and pregnancy. If strings are missing refer to specialist for further evaluation If strings are seen, reassure client that strings are present and help her feel them.
Partner complains about strings	Check to be sure that IUD is in place (i.e., not partially expelled).	Counsel client that one option is to cut strings close to the cervical os and inform her that she will no longer be able to feel strings. Record in the chart that strings have been cut to the level even with cervical os for future removal.
Vaginal	Do pelvic exam. Rule	Refer for evaluation and further management.

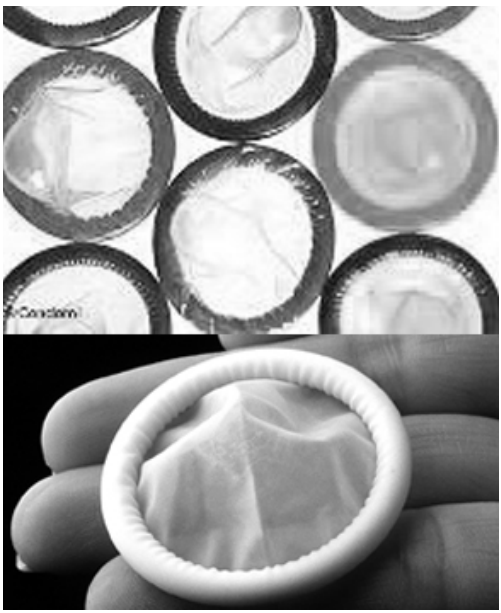
discharge	out pelvic tenderness	

10.11 RECORD KEEPING AND REPORTING

The provider should legibly record information in the Client Clinic Card and Family Planning Register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.



11 Barrier Methods



Chapter 11: BARRIER METHODS

11.1 INTRODUCTION

Barrier contraceptive methods act in one or more ways to prevent pregnancy. Mechanical barriers such as male condoms, female condoms and diaphragms, prevent the sperm from entering the vagina and uterine cavity.

If there is risk of STI/HIV (including during pregnancy or post partum) condoms should be used correctly and consistently. Male latex condoms also protect against STI/HIV.

11.2 TYPES OF BARRIER METHODS

Male condoms are widely available in Maldives. Other barrier contraceptive methods are various kinds of spermicides, female condoms and diaphragms.

A condom is a sheath made of thin latex (synthetic rubber) that is put on a man's erect penis before intercourse. However some condoms are made of animal tissue (lamb caecum) or of polyurethane**.** Condoms prevent pregnancy by creating a barrier, which prevents the sperms from entering the vagina and thereby preventing fertilization of the ovum. Male latex condoms also protect from STI and HIV/AIDS.

Condoms used correctly and consistently are the only method currently available for DUAL PROTECTION[20], i.e. they prevent unwanted pregnancy as well as STIs including HIV/AIDS.

11.3 EFFECTIVENESS OF MALE CONDOMS

If used correctly and consistently, condoms are 98% effective* in preventing pregnancy. However, the typical use effectiveness* is only 85%.

11.4 CATEGORY OF PROVIDERS

Condoms are available free of charge from NGO clinics and public facilities. Male condoms can be purchased from pharmacies. It is important that personnel who provide condoms both in health facilities as well as pharmacies should be trained in providing correct information regarding condom effectiveness and the correct use of

[20] Dual protection refers to preventing both STI/HIV and unwanted pregnancy. This can be achieved by the correct and consistent use of condoms alone or by simultaneous use of 2 methods, one of which is a condom.
Dual method use refers to using a barrier method for protection against STI/HIV and another method for contraception.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

condoms. Printed information sheets should be provided with condoms supplied in pharmacies.

11.5 ELIGIBILITY

Barrier methods should be provided to any client who requests them, who has received appropriate counselling and made an informed decision.

Indication
Condoms are appropriate for most couples because they rarely cause any side effects. They are also appropriate for couples:

- where the husband wants to actively participate in family planning
- who need or desire protection against STIs, including HIV
- where the wife has conditions that are considered precautions for other methods of contraception
- where the wife is within the first 6 months of lactation and wants to use a contraceptive
- waiting for surgical contraception or IUD insertion
- who need a temporary alternative or backup to another method (e.g. for the first 3 months following vasectomy).

Precautions
Allergy to latex in either man or woman.

11.6 COUNSELLING AND INFORMED CHOICE

In the process of assisting clients (male or female) to decide a barrier method, they should be counseled on the use of contraception in general, including other methods, and their advantages and disadvantages. Confidentiality is important and should be ensured even when condoms are provided through pharmacies and public outlets.

- Clients requesting condoms should receive appropriate counselling for selecting and using the method, whenever possible and convenient for them. Counselling helps to ensure informed choice and proper condom use. However, counselling should not be a prerequisite for providing condoms.
- As for other methods the following should be included in counselling:
    - effectiveness and the importance of correct and consistent use
    - advantages and disadvantages
    - alternative methods of contraception

  Clarify rumours related to condoms (refer to Appendix 4) and counsel regarding fears about breakage of condoms.
- While instructing a male or female client, show them the condom. Demonstrate using anatomical models/illustrations (if possible).
- As with female clients, male counselling should include information on reproduction, sexuality and contraception, and should involve the use of flipcharts and anatomical models.

- When condoms are provided through pharmacies and other freely accessible outlets it is important that written instructions for use are provided with the condoms.
- Couple counseling should be encouraged.
- Ensure that the client has understood the correct use of condoms

For more details on counselling refer to Chapter 3 Counselling and Informed Choice.

11.7 CLIENT ASSESSMENT

The purpose of the health assessment is to determine the client's suitability for the use of a method. It is also an opportunity to assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI and to offer other available sexual and reproductive health services as appropriate. Refer to Chapter 5 for further details on STI/RTI assessment.

11.8 PROVISION OF CONDOMS

11.8.1 Client instructions for condom use

- **When should you use a condom:**
  - Use a condom **every time** with **every act of intercourse**.
  - Be sure you have a condom before you need it.
  - Each condom should be used only once and discarded.
- **How to check the expiry date on the packet**
- **How to use the condom correctly:**
  - Put the condom on the penis when it is erect and before the penis is in contact with the spouse's genitals.
  - Remove the condom carefully from the packet taking care not to tear it.
  - Do not unroll the condom before it is put on the penis.
  - Place the condom on the erect penis ensuring that the rolled rim remains on the outside of the condom.
  - **Squeeze the tip of the condom** to ensure that half an inch air free space is left to collect the ejaculate. In case of condoms with a readymade tip, squeeze the tip first to expel air. Care should be taken not to tear the condom with fingernails.
  - Continue to squeeze the tip while unrolling it all the way to the base of the penis.
  - Cover the penis fully to preventing slip of condoms as well as preventing contact with ulcers (if present) on the penis or in the vagina.
  - After intercourse, hold the rim of the penis before coming out of the vagina to prevent slippage of the condom and spilling of contents in the vagina.
  - Pull the penis out before it goes limp so that the condom does not slip and get left in the vagina which will result in the ejaculate spilling and causing a pregnancy or transmitting STIs / HIV.
  - Slide the condom off slowly without spilling the contents **only after** the penis is pulled out of the spouse and is not in contact with the spouse.
  - Tie a knot over the mouth of the used condom so that the contents do not spill and dispose of the used condom in a rubbish bin or by burying or burning it.

  - Use a new condom if the condom has not been properly put on or there is a breakage.
- **If the condom slips or breaks:**
  - Immediately wash the genitalia with soap and water to minimize risk of pregnancy and STIs/HIV.
  - Contact a health worker for emergency contraception.
- **Instruct on the following:**
  - Do not use the condom if it is discolored or brittle.
  - Do not test the condoms for holes as it is already electronically tested.
  - Do not lubricate the condom as it is already lubricated.
- **Storage of condoms**
  - Make sure supplies are adequate. (Keep an extra supply of condoms on hand.)
  - Store condoms in a cool and dry place and not exposed to sunlight as heat and sunlight cause breakage of condoms.
  - The date on the condom package is the date that the condom was manufactured, not the expiration date. Under proper storage conditions the condom should be safe for 5 years.
- **Ask the client to demonstrate proper use of condoms**
- **Instructions for return visit**
  - Return to the provider if your spouse or you are not satisfied with the method.
  - In case of allergy, return to the provider for advice.
  - Return after one month or earlier for supplies. Provide information on other sources of supplies (if any).

11.9 ROUTINE FOLLOW-UP CARE

No routine follow up visit is required. The client can return for further supplies as required. Advise the client to return at anytime if he/she has any concerns or if he/she wants to change the method.

At follow-up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems or side effects and, if so, record them in the client clinical card/record.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history and perform any examination indicated by the history.
- Provide appropriate counseling and/or treatment as required.
- Refer client to an appropriate referral facility/specialty if any serious problems or side effects cannot be managed at the facility were client has attended for follow-up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- Replenish supplies.

11.10 SIDE EFFECTS AND MANAGEMENT

Clients should be routinely counseled about common side effects and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counseled and managed appropriately. Refer to Chapter 3 for details on counseling clients with problems using a contraceptive method.

Table 11.1 Management of side effects of the condom

Side effect or problem	Assessment	Management
Condom broken before or after use	Check for holes	Before use: advise to use a new condom. After use: advise to wash the genitalia with soap and water immediately. Provide emergency contraception as discussed in Chapter 15.
Local irritation to penis or vagina	Rule out allergy	If allergic to latex, counsel for another method.
Diminished sexual pleasure		Counsel for another method.

Note: Abortion is illegal in Maldives. A client needs counseling should an unplanned or unwanted pregnancy occur. Unplanned pregnancy may be followed by many conflicting emotions such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

11.10.1 Quality control

Any programme offering barrier methods must have a system to ensure that the products offered are of acceptable quality and size. This requires:

- Proper transport and storage.
- A 'check' system to make sure that the products are not used after their expiry dates or after their recommended shelf life.
- A procedure put in place to ensure that samples of the products are checked or tested every 3 - 6 months.
- Testing of the product before distribution.
- Purchase of the condoms from a government approved supplier.

11.11 RECORD KEEPING AND REPORTING

Formal registration is not required for obtaining condoms. However, the health facility or health worker can maintain a register for recording clients and information on the number of condoms distributed.

.12 OTHER BARRIER METHODS

11.12.1 Female condoms

The female condom is a loose plastic sheath that is inserted into the vagina before sexual contact and helps to protect against both pregnancy and STIs/HIV. However it may be less effective than the male condom in preventing pregnancy, HIV and other STIs. Female condoms may be more effective against pregnancy when used consistently i.e. at each act of sexual intercourse and when combined with another method. However female condoms cannot be used at the same time as the male condom. The female condom may also be more expensive than male condoms.

Client instructions for female condoms
Advise the client:

- Use a new condom for each act of intercourse.
- Do not use if unopened package is torn or leaking, or the condom is dried out.
- Insert before penis touches vagina.
- Can be inserted up to 8 hours ahead of time.
- Condoms are lubricated but may need extra lubricant inside so that they are not moved out of place during sex. More lubricant can be added either inside the condom or onto the penis.
- Removing the female condom: when finished, the woman must move away from partner and take care not to spill semen on the vaginal opening.
- Disposing of a used condom: tie a knot over the mouth of the used condom so that the contents do not spill and dispose of the used condom in a rubbish bin or by burying or burning it.

11.12.2 Spermicides

Spermicides are available in the form of jellies, creams, foams, foaming tablets and suppositories. Spermicides act by killing the sperm or by making the sperm unable to move towards the egg. The effectiveness of spermicides ranges from 71-85% and is highly dependent upon correct use and greatly increased when used together with condoms.

Women at high risk of HIV infection or those already HIV infected should not use spermicides. Repeated and high-dose use of spermicide nonoxynol-9 is associated with an increased risk of genital lesions, which may increase the risk of acquiring HIV infection.

Client instructions for spermicides
Advise the client about the importance of:

- using spermicide before each act of intercourse
- following the recommendations of the manufacturer for use and storage of each individual product
- another application if intercourse takes place more than 1 hour after initial application.

12 Lactational Amenorrhea Method and Post Partum Contraception

Chapter 12: LACTATIONAL AMENORRHOEA METHOD AND POST PARTUM CONTRACEPTION

12.1 INTRODUCTION

Breastfeeding is internationally recognized as an effective, temporary contraceptive. The lactational amenorrhoea method (LAM) enables both mother and infant to take full advantage of the numerous other benefits of breastfeeding, including longer birth intervals and the healthiest source of nutrition for infants.

12.2 CRITERIA FOR USING LAM

- exclusively/fully[21] breastfeeding
- no return of menses[22], and
- less than 6 months postpartum

ALL THREE CRITERIA MUST BE MET FOR EFFECTIVE USE OF LAM AS A METHOD OF CONTRACEPTION.

The lactational amenorrhoea method (LAM) does not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or post partum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

Women with conditions which make pregnancy an unacceptable risk should be advised that LAM may not be appropriate for them because of its relatively higher failure rates for typical use.

12.3 EFFECTIVENESS AND RETURN TO FERTILITY FOR LAM

LAM provides more than 98% effectiveness for women who satisfy the three criteria stated above. Ovulation in a lactating woman often naturally resumes around 6 months postpartum.

12.4 CATEGORY OF PROVIDERS

Counselling for LAM can be provided by any health worker who has been trained and is competent to explain the criteria for LAM and instruct on the use of LAM as well as to explain alternative methods of contraception and their use. The following providers can counsel on LAM: family health worker (FHW), community health worker (CHW), community health supervisor (CHS), staff nurse, medical officers and gynecologist.

[21] Baby fed on demand, more than 6 times per day/night without supplementation (baby's diet is 90% breast milk).
[22] Spotting that occurs during the first 56 days is not considered as menses

12.5 ELIGIBILITY

For mothers who wish to use LAM as a contraceptive, a central consideration must be that she should fully/exclusively breastfeed her baby. This means that the principal source of nutrition for an infant comes from breast milk:

- Feeding is on demand (whenever baby demands) more than 6 times per 24 hours i.e. including night feeds.
- Intervals between feedings should not exceed 4 hours during the day and 6 hours during the night.

If a mother cannot exclusively/fully breastfeed, then another method of contraception must be used.

12.5.1 Contraindications for LAM

- Client has resumed her menses.
- Baby suckles infrequently (i.e. less than 6 to 10 times a day on both breasts) or baby sleeps through the night.
- Client has added regular supplemental foods or liquids to her baby's diet[23].
- Baby is 6 months old or older.

In the event of any of the above, LAM is contra-indicated. Clients should be counselled about the need for another method for contraception.

12.5.2 Special situations

12.5.2.1 Conditions affecting the newborn
Newborns who are small for date or premature and need intensive neonatal care, or who have congenital deformities of the mouth, jaw or palate, or certain metabolic disorders can make breast feeding difficult.

12.5.2.2 Medications during breast feeding
In order to protect infant health, breastfeeding is not recommended for women using such drugs as: anti-metabolites, bromocriptine, certain anti-coagulants, corticosteroids, cyclosporine, ergotamine, lithium, mood-altering drugs, radioactive drugs, and reserpine.

12.5.2.3 HIV infection
Breast feeding should be promoted, protected and supported in all populations, for all women who are HIV negative or of unknown HIV status. When replacement feeding is acceptable, feasible, affordable, sustainable and safe, avoidance of all breastfeeding by HIV infected mothers is recommended. Otherwise exclusive breastfeeding is recommended during the first month of life and should then be discontinued as soon as it is feasible. Women who are HIV positive should receive counselling that includes information about both the risks and benefits of various infant feeding options based on local assessments, and guidance in selecting the most suitable option

[23] NOTE: 'Supplemental' does not include tiny amounts of ritual or medicinal liquids or food; 'supplemental' refers to liquid or food, which substitutes for a breastfeed.

for their situation and should be supported in their choice. They should also have access to follow-up care and support, including family planning and nutritional support.

12.6 COUNSELLING FOR LAM

Lactational amenorrhoea method (LAM) is understood by the mother if the time is taken to explain it in a language she understands, and her concerns and questions are addressed. The desired outcome is a woman who:

- clearly understands the three major conditions which make LAM effective
- knows what optimal breastfeeding practices are and when to stop using LAM and adopt another contraceptive method
- knows what contraceptive method she wants to use that is compatible with breastfeeding
- knows that condoms should be used if there is a risk of STI/HIV.

