POST PREGNANCY FAMILY PLANNING PROTOCOL

for service providers

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PREFACE

Women who have recently undergone a pregnancy event–whether birth or abortion- need extra attention and care from the health care providers so as to reduce their number of unwanted births & abortions and to increase the subsequent birth intervals. An analysis of data from the Demographic and Health Survey (DHS) for various years shows that babies born less than two years after the next oldest sibling were more than twice as likely to die in the first year as compared to babies born after an interval of three years. In addition, women with short inter-pregnancy intervals (less than 6 months) were at higher risk of maternal death, third trimester bleeding, premature rupture of membranes and anemia.

According to the latest Sample Registration System (SRS) 2014 estimates approximately 18% of births in the state occur within 24 months of the mother's last birth, and another 23% occur within 24–35 months of her last birth. An increase in contraceptive use during the postpartum period substantially reduces the rates of maternal and infant mortality by preventing unplanned and unwanted pregnancies, and spacing new pregnancies to at least two years after the previous birth. Furthermore, since the largest proportion of women with an unmet need for contraception is found among those in their first year after childbirth, concentrating efforts to reduce unmet need among these women could have a proportionally bigger impact on increasing contraceptive use than concentrating on any other group.

India accounts for 6.4 million induced abortions and approximately 4 million spontaneous abortions each year usually without any contraceptive counseling or services. Most of these are performed in unsafe conditions which account for 8% of the maternal mortality in India. According to a study of data from District Level Household Survey (DLHS)-3, (2007-2008) women aged 25-34 are more likely to use contraceptive methods than the women aged between 15-24, indicating the use of induced abortion as a contraceptive method due to their limited understanding of the side effects of repeated induced abortion.

Recognizing the need to reduce the potential risks to the maternal and child mortality and morbidities associated with unintended pregnancies that either lead to high-risk pregnancies due to narrow pregnancy intervals or repeated unsafe abortion, Government of Uttar Pradesh decided to create the post pregnancy protocol. This protocol will enable providers to support clients to choose the most appropriate method best suited to their individual situation.

The efforts of the Government of Uttar Pradesh; State Innovations in Family Planning Services Project Agency (SIFPSA), National Health Mission (NHM), Directorate of Family Welfare and Uttar Pradesh Technical Support Unit (UPTSU) in developing this Protocol are highly appreciated.

(Prashant Trivedi)

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MESSAGE

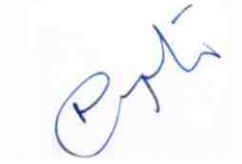
In India, 65% women in the first year postpartum have an unmet need for family planning. The dynamics of contraceptive use among women in extended postpartum period, i.e. one year period after the birth of child, is of interest at the family planning program level, since delay of use until the return of menstruation might subject women to the risk of unwanted pregnancy.

Similarly women in post abortion period are vulnerable to the risk of unwanted pregnancies because of the rapid return to fertility after the procedure.

Best practice aims to ensure that women have a method of contraception that they can start before the risk of pregnancy returns after childbirth and abortion. Therefore, uptake of short or long-term contraceptive methods in the postpartum and post abortion period will reduce maternal and newborn deaths, improve maternal and child nutrition and prevent unplanned pregnancy and unsafe abortion.

The postpartum and post-abortion periods may be the only opportunities a woman comes in contact with a health personnel. Therefore, contraceptive counselling done in these periods is very crucial and can be made effective. Women should be given the opportunity to make an informed choice about their contraceptive method. Thus, immediate postpartum and post abortion family planning services need to be strengthened wherein the woman leaves the hospital with an effective contraception in place.

The Post pregnancy Family Planning protocol has been developed keeping these objectives in mind. I congratulate the Family Planning Division, Government of Uttar Pradesh on this initiative.



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ACKNOWLEDGEMENT

Integration of Family planning (FP) and maternal and child health (MCH) services will ensure healthy timing and spacing of pregnancies resulting in significant reduction of both maternal and perinatal mortality and morbidity.

Although service providers have the basic knowledge of Family planning methods there is a need to integrate the provision of different methods into routine practice of providers as they serve clients in the post- partum and post abortion period. Keeping this in mind this ready reckoner was developed for service providers of all levels of health facilities from district hospital to sub-center.

The valuable inputs provided by the representatives from National Health Mission (NHM), State Innovations in Family Planning Services Project Agency (SIFPSA), King George Medical University (KGMU), Directorate of Family Welfare, and Technical Specialists from Avanti Bai, Jhalkari Bai & Ram Manohar Lohia hospital were incorporated.

The endeavor had not been made possible without unconditional support and guidance of Mr. Vikas Gothalwal (IAS), Executive Director, Uttar Pradesh Technical Unit (UPTSU).

I am thankful to Dr. Aruna Narayan for her leadership and guidance in the entire process and her valuable inputs which have enriched the document and ensured its relevance to the service providers.