Counselling should include the following:

- Begin immediately to obtain the benefit of colostrums.
- Feed on demand, at least every 4 hours in day, every 6 hours at night.
- Fully breastfeed for 6 months (baby's diet is more than 90% breast milk).
- Encourage nutritious diet for mother.
- Continue to breastfeed as long as possible (2 years or more).
- Initiate an alternative contraception method before 6 months postpartum in women desiring continued contraception.

When to stop using LAM as the sole contraceptive method:

- Baby reaches 6 months
- Menses returns
- Baby receiving supplemental feedings

Discuss complementary family planning methods for the lactating mother:

- Refer to Table 12.2 in this chapter for description of other methods for lactating women.
- Offer client a back-up method before she no longer meets the LAM criteria, so she can be fully protected before she is at risk for pregnancy.
- Counsel the client that lubricated condoms can help with vaginal dryness associated with breastfeeding. The client will then be protected until she can visit the family planning clinic for help in choosing a different method if desired.

12.7 CLINICAL ASSESSMENT

A physical exam or laboratory investigations are not mandatory prior to using LAM.

12.8 ROUTINE FOLLOW-UP CARE

- Women who choose LAM for contraception should be seen again 5 months postpartum to help them choose another method if desired.
- The client should also be advised to return to facility earlier if she has any concerns or if she wants to change the method.
- Clients who have decided on the method to use after stopping LAM should be given:
    - instructions on how to use the chosen method or when to return to initiate the method
    - the selected method, when appropriate, prior to leaving the facility rather than referring the client to an outpatient department or other clinic to obtain services.

It is important that providers who perform outreach services to women who have had home births carry with them a supply of family planning methods in order to provide these methods to women who choose them.

12.9 POST PARTUM CONTRACEPTION

All post partum women should be counselled and provided with the family planning method they choose prior to their discharge from the birthing facility. All methods of contraception are appropriate for postpartum women. However, the time for starting each method depends on a woman's breastfeeding status.

12.9.1 Return to fertility post partum

Following delivery every woman experiences a period of infertility. The period of infertility following delivery in **non-breastfeeding** women may be less than 6 weeks post delivery (on average, the first ovulation occurs around 45 days postpartum). The period of infertility for **breastfeeding** mothers is longer than for non-breastfeeding mothers. The return of fertility, however, is not predictable (conception can occur before the woman has signs or symptoms of the first menses). This period of temporary infertility is due to the effect of suckling which causes a surge in the hormone prolactin thereby inhibiting ovulation. Ovulation remains disrupted or suppressed, as long as the frequency, duration and intensity of suckling are high. Ovulation in a lactating woman often naturally resumes around 6 months postpartum.

12.9.2 Counselling postpartum women

Contraceptive counselling and service provision should be part of:

- immediate postpartum care for hospital-based birthing services
- initial and follow-up visits to postpartum women during outreach services
- routine postpartum services offered to women in the first 6 weeks following childbirth.

It is best if counselling for postpartum contraception begins in the antenatal period.

The following guidelines for counselling postpartum women have been adapted from the International Planned Parenthood Federation (IPPF):

- Encourage full breastfeeding.
- Do not recommend that clients discontinue breastfeeding to begin use of a contraceptive method.
- Counsel clients to choose a contraceptive method that does not adversely affect breastfeeding or the health of the infant.

Refer to Chapter 3 Counselling and Informed Choice for the general principles of counselling, informed choice and client provider interaction. Chapter 2 Overview of FP provides information on the mechanism of action, effectiveness, advantages and disadvantages of the various FP methods.

12.9.3 When to start contraception

While all methods of contraception are appropriate for postpartum women, the time for starting each method depends on a woman's breastfeeding status. Methods that can be used whenever a couple resumes sexual intercourse, even in the immediate postpartum period, include:

- spermicides
- condoms (lubricated condoms may help overcome vaginal dryness)
- withdrawal (both condoms and withdrawal prevent seminal fluid from being deposited in the vagina).

12.9.3.1 Contraception for breastfeeding women

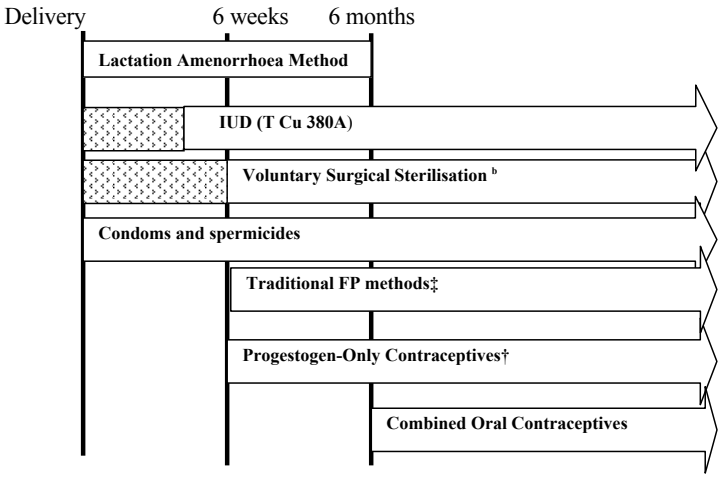
Breastfeeding women need contraceptive methods before or at the time fertility recovers during lactation. This will depend on personal and social circumstances. It is crucial that contraceptives provided for breastfeeding mothers are safe and effective without affecting lactation and health.

Additional contraception is not necessary for breast feeding women for at least 6 weeks postpartum, and for up to 6 months if they are using LAM. Figure 12.1 shows the recommended time of starting contraception for breastfeeding women. Breastfeeding women deciding to use contraception other than LAM should be counselled about the potential effects of some contraceptives on breastfeeding.

COCs should NOT be given to post partum women who are breastfeeding as it can

decrease breast milk production. IUD is inserted when menses returns the earliest being during her first menses after delivery of her baby which usually occurs 4 to 6 weeks post delivery.

Figure 12.1 Recommended times to start for breastfeeding women



[b] Vasectomy can be performed at any time. Tubal occlusion can be performed within 7 days postpartum or after 6 weeks as interval sterilization.

‡ Traditional FP methods such as fertility awareness-based methods (FAB) may be harder for breastfeeding women to use because reduced ovarian function makes fertility signs more difficult to interpret. As a result, FAB can require prolonged periods of abstinence during breastfeeding.

† Progestogen-only contraceptives include POP, POI and hormonal implants.

Source: Adapted from Family Health International 1994

12.9.3.2 Contraception for non-breastfeeding women

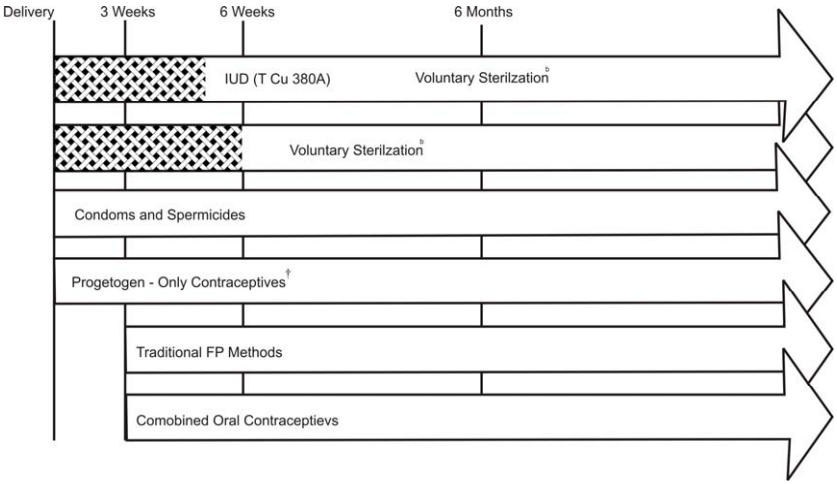
Although most non-breastfeeding women will resume menstrual cycles within 4 to 6 weeks after delivery, only about one-third of first cycles will be ovulatory and even fewer will result in pregnancy. In order to avoid all risk of pregnancy, however, contraception should be started at the appropriate time:

- barriers, spermicides or withdrawal with the resumption of sexual intercourse following delivery
- hormonal contraceptives, IUDs or voluntary female sterilization BEFORE the resumption of sexual intercourse following the delivery.

Due to pregnancy-induced risks of possible blood clotting problems (elevated coagulation factors) present until 3 weeks postpartum, COCs **should not** be started before that time. IUD is inserted when menses returns, the earliest being during her first menses after delivery of her baby which usually occurs 4 to 6 weeks post delivery. IUD should be inserted between D1 and D7 of her menses.

Figure 12.2 shows the recommended time of starting contraception for non-breastfeeding women.

Figure 12.2 Recommended time to start for non-breastfeeding women



b Vasectomy can be performed at any time. Tubal occlusion may be performed within 7 days post partum or after 6 weeks as interval sterilization.

† Progestogen-only contraceptives include POP, POI and hormonal implants.

Source: Adapted from Family Health International 1994

Table 12.1 Postpartum contraception for NON-BREASTFEEDING WOMEN

Method	Timing
IUD	• With the return of her menses (D1-D7) which usually occurs 4 to 6 weeks after child birth (Refer to Ch 10 for specific details)
Condom	• As soon as sexual intercourse has resumed
Progestogen-only contraceptives - POP and POI	• Immediately after delivery • During her menses any time after 6 weeks postpartum i.e. after ruling out pregnancy (Refer to Ch 7 and Ch 8 for more details)
Progestogen-only contraceptives - sub dermal implants (Norplant)	• Immediately after delivery • During her menses (D1-D7) any time after 6 weeks postpartum after ruling out pregnancy (Refer to Ch 9 for specific details)
Female sterilization	• Immediately postpartum • During menses (D1-D5) after child birth after ruling out pregnancy (Refer to Ch 14 for specific details)
Male sterilization	• Anytime after childbirth
Combined oral contraceptive pills	• Start 3 weeks after childbirth (Refer to Ch 6 for specific details)

Table 12.2 Postpartum contraception for BREASTFEEDING WOMEN

Method	Timing
LAM	• Begin fully breastfeeding immediately after delivery • Highly effective for up to 6 months if fully breastfeeding and amenorrheic
Condoms	• When sexual activity is resumed
IUD	• With the return of her menses which usually occurs 4 to 6 weeks after child birth (Refer to Ch 10 for specific details)
Female sterilization	• Immediately postpartum • 6 weeks after delivery during menses (D1-D5) (Refer to Ch 14 for specific details)
Male sterilization	• Any time after childbirth
Progestogen-only contraceptives - POP and POI	• 6 weeks after childbirth (Refer to Ch 7 & Ch 8 for specific details)
Progestogen-only contraceptives - sub dermal implants (Norplant)	• 6 weeks after childbirth (Refer to Ch 9 for specific details)
Combined oral contraceptive pills	• 6 months after childbirth (Refer to Ch 6 for specific details)

Source: Adapted from Nepal National Medical Standards, 3rd edition 2001

13 Traditional Methods

Chapter 13: TRADITIONAL FAMILY PLANNING METHODS

13.1 INTRODUCTION

The two commonly used traditional methods of family planning are:

- Fertility awareness based methods
- Coitus interruptus (withdrawal method)

Traditional family planning methods, both fertility awareness-based methods (FAB) and coitus interruptus, do not protect against STI/HIV. If there is a risk of STI/HIV (including the post partum period), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

Women with conditions which make pregnancy an unacceptable risk should be advised that traditional methods of family planning may not be appropriate for them because of their relatively higher failure rates with typical use.

13.2 CATEGORY OF PROVIDER

Health professionals and experienced couples can teach the method, provided they have had appropriate training.

13.3 TYPES OF FERTILITY AWARENESS-BASED METHOD (FAB)

There are a variety of fertility awareness-based methods used for contraception. Fertility awareness-based methods are based on the practice of voluntarily avoiding sexual intercourse during the fertile period of a woman's cycle (i.e. when the ovum is released) to avoid pregnancy. For this method to be effective the following are essential:

- Good communication and understanding should be present between spouses.
- The sexual behaviour of couples will have to be modified.

Fertility-awareness based methods can also be used to achieve pregnancy by having intercourse during the fertile phase.

13.3.1 New fertility-awareness based method

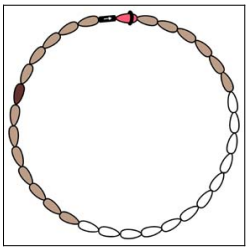
Standard days method (SDM) This new method relies on a 'standard rule' or a fixed window of fertility that makes it easy for women to know when they are likely to become pregnant. The fertile window is on day 8 to day 19 for women whose cycle lengths range from 26 to 32 days.

This method does not involve calculation or observation and hence it is easy for providers to teach and for women to learn and use. It is easy to incorporate this

method into the existing family planning menu as the method has minimal logistical burden and can be offered either in clinics or community based programs.

A colour coded string of beads (see Figure 13.1) called **Cycle beads™** can be used by women using SDM as it facilitates tracking a woman's menstrual cycle and the fertile days. Refer Box 13.1 on how to use cycle beads.

Box 13.1: **CYCLE BEADS**



How to use cycle beads
Cycle beads represent each of a woman's cycle. They include 32 beads: a red band represents the first day of the menstrual bleeding, followed by 6 brown beads representing days when pregnancy is very unlikely and 12 white glow-in-the-dark beads representing days when pregnancy is likely. The remaining brown beads represent days when pregnancy is unlikely. A client can track her cycle days by moving a small rubber ring from one bead to the next each day starting with the first day of her period.

13.3.2 Other fertility-awareness based methods used are calendar method, basal body temperature method, cervical mucus method and symptom thermal method.

13.4 EFFECTIVENESS OF FERTILITY AWARENESS-BASED METHODS

Effectiveness
The effectiveness (in preventing pregnancy) ranges from 91-98% when the **method is used correctly and consistently.** The typical effectiveness rate ranges from 80-88%. The effectiveness of these methods depends on the accuracy of the method to identify the fertile days, a couple's ability to correctly identify the fertile period and their ability to follow the rules of the method they are using. SDM has been shown to have an effectiveness of 95% for perfect use and 88% for typical use.

Return to fertility
Fertility awareness-based methods can also be used to achieve pregnancy by having intercourse during the fertile phase.

13.5 ELIGIBILITY FOR FERTILITY AWARENESS-BASED METHODS

The following couples are eligible to use the method:

- Couples who can abstain from sexual intercourse during fertile periods.
- Women with regular menstrual cycles (SDM users should have regular cycles ranging between 26 – 32 days).
- Women who want to practice contraception using non-mechanical or chemical methods.
- Women who have contraindications for other methods.
- For religious or cultural reasons.
- Couples with the need to delay the use of other family planning methods.
- Post abortion (delay till after next period).
- Irregular periods.

13.6 COUNSELING FOR FERTILITY AWARENESS-BASED METHODS

In the process of assisting clients (male or female) to decide on FAB methods, they should be counseled on the effectiveness of the method, how it works, advantages and disadvantages, alternativee methods of contraception and how to use the method correctly and consistently. For more detail, refer to Chapter 3 Counselling and Informed Choice.

Counseling is critical for couples who want to practice fertility awareness method:

- Ensure the spouse is present.
- Ensure the client/couple understands the fertile period.
- Provide condoms as a back-up method and demonstrate the use of condoms.
- Clients should be counseled that SDM is not appropriate for clients with menstrual cycles outside the 26-32 days range because of a higher risk of pregnancy. Help them to consider another method.
- The client should use condoms in addition if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/AIDS.

13.7 CLIENT ASESSMENT FOR FAB

The purpose of the health assessment is to determine the client's suitability for the use of the method. It is also an opportunity to assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI and offer other available sexual and reproductive health services as appropriate. Refer to Chapter 5 for further details on STI/RTI assessment.

13.8 INSTRUCTIONS ON THE USE OF FERTILITY AWARENESS-BASED METHODS (STANDARD DAYS METHOD)

13.8.1 Provider Instructions

- Find out the menstrual cycle pattern of the client and advise on the period of fertility, based on the menstrual cycle pattern.
- Ensure that the client understands the period of fertility.
- Use colored illustrations (if possible) to explain the menstrual cycle and fertile period.
- Provide condoms as a back-up method and demonstrate the use of condoms. Ensure that the client has understood the use of condoms.
- SDM is not appropriate for clients with menstrual cycles outside the 26-32 days range because of a higher risk of pregnancy. Help her consider another method.

13.8.2 Client Instructions

- Count the 8th day of the menstrual cycle (counting the first day of onset of bleeding/spotting as day 1).
- Avoid sexual intercourse from the 8th to the 19th day. This is the time when the ovum is released and the risk of pregnancy is high.
- From the 20th day it is safe to have sex.
- If cycle beads are to be used then demonstrate how to use them.
- If sex cannot be avoided, use a condom.
- Tell her to seek advice from health care provider if she has changes in the days of menstrual cycle.

13.9 ROUTINE FOLLOW UP CARE FOR FAB METHOD

- No routine follow-up visit is required.
- Advise client to return at anytime if he/she has any concerns or if he/she wants to change the method.

At follow-up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems such as changes in her menstrual pattern and, if so, record them in the client clinical card/record.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history and perform any examination indicated by the history.
- Provide appropriate counselling and/or treatment as required.
- Refer client to an appropriate referral facility/specialty if any serious problems cannot be managed at the facility were client has attended for follow-up care. Provide referral slip.
- Advise on alternate methods of contraception if menstrual cycles have become irregular.
- Update client's contact information (address, telephone number etc).

- Ensure/provide supply of condoms as a back-up method and demonstrate the use of condoms. Ensure that the client has understood the use of condoms. (Refer to Chapter 11 for further details on condoms.)

Note:
Abortion is illegal in Maldives. A client needs counselling should an unplanned or unwanted pregnancy occur. Unplanned pregnancy may be followed by many conflicting emotions such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

13.10 COITUS INTERRUPTUS (WITHDRAWAL METHOD)

Coitus interruptus is a traditional method of FP in which the man completely withdraws his penis from the woman's vagina before he ejaculates. This method prevents pregnancy by preventing the deposition of sperm in the vagina. For this method to be effective it is essential that there is good communication and understanding between the couple and that they can modify their sexual behaviour.

13.11 EFFECTIVENESS OF COITUS INTERRUPTUS

The effectiveness (in preventing pregnancy) is 96% when the method is used correctly and consistently.

13.12 ELIGIBILITY FOR COITUS INTERRUPTUS

The following are eligible to use the method:

- couples who have control over their sexual act and can withdraw fully before ejaculation
- women who want to practice contraception using non-mechanical or chemical methods
- women who have contra-indications for other methods
- for religious or cultural reasons

13.13 COUNSELING FOR COITUS INTERRUPTUS

Counseling is critical for couples who want to practice fertility awareness method.

- Ensure the spouse is present.
- Ensure the client/couple understands the importance of full withdrawal.
- Explain to the client/couple the fertile period to enable them to avoid sex during that period.
- Provide condoms as a back-up method and demonstrate the use of condoms. Ensure that the client has understood the use of condoms.

13.13.1 Advice in situations where the method is not used correctly

Counsel and provide emergency contraception in case the penis is not withdrawn before ejaculation.

13.14 ROUTINE FOLLOW-UP CARE

- No routine follow up visit is required.
- Advise the client to return at any time if he/she has any concerns or if he/she wants to change the method.

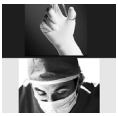
At follow-up:

- Assess the client's satisfaction with the method.
- Determine if the client has had any problems and, if so, record them in the client clinical card/record.
- Assess for any STI/RTI related concerns and if the client has any symptoms related to STI/RTI.
- Update the medical history and perform any examination indicated by the history.
- Provide appropriate counselling and/or treatment as required.
- Refer client to an appropriate referral facility/specialty if there are any serious problems that cannot be managed at the facility were client has attended for follow-up care. Provide referral slip.
- Update client's contact information (address, telephone number etc).
- If they are continuing to use the method, ensure that the client has a supply of condoms to be used as back-up. Ensure that the client has understood the use of condoms. (Refer to Chapter 11 for further details on condoms.)

Note:
Abortion is illegal in Maldives. A client needs counselling should an unplanned or unwanted pregnancy occur. Unplanned pregnancy may be followed by many conflicting emotions such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

13.15 RECORD KEEPING AND REPORTING FOR TRADITIONAL METHODS

The provider should legibly record information in the Client Card and Family Planning Register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.



14 Voluntary Surgical Sterilization: Female and Male

Chapter 14: VOLUNTARY SURGICAL STERILIZATION FEMALE AND MALE

14.1 INTRODUCTION

Surgical contraceptive methods (male and female sterilization) are effective permanent methods of contraception available to men and women who desire not to have any more children.

Essential elements of quality sterilization services include counseling and client assessment, informed consent, infection prevention, selection of appropriate procedures, safe anesthesia regimens, and post-operative care and instructions. Strict adherence to infection prevention practices at all times (before, during and after surgery) is crucial to the safety of the procedure.

14.2 TYPES OF VOLUNTARY SURGICAL STERILIZATION

The various types of male and female sterilization are listed below

- **Female surgical sterilization – Tubal Occlusion**
    - Interval Sterilization
        - Minilaparotomy
        - Laparoscopic sterilization using Falope Rings
    - Post Partum Sterilization
        - Minilaparotomy
        - Tubal occlusion at the time of Caesarean section
- **Male surgical sterilization – Vasectomy**
    - Modified Standard Technique (MST)
    - No-scalpel Vasectomy (NSV)

Male and female surgical sterilization does not protect against STI/HIV. If there is a risk of STI/HIV (including pregnancy or post partum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

14.3 EFFECTIVENESS OF FEMALE AND MALE SURGICAL STERILIZATION

Effectiveness

Tubal occlusion and vasectomy both have effectiveness* of over 99% and complication rates of < 2%. Failure usually is due to one of the following:

- vas deferens or fallopian tube spontaneously recannalise
- inability to complete procedure
- incorrect surgical technique

Permanency

Voluntary sterilization procedures should be considered permanent (irreversible). It is possible in some cases to reverse the procedure, that is, rejoin the cut fallopian tubes (females) or the vas deferens (males). The microsurgical services required to reverse female and male surgical sterilization are rare. Even when such services are available, the client may not be a proper surgical candidate or a reversal attempt may not be successful. Therefore, couples considering voluntary surgical sterilization should be certain that they do not wish to have any more children.

14.4 FEMALE SURGICAL STERILIZATION

Female surgical sterilization is a relatively simple procedure that involves permanently blocking/occluding both the fallopian tubes to prevent fertilization.

14.5 CATEGORIES OF PROVIDERS FOR FEMALE SURGICAL STERILIZATION

Female sterilization should be performed only by trained and competent gynecologists or surgeons. The following table shows the category and number of staff required to perform female sterilization safely.

* The effectiveness data is the percentage of women without unintended pregnancy within the first year of use.

Table 14.1

No.	Position	Function
1	Trained and competent gynaecologist/surgeon	Oversee pre-operative client assessment and perform surgery
1	Anaesthetist	Provide general anaesthesia (GA) and spinal anaesthesia (SA)
1	Staff nurse	Client screening, ensure understanding and documentation of informed choice/informed consent, and postoperative care
1	Staff nurse	Operating theatre (OT) management
1	Assistant nurse	Assist in OT
1	Nurse	Work in the OT/sterilization, instrument cleaning and packing
1	Attendant/peon	Assist in cleaning instruments
1	Attendant/sweeper	Cleaning operating theatre
1	Electrician	For laparoscopy only

14.6 ELIGIBILITY FOR FEMALE SURGICAL STERILIZATION

14.6.1 Indications

Female sterilization can be done for clients seeking a permanent contraceptive method and wanting no more children. In addition to a client's request for permanent contraception:

- The client should be ≥30 years of age.

AND

- She should have at least 2 (two) living children. If only 2, the age of the last child should be ≥ 3years of age.

However, with adequate counselling there is no parity or age restriction and advice should be individualized.

- The client has had three (3) lower segment Caesarean sections.
- The client or partner has a medical condition that would lead to a high-risk pregnancy or serious health problems.

In clients with thalassaemia, extra preparations and precautions should be taken while performing female sterilization.

14.6.2 Absolute contraindications for female surgical sterilization

Generally there are no absolute medical contraindications to voluntary female surgical sterilization.

Box 14.1 FEMALE SURGICAL STERILIZATION IS NOT APPROPRIATE IF THERE IS ANY SUGGESTION THAT THE CLIENT:

- shows excessive interest in reversal
- disagrees with/does not want to sign informed consent
- is under pressure from another person.

14.6.3 Delay[24] female surgical sterilization

For the conditions below, surgical sterilization should be delayed until specific conditions resolve. Help the client to choose another method for the interim.

- pregnancy
- acute systemic infection or gastroenteritis
- abdominal skin infections
- acute hematometra
- current STI: chlamydial and gonococcal infection, current PID
- post partum 7 to <42 days.
- severe anaemia (Hb < 7 gm/dl, or Hct < 20%)
- unexplained vaginal bleeding
- puerperal sepsis, intra partum or puerperal fever
- severe pre-eclampsia/eclampsia
- severe ante partum or post partum hemorrhage
- severe trauma to the genital tract at the time of delivery
- malignant gestational trophoblastic disease
- cervical cancer, endometrial cancer, ovarian cancer
- depression: help client choose another method and refer for treatment of depression
- current DVT/PE
- uncontrolled diabetes
- current ischaemic heart disease
- acute respiratory disease
- current gall bladder disease
- active viral hepatitis

Documenting denial of voluntary sterilization
When a client is judged unsuitable for voluntary sterilization, the reason(s) and the action taken should be stated on the client card/record/case sheet.

[24] Procedure is delayed until the condition is evaluated or corrected. Appropriate alternate temporary methods of contraception should be provided in the interim.

14.7 COUNSELLING AND INFORMED CHOICE FOR FEMALE SURGICAL STERILIZATION

A couple's decisions about fertility and contraception are made for a variety of reasons. Decisions are influenced by personal circumstances such as family size, economic situations and the health status of one or both partners. The decision may also be affected by cultural expectations and information available about family planning. The person counseling should only explain the procedures, not coerce the client into making the decision to undergo sterilization. The decision remains with the client.

Tubal occlusion is intended to be a permanent method and involves surgery with its associated risks. Voluntary sterilization has consequences, risks and concerns that need to be discussed with each client. It is therefore essential that service providers provide clients with necessary information and counseling about the procedure so that the client can reach an independent and informed decision. Counsel both partners if possible.

Pre operative counseling should focus on:

- preparing her for the operation
- giving her instructions on how to prepare for surgery and what to expect during and after the operation
- ensuring that she has made the decision voluntarily, without any coercion and incentives
- documenting her informed consent as well as her spouse's signature
- discussing other temporary and permanent family planning methods that are available

The client and spouse must be counselled in a language and terminology they understand. Privacy must be maintained during counselling. The following information should be understood by the client:

- effectiveness, permanency of the procedure, small failure rate
- advantages/disadvantages of the method
- side effects.

For more detailed information refer to Chapter 2 Overview of FP, Chapter 3 Counselling and informed choice.

Informed Consent
Informed consent is the client's voluntary decision to undergo or not to undergo a surgical sterilization procedure, in full possession and understanding of the relevant facts. In Maldives, the informed consent should be **signed by both the client and spouse** and is the legal authorisation for performing the procedure. Therefore service providers should ensure that client and spouse have signed the informed consent form with full understanding. In special cases where the client is mentally disabled the guardian can give consent. A sample of the informed consent form is provided in the appendices.

Informed consent for surgical sterilization is an agreement by an individual (male or female), after appropriate counseling has been given. The consent is an exercise of free choice with a full understanding of the nature and consequences of the procedure to be performed. The consent must be obtained BEFORE performing the procedure.

The following are primary and ethical obligations and responsibilities of the service provider:

- Ensure that the individual gives free and informed voluntary consent for the operation.
- Ensure she and her spouse are legally competent to give consent.
- Written consent signed by both the client and the spouse must be obtained for all clients requesting surgical contraception. This serves as legal authorization for surgery and documents informed and voluntary choice.

Make sure that the client has been informed about the following:

- alternatives to the procedure
- availability of reversible methods of contraception
- specific surgical procedures to be followed
- health risks of surgical procedures and of anesthetic
- risk of failure
- benefits to be expected
- permanency of the method
- free choice of the client.

Signature
The form must be signed by the client undergoing the operation and her spouse. The surgeon should also sign each consent form prior to performing the surgery. Parental or guardians' signatures are required if the individual is mentally ill or disabled or legally incompetent. For those illiterate the form must be read aloud and explained.

14.8 CLIENT ASSESSMENT FOR FEMALE SURGICAL STERILIZATION

Client assessment prior to surgical sterilization is necessary to:

- ascertain the client's fitness for the surgical sterilization procedure
- exclude possible risks associated with the procedure
- provide the best surgical approach, type of anaesthesia and type of facility best suited to the client for providing the procedure
- exclude pregnancy. (Pregnancy should be ruled out prior to performing female surgical sterilization. A pregnancy test should be done if there is any suspicion of pregnancy. Refer to Chapter 4 for indications for performing a pregnancy test.)

The following should be taken/assessed and recorded in client case sheet/record:

Demographic information
Includes client's name, address, age, spouse's name, occupation, education, number of living children and age of the youngest child.

Medical history

- history of chronic/acute conditions: active tuberculosis, heart disease, hypertension, anaemia, diabetes, bleeding disorders, convulsions, psychiatric conditions, pelvic or abdominal surgery, pelvic inflammatory disease, vaginal discharge, urinary tract infections
- recent injuries or infections
- history of pregnancies, miscarriages, abortions, deliveries and any complications
- date of last menstrual period and description of menses
- breastfeeding
- family planning method use, side effects, reason for discontinuation
- STI risk assessment
- allergies to medication

Physical examination and tests
The following physical examination and tests should be done:

- pulse, temperature and blood pressure
- auscultation of heart and lungs
- pelvic examination: speculum visualization of cervix and bimanual pelvic examination – bimanual vaginal examination is done to identify the position of the uterus (anteverted or retroverted) and to rule out pregnancy, PID, other pathology of the uterine cavity and overt malignancies.
- pregnancy test if LMP, history and pelvic exam is suggestive of pregnancy
- body weight
- urine analysis for sugar and protein
- haemoglobin test.

Other examination/tests

A client's visit to a health facility is an opportunity to offer other available sexual and reproductive health services as appropriate.

- Breast examination: All FP clients should be educated and shown how to perform a breast self exam and to report if there are any abnormalities noted. It is good preventative health practice to perform a clinical examination of the breast during the physical examination.
- Blood test for Hepatitis B.

14.8.1 Conditions that can make the procedure difficult

Clients who have conditions that make the surgical sterilization procedure difficult or increase the risks should have their surgery performed by a highly skilled provider in a well-equipped facility, where general anaesthesia and other special requirements are available. The conditions include:

- pelvic or abdominal adhesions due to previous surgery
- uterine perforation post abortion[25]
- endometriosis
- known pelvic TB
- obesity [≥ 30 kg/m2 body mass index (BMI)]
- abdominal wall or umbilical hernia (for immediate postpartum and laparoscopic procedures)
- severe organ disease of heart, lung, kidney, liver
- thyroid disorders (hyperthyroidism and hypothyroidism)
- coagulation disorders
- hypertension
- diabetes with nephropathy, retinopathy, neuropathy, or diabetes of ≥ 20 years duration.

14.9 PROCEDURE: FEMALE SURGICAL STERILIZATION

14.9.1 Timing of procedure

- Interval female surgical sterilization should be performed within the first five days of the menstrual cycle. Pregnancy should be ruled out in all women undergoing female surgical sterilization.
- Postpartum female surgical sterilization should be performed within the first 7 days after vaginal delivery or ≥6 weeks after delivery just as interval female surgical sterilization. Post partum surgical sterilization can also be performed in conjunction with a Caesarean section performed for obstetric indications if the client has been appropriately counselled well in advance.
- Post miscarriage sterilization in the absence of sepsis can be done within the first 7 days after miscarriage if client desires female sterilization.

14.9.2 Type of anesthesia for female surgical sterilization

The goal of anaesthesia is to minimize psychological and emotional distress and trauma in the client and keep her free from pain and discomfort. The following factors should be considered in the choice of anesthesia: type of surgical technique, the skill of the surgeon and anesthetist, the availability of appropriate drugs, the safety and comfort of the client, the ability of the surgeon to manage complications should they occur.

- Interval female sterilization using minilaparotomy can be performed either under spinal anesthesia or general anesthesia.

[25] If exploratory surgery or laparoscopy is performed, repair of the problem and tubal sterilization may be performed concurrently if no additional risk is involved

- Post partum female surgical sterilization can be performed under local anesthesia with sedation or under general anesthesia.