A special note of thanks to Dr Irfan Wajih, General Manager- Family Welfare (GM-FW) and Dr Pankaj Saxena, Dy. General Manager Family Welfare (DGM-FW), National Health Mission (NHM), Uttar Pradesh. The critical and constructive feedback of Dr Rinku Srivastava, Deputy General Manager (DGM), SIFPSA ensured the precision and quality to the document.

Lastly, special note of gratitude is due to Ms. Preeti Anand, Project Director Family Planning, Dr. Brinda Frey, Senior Technical Specialist and Ms. Sadhna Mohan, of Uttar Pradesh Technical Support Unit (UPTSU) for their passion and hard-work towards the development of this ready reckoner.

(Alok Kumar)

ABBREVIATIONS

AIDS	Acquired Immunodeficiency Syndrome
ANM	Auxiliary Nurse Midwife
ASHA	Accredited Social Health Activist
BCC	Behaviour Change Communication
COCs	Combined Oral Contraceptive Pills
CHC	Community Health Centre
CPR	Contraceptive Prevelance Rate
CDRI	Central Drug Research Institute
DH	District Hospital
DLHS	District Level Household Survey
DMPA	Depo Medroxy Progestrone Acetate
DQAC	District Quality Assurance Committee
ECP	Emergency Contraceptive Pill
GMSD	Government Medical Store Depot
Hb	Haemoglobin
HIV	Human Immunodeficiency Virus
HTSP	Healthy Timing and Spacing of Pregnancy
IEC	Information Education Communication
IM	Intra Muscular
IP	Infection Prevention
IUCD	Intra Uterine Contraceptive Device
LAM	Lactational Amenorrhoea Method
LMP	Last Menstrual Period
LNG	Levonorgestrol
MEC	Medical Eligibility Criteria

MO	Medical Officer
MTP	Medical Termination of Pregnancy
NFHS	National Family Health Survey
NGO	Non-Government Organization
NHM	National Health Mission
NSAID	Non Steroidal Anti-Inflammatory Drug
OCP	Oral Contraceptive Pills
PHC	Primary Health Centre
POC	Progestogen Only Contraceptive
POI	Progestogen Only Injectable
POP	Progestin Only Pills
QA	Quality Assurance
RCH	Reproductive and Child Health
RTI	Reproductive Tract Infections
SC	Sub Cutaneous
SC	Sub Centre
SDH	Sub District Hospital
SN	Staff Nurse
SQAC	State Quality Assurance Committee
STI	Sexually Transmitted Infections
TFR	Total Fertility Rate
WHO	World Health Organization

POST PREGNANCY FAMILY PLANNING

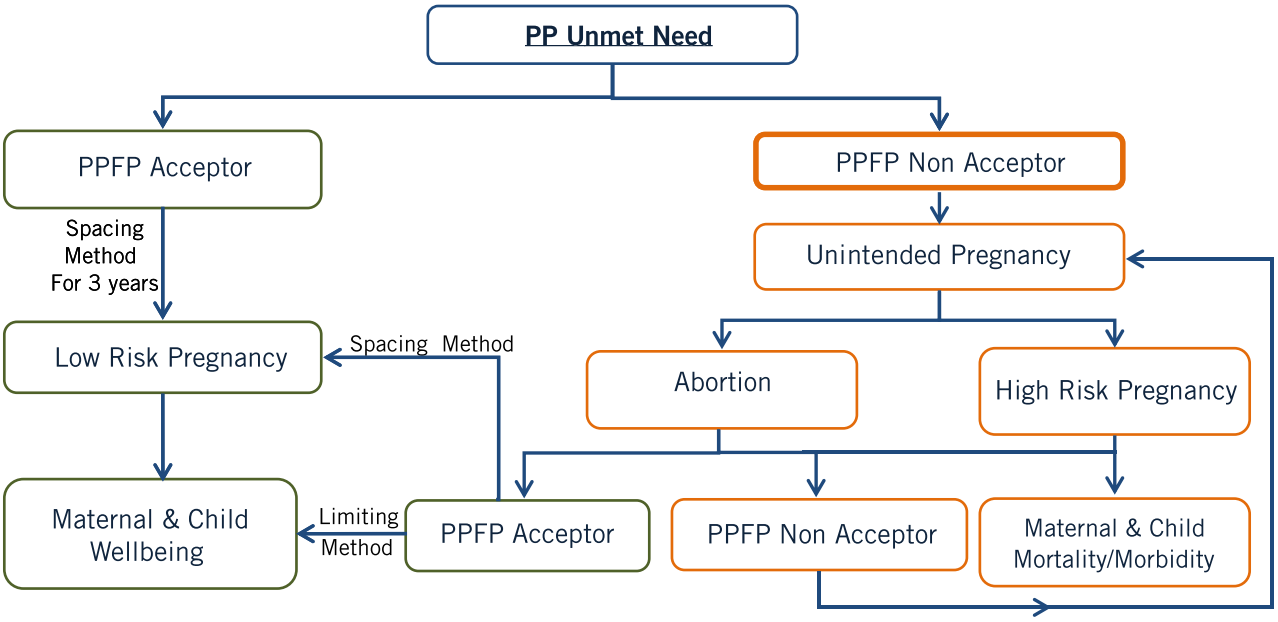
Making the correct contraception choices in post partum and post abortion periods can have a significant impact on material and infant morbidity. PPFP is now increasingly being defined as Post Pregnancy Family Planning to include both these periods. The need for curative services and the strong desire of women to avoid unintended pregnancy during these periods assures a higher possibility for acceptance of contraception.