Local Anesthesia

Preoperative medication and anesthesia
Premedication serves to reduce fear and anxiety. It can provide analgesia, prevent postoperative nausea and vomiting, and induce amnesia.

Conscious sedation with local anaesthesia
The following regimen is recommended when performing minilaparotomy under local anesthesia with conscious sedation:

Table 14.2 Regimen for local anesthesia with conscious sedation

Diazepam 5 mg orally for client <35 kg weight or **Diazepam 10 mg** orally for client ≥ 35 kg by weight Give 45 minutes before the operation
Pethidine 25 mg IV WITH **Phenergen 12.5 mg IV WITH** **Atropine 0.6 mg IV** To be administered together intravenously in operating theatre just before procedure with monitoring of vital signs every 5 minutes.
Xylocaine 1% 10–20 ml Local infiltration to the skin and wait 1–2 minutes after infiltration to begin procedure.

General anesthesia and spinal anesthesia
The provision of general and spinal anesthesia including preoperative medication should be provided as per anesthesia protocols.

14.9.3 Technique of female surgical sterilization

Abdominal approach is used to access and occlude (cutting and sealing) the fallopian tubes.
Interval Sterilization can be performed by minilaparotomy or using the laparoscope.

Minilaparotomy[26]**,** often referred to as minilap, is accomplished through an incision measuring 3-5 cm in length placed supra pubically. The abdomen is opened in layers, with care taken not to avoid injury to underlying structures such as the uterus, bowel or bladder.

Laparoscopy This method is used ONLY for interval sterilization. The laparoscope is introduced into the abdominal cavity using a small sub-umblical incision. This method permits direct visualization and manipulation

[26] Laparotomy is defined as abdominal entry through an incision greater than 5 cm performed under regional or general anesthesia. Laparotomy is not recommended for the sole purpose of surgical sterilization.

of abdominal and pelvic organs. The fallopian tubes are occluded using Falope Rings. Laparoscopic sterilization is performed under general anesthesia.

Post partum Sterilization A sub umbilical incision is used to perform the mini laparotomy when the procedure is done post partum.

14.9.4 Monitoring client during female sterilization procedure (per operative)

Monitoring of clients having local anesthesia using conscious sedation for female sterilization
Monitoring and recording of vital signs must take place before, during and after the operation until the client has fully recovered.

- Preoperative: Blood pressure, pulse and respiration should be monitored and recorded before and after the preoperative dose of sedative is given. This provides the baseline data for the client.
- Intraoperative: During surgery, the medical team should monitor and record blood pressure, pulse and respiration at least every 5 minutes. When procedure performed under local anesthesia, a staff member should converse with the client continuously to assess the status of analgesia.
- Postoperative: Blood pressure, pulse and respiration must be monitored and recorded at least every 15 minutes until stable (they have returned to preoperative levels). Under no circumstances should the client be left alone. The client must be observed constantly during the postoperative period. Once the client is stable, vital signs should be monitored once every hour until she is fully awake.

Clinical staff should be observant for the following signs of distress:

- excessive somnolence
- breathing rate of less than 10 per minute
- hyperventilation
- systolic blood pressure less than 90 mm Hg
- rapid (over 100) or weak pulse
- pallor or cyanosis

Monitoring clients having general anesthesia or spinal anesthesia for female sterilization
All clients having general anesthesia or spinal anesthesia should be closely monitored during the surgery and post operatively as per anesthesia protocols.

14.9.5 Discharge after female surgical sterilization

Discharge

Following female sterilization done under local, spinal or general anesthesia, clients can be routinely discharged on the second post operative day (considering day of surgery as operation day). Prior to discharge ensure client:

- can stand or walk steadily
- can talk or converse clearly and coherently
- has eaten and has passed urine
- can dress herself and is ambulatory
- is afebrile and the wound is clean.

Box 14.3 CLIENT INSTRUCTIONS FOR FEMALE STERILIZATION: PREOPERATIVE, POSTOPERATIVE AND DISCHARGE

Preoperative client information

- Bathing, wearing clean and loose clothes
- Fasting for 8 hours before surgery and taking no medications for 24 hours prior to surgery unless prescribed by a physician
- Being accompanied to the facility and home after the procedure
- The steps of the operation, including information on sedation/anaesthesia, screening, lab tests, what to expect in operating theatre, expectations about pain/discomfort, emptying bladder before surgery
- Removal of jewellery, nail polish, hairpins, eye glasses and dentures before surgery

Post-operative client information

- She should rest at home for 1-2 days after discharge in order to decrease complications.
- She may resume light activities 2-3 days after discharge and normal activities after 1 week.
- She may resume intercourse after 1 week.
- Keep the incision clean and dry. She may bathe or wash after 2 days.
- Explain how to use post op medications that are given. The following are the routine post op medications:
  - analgesics tablets for 3 days post surgery
  - antibiotics: Amoxycillin 500 mg 8 hourly for 5 days
  - multivitamin tablets for 5 days.
- Explain what problems to look out for (for danger signs refer to Box 14.4), what to do about each of the problems such as fever, pain and bleeding, and where to go and whom to contact in case of emergency and for any other problems and questions she may have.
- Any other relevant information such as:
  - Once the operation is completed she is sterile.
  - Her menstrual periods will continue until she reaches menopause.
  - If she misses a menstrual period and has any other signs of pregnancy, abdominal or pelvic pains she should contact the clinic.
  - Give the client a chance to ask questions and express any other concerns.
- Give the exact date and time for a follow-up visit (within 7 days post surgery).
- Written/printed postoperative and discharge instructions should be given to the client.

NOTE for formatting the box with warning signs post female sterilization should be as a nested table within the larger box on client instructions.

Box 14.4 POSTOPERATIVE DANGER SIGNS POST FEMALE STERILIZATION
See doctor promptly in the case of:

- fever (greater than 38°C or 100.4°F)
- dizziness with fainting
- persistent or increasing abdominal pain and/or swelling
- bleeding or fluid coming from the incision.

14.10 ROUTINE FOLLOW-UP CARE

All clients who have had female sterilization should be advised the following:

- First follow-up should be done within 7 days of surgery.
- Return to facility earlier if she has any concerns.
- Contact doctor immediately if she has any of the warning signs as in Box 14.4.

At follow-up:
The following should be done at the follow up visit

- Inspect the wound site.
- Remove sutures if any.
- Address client concerns.
- Perform any other client evaluation/referral as indicated.

A second follow- up visit should be scheduled if continued care is required.

14.11 MANAGEMENT OF COMPLICATIONS OF FEMALE SURGICAL STERILIZATION

Serious complications are rare and occur in fewer than 1% of all female sterilization procedures. Clients should be routinely counselled about common side effects and possible complications and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counselled and managed appropriately. Refer to Chapter 3 for details on counselling clients with problems using a contraceptive method.

Anaesthesia complications
Major complications may occur with general and local anaesthesia for both minilaparotomy and laparoscopy. Serious complications are likely to occur as a result of overdose or improper administration of anaesthesia. However, toxic reactions may manifest as convulsions requiring assisted ventilation and anticonvulsants (e.g., diazepam). Adequate monitoring and early recognition of complications is the key to minimizing adverse outcomes.

Surgical emergencies
The surgical team should manage surgical emergencies at the operative site.

Table 14.3 Management of complications of female sterilization

Complications	Assessment	Management
Intraoperative haemorrhage (injury to mesosalphinx)	Determine presence of injury to mesosalphinx.	Identify the source of bleeding and ensure hemostasis.
Bladder, intestinal injuries (rare)	Determine presence of hematuria and other signs of internal injury.	Identify and repair. The procedure should be performed by a trained and competent surgeon.
Shock or acute distress (very rare)	Check for increased respiration and pulse, decreased blood pressure, evidence of hemodynamic instability.	Cardio pulmonary resuscitation
Wound infection	Confirm presence of infection or abscess.	If skin infection is present, treat with antibiotics. If abscess is present, drain and treat as indicated.
Postoperative fever	Determine source of infection.	Treat infection based on findings.
Haematoma (subcutaneous)	Determine presence of infection or abscess.	Apply warm, moist packs to site. Observe – usually will resolve over time but may require drainage if extensive.
Pain at incision site	Determine presence of infection or abscess.	Treat based on findings.
Superficial Bleeding (skin edges or subcutaneously)	Determine presence of infection or abscess.	Treat based on findings.
Failure of tubal occlusion/tubal ligation	Confirm with pregnancy test.	Explain how failure happened. If **intrauterine pregnancy** is confirmed, counsel client and refer for appropriate care. If **ectopic pregnancy** is suspected, refer immediately for complete evaluation.

Box 14.5 FAILURE OF SURGICAL STERILIZATION

Abortion is illegal in Maldives. However, a client needs counselling if an unplanned or unwanted pregnancy occurs. Unplanned pregnancy may be followed by many conflicting emotions' such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.

It is important to resolve the conflict over the unplanned pregnancy as quickly as possible in order to limit the psychological and physical damage to the client. Counselling is extremely helpful in assisting the client to come to terms with the pregnancy. Counselling sessions also provide an important opportunity to offer help with future contraception after the baby.

14.12 RECORD KEEPING AND REPORTING FOR FEMALE SURGICAL STERILIZATION

The provider should record information in the Client Clinic Card/Case Sheet/Record and Family Planning Register legibly. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.

14.13 MALE STERILIZATION (VASECTOMY)

Vasectomy is a simple minor surgical procedure performed as an outpatient/ambulatory procedure. The vas deferens on each side of the scrotum is identified by palpation before entering the scrotum. The vas deferens on each side is occluded so that the sperm are not released into ejaculation.

14.14 CATEGORY OF PROVIDERS FOR VASECTOMY

Male sterilization should be performed only by trained and competent medical officer and surgeons. The following table shows the required staff to safely conduct a vasectomy operation:

Table 14.4

No.	Position	Function
1	Trained and competent medical officer/surgeon	Oversee preoperative assessment and perform surgery
1	Staff nurse	Perform preoperative assessment, ensure understanding and documentation of informed choice/informed consent and assist the surgeon in OT and prepare OT
1	Nurse	Work in the OT/sterilization, instrument cleaning and packing
1	Attendant/peon	Assist in preoperative preparation and other tasks

14.15 ELIGIBILITY FOR VASECTOMY

14.15.1 Indications

Vasectomy can be done for a client who seeks permanent contraceptive method and wants no more children. In addition to a client's request for permanent contraception:

- The client should be ≥30 years of age.

AND

- The client should have at least 2 (two) living children. If only 2, the age of the last child should be ≥ 3years of age.

However, with adequate counselling there is no parity or age restriction and individual circumstances should be taken into consideration.

- The client or partner has a medical condition that would lead to a high-risk pregnancy or serious health problems.

Box 14.6

Male surgical sterilization is not appropriate if there is any suggestion that the client:

- shows excessive interest in reversal
- disagrees with/does not want to sign informed consent
- is under pressure from another person.

14.15.2 Absolute contraindications for vasectomy

Generally there are no absolute medical contra indications to voluntary male sterilization

14.15.3 Delay[27] vasectomy

For the conditions below, vasectomy should be delayed until specific conditions resolve. Help the client choose another method for the interim.

- acute systemic infection or gastroenteritis
- depression: help client choose another method and refer for treatment of depression
- STI: chlamydial and gonococcal infection
- uncontrolled diabetes
- local skin or scrotal infections
- large varicocele*
- large hydrocele*
- intrascrotal mass

[27] Procedure is delayed until the condition is evaluated or corrected. Alternative temporary methods of contraception should be provided in the interim.

- inguino scrotal hernia†

14.15.4 Conditions with anticipated difficulties

In the following conditions surgery should be undertaken in a setting with an experienced surgeon and staff, equipment required to provide general anesthesia and other back-up medical support. Alternate temporary methods of contraception should be provided, if referral is required or there is otherwise any delay.

- Cryptorchidism
- Filariasis involving the scrotum can lead to difficulties to palpate the spermatic cord.
- Coagulation disorders (risk of hematoma, risk of infection)

***Large hydrocele or large varicocele**: Vas may be difficult or impossible to locate in the presence of a large hydrocele or large varicocele. A single procedure to repair hydrocele/varicocele and vasectomy can decrease the risk of complication. Alternative methods of contraception should be provided if referral is required or there is any delay in performing the procedure.

†**Inguinal hernia**: clients with inguinal hernia requesting vasectomy: Vasectomy can be done concurrent with hernia repair. The procedure should be done in a setting with experienced surgeon and staff under GA and other back up medical support. Alternative temporary methods of contraception should be provided if referral is required or there is any delay in performing the procedure.

Documenting denial of voluntary sterilization
When a client is judged unsuitable for voluntary sterilization, the reason(s) and the action taken should be stated on the client card/record/case sheet

14.16 COUNSELLING AND INFORMED CHOICE FOR VASECTOMY

The couple's decisions about fertility and contraception are made for a variety of reasons. Decisions are influenced by personal circumstances such as family size, economic situations and the health status of one or both partners. The decision may also be affected by cultural expectations and information available about family planning. The person counseling should only explain the procedures not coerce the client into making the decision to undergo sterilization. The decision remains with the client.

Vasectomy is intended to be a permanent method and involves surgery with its associated risks. Voluntary sterilization has consequences, risks and concerns that need to be discussed with each client. It is therefore essential that service providers provide clients with necessary information and counseling about the procedure, clarify rumours (refer to Appendix 4) and emphasize that vasectomy is not castration. Counsel both partners if possible.

Pre operative counseling should focus on:

- preparing him for the operation
- giving him instructions on how to prepare for surgery and what to expect during and after the operation
- ensuring that he has made the decision voluntarily
- documenting client and spousal informed consent
- discussing other temporary and permanent family planning methods that are available
- ensuring that client has decided to use the method without any coercion and incentives.

The client must be counselled in a language and terminology he understands. Privacy must be maintained during counselling. The following information should be understood by clients:

- side effects of the method
- advantages/disadvantages
- the need to use contraception such as condoms or for the partner to use temporary methods for 3 months post vasectomy and the need for confirmatory semen analysis 3 months post vasectomy.

For more detailed information refer to Chapter 2 Overview of FP and Chapter 3 Counselling and informed choice.

Informed consent for vasectomy

Informed consent is the client's voluntary decision to undergo or not to undergo a surgical sterilization procedure, in full possession and understanding of the relevant facts. In Maldives, the informed consent should be signed by both the client and spouse and is the legal authorisation for performing the procedure. Therefore service providers should ensure that client and spouse have signed the informed consent form with full understanding. In special cases where the client is mentally disabled, the guardian can give consent. A sample of the informed consent form is provided in the appendices.

Informed consent for surgical sterilization is an agreement by an individual, after appropriate counseling has been given. The consent is an exercise of free choice with a full understanding of the nature and consequences of the procedure to be performed. The consent must be obtained BEFORE performing the procedure.

The following are primary and ethical obligations and responsibilities of the service provider:

- Ensure that the individual gives a free and informed, voluntary, consent for the operation.
- Ensure that the client and spouse are legally competent to give consent.
- Written consent signed by both the client and the spouse must be obtained for all clients requesting surgical contraception. This serves as legal authorization for surgery and documents informed and voluntary choice.

- Make sure that the client has been informed about the following:
    - alternatives to the procedure
    - availability of reversible methods of contraception
    - specific surgical procedures to be followed
    - health risks of surgical procedures and of anesthetic
    - risk of failure
    - benefits to be expected
    - permanency of the method
    - free choice of the client.

Signature
The form must be signed by the client undergoing the operation and spouse. The surgeon should also sign each consent form prior to performing the surgery. A parental or guardian's signature is required if the individual is mentally ill or disabled or legally incompetent. For those illiterate the form must be read aloud and explained.

14.17 CLIENT ASSESSMENT FOR VASECTOMY

The purpose of client assessment prior to surgical sterilization is necessary to:
- ascertain clients' fitness for the surgical sterilization procedure
- exclude possible risks associated with the procedure
- provide the surgical approach, type of anaesthesia and type of facility best suited to the client for the providing the procedure.

Preoperative Assessment
The recommended information to include in a preoperative medical evaluation of a male client are:

Demographic information
Includes client's name, address, age, marital status, spouse's name, occupation, education, number of living children, and age of the youngest child

Medical history to include the following

- Respiratory problems (e.g. asthma)
- Heart disease
- Diabetes
- Bleeding disorders
- Scrotal or inguinal surgery
- History of recent trauma
- Genitourinary infections/STI risk assessment
- Sexual impairment and scrotal abnormalities
- Current medications
- Allergies to medications

Physical examination
Genital examination is mandatory prior to performing vasectomy. Other examinations should be done as indicated by the medical history. It is important that providers

review history and perform the clinical examination and ensure the client's voluntary consent for the procedure.