Post partum period is a critical time when women need a special and integrated package of health services because of their vulnerability to unwanted pregnancy. In India, 65% of women in the first year postpartum have an unmet need for family planning, but only 26% of the women are using any method of family planning during the first year postpartum.

Studies show that pregnancies taking place within 24 months of a previous birth have a higher risk of adverse outcomes like abortions, premature labor, postpartum hemorrhage, low birth weight babies, fetal loss and maternal death[2]. **According to the AHS 2012-13 data only 43.7% births in U.P. are born after a birth interval of more than 36+ months which implies that more than half of the pregnancies are high risk pregnancies highlighting the urgent need for post-partum family planning[3].**

There is evidence that family planning reduces abortions, thereby decreasing the risk of maternal death. Women have a significant unmet need during the post abortion period which needs to be brought into focus and addressed. Post abortion care (PAC) includes three components: (1) emergency treatment for complications (2) family planning counselling and service provision and, where financial and human resources are available, evaluation and treatment for sexually transmitted infections (STIs) as well as HIV counselling and/ or referral for testing of post abortion women; and (3) community empowerment through community awareness and mobilization (USAID, 2004). Strong evidence demonstrates the feasibility, acceptability, and effectiveness of providing family planning services at the same time and location as post abortion services. Despite this evidence, many post abortion clients leave facilities without providers offering them family planning counselling or services[4].

According to India abortions and live births report 59032 abortion cases were reported in Uttar Pradesh in the year 2012-13[5]. A 2014 systematic analysis of worldwide data estimates that approximately 8% of all maternal deaths are attributable to unsafe abortion and related complications[6]. Overlooking this potential of post abortion care - to interrupt the cycle of repeat unplanned pregnancy - as fertility returns within 10 days–4 weeks after abortion, once again throws the woman into the cycle of resorting to unsafe methods leading to complications further le



Postpartum Family Planning

Postpartum Period

The postpartum period has traditionally been understood as the first six weeks after the birth of a child, as by then, the woman's body has largely returned to its pre-pregnancy state. However there is a need to focus on the "extended postpartum period;" i.e., the first 12 months after birth.

Programmatically it is convenient to further define the time periods as the interventions and issues vary during the period of first 6 weeks and beyond up to one year after childbirth.

1. Immediate Postpartum - Post placental and within 48 hours after delivery

The immediate postpartum period is an ideal time to educate and counsel a woman on exclusive breastfeeding as a contraceptive method. Counselling on future fertility, birth spacing or limiting intentions, and provision of appropriate family planning methods like IUD, sterilization should also be provided in this period.

2. Early Postpartum - up to 7days

Postpartum Sterilization can be performed within this time period. Messages on Lactational Amenorrhea Method (LAM) should be reinforced.

3. Extended Postpartum - 6 weeks to 1 year

Spacing methods like IUCD and other methods as per the Medical Eligibility Criteria (MEC) can be provided. Laparoscopic/minilap tubal ligation can also be performed during this period. Women are highly motivated and receptive to accept Family Planning (FP) methods during the postpartum period.

Demographic and Health Survey show that 40 percent of women in the first year postpartum intend to use a family planning (FP) method but are not doing so[1]. Institutional deliveries have increased

significantly all across the country, thereby creating opportunities for providing quality postpartum family planning services. The postpartum services need to be strengthened by integrating maternal and child health (MCH) and FP services at each level of health facility from the district hospital to the sub-centre.

Risk of decreased birth interval on mother and baby

Risk to Baby: A **baby** born after a short birth interval has increased chances of

- being born pre-term
- being small for gestational age
- dying during newborn period or childhood

Risk to Mother: A **woman** who becomes pregnant too quickly following a previous birth or spontaneous or induced abortion faces higher risks of:

- anemia
- abortion
- premature rupture of membranes
- maternal mortality

Risk of Adolescent pregnancy: Adolescent mothers aged 15-19 years are twice as likely to die during pregnancy or childbirth as those over 20; girls below the age of 15 are five times more likely to die. Pregnancy during adolescence poses a higher risk of adverse outcome for the mother and the baby[7].

Return of fertility

Fertility returns quickly following childbirth. The time of return of fertility may differ in different subsets of women.

- **Exclusive breastfeeding-** While more than 55% of women exclusively breastfeed their babies in the first three months following delivery, this rate drops to nearly zero by one year and this exposes them to risk of pregnancy [7]. Return of fertility is variable, in women who are using LAM accurately, it may return even after 6 months but for those women who do not use LAM accurately, it may return even earlier
- **Partially breastfeeding or not breastfeeding -**Women may resume menses within 4-6 weeks of delivery and first ovulation may occur as early as 45 days postpartum thereby increasing the risk of pregnancy soon after childbirth
- **Lactational Amenorrhea–**Some women may experience amenorrhea during breast feeding even if they are not practicing exclusive breast feeding or do not satisfy the three criteria of Lactational Amenorrhea Method (LAM). There is a probability that ovulation may occur before the return of menstruation. Therefore, amenorrhea after child birth is an unreliable indicator that a woman is protected against pregnancy
- **Following an abortion,** a woman's fertility returns within 10–11 days. Women who have experienced a spontaneous or induced abortion should begin use of a contraceptive method within 48 hours to prevent an unintended pregnancy

Return to sexual activity

During the first year postpartum, approximately 40% women return to sexual activity within the first three months and by 10-12 months postpartum, 90% have resumed sexual activity which exposes the woman to risk of having an unintended pregnancy[7]. **The period after three months, when exclusive breastfeeding is falling, menses is returning and couples resume sexual activity, can be considered a period of high–yet unperceived–risk of an unintended pregnancy.** Couples will not necessarily see themselves at risk of pregnancy at this time and will not fully recognize the need for family planning[1].

Therefore, Healthy Timing and Spacing of Pregnancy (HTSP) is important as it not only decreases the mortality among women, but also has a positive impact on women's health and social and economic well-being and contributes to improving children's lives by increasing their access to adequate food, clothing, housing and educational opportunities. For such **healthier outcomes:**

- After a live birth, a woman should wait at least 24 months (but not more than five years) before attempting the next pregnancy

- After a spontaneous or induced abortion, a woman should wait at least 6 months before attempting the next pregnancy
- Adolescents should delay first pregnancy until the age 20 years

Information about optimal birth spacing—including the benefits of spacing births—should be provided to the woman /couple at various points of contact like in family planning clinics; antenatal clinics; labor wards/rooms; postpartum and postnatal care facilities; immunization and child health services; and any service or facility where mothers and children receive routine health care. It is necessary to establish linkage of maternal and newborn health and family planning services at all levels.