Laboratory examination
There are no mandatory laboratory tests to be done prior to vasectomy.
The following tests are recommended as a good preventative health measures:

- pulse and BP
- urine sugar and protein
- hepatitis B test

14.18 VASECTOMY PROCEDURE

14.18.1 Timing of procedure

Vasectomy can be performed for male clients as requested as long as there are no reasons to delay the procedure. Procedure should be delayed till after successful treatment if the client has infection of the operative area, acute systemic infections or if there are associated inguino-scrotal problems.

14.18.2 Anaesthesia

Vasectomy can be performed under local anesthesia using 1% Xylocaine.
Occasionally general anesthesia can be used when vasectomy is performed using the Modified Standard Vasectomy technique. When GA is used client requires admission day prior to the surgery and is discharged on the first post operative day.

14.18.3 Vasectomy techniques

The two techniques of vasectomy are

1. Modified standard vasectomy
2. No-scalpel techniques

Modified standard vasectomy
Currently in Maldives **modified standard vasectomy** is the commonly used technique. This technique involves making a small midline incision on the scrotum followed by blunt and sharp surgical dissection to deliver the vas deferens. The vas deferens is then tied with suture material, cutting and removing a section of the vas on both sides.

No-scalpel vasectomy technique (NSV)
This method is also done in Maldives. It requires two specially designed but simple instruments to puncture the scrotal skin to access the vas deferens. The instruments are:

- NSV ringed forceps (3.0 to 4.0 mm diameter ring)
- NSV dissecting forceps

Compared with traditional vasectomy, NSV results in fewer complications, produces less pain during the procedure and early follow-up period, and permits couples to resume sexual activity earlier after surgery. Also, there is a reduction in the time required for the vasectomy when skilled providers use the no-scalpel approach.

In NSV, the vas deferens is palpated and then isolated using the ringed NSV forceps. The dissecting forceps are then used to puncture the scrotal skin (as opposed to an incision) to access and deliver the vas. The NSV technique does not require skin suture as the scrotal skin puncture is very small.

Vas occlusion by fascial interposition
The preferred method to occlude the vas is to divide the vas, remove a small segment followed by fascial interposition and ligation of both ends with non-absorbable sutures. In fascial interposition, the fascial sheath (the thin layer of tissue that surrounds the vas) is sutured over one end of the cut vas. Fascial interposition thus places a tissue barrier between the cut ends of the vas.

14.18.4 Monitoring the client during vasectomy procedure

The client should be monitored by observing his general condition and state of consciousness during and after surgery. Vital signs should be monitored continuously if general anaesthesia is used.

14.18.5 Post-operative care and discharge

14.18.5.1 Vasectomy under local anesthesia: Clients who have had their vasectomy performed under local anesthesia can be discharged after 30 minutes if they are stable and do not have abnormal findings. Before the client is discharged, a trained staff member should repeat and verify his understanding of the discharge instructions. Routine antibiotic prophylaxis is NOT given for vasectomy. Clients are provided analgesics such as paracetamol for 3 days.

14.18.5.2 Vasectomy under general anesthesia: If vasectomy was performed under general anesthesia, the client's vital signs and state of consciousness should be closely monitored post operatively in the recovery room. The client must be ambulatory, alert and oriented with normal vital signs before being sent to the ward. Clients are then discharged on the first post operative day (considering day of surgery as day of operation). Before the client is discharged, a trained staff member should repeat and verify the client's understanding of the discharge instructions.

14.18.5.3 Post vasectomy contraception
All clients should be counselled on the importance of using post vasectomy contraception till semen analysis confirms the effectiveness of vasectomy. A client who has undergone vasectomy should wait 3 months before relying on his vasectomy for contraception. Current evidence shows that 20 ejaculations after vasectomy (in the absence of a 3 month waiting period) is not a reliable determinant of vasectomy effectiveness. The client should however resume sexual activity (while using contraceptive protection) during the 3 month waiting period after his vasectomy in order to clear any remaining sperm from his semen.

Box 14.7 PREOPERATIVE, POSTOPERATIVE AND DISCHARGE CARE AND CLIENT INFORMATION: VASECTOMY

Pre-operative client information

- **At community level:**

Community health staff should inform the clients to prepare for surgery by:

  - receiving counselling about family planning procedures and specifics about surgical sterilization
  - bathing, wearing clean clothes

- **At facility site:**

Health staff and counsellors should explain in detail the following before the client undergoes the procedure:

  - steps of the operation, including information on local anaesthesia and screening
  - what to expect in operating theatre
  - expectations about pain/discomfort

Post-operative client information

The following points must be explained to all clients:

  - Resume normal activities in 3 days.
  - Resume sexual activity whenever comfortable but with an additional contraceptive method for 3 months post vasectomy. A client who has undergone vasectomy should wait 3 months before relying on his vasectomy for contraception. During this period, he should resume sexual activity, but he or his partner will need to use additional contraceptive protection. Provide the client with supply of condoms, and explain how to use them. Effectiveness of vasectomy is confirmed by a semen analysis done 3 months post vasectomy.
  - Wound care: Keep incision clean and dry. Avoid getting the wound wet while bathing. Soap and water can be used to wash the wound after 3 days.
  - Wear close fitting scrotal support for at least 48 hours and then as long as it is needed.
  - Describe the warning signs (refer to Box 14.8 – signs of infection, bleeding, pain) and where to go if needed.
  - Explain how to use medications that are given. Clients are provided with analgesics such as paracetamol for 2 days. (Antibiotics are not used routinely for vasectomy.)
  - Reiterate that sexual performance is unchanged after vasectomy and that vasectomy does not affect a man's ability to have sex.
  - Dates of follow-up visits: first follow-up day 3 post surgery to check wound and second follow-up at 3 months post vasectomy to do semen analysis to confirm effectiveness of vasectomy.
  - Written or printed post-operative care and discharge information should be given to the client before he is discharged.

Box 14.8 POSTOPERATIVE DANGER SIGNS POST VASECTOMY

See doctor in the event of:

- fever (greater than 38°C or 100.4°F)
- dizziness with fainting
- persistent or increasing scrotal pain and/or swelling
- bleeding or pus coming from the incision

14.19 ROUTINE FOLLOW-UP CARE AFTER VASECTOMY

All clients who have had a vasectomy are advised the following:

- First follow up 3rd day post vasectomy to check wound.
- Second follow up 3 months post vasectomy to do mandatory semen analysis to confirm effectiveness of vasectomy.
- Return to facility earlier if he has any concerns.
- Contact doctor immediately if he has any of the warning signs in Box 14.8.

At follow-up
The operating surgeon if possible should conduct the follow up assessment:

- During the first follow up visit:
    - Inspect the wound site.
    - Remove sutures if any.
    - Perform any other client evaluation that should be done.
    - Address client concerns if any.
- At second follow at 3 months post vasectomy: do semen analysis to confirm effectiveness of vasectomy. Address client concerns if any.
- Further follow-up can be scheduled if continued care is required

14.20 MANAGEMENT OF COMPLICATIONS OF VASECTOMY

Serious complications are extremely rare and occur in less than 1% of all male sterilization procedures. Clients should be routinely counseled about common side effects and possible complications and what to do if certain problems occur. When a client presents with side effects or complications they should be assessed, counseled and managed appropriately. Refer to Chapter 3 for details on counseling clients with problems using a contraceptive method.

14.20.1 Anaesthesia complications

Use of general anaesthesia significantly and unnecessarily increases the risks of major complications associated with vasectomy and is not recommended except in certain complicated procedures. For local anaesthesia, when intravascular injections are avoided and the recommended doses of xylocaine are not exceeded, toxic reactions are rare. However, toxic reactions may be manifested as convulsions requiring

14.20.2 Surgical complaints

The most common complaints following vasectomy are swelling of scrotal tissue, bruising and pain. While these symptoms generally disappear without treatment, ice packs, scrotal support and simple analgesics provide relief. The incidence of these symptoms can be reduced by using gentle operating technique and checking for bleeding.

Complications, such as haematomas and infections, are uncommon. Haematomas can be minimized by ensuring meticulous haemostasis. Also, clients must be careful not to strain the scrotal sac for several days after surgery. Infections can be minimized through the use of meticulous aseptic technique and good postoperative care. There is no evidence that routine prophylactic use of antibiotics is beneficial if asepsis is adequate.

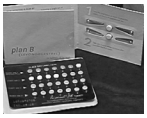
Table 14.5 Management of complications of vasectomy

Complication	Assessment	Management
Superficial bleeding (skin edges or subcutaneously)	Apply secure pressure over wound. Then check if bleeding persists.	***Postoperatively*** Place secure pressure dressing on wound. If bleeding persists, reopen wound under local anaesthesia, identify the bleeders and ligate them with sterile suture.
Vasovagal reaction	Check vital signs.	Reassure client. Elevate client's lower extremities. Provide additional local anaesthesia if needed.
Wound infection	Confirm presence of infection or abscess.	If skin infection is present, provide antibiotics. If abscess is present, drain and treat as indicated.
Postoperative fever	Determine source of infection.	Treat infection based on findings.
Haematoma	Confirm presence of infection or abscess.	Apply warm, moist packs to site. Observe; if extensive may require drainage. If infected, treat as indicated.
Unusually severe **pain** at incision site	Determine presence of infection or abscess.	Treat based on findings (e.g., moist heat, analgesics).
Vaso-cutaneous sinus (Discharging scrotal sinus)	Confirm the presence of discharging sinus and any concomitant infection.	If infection – treat before referring for release operation. Amoxicillin 250 mg and cloxacillin 250 mg given together 6 hourly for 7 days.
Sperm granuloma	Confirm presence of nodule. Determine if infection	Asymptomatic: no treatment. Pain: analgesic if persistent pain. Evacuate cyst, cut and seal ¼"

Complication	Assessment	Management
	is present.	towards the testis.
Chronic pain	History of reaction of unilateral or bilateral scrotal pain.	Non-steroidal analgesic.
Pregnancy of the partner	Determine if pregnant and age of gestation. Determine period elapsed since the procedure. Assess for azospermia by semen analysis.	Refer for appropriate care. If more than 3 months since vasectomy and semen analysis is positive for sperm, discuss repeat vasectomy for man, if necessary, or possibly tubal ligation for partner.
Vasectomy failure	Repeat semen analysis to confirm previous semen analysis result.	Explain how failure happened. Refer client for repeat vasectomy if so desired by client.
Note: Abortion is illegal in Maldives. A client needs counselling should an unplanned or unwanted pregnancy occurs. Unplanned pregnancy may be followed by many conflicting emotions' such as fear, anger, excitement and despair following the discovery. The conflicting emotions are influenced by her social circumstances and her relationship with her partner.		

14.21 RECORD KEEPING AND REPORTING FOR VASECTOMY

The provider should record information in the Client Clinic Card/Case Sheet/Case Record and Family Planning Register legibly. The provider should ensure that registers are completed, regularly maintained and reported to the Department of Public Health.



15 Emergency Contraception

Chapter 15: EMERGENCY CONTRACEPTION (EC)

15.1 INTRODUCTION

Emergency contraception refers to contraceptive methods that can be provided to women following unprotected sexual intercourse to prevent an unintended pregnancy. Emergency contraceptive methods are effective and safe for the majority of women who may need them, as well as being simple to use.

Emergency contraception can be provided by hormonal pills or by Cu IUD. The discussion in this chapter is only on emergency contraceptive pills.

Emergency contraceptive pills are often called 'morning after pills', however they are better named 'secondary' or 'emergency contraceptive pills'. These names remove the idea that the user must wait until the morning after unprotected intercourse to start treatment or that she will be too late if she cannot obtain the pills until the afternoon or night after intercourse.

The mechanism of action of emergency contraceptive pills depends on the time during the menstrual cycle that they are taken. Emergency contraceptive pills may inhibit or delay ovulation, inhibit tubal transport of the egg or sperm, interfere with fertilization or alter the endometrium, thereby inhibiting implantation of a fertilized egg.

Emergency contraceptive pills do not protect against STI/HIV. If there is a risk of STI/HIV (including during pregnancy or post partum), the correct and consistent use of condoms is recommended, either alone or with another contraceptive method. Male latex condoms are proven to protect against STI/HIV.

15.2 TYPES OF EMERGENCY CONTRACEPTIVE PILLS (ECP)

The following are the types of emergency contraceptive pills:

- Levonorgestrel contraceptive pills
- Combined oral contraceptive pills (combined ethinyl estradiol and levonorgestrel)

Emergency contraceptive pills are available in many countries world-wide as special emergency contraceptive pill packages (dedicated packages).

15.3 EFFECTIVENESS OF EMERGENCY CONTRACEPTIVE PILLS

Overall, only 1–3% of women using emergency contraceptive pills initiated within 72 hours after unprotected intercourse become pregnant during that cycle (the chances of pregnancy are approximately four times greater when no emergency contraceptive is used). If the woman has used hormonal emergency contraception and pregnancy does occur, the small doses of hormones are not harmful to the developing foetus and will not terminate a pregnancy.

Ideally, emergency contraceptive pills should be taken as early as possible after unprotected intercourse – that is, within 72 hours. If the above is not possible, emergency contraceptive pills may be taken up to 120 hours after unprotected intercourse. The longer the delay the lower is the effectiveness of the pills.

15.4 CATEGORY OF PROVIDER

Emergency contraceptive pills should be provided by doctors (gynecologists or medical officers) who have been properly trained to counsel and provide emergency contraceptive pills. All providers must adhere to service standards.

15.5 ELIGIBILITY FOR EMERGENCY CONTRACEPTIVE PILLS

15.5.1 Indications

Emergency contraception is meant to be used only following an unprotected act of sexual intercourse to prevent pregnancy. The following are a number of situations when a woman can use or may need to use emergency contraception:

- When a woman has been a victim of sexual assault.
- After incorrect or inconsistent use of regular contraceptive methods:
    - failed coitus interruptus, when ejaculation has occurred in the vagina or on the external genitalia;
    - miscalculation of the infertile period when using periodic abstinence or failure to abstain from sexual intercourse during the fertile days;
    - being late for a contraceptive injection;
    - missed 3 or more active (hormonal) combined oral contraceptive pills in the first week and had unprotected intercourse;
    - missed one or more progesterone only pills by more than 3 hours and had unprotected intercourse;
    - unprotected intercourse prior to the effective time of vasectomy.
- Accidental failure of other contraceptive methods such as:
    - condom breakage or slippage
    - IUD expulsion.

15.5.2 Risk to clients with medical problems

The duration of use (2 days or less) of emergency contraceptive pills is less than that of regular use of COC or POP and so is expected to have less clinical impact in women with:

- history of current or past blood clotting problems
- cardiovascular complications
- migraine
- liver disease.

THERE ARE NO RESTRICTIONS FOR USE OF EMERGENCY CONTRACEPTIVE PILLS IN CASES OF RAPE.

15.6 COUNSELING

All clients should be counseled prior to providing emergency contraception. Let the client tell her story if she so wishes. Offer support without judging the client. If she decides to take emergency contraceptive pills, inform her that:

- Emergency contraceptive pills prevent pregnancy.
- ECP do not cause abortion.
- ECP should not be used as regular contraception – counsel on regular contraception.
- ECP dp not protect against STIs or HIV/AIDS.

Explain the effectiveness of emergency contraceptive pills if used correctly and their mechanism of action depending on when in the menstrual cycle the ECPs are taken. For more detailed information refer to Chapter 3 Counselling and Informed Choice.

15.7 CLIENT ASSESSMENT

Prior to providing emergency contraceptive pills, it is mandatory to ensure the client is **NOT** already pregnant (i.e. she might have become pregnant in the previous month) and a pregnancy test should be done to confirm client is not already pregnant.

15.8 PROVISION OF EMERGENCY CONTRACEPTIVE PILLS

15.8.1 Regimen

Preferred regimen for emergency contraceptive pills (ECP)
SINGLE DOSE LEVONORGESTREL 1.5 MG ORALLY to be taken as early as possible after unprotected intercourse, within 72 hours.