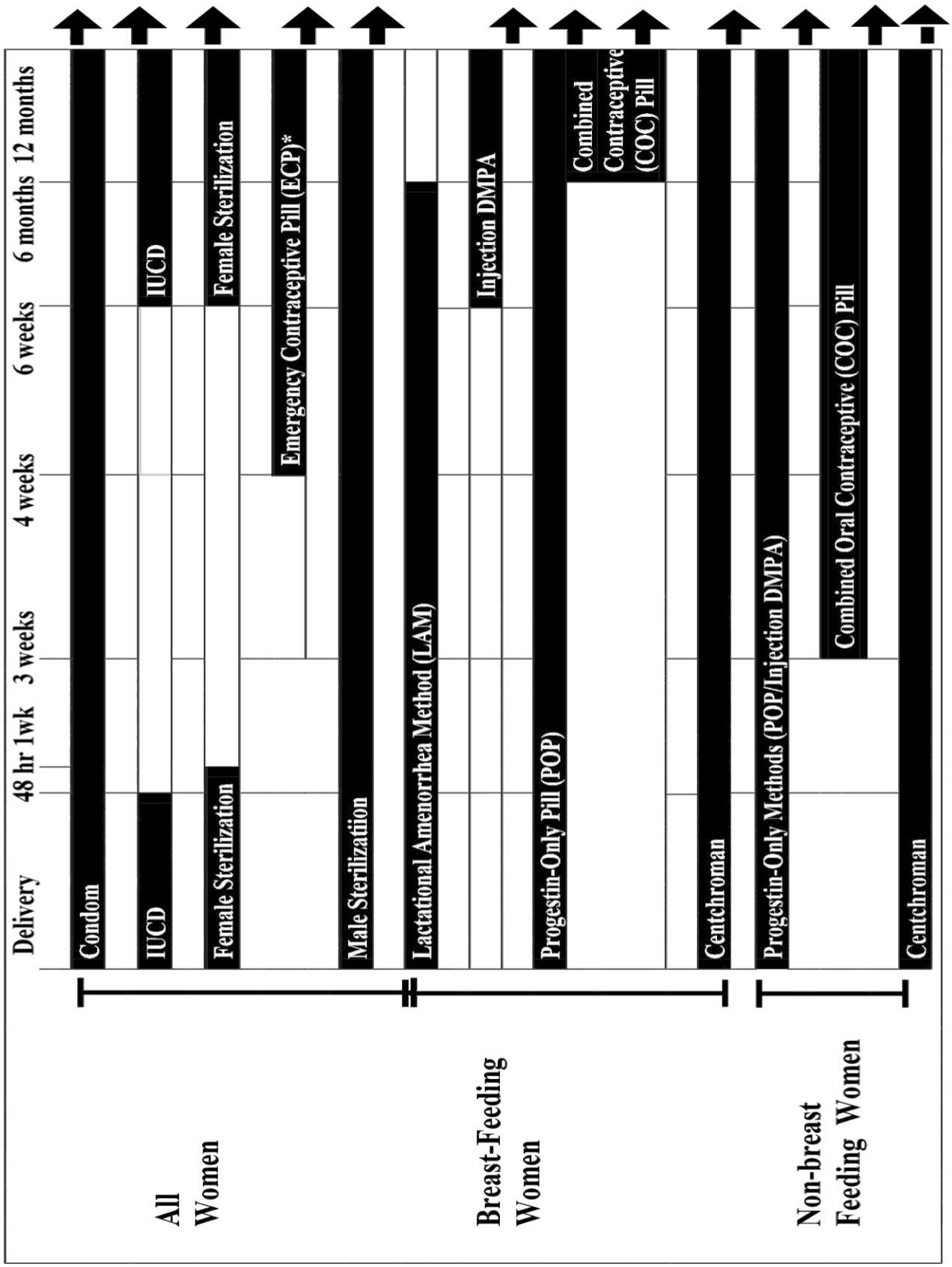
PROVIDING POSTPARTUM FAMILY PLANNING SERVICES

Counselling and provision of family planning methods during the postpartum period is critical to ensure the health of both the mother and child. Recent studies estimate that the prevention of unplanned and unwanted pregnancies could help avert 20 - 35% of maternal deaths and as much as 20% of child deaths[7]. Evidence also indicates that the provision of postnatal family planning counselling increases contraceptive awareness and use.

Methods Appropriate for Postpartum Use

Several modern contraceptive methods, including long-acting and permanent FP methods IUD, vasectomy and tubectomy are appropriate for use immediately after delivery. Lactational Amenorrhea Method (LAM) is a good contraceptive method to prevent pregnancy for up to six months after delivery if the mother is exclusively breastfeeding and not yet menstruating. The following chart shows FP methods appropriate during postpartum period and their timing of initiation:

Timing of initiation of Post-partum Family planning methods



* This is to be used only in emergency. For a regular contraceptive use, take advice from ANM/Doctor at government health centre.

Advantages of Postpartum Family Planning

The advantages of providing post-partum Family planning services are:

- **Prevents maternal and child mortality:** Family planning could prevent as many as one in every three maternal deaths by allowing women to delay motherhood, space births, avoid unintended pregnancies and abortions, and stop childbearing when they have reached their desired family size. After giving birth, family planning can help women wait at least two years before trying to become pregnant again, thereby reducing newborn, infant, and child deaths significantly[8].
- **Meeting the Unmet need of the women:** Demographic and Health Survey show that 40 percent of women in the first year postpartum intend to use a family planning (FP) method but are not doing so[7].
- **Reduce number of abortion:** Different studies have shown that there are more possibilities of the risk of abortion if the women conceive immediately after delivery. Those women who conceive within 6 months of delivery are at risk of having an abortion (this increases the chances of unsafe abortion).
- **Peri-natal care creates scope:** Information about family planning methods are provided to those women who come for antenatal care. Mothers receiving counselling on family planning during antenatal care can make a decision on whether to use postpartum family planning before their delivery.
- **Availability of services:** Many women come to the service centre for antenatal, peri-natal and postnatal care. This is a good time to counsel the women on postpartum family planning. The ideal time for accepting postpartum family planning methods is immediately after delivery. They can receive the FP method before leaving the hospital.
- **Cost effectiveness:** Postpartum family planning is cost-effective. Studies have shown that acceptance of FP methods during postpartum stay in the hospital is cost-effective.
- **Safety:** The service provider can ensure that there is no risk of pregnancy.

Linking Family Planning (FP) with Maternal and Child Health (MCH)

Family planning should be an integral part of maternal and child health care (MCH) to prevent maternal and child deaths. All service providers like Ob-Gyns, other doctors, nurses, paramedics, FWVs should be trained and equipped to provide FP services. Service providers should ask all pregnant and postpartum women about their desired family size, and provide methods or refer for services as needed.

Establishing Linkages

1. **At ANC and PNC Visits:** At every ANC and PNC visit and at every immunization visit ask about FP intentions and LAM transition plan. During ANC; ask mothers about their desired family size and start a discussion on the importance of child spacing and what family planning options they have.
2. **During immunization sessions:** When infants are seen 5 times during the first year for

immunization; use this opportunity to ask mothers about their need for contraception.

Post Abortion Family Planning

Post abortion family planning is the initiation and use of family planning methods at the time of management of an abortion or before fertility returns after the abortion. It is estimated that of the 210 million pregnancies that occur each year, some 80 million are unintended. In 2008, 21.6 million unsafe abortions were estimated to have occurred, causing the deaths of 47,000 women. Deaths due to unsafe abortion are mainly caused by severe infections or bleeding resulting from the unsafe abortion procedure, or due to organ damage[9]. Majority of these women do not want to become pregnant again in the near future. WHO recommends spacing of at least 6 months between abortion and next pregnancy. Therefore, providing family planning services as a part of post abortion care can improve contraceptive acceptance and help break the cycle of repeated unwanted pregnancies.

Post abortion family planning can avert unintended pregnancies and abortion associated problems.

Abortions account for approximately 8% of maternal mortality in India and family planning could prevent 90% of maternal mortality associated with unsafe abortions. Since women receiving abortion services at a facility usually do not return for family planning services even though they do not want to become pregnant again in the near future, immediate post abortion period when the woman is still at the facility or in contact with the health care provider is the opportune time to provide family planning counselling and services[7].

If contraception were accessible and used consistently and correctly by women wanting to avoid pregnancy, maternal deaths would decline by an estimated 25–35%.

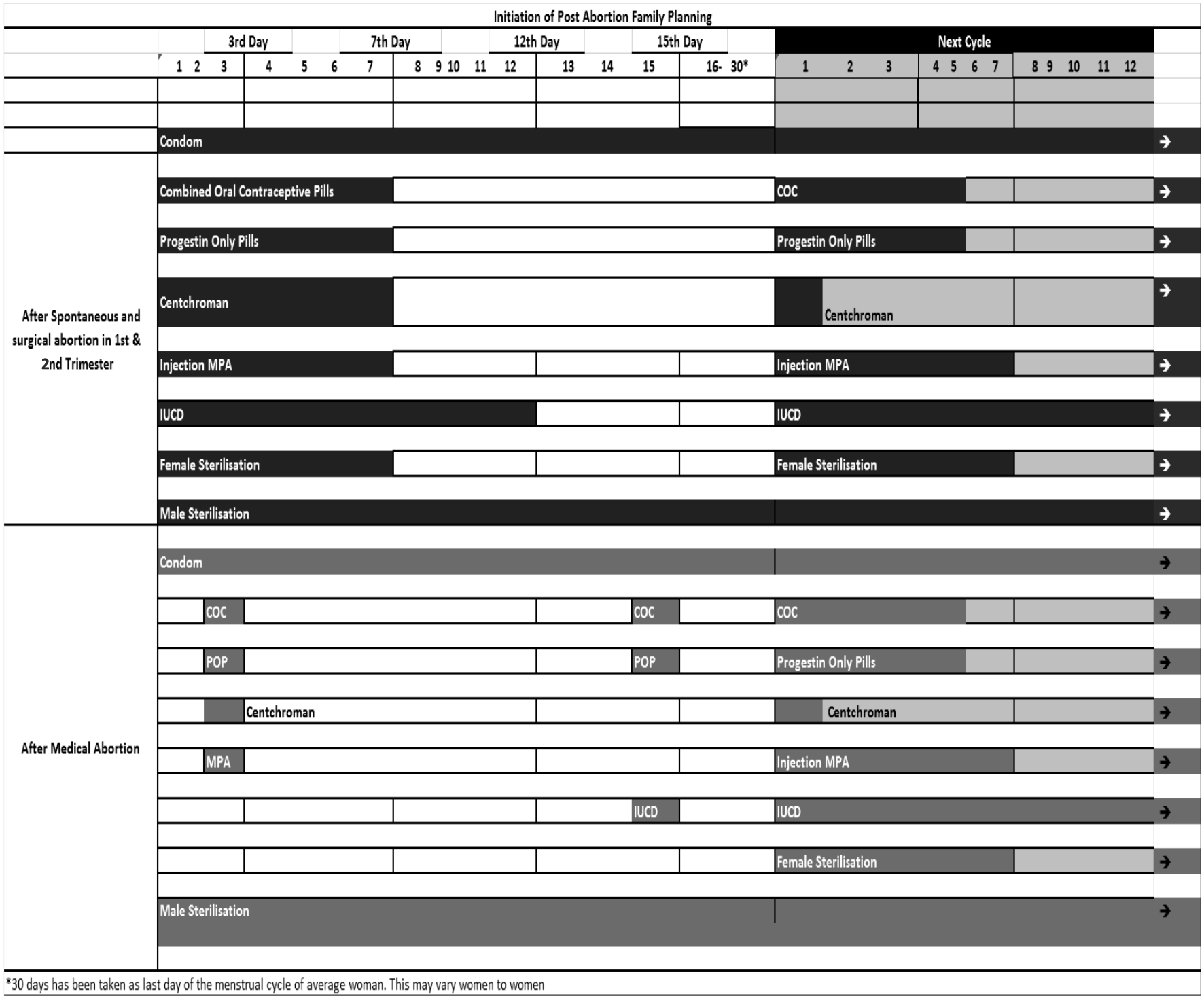
Providing Post Abortion Family Planning Services

A recent study by Banerjee et.al ICFP 2016, indicates that overall uptake of contraception after abortion is low for long acting reversible or permanent methods with only 20% women opting for female sterilization and 15% opting for IUCDs. More than half of the women (41% COCs and 24% condoms) opted for short term methods. This same study also reveals that since surgical abortion provides a greater opportunity for interaction and counselling between providers & clients than after medical methods of abortion, the uptake of long term contraception is significantly higher (30% as opposed to 10%).

Counselling and provision of family planning methods during the post abortion period is therefore critical to ensure the health of the woman.