Alternative regimens of emergency contraceptive pills
Two doses Levonorgestrel 0.75 mg orally at an interval of 12 hours. First dose should be taken as early as possible after unprotected intercourse, within 72 hours, and the second dose 12 hours after the first dose.
OR
Two doses of combined ethinyl estradiol 100 micrograms and levonorgestrel 0.5 mg orally at an interval of 12 hours. First dose should be taken as early as possible after unprotected intercourse, within 72 hours and the second dose 12 hours after the first dose

Ideally emergency contraceptive pills should be taken as early as possible after unprotected intercourse, that is within 72 hours. If the above is not possible, ECPs may be taken up to 120 hours after unprotected intercourse. The longer the delay the lower is the effectiveness of the pills.

15.8.2 Nausea and vomiting associated with emergency contraceptive pills

Preventing emergency contraceptive pills associated nausea and vomiting
Many women will not experience nausea and vomiting when taking emergency contraceptive pills. However, it is difficult to predict which women will experience nausea and vomiting. Women taking levonorgestrel-only emergency contraceptive pills are less likely to experience nausea and vomiting compared to women taking combined estrogen progesterone emergency contraceptive pills.

Routine anti-emetics before taking emergency contraceptive pills is not recommended. Pre-treatment with anti-emetics can be considered depending on availability and clinical judgement.

Management of vomiting after taking emergency contraceptive pills
If a woman vomits within 2 hours after taking a dose of emergency contraceptive pills she should take another dose as soon as possible. If she is taking combined estrogen progesterone emergency contraceptive pills she can use an anti-emetic before taking the combined estrogen progesterone emergency contraceptive pills.

If vomiting continues, a repeat ECP dose can be given vaginally.

Vomiting 2 hours after taking emergency contraceptive pills does not require further action as 2 hours is considered sufficient for hormone absorption.

15.9 INSTRUCTIONS FOR CLIENTS TAKING EMERGENCY CONTRACEPTIVE PILLS

- How to take the emergency contraceptive pills.
- What to do if she has nausea and vomiting.
- May have spotting or bleeding a few days after taking pills.
- Expect a menses within 3-4 weeks.
- Return for follow up check after 4 weeks. Provide date for next visit.
- Return to clinic/facility earlier if she has any concerns.
- Emphasize that emergency contraception SHOULD NOT be used on a regular basis (from month to month) because it is much less effective than other methods.
- If already chosen a method for future contraception counsel on how and when to start her chosen future contraceptive method.

15.10 ROUTINE FOLLOW-UP CARE

- All clients provided with emergency contraception should be followed up at 4 weeks after, for a check-up.
- If a client has not had a menses within 4 weeks, check for pregnancy. If positive, she should receive counseling and referral to antenatal care. Note: It is important to exclude ectopic pregnancy.
- If not pregnant, counsel regarding regular contraception and assist client to

- Counsel client to use condoms if she thinks there is any chance that she or her partner are at risk for exposure to STIs, including HIV/AIDS. Demonstrate the use of condoms and provide supplies.

Emergency contraceptive pills are for emergency use only and not recommended for routine use because of the higher possibility of failure compared to regular contraceptives and the increase in side effects such as nausea and vomiting.

15.11 RECORD KEEPING AND REPORTING

The provider should legibly record information in the client clinic card and family planning register. The provider should ensure that records and registers are completed, regularly maintained and reported to the Department of Public Health.

Abbreviations

AIDS	Acquired Immune Deficiency Syndrome
ANC	Ante-Natal Clinic
BP	Blood Pressure
CBD	Community Based Distribution
CHS	Community Health Supervisor
CHW	Community Health Worker
COC	Combined Oral Contraceptives
CPR	Contraceptive Prevalence Rate
DMPA	Depo Medroxy Progesterone Acetate (also referred to as Depo Provera)
ECP	Emergency Contraceptive Pills
FAB	Fertility Awareness-Based Methods
FHW	Family Health Worker
FP	Family Planning
FU	Follow-Up
GA	General Anesthesia
Hb	Haemoglobin
HBV	Hepatitis B Virus
HCV	Hepatitis C Virus
HIV	Human Immunodeficiency Virus
HLD	High Level Disinfection
ICPD	International Conference on Population and Development
IP	Infection Prevention
IUD/IUCD	Intra-Uterine Device/Intra-Uterine Contraceptive Device
LA	Local Anesthesia
LAM	Lactational Amenorrhoea Method
LMP	Last Menstrual Period
LSCS	Lower Segment Caesarean Section
MCH	Maternal and Child Health
NET-EN	Norethisterone Enantate
NSV	No-Scalpel Vasectomy
OC	Oral Contraceptives
OT	Operating Theatre
PID	Pelvic Inflammatory Disease
POC	Progestogen-Only Contraceptives
POI	Progestogen-Only Injectable
POP	Progestogen-Only Pill
RH	Reproductive Health
RTI	Reproductive Tract Infection
SA	Spinal Anesthesia
SDM	Standard Days Method
STI	Sexually Transmitted Infection
TBA	Traditional Birth Attendant
TFR	Total Fertility Rate
UNFPA	United Nations Population Fund
VDRL	Venereal Disease Research Laboratory
WHO	World Health Organization

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7. EngenderHealth, *Infection prevention: a reference booklet for health care providers*, EngenderHealth, New York, USA 2001
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Appendix A1: Worksheet for dispensing oral contraceptives in community based family planning services

Name of community worker/Service post:
Client's name: Age:

Address: Date:

Date of last menstrual period or childbirth as applicable:

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1. Has the client missed her period? **YES** ☐ **NO** ☐

If YES, don't offer Oral Contraceptive Pills unless pregnancy has been ruled out.
If NO, go to next question.

2. Is the client known to have any of the following problems?

Cancer of the uterus, breast or liver **YES** ☐ **NO** ☐

Severe heart disease **YES** ☐ **NO** ☐

Recent blood clots or strokes **YES** ☐ **NO** ☐

Recent acute liver disease (hepatitis) **YES** ☐ **NO** ☐

If YES, to any item, do not give her any oral contraceptive pills until she has been evaluated at a clinic. In the meantime, provide her with condoms.

3.Does the client have any of the following problems?

Yellow skin or yellow eye colour	**YES**	☐	**NO**	☐
Severe chest pain.				
Unusual shortness of breath	**YES**	☐	**NO**	☐
Severe headaches	**YES**	☐	**NO**	☐
Taking long-term medicines such as rifampicin	**YES**	☐	**NO**	☐
Lumps in the breast	**YES**	☐	**NO**	☐
Blood discharge from the nipples	**YES**	☐	**NO**	☐
Abnormal vaginal bleeding	**YES**	☐	**NO**	☐
Severe pain and/or swelling in the legs	**YES**	☐	**NO**	☐
Heavy smoking	**YES**	☐	**NO**	☐

If YES to any item, refer her for evaluation. In the interim provide her with condoms and appropriate instructions on how to use them.
For all clients, go to next question.

4. Is the client breastfeeding? **YES** ☐ **NO** ☐

If YES, give only POP if the infant is between six weeks and six months of age.
If the infant is six months or older, recommend POP, but you can provide either POP or COC, as acceptable to the client.
If NO, recommend the COC but you can provide either COC or POP, as acceptable to the client.

If the client needs to be seen at a clinic, give her a letter of referral, and help her in any possible way to obtain a consultation.

Appendix 2: FACILITY, EQUIPMENT AND SUPPLIES

A2.1 INTRODUCTION

Clean and well maintained physical facilities with electricity and running water, functioning equipment and continuous reliable supplies are crucial for the provision of quality family planning services.

A2.2 FACILITY

Health facilities providing family planning services should be clean and well maintained. Facilities should have a waiting room for new and follow-up clients. The environment should be consistent with the cultural background and should have educational material such as posters and pamphlets on all family planning methods as well as material on other aspects of reproductive health.

There should be a designated space for counselling, ensuring privacy, with job aids such as flip charts for providers. Client examination and provision of family planning methods should be done in a room that is clean, well maintained with adequate and appropriate equipment and supplies.

Minimum facilities for providing temporary methods of family planning are: waiting room for clients, a designated area conducive to privacy and confidentiality for counselling, client examination and provision of services. Laboratory services or access to such services should be available.

Facilities providing surgical sterilization should in addition to the above have a clean operating room/operating theatre isolated from the outside and from clinic traffic. The operating theatre/room should have a tiled or concrete floor that could be easily and thoroughly wet mopped and disinfected. The operating theatre should be enclosed and kept free of dust and fly proofed and should have adequate lighting. Adjacent to the surgical room there should be a designated area for surgical personnel to change clothes and scrub. There should also be a post operative recovery room for clients after surgery. Laboratory services or access to such services should be available.

All health facilities should have designated areas for cleaning, sterilizing and disinfecting surgical instruments and materials and storage of processed instruments. Similarly, designated space and cabinets should be available in all health facilities to file records and registers for easy retrieval of client records and registers. It is important that facilities have adequate space and shelves to organize and store contraceptive supplies. Contraceptives should be stored safely under proper conditions to maintain their quality as well as ensure easy access to the supplies. For detailed information on the requirements for storage of contraceptive supplies refer to *Logistics Management Guidelines for Family Planning* developed by Department of Public Health, Maldives.

Another important requisite is toilet and washing facilities for clients as well as an area for clients to change their clothes depending on the family planning service.

A2.3 MINIMUM EMERGENCY PROCEDURE REQUIREMENTS

All facilities where surgical procedures are performed MUST:

- have basic emergency equipment
- be able to perform emergency surgical procedures including emergency laparotomy or else an efficient ambulance service for the transport of a patient to the nearest hospital
- be adequately staffed to perform these emergency procedures
- have an anaesthetist available for emergencies
- have personnel trained in basic resuscitation procedures.

A2.4 EQUIPMENT AND SUPPLIES FOR NORPLANT, IUD AND MALE AND FEMALE SURGICAL STERILIZATION

All equipment, instruments and supplies must be in optimum working order, available and accessible to the provider. A functioning laparoscope and all its attachments are mandatory for laparoscopic sterilization. The following table is a list of equipment and supplies needed for Norplant insertion and removal, IUD insertion and for male and female sterilization.

Table A2.1 Equipment and supplies for hormonal implants (Norplant) insertion and removal

Non expendable equipment & supplies
Scalpel handle
Syringe 5 ml
Needle 20 Gauge x 4”
Mosquito forceps, curved 5”
Dissecting forceps
Forceps, circle, curved 5.5”
Norplant trochars with cannula
Sponge holding forceps
Small metal bowl
Scalpel blade size 11
Cheatle forcep with jar
Spot light
Torch/flashlight
Expendable supplies
Instruments wrapping cloth 18” sq
Arm drapes with centre hole (Eye-towel) 12” sq
Small hand towel
Steri-strips, butterfly or plain band-aid
Sterile gloves various sizes
Gauze 4” X 4”
Roller bandage 3”
Norplant implants
Local anaesthetic 1% xylocaine 30 ml
Bar soap
Betadine antiseptic solution/Hibiscrub
Bulbs
Batteries

Table A2.2 Supplies for hormonal injectables (POI

Disposable syringes and needles
Gauze sponges or cotton swabs
Antiseptic solution
Soap

Table A2.3 Equipment and supplies for IUD insertion and removal

Non-expendable equipment
Vaginal speculum, medium (Sims/Cuscos)
Sponge holding forceps
Small metal bowl (Galley pot) for antiseptic solution
Cervical tenaculum/Vulsellum (small toothed)
Uterine sound
Scissors, long handled
Instrument pan and cover
Long curved artery forceps
Cheatle forceps
Cheatle jar
Kidney tray (big size) for keeping used instruments
Spot light
Torch/flashlight
Expendable supplies
Copper-T 380A in a pre-sterilized pack.
Bar soap
Torch with batteries, appropriate sizes
Gloves various sizes
Antiseptic solution/Betadine (povidone iodine) solution/Hibiscrub
Instrument wrapping cloth 18" sq
Small hand towel (inside set)
Bulbs
Batteries

Ensure IUD packet is not open or damaged and that date of expiry is not over. Tarnishing on the surface of CuT may be seen occasionally due to moisture. Tarnishing does not affect the safety or effectiveness of the CuT, provided the packet is NOT open or damaged.

Table A2.4 Expendable supplies for female sterilization

Female sterilization: laparoscopic
Gauze cloth
Adhesive tape 4"x 5m roll
Sterile gloves various sizes
5 cc disposable syringes
Surgical blade # 11
Falope rings/bands
Vicryl for skin
Liq. Betadine
Liq. Cidex
Multivitamin tablets
Antibiotics (Amoxycillin)
Paracetamol
Female Sterilization: Minilaparotomy
Gauze cloth
Adhesive tape 4"x 5 m roll
Sterile gloves various sizes
5 cc disposable syringes
10 cc disposable syringes
Surgical blade # 10
Surgical blade handle #3
Forceps tissue delicate 5.5"
Forceps artery straight 5.5"
Forceps artery/ mosquito, delicate curved 5"
Forceps Allis, delicate 6", 5x6 teeth
Forceps Babcock 7.5"
Forceps Schroeder Tenaculum 10"
Forceps sponge straight 9.5"
Retractor abdominal wall (Richardson-Eastman, small size – interval sterilization)
Retractor abdominal wall double ended for post partum sterilization
Scissors (Metzenbaum) 7" curved
Scissors operating Mayo 6.75" curved
Needle holder Mayo Hegar 7"
Round body needle # 10/11
Catgut plain # 1/0
Catgut chromic 1/0
Vicryl for rectus sheath
Vicryl for skin
Vaginal speculum Sims/Cuscos
Catheter female urethral
Xylocaine Inj. 1% vials
Liq. Betadine, 500 ml
Inj. Pethidine 50 mg
Inj. Phenargan 50 mg.

Inj. Atropine 0.6 mg
Hypochlorite for decontamination
Antibiotics Amoxcillin
Multivitamin tablets
Paracetamol tablets

Table A2.5 Instruments for vasectomy including special instruments required for no scalpel vasectomy

Iodine cup, 4 oz 1.5” high
Addison forceps, 5”
Forceps, artery, straight, 51/2”
Forceps, artery, curved
Scalpel handle
Surgical blade, size 10
Iris scissors, curved
Sponge holding forceps
Ringed forceps, 4.0 mm ring (NSV)
Ringed forceps, 3.0 mm ring (NSV)
Hemopoint/dissecting forceps for NSV

Table A2.6 Expendable supplies for vasectomy

Gauze cloth 18 m x 1 m
Sterile gloves various sizes
Liq. Betadine
Xylocaine Inj. 1% 30 ml vial
Disposable Syringe 5 ml with 1.5”, gauge 23-24 needle
Black silk
Paracetamol tablets
Hypochlorite solution for decontamination
Dressing
Adhesive tape 4” x 5” roll

Further reading

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Appendix 3: INFECTION PREVENTION

A3.1 INTRODUCTION

Infection prevention practices are crucial to minimize the transmission of infections to clients and service providers, including clinic helpers who handle contaminated instruments and wastes.

A3.2 PROTECTIVE BARRIERS

Protective barriers are physical, mechanical or chemical processes which help prevent the spread of infectious microorganisms from client to client, clinic staff to client, or vice versa.

Protective barriers include:

- handwashing
- wearing gloves and surgical attire
- antisepsis
- processing equipment, instrument and other items
- managing clinical waste.

A3.2.1 Handwashing

Handwashing may be the single most important procedure in preventing infection. To encourage handwashing, a continuous supply of fresh water, either from the tap or a bucket, and soap should be provided. Microorganisms grow and multiply in moisture and in standing water. Therefore, avoid basins containing standing water, even with the addition of an antiseptic agent such as Dettol® or Savlon®, because microorganisms may survive and multiply in these solutions.

A3.2.1.1 Indications for hand washing

- Before and after examining a client especially when touching mucous membranes
- Provision of injectables
- Before putting on sterile or high-level disinfected (HLD) gloves
- After removing gloves, as they may have invisible holes or tears
- After handling contaminated objects, such as used (soiled) instruments
- When accidentally touching blood or other body fluids (e.g., when collecting laboratory specimens).

Technique of hand washing
It is the best practice for providers to wash their hands between each client contact.
For clinical examination, pelvic examination (bimanual and speculum examination and insertion/removal of IUD):

- Wash hands with plain soap for about 15–30 seconds; then rinse in a stream of water. Dry hands with a clean towel or air dry.