Methods Appropriate for Post abortion Use

Several modern contraceptive methods, including long-acting and permanent FP methods IUD, vasectomy and tubectomy are appropriate for use immediately after abortion. The following chart shows FP methods appropriate during post abortion period and their timing of initiation:



*30 days has been taken as last day of the menstrual cycle of average woman. This may vary women to women

Advantages of Post Abortion Family Planning

Since abortion is legal in India, programs can offer post abortion family planning services after the abortion has been completed. There are a number of benefits of expanding the focus of post abortion care to include family planning counselling and service provision.

- ***Increased contraceptive use and decreased abortion.*** Many countries across the world have demonstrated that the use of modern contraceptives increased dramatically after the focus of post abortion care included provision of contraceptive method. In the Women and Infant Health Project in Russia, where abortion is legal, family planning was strengthened for postpartum and post abortion women. Within four years (1999 to 2003), the number of women using a modern method of contraception increased by 16% (from 50% to 58%). From 2003 to 2005, the number of abortions per 1,000 women decreased from 49 to 43 per 1,000 women[11].

- ***Reduced child mortality.*** Ensuring that every woman seeking post abortion care (PAC) services for complications of unsafe abortion or miscarriage is offered family planning counselling and a contraceptive method before discharge from the facility will help to decrease repeat unplanned pregnancy and unsafe abortion. Moreover, post abortion family planning assists in reducing child mortality. Children whose mother dies are much more likely to be ill and die themselves than children whose mother remains alive.

- ***Prevention of mother-to-child transmission of HIV and new infections.*** Post abortion family planning is also important for women who are HIV-positive. These women have a greater risk of miscarriage than HIV-negative women, and also risk passing the infection to their child during gestation or through breast-feeding. Improving voluntary post abortion contraception for this group of women will allow them to consider their own health and desire for further childbearing in light of their HIV status. Through the promotion of dual protection via post abortion family planning counselling and service delivery, new HIV infections as well as unintended pregnancies can be prevented.

COUNSELLING FOR PPFP

Introduction

The purpose of postpartum family planning counselling is to ensure that the clients make a free and informed decision about reproduction and postpartum contraception either during the antenatal period or after child birth. The decision must not be made when the client is in stress of labor or by using any pressure or coercion.

When counselling about postpartum family planning, special issues need to be considered. Postpartum family planning counselling can help educate mothers about:

- Taking advantage of the natural infertility created by exclusive breastfeeding through Lactational Amenorrhea Method (LAM)
- Learning the health benefits for both the mother and infant by maintaining healthy timing and spacing of pregnancies (HTSP)
- Understanding the return to fertility (which may be as early as few weeks after delivery)
- Learning about FP methods that are safe during breastfeeding and their Efficacy
- Learning about the Common side effects of methods
- Learning when and how to initiate a FP method

Timing of Counselling Constraints

The best time to counsel for postpartum family planning is during the antenatal period, before the stress of labor and delivery. If counselling was not provided during the antenatal period service providers can provide it before the woman is discharged. Effective counselling and provision of postpartum family planning services require good communication between antenatal, labor and delivery, maternity, and FP services. counselling as well as service provision for PPFP is often provided by antenatal, labor and delivery, and maternity staff.

Factors Affecting Method Choice

Mothers coming for antenatal care or postnatal care should be counseled for:

- Future reproductive goals of couple for spacing or limiting
- Personal factors including time, travel costs, discomfort associated with FP method
- Accessibility and availability of other products that are necessary to use
- Medical factors

Postpartum Family Planning immediate after childbirth

- Start discussing about Postpartum Family Planning during Antenatal Care (ANC)
- Discuss benefits of immediate and exclusive breastfeeding… LAM
- Discuss possibilities for long-acting and permanent methods
- For spacing future pregnancies: Postpartum IUD insertion, or

- For limiting future pregnancies: postpartum tubectomy or vasectomy

Male Involvement in Postpartum Family Planning

Postpartum family planning services usually focus on women. However, men play an important role in the decision to use FP. Many couples use a contraceptive method that relies on the man's active cooperation, such as condoms, vasectomy, withdrawal or standard day's method.

The role of men can influence the decision to choose and use a family planning method correctly like many other decisions made in the family. It is the responsibility of the service provider to understand this and take the necessary the steps to ensure that a joint decision is made by the couple.