For surgical procedures (e.g., laparoscopy, minilaparotomy, vasectomy, insertion and removal of Norplant implants):

- Remove all items of jewellery, including wristwatch.
- Wash hands with an antiseptic soap for 3 to 5 minutes.
- Scrub hands with a soft brush or sponge. Begin at the fingertips; wash between all fingers and move toward the elbow.
- Repeat for the second hand.
- Rinse each arm separately, fingertips first, holding hands above the level of the elbows to prevent water from running down from the elbow to the hands.
- Dry hands with a sterile towel.
- After handwashing has been completed, hold hands above the level of the waist.

Repeat handwashing if hands touch any unsterile object before gloves are put on. However, if this happens while wearing gloves, just change gloves.

A3.2.2 Wearing gloves and surgical attire

Wearing gloves
Gloves should be worn by all staff prior to contact with blood and body fluids, either when serving a client or when handling contaminated equipment and materials. Change gloves between each client to avoid cross contamination. Using new, single-use (disposable) gloves is preferable. However, re-usable gloves can be washed and sterilized by autoclaving, or washed and high-level disinfected by boiling before reuse. Table A3.1 lists indications for using gloves

Table A3.1 Indication for using gloves

Types of gloves	Indications
Sterile gloves	While performing surgical procedure such as minilaparotomy, vasectomy, insertion and removal of Norplant etc.
High-level disinfected gloves (single use or reusable)	When sterile gloves are not available for surgical procedure.
Sterile Gloves (Clean non-sterile gloves can be used when 'No touch technique' is used for IUD insertion.)	IUD insertion and removal [When 'no-touch technique' [28]is used] Pelvic examination
Utility gloves	While handling used instruments, cleaning blood or bloody fluids and handling waste.

Do not use gloves which are cracked, peeling or have detectable holes or tears.

Using other surgical attire

Other surgical attire such as caps, masks and gowns help reduce the risk of post-procedure infections in clients. Table A3.2 lists the required surgical attire for family planning procedures.

Table A3.2 Surgical attire required for family planning procedures

Family Planning Procedure	Gloves	Cap/Mask	Gowns
IUD	Yes	No	No
Norplant implants and removal	Yes	No	No
NSV	Yes	Yes	No
Minilaparotomy	Yes	Yes	Yes
Laproscopy	Yes	Yes	Yes

A3.2.3 Antisepsis

Antisepsis involves cleaning of the client's skin or mucous membrane with an antiseptic substance to remove or eliminate as many microorganisms as possible, prior to any invasive procedure. Care should be taken not to irritate or damage skin or mucous membrane.

[28] 'No touch technique' is used to insert an IUD aimed to minimize chances of uterine infection following insertion. The method involves loading sterile packaged IUD into their inserters while both IUD and inserter are still in the sterile packaging.

Indications to use antiseptics

- Surgical handscrub
- Skin, cervical and vaginal preparation before a clinical procedure
- Handwashing in high-risk situations, such as before invasive procedures (e.g., insertions of central venous catheters or tubes) or before contact with clients at high risk of infections (e.g., newborns or immunosuppressed clients)

Note: While preparing skin for surgical procedure, do not shave hair at the operative site. Shaving increases the risk of infection as the tiny nicks in the skin provide an ideal setting for microorganisms to grow and multiply. If the hair must be cut, trim the hair close to the skin surface immediately before surgery.

Selection of antiseptics
The following antiseptic solutions are approved for use:

- Idophors, various concentrations 0.5% to 10% (e.g. Betadine)
- Alcohols (60 to 90%), ethyl, isopropyl, 'methylated spirits'
- Chlorhexidine gluconate 4% (e.g. Hibitane, Hibiscrub) Centrimide and chlorohexidine gluconate (CHG), various concentrations (e.g., Savlon)
- Iodines (2 to 3%), tincture and aqueous (e.g., Lugol's) (not for use on mucous membranes such as vagina)

Remember: antiseptics do not have the same killing power as the chemicals used for HLD. Therefore, antiseptic solutions should never be used to:

- disinfect inanimate objects, such as instruments and reusable gloves
- clean surfaces, such as floors or countertops.

Instruments and items such as pickups (lifters, cheatle forceps), scissors, scalpel blades and suture needles should never be left soaking in an antiseptic solution; they should always be stored dry. Microorganisms can live and multiply in antiseptic solutions and contaminate the instruments and other items, leading to infections.

Storage and dispensing of antiseptics
Contamination of every antiseptic has been documented. Microorganisms contaminating antiseptic solutions include gram-negative bacilli and endospores and, rarely, staphylococcus. These organisms can cause subsequent infection when used for handwashing or on a client's skin or mucous membrane.

To prevent contamination of antiseptic solutions:

- Pour the antiseptic, unless supplied commercially in small quantities, into small, clean, reusable containers for daily use. This prevents evaporation and contamination, which could occur if the large container is opened too often. Do not store gauze or cotton wool in aqueous antiseptics as this promotes contamination.
- Establish a routine schedule (e.g., each week) for preparing new solutions.
- Store antiseptics in a cool, dark area. Never store chemicals in direct sunlight or in excessive heat (e.g., upper shelves in a tin-roofed building).

- When using antiseptic solutions, always pour the solution out of the container. Touching the rim or contents of the container with gauze, a cotton swab or hand contaminates the entire bottle of antiseptic.

A3.2.4 Processing of equipment and other items

The purpose of processing of instrument is to reduce the spread of microorganisms by equipment, instrument and other items while reusing these materials for providing services. It is not only for clients/patients but also for service providers and clinic support staff.

Steps in processing equipment and other items:

1. Decontamination
2. Cleaning
3. Sterilization [Rarely High level disinfection (HLD)]
4. Storage

Decontamination
Decontamination is important for pre-treating instruments and objects that may have come in contact with body fluids, to make them safer to handle by personnel who clean them. Proper decontamination will inactivate Human Immunodeficiency Virus (HIV) and hepatitis B virus (HBV), hepatitis C virus (HCV) and hepatitis D, making instruments safer for staff to handle. Using 0.5% chlorine solution is an inexpensive and effective way for decontamination.

Preparation of 0.5% chlorine solution
Chlorine solution can be made from liquid household bleach (sodium hypochlorite) or from other chlorine compounds available in powder (calcium hypochlorite or chlorinated lime) or tablet form (sodium dichloroisocyanate). Refer to Table A3.3 for required items for decontamination.

Process of decontamination

- Keep a fresh plastic bucket containing 0.5% chlorine solution near the procedure site.
- Immediately after each procedure, place the used items in 0.5% chlorine solution for 10 minutes. Do not wait too long before starting decontamination, to prevent organic materials from drying and becoming hard to remove.
- After 10 minutes, rinse with water and remove gross organic material before being cleaned. **Soaking instruments for excessive periods of time in the chlorine solution damages them.**
- Decontaminate large surfaces (e.g., pelvic examination tabletop) by wiping them with 0.5% chlorine solution.

Precautions

- Use only plastic containers for chlorine solution. Chlorine damages metal containers.
- Use utility gloves while working with chlorine solution.
- Submerge all the instruments in 0.5% chlorine solution so that the chlorine solution level is above the instruments. Open jointed items such as clamps and scissors.
- To prevent damage to the instruments do not keep them in chlorine solution for more than 10 minutes.
- **Chlorine solutions should be replaced DAILY or MORE OFTEN if necessary, because they lose potency rapidly over time or after exposure to light.**
- Rinse the instruments with cold water immediately after decontamination.
- Store the chlorine powder where there is good ventilation. Do not keep it in a general storage area where there are other metal instruments and equipment.

Cleaning

Cleaning is a crucial step in instrument processing. Cleaning greatly reduces the number of organisms and endospores on instruments and other equipment. Refer to Table A3.3 for list of required items for cleaning.

Process

- Hold items under soapy water (warm, if available) and vigorously scrub with a brush to completely remove all blood, tissue and other residue. Use a liquid or powdered detergent, which can easily dissolve in water. Avoid the use of soap or detergents that contain soap, because fatty acids contained in soap react with the minerals in hard water and form residue, which is difficult to remove. Do not use abrasives because they may damage instruments.
- Be sure to remove all materials caught in the small spaces (e.g., between the teeth of clamps or hemostat) and around the joints.
- Rinse thoroughly with water, as soap may interfere with chemical disinfection or sterilization.
- Dry by air or with a clean towel. (Water from wet instruments will dilute chemicals used for sterilization or disinfection.) Drying is not necessary for instruments which are to be boiled.

High-level disinfection (HLD)

High-level disinfection is effective in destroying all microorganisms but does not always kill endospores. High-level disinfection is appropriate for items that do not come into contact with the bloodstream or tissues under the skin. Also, when sterilization is not possible, high-level disinfection is the only acceptable alternative for processing instruments and other items for reuse. Table A3.3 gives the list of required items for HLD.

HLD can be achieved by two techniques: boiling and chemical disinfection.

Process

- Decontaminate, clean and rinse items thoroughly. Completely immerse items in water. Open instrument with joints such as clamps and scissors. Disassemble items composed of more than one part. Make sure that any bowls and containers to be disinfected are full of water.
- Cover and bring water to a rolling boil. **Boil items for 20 minutes**. Begin timing after water reaches a rolling boil. **Do not add or remove any item once timing begins.**
- Lower heat to keep water at a rolling boil because too vigorous boiling wastes fuel, evaporates the water and may damage equipment.
- After 20 minutes, remove items from water using high-level disinfected forceps/pickups.
- Allow items to air dry. Use immediately or store in a high-level disinfected container for up to 1 week.
- Use the same water throughout the day, adding only enough to keep the surfaces at least 2 cm above the equipment to be disinfected. Frequent draining and replacement of water increases the risk of mineral deposit.

High-level disinfection with chemicals

Process

- Decontaminate, clean and rinse items thoroughly.
- Completely immerse items in a high-level disinfectant solution so that the solution touches all surfaces. Open instrument with joints such as clamps and scissors. Disassemble items composed of more than one part. Make sure that any bowls and containers to be disinfected are full of chemical solution.
- **Soak for 20 minutes**. Do not add or remove any items once timing has begun. Remove, using disinfected forceps or gloves.
- Thoroughly rinse items with boiled water.
- Allow to air dry. Use immediately or store in a high-level disinfected container for up to 1 week.

Precautions

- The vapours of glutaraldehyde are toxic and irritating to the skin, eyes and respiratory tract. Always wear gloves and use it in a well-ventilated area.
- Chemical disinfection of needles and syringes should be avoided because they are difficult to rinse effectively, and chemical residues may interfere with the action of medications being injected.

Sterilization

Sterilization kills all microorganisms including endospores and should be used for all objects entering body cavities or the vascular system. Sterilization can be achieved by using steam (autoclaving) or soaking in a chemical sterilisation liquid. Refer to Table A3.3 for list of items required for sterilization.

Steam sterilization
High-pressure saturated steam is generally the method of choice for sterilizing instrument and other items used in family planning and other healthcare facilities.

Process

- Decontaminate, clean, rinse and air dry items thoroughly.
- Wrap items with desired wrapping materials.
- Arrange items/packs in autoclave to allow free circulation of steam.
- Sterilize wrapped items for 30 minutes, unwrapped items for 20 minutes at 121°C (250°F) and 106 kPa pressure (915 lbs./in). If using a mixed load, sterilize for 30 minutes. Start timing when required temperature and pressure have been reached.
- When time is complete, turn off heater and release the pressure valve. Wait until pressure gauge reads zero (approximately 20 to 30 minutes) to prevent steam from escaping abruptly when opening the door and hurting the person performing the procedure.
- Wrapped items can be stored for up to 7 days. Unwrapped items should be used immediately or stored in a covered sterile container for up to 7 days.

Chemical sterilization
Chemical sterilization may be used for items which are sensitive to heat such as endoscopes.

Process

- Decontaminate, clean, rinse and dry items thoroughly.
- Completely immerse items in chemical sterilant solution. Open instrument with joints such as clamps and scissors. Disassemble items composed of more than one part. Make sure that any bowls and containers to be disinfected are full of chemical solution.
- Allow to soak for at least 8–10 hours in 2% glutaraldehyde solution**.** Do not add or remove any items once timing has begun.
- Remove items with sterile forceps/pickups, rinse well with sterile water and allow to air dry.
- Store in a covered sterile container for up to 7 days.

Storage of sterile or disinfected equipment
Proper storage of high-level disinfected and sterilized equipment is just as important as the high-level disinfection or sterilization process itself.

Sterilized/disinfected equipment should be stored in enclosed shelves or in covered containers to protect it from moisture, dust and debris. The storage area should be easily accessible, but away from circulation of contaminated material and individuals not related to the preparation or handling of equipment and materials. It should also be separated from the area where contaminated material is cleaned and prepared for sterilization or disinfection.

Box A3.1 STORAGE OF STERILE OR DISINFECTED EQUIPMENT: KEY POINTS

- Store the packs when they reach room temperature.
- Do not place warm packages in plastic dust covers. Moisture will be trapped and remain there until opened.
- If the pack is dropped, torn or gets wet, consider it contaminated.
- Mark packs and containers used for storing sterile or disinfected items with expiration date and list of items.
- Store packs and containers (drums) containing sterile items off the floor.
- Items should be stored in an enclosed cabinet.
- Re-process objects which have not been used within 1 week.

A3.2.5 Managing clinical waste

Wastes from family planning and health care facilities may be non-contaminated or contaminated.

The purpose of proper disposal of clinic wastes is to:

- prevent the spread of infection to clinic personnel who handle the waste and to the local community
- protect those who handle wastes from accidental injury
- provide an aesthetically pleasing atmosphere
- prevent infestation of vermin and other disease carriers.

Do not pile contaminated waste behind the clinic. This practice puts staff and members of the community at risk for injury and infection.

Proper management of waste items minimizes the spread of infection and harm to clinic personnel and to the local community. Proper management includes sorting, transportation and disposal.

A3.2.5.1 Sorting

Separate containers should be used for disposing of general and medical waste. The person who generates it should put waste in the appropriate containers.

Within the health facility wastes are to be sorted and segregated as follows:

- **sharps** disposed in puncture proof container
- **burnable contaminated and non-contaminated wastes** collected in covered plastic or metal buckets
- **human tissues** collected in leak-proof container
- **glass** collected in separate container with lid

A3.2.5.2 Transportation of waste

Waste containers in operating theatres, procedure rooms, indoor rooms, toilets and sluice rooms should be emptied when they become three quarters full (at least once daily). Transport contaminated waste in covered, leak-proof waste containers to the disposal site. Persons handling wastes should wear heavy duty gloves.

Box A3.2 DISPOSAL OF SINGLE USE NEEDLES AND SYRINGES

- After use, dispose of used needles and syringes in special puncture proof containers for sharp objects to avoid accidental injury and possible infection of workers during refuse removal.
  - Puncture-resistant containers can be made of easily available objects such as a heavy cardboard box, a tin can with lid, or a heavy plastic bottle.
  - Place the container close to the area where it will be used so that workers do not have to carry sharp items any distance before disposal.
- Avoid accidental needle sticks; do not bend or break needles prior to disposal.
- Needles should not be recapped routinely, but if necessary, a one-handed recap method should be used:
  - First, place cap on a hard, flat surface, then remove hand
  - Next, with one hand, hold syringe and use needle to 'scoop up' cap
  - Finally, when cap covers needle completely, use other hand to secure cap on needle.
- When the "sharps" container is 3/4 full, tightly close the container.
- Dispose of container when 3/4 full by burying.
- Wash hands after handling sharps containers and decontaminate and wash gloves.

A3.2.5.3 Disposal of waste

Whenever possible, medical waste should be disposed of on the premises ,this allows staff who understand the risks involved to supervise the disposal process.

Burning is preferable method to burying medical waste, because the high temperature destroys microorganisms and reduces the amount of waste. Burning in an incinerator or oil drum is recommended.

If medical waste cannot be burned, onsite burial is the next best option. However, burial is feasible only when there is sufficient space to dig a pit the size needed to accommodate the amount of medical waste generated at the facility. Choose a site that is at least 50 meters away from any water source to avoid contaminating the water source. A fence or wall to limit access to it and to prevent scavenging for waste should surround the pit.

Box A3.3 WASTE DISPOSAL: KEY POINTS

- Use non-corrosive washable containers (plastic or galvanized metal) with covers for contaminated wastes.
- Place waste containers at convenient places for users (carrying waste from place to place increases the risk of infection for handlers).
- Equipment which is used to hold and transport wastes must not be used for any other purpose in the clinic or health care facility.
- Wash all waste containers with a disinfectant cleaning solution (e.g. 0.5% chlorine solution) and rinse with water. (Clean contaminated waste containers each time they are emptied and non-contaminated ones when visibly soiled.)
- When possible, use separate containers for combustible and non-combustible wastes. (This prevents workers from having to handle and separate wastes by hand later.)
- Wash hands after handling wastes.

A3.3 MAINTENANCE OF OPERATING THEATRE

The following points should be considered to maintain the operating theatre as a standard facility for providing services.

- In static clinics, the operating theatre and the IUD insertion area should have a tile or concrete floor that can be easily and thoroughly cleaned.
- The operating theatre should be enclosed, free of dust, fly-proof, have adequate lighting, and be well isolated from the part of the clinic that is open to the public. The operating theatre should be locked when not in use.
- The operating theatre should not store unnecessary drugs, equipments and supplies. Ideally, the operating theatre should be air-conditioned, but if a fan must be used, it should be a pedestal fan (stand fan).
- Windows should be 1.8 m (6 ft.) above the floor, or high enough to prevent cross-ventilation in the operative field, and should be screened against flies and mosquitoes.

- Cleaning schedule
    - Beginning of each day: The operating theatre/room to be used should be cleaned in the following manner – the floor should be cleaned with a damp mop (water only) and counters/table tops wiped with a damp rag (water only).
    - After each case: The operating table, floor around the table (if blood or body secretion spilled), instrument stands and other potentially contaminated areas such as light handles and counter tops should be wiped down with a 0.5% chlorine solution.
    - End of the day: Wipe down from top to bottom all surfaces, including counter tops, tables, sinks, lights, door handles, plates and walls, with a cloth dampened with a disinfectant cleaning solution. Rinse sinks with clean water. Clean the floor with a mop soaked in a disinfectant cleaning solution. Empty and clean all waste disposal containers.
    - Each week: Clean ceilings with a mop dampened with a disinfectant cleaning solution.

A3.3.1 Equipment processing area

The equipment processing area should be designed in such a way so that there is no chance of cross contamination. Different steps of equipment processing activities should be done in separate area as follows:

- Receiving and clean-up area: All soiled items are received and washed, rinsed and dried in this area. They should already be decontaminated before they arrive here. Items should be decontaminated immediately after use, in the area where they were used.
- Clean work area: Cleaned items are wrapped when appropriate and high-level disinfected or sterilized in this area.
- Sterile storage area: All processed items should be stored in this area, which is not located next to the receiving area. Sterile items should be stored in a closed cabinet so that they do not become easily contaminated by general activity in the room, and should be kept dry.

A3.4 MANAGEMENT OF INJURIES FROM NEEDLES AND OTHER SHARPS

In case of injury with a used needle or other sharp or if blood/body fluids are splashed into the mouth, eyes or onto broken skin, carry out the following procedure:

Needle pricks, cuts, or scratches (that penetrate the skin)

- Wash thoroughly with soap and water.
- Cover with a waterproof sterile dressing.

Splashes to mouth or eyes

- Rinse thoroughly with plenty of running water.

Most experts agree that the larger the volume of blood involved in the exposure, the greater the risk of infection. Therefore first aid must begin as soon as possible after the exposure and aim to flush away as much inoculation as possible.

Table A3.3 Required items

Hand washing	Decontamination	Cleaning	HLD	Sterilization
Soap Clean running water Basin to collect water Clean, dry towel	Plastic bucket Utility gloves Chlorine powder or liquid bleach Plastic jug to measure water	Soap or detergent (a disinfectant is not needed) Clean water (warm water if available) Brush (fine bristled), such as a toothbrush Utility gloves and other protective attire	**HLD Boiling** Pot with a lid Fuel source: either electric stove or kerosene stove **HLD using chemicals** Disinfectant solution such as 2% glutaraldehyde (e.g. Cidex) Plastic bucket or container for soaking Boiled water for rinsing	**Steam Sterilization** Autoclave Wrapping material (paper or double-layered cotton) Fuel source: electricity or kerosene stove **Chemical Sterilization** Chemical sterilant: 2% glutaraldehyde (e.g. Cidex) Clean container with cover Sterile water for rinsing

Appendix 4: Rumors and Facts about Contraception

Table A4.1 Condoms

Condom RUMOR	Condom FACT
1. Condoms may remain in the vagina	1. If condoms are used properly, it is unlikely that they will slip off.
2. Condoms decrease sexual pleasure.	2. Condoms may increase the period of erection and prevent premature ejaculation. Condoms provide protection against pregnancy and STIs and HIV, which makes sexual intercourse free of worries.
3. The rubber in the condom causes pain in the vagina during sexual intercourse.	3. Latex does not cause any pain. However, there may be pain if there is allergic reaction to latex (rare). Pain also may be felt due to dryness of the vagina and use of non-lubricated condoms.
4. Condoms are meant to be used only by commercial sex workers.	4. Condoms are used by many married couples as a form of contraception.

Table A4.2 Oral Contraceptive Pill

Oral contraceptive pills RUMOR	Oral contraceptive pills FACT
1. The pill causes cancer.	1. Women on pills are less likely to develop cancers of the ovary and endometrial lining. It also decreases benign breast diseases, uterine fibroids and ovarian cysts.
2. The pill causes deformed babies and multiple deformities.	2. The number of babies born deformed or the numbers of multiple births among women who use pills are no different from those who do not use them.
3. When a woman stops taking the pill, she will have trouble getting pregnant.	3. After stopping the pill, the ovaries function as before taking the pill and women get pregnant soon after stopping the pill. However, in some women, there may be a delay of 2-3 months in becoming pregnant. Experts feel that these women may have experienced trouble in getting pregnant even if they were not on the pill.

Table A4.3 Injectable (Depo Provera)

Depo Provera RUMOR	Depo Provera FACT
1. The injectable causes weakness in woman and she is less able to work.	1. Experience from the world shows that the injectable does not cause weakness. In fact it strengthens the woman by decreasing the anemia through decreased blood loss.
2. Injectable causes heavy bleeding.	2. Heavy bleeding is unlikely. Injectable may cause frequent and irregular light bleeding, which subsides in few months. The woman may have no menstrual periods at all.
3. Injectable cause loss of appetite and weight.	3. It causes gain in weight more often than loss of appetite and weight.
4. Women on injectable may need to stop it for few days to regain fertility.	4. Experience from around the world has shown that a woman can continue with the method continuously as long as she wishes and does not affect her fertility.
5. Since the injectable stops menstruation, unclean blood builds up in the body.	5. Injectable does not cause any build up of blood in the body. In fact, it decreases menstrual bleeding.

Table A4.4 IUD

IUD RUMOR	IUD FACT
1. The IUD causes discomfort to the man during intercourse.	1. The strings if left long can cause discomfort to the man during intercourse. The strings can be trimmed. If the IUD is felt, it may be because it is being expelled and needs a check-up at the clinic.
2. The IUD can travel up from the uterus into the stomach.	2. IUD does not leave the womb and move around inside the body. Rarely, perforation of the uterus takes place and in such situations, it remains inside the abdominal cavity.
3. IUD can rust inside the body.	3. IUD does not rust inside the body, even after many years.

Table A4.5 Female Sterilization

Female sterilization RUMOR	Female sterilization FACT
1. Female sterilization changes a woman's monthly period and/or makes menstrual bleeding stop.	1. Usually there are no major changes in bleeding pattern after female sterilization. A woman's bleeding pattern may change however if she has been using the pill or the IUD before the procedure. A woman's menstrual period usually becomes less regular as she gets older.
2. Female Sterilization can make a woman lose her sexual ability.	2. Woman's sexual ability will be the same as before the procedure.
3. Female sterilization can make a woman weak and fat.	3. A woman will continue to look and feel the same as before the procedure. She will be as strong as before and will be have the same energy and strength as before the procedure.

Table 4.6 Male Sterilization

Male sterilization RUMOR	Male sterilization FACT
1. Man will lose his sexual ability.	1. Vasectomy will not harm the testes which are the organs that produce male hormones. Male sterilization is not castration. And it does not affect the testes and it does not affect sexual ability. He can have sex same as before.
2. Ejaculation will not be the same as before.	2. Semen after vasectomy appears as before in terms of amount, smell, appearance and thickness. The only difference is that the semen will not have sperms 3 months after the vasectomy. (Refer Chapter 14 on male sterilization and post vasectomy advice).
3. Will make a man weak and fat and he will look and sound different.	3. After vasectomy a man will look and feel the same as before. He can work as hard as before. His beard will grow and his voice will not change.

Appendix 5: SAMPLE INFORMED CONSENT FORM FOR VOLUNTARY SURGICAL STERILIZATION: MALE AND FEMALE

I, _____, the undersigned, (client's name) request that a sterilization via_____ (specify the procedure) be performed on my person.

I make this request of my own free will, without having been forced or given any special inducement. I understand the following:

1. There are temporary methods of contraception available to me and my partner.
2. The procedure to be performed on me is a surgical procedure, the details of which have been explained to me.
3. This surgical procedure involves risks, discomfort and complications in addition to benefits, all of which have been explained to me.
4. If the procedure is successful, I will be unable to have any more children.
5. The procedure is less then 100% effective.
6. The effect of the procedure is permanent.
7. I can decide against the procedure at any time before the operation is performed (and no medical, health, or other benefits or services will be withheld from me as a result).

Signature of client Date

Signature of Spouse/s Date

Signature of attending physician/ counselor or delegated assistant Date

If the client cannot read, a witness of the client's choosing, and speaking the same language must sign the following declaration:

I, the undersigned, attest to the fact that the client has affixed his/her thumbprint or mark in my presence.

Signature or mark of witness/guardian Date

Appendix 6: REFERRALS

A6.1 INTRODUCTION

Referral service is one of the critical elements of the continuum of quality FP services as it helps health workers provide continuum of FP care in situations beyond their level of competence. An efficient referral system is a two-way system, involving the smooth transfer of information between facilities and facilitating client management at all levels and for all needed care.

A6.2 OBJECTIVES OF REFERRALS

The objectives of referral are to:

- help clients to sustain the use of contraceptives by minimizing physical and psychological risks to them through early provision of specialist care in case of complication
- provide access to a wider choice of FP methods by referring clients to a facility where the method of choice of the client can be provided.

A6.3 PREREQUISITES FOR EFFECTIVE REFERRAL

A formal functioning referral linkage between health posts and health centers with a higher facility should be in place.

Orientation should be provided to the staff at the facility referring the client (referring facility[29]) for further care, on the indications for referral, communicating relevant client information to the staff at the referral facility[30], and providing clear verbal and written instructions to the client.

Orientation should also be provided to the staff of the referral facility on procedures related to referred cases including feedback to the worker/facility that has referred the cases.

Health workers should refer clients to the nearest hospital, if they have the following:

- issues regarding eligibility
- side effects
- complications
- need for further medical evaluation.
-

A6.4 COUNSELING OF CLIENTS BEING REFERRED

Counseling of clients being referred along with spouse/relative is important for facilitating the utilization of the referral facility. Chapter 3 provides the steps in

[29] Referring facility is a health facility that sends a client elsewhere for services.
[30] Referral facility is a health facility to which a client is sent for services.

counseling clients who are being referred. In addition to the steps listed in Chapter 3, the counseling should focus on the following:

- Being extremely sensitive to the fears of the clients in case of side effects/complications
- Allaying the fears of the client. This is critical for providing motivation for the clients to follow the referral advice and for ensuring that the clients continue using FP.
- Assuring that continued care will be provided.

A6.5 REFERRAL SLIP

- All clients referred should be provided with a referral slip that includes relevant information on the client, the method in use (in case of referrals for side effects/complications) and the reason for referral. The referral slip should also have the name and address of the referring facility as well as the referral facility.
- A request for feedback should be included in the referral slip.

The referral slip is a very useful tool for improving quality of FP services as described below:

- It helps to monitor complications of methods and to design strategies for minimizing complications based on in-depth analysis of such cases.
- It helps to identify training/refresher needs of health workers (based on analysis of common complications referred).

A6.6 FOLLOW-UP

All cases referred must be followed up through home visits or requesting the clients to report to the health post or health center. Follow-up is one of the elements of quality of care and is critical in FP services. Follow-up helps to:

- nurture the trust of the client
- ensure that the client is following instructions
- monitor any new problems.

A6.7 FEEDBACK SYSTEM (Counter-referral)

Information on the client attending the referral facility (including clinical findings, results of investigations done, any treatment provided and follow-up recommendations) should be communicated back to the staff who referred the client. If follow-up can be done at the original facility then such information, as well as what needs to be done at follow-up and by whom, should be provided in the feedback letter.

Appendix 7: SUPERVISION AND MONITORING

A7.1 INTRODUCTION

Supervision and monitoring systems have two main objectives:

- to improve and maintain the quality and safety of family planning services
- to improve the ability of the program to deliver services for the benefit of the client.

Supervision and monitoring is an ongoing process performed internally by the staff at the service site and externally from the central/regional/atoll level.

A7.2 FAMILY PLANNING CARDS, REGISTERS AND REPORTS

Family planning records and reports are important tools for supervision and monitoring and provide input into the Health Information System.

Client Clinic Card
The Client Clinic Card records the socio-demographic and health history, physical examination findings and current method of use. The follow-up section of the card records the history and physical examination findings at the time of the visit

The Client Clinic Card provides information on past and current use of a FP method and method switch (if any).

- It is an important tool for monitoring the quality of services as it provides information on whether the client has been screened for eligibility to use the method.
- It is useful for follow up of clients.
- When the client cards are organized in a systematic way, it helps to track defaulters.

Family Planning Register
This register records relevant information on all the couples eligible for FP in a defined geographical area. The information is usually collected through a survey and updated periodically. The register includes information on the parity of the client, FP method used and the date of last visit and the method being used. The register:

- provides information on contraceptive users in a specified geographical area
- is a useful tool for tracking clients, especially defaulters.

Referral Register
Records of clients referred should be maintained in a special referral register.

Supplies Register
This records information on contraceptive supplies.

Reports
Family planning reports provide information on the progress of the various indicators that have been identified by the Ministry of Health. Information on complications in clients using contraceptives is entered in the Health Information Database. These reports are important tools for monitoring.

A7.3 SUPERVISION

Supervision is a **continuous, interactive process** that enhances the capability of the health system to:

- meet the FP objectives of the Regional/Atoll/Island health system and thus contribute to achieving the FP objectives of the National Reproductive Health Strategy
- maintain the quality of care
- keep the staff trained and motivated
- monitor the supplies
- meet client needs.

Supportive supervision helps to achieve the above as described below:

- It emphasizes helping health workers to:
    - understand the objectives of FP services
    - identify gaps in meeting the objectives
    - reach the objectives
- It facilitates two-way communication between the supervisor and the provider who is being supervised leading to improved performance and outputs and to improved client satisfaction.
- It helps to provide feedback to higher level authorities about successes and constraints in order to facilitate assistance as required.
- It ensures involvement of all levels of staff promoting ownership that leads to sustainability.

A7.3.1 Roles of supervisor

Some suggested roles of supervisors are to:

- help health workers to do self-assessment of their own performance using National Standards for Family Planning Services and to provide assistance in meeting the needs for information and training
- assess sites where FP is provided and facilitate meeting the gaps
- provide feedback to staff at the health care facility – when external supervisory visits are conducted, constructive feedback should be provided prior to leaving the facility and a written report should be sent to the staff at the facility as soon as possible.

A7.3.2 Prerequisites for effective supervision

- Training of supervisors to be a catalyst for quality improvement, joint problem solving and facilitative styles of communication, as well as in technical skills (as required)
- Development of job aids such as checklists to facilitate supervision and monitoring
- Development of a supervisory plan that includes the following:
    - Who is to be supervised and the frequency of supervision
    - What will be reviewed: records, skills of providers, attitudes of providers, client assessment, clinic visits (maintenance of building and equipment, cleanliness, privacy, confidentiality, infection prevention measures, emergency preparedness, adequacy of equipment and supplies)
    - What should be achieved before the next visit (decided jointly with the provider who is being supervised).

A7.4 MONITORING

Monitoring is a continuous process that helps to gauge progress towards achieving the objectives of the program. Monitoring may be qualitative as well as quantitative. Qualitative monitoring is an integral part of supportive supervision.

Tools for quantitative monitoring are the FP records and reports including reports of complications with use of contraceptives.

- Health workers should be trained to monitor their own progress towards achieving the objectives of the program.
- Managers at the district, province and national level should provide regular feedback on findings of the monitoring review.