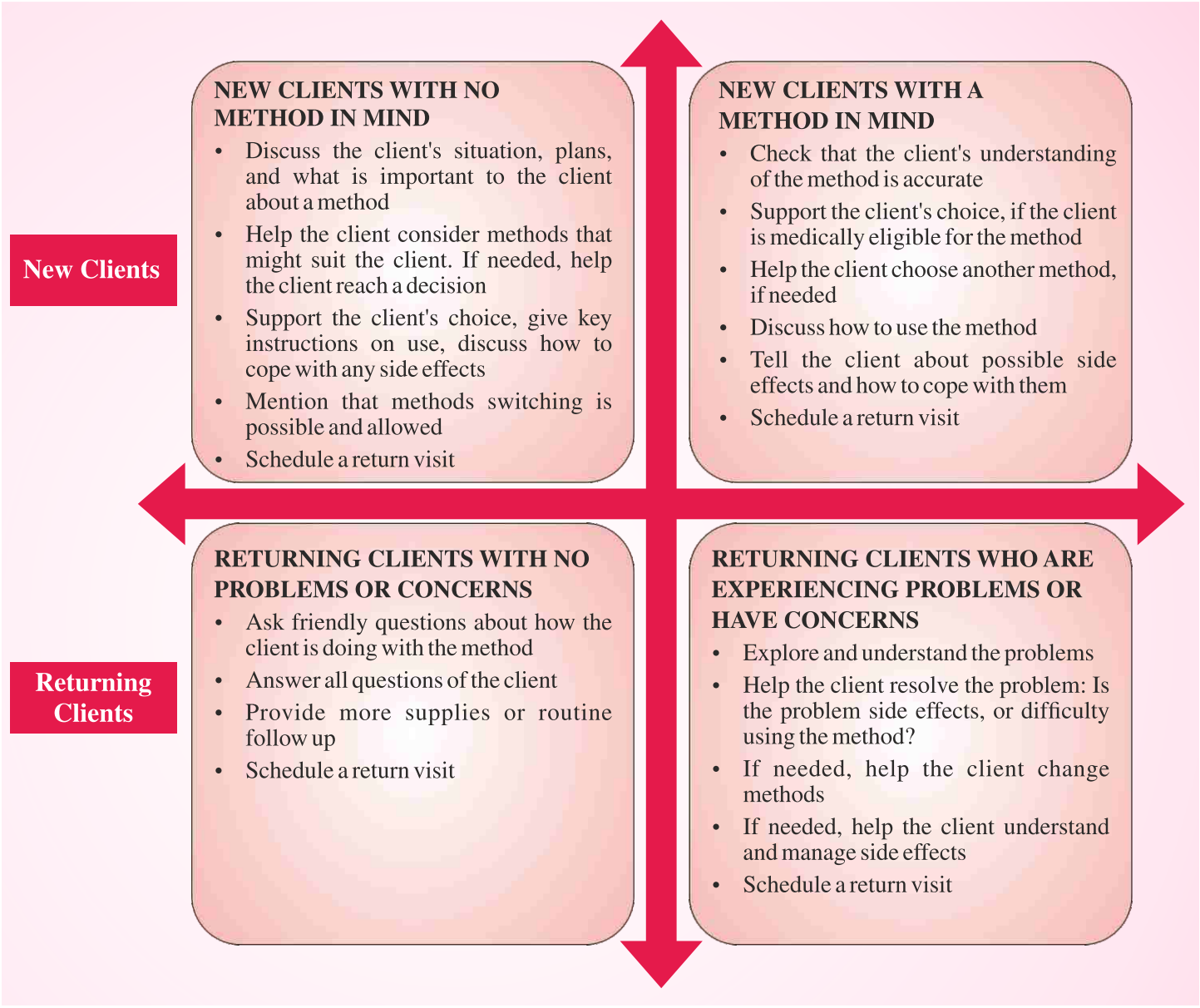
For effective PPFP counselling all providers should remember the following key points

- Promote and encourage exclusive breastfeeding & Lactational Amenorrhea Method (LAM) for contraception
- Counsel on return to fertility and the risk of becoming pregnant during the postpartum period
- Counsel on benefits of healthy timing and spacing of pregnancy. Couple should wait at least 2 years after the birth before they try to get pregnant again
- Provide correct and complete information on the various methods that are available
- Use the Integration of FP / MCH services such as during ANC and postpartum visits, Newborn care and Immunization for counselling the clients

If a postpartum client is ready to choose a family planning method, the provider should

- Ensure that the client is having informed choice
- Instruct the client on how to use the method
- Explain when the client should begin using the method
- Explain the common side effects of the method she has chosen. Reassure the client that the side effects usually resolve or go away after a few months. Discuss what to do if she has problems with the method
- As appropriate, reinforce information on the use of FP methods by breastfeeding women
- Refer clients for FP methods such as IUDs, injectable, implants or sterilization if they cannot be provided at that particular facility
- If the chosen method cannot be provided, provide the client with a back-up method until she can obtain her preferred method

Counselors/providers will be examining different categories of PPFP clients', i.e. some may be new clients while some may be returning. So their needs and expectations from counselling can be different. Hence, it is important that they can quickly identify the category or categories in which a client fits. This will help providers to streamline and tailor their counselling to meet the client's needs, thus providers can better address their needs and avoid spending time on unnecessary issues. Following is the different category of clients :



Counselling for Post Abortion Contraception

Counselling is a critical component in providing quality post-abortion family planning services and involves communication between a service provider/ counsellor and a client. It helps the client to understand the essential concepts of family planning, to have options for contraceptive methods and to choose a method based on her needs and preference.

Need for PAFP services & PAFP counselling

- Majority of women do not want to become pregnant in near future after abortions
- PAFP can avert unwanted pregnancies and abortion related problems
- Prevents maternal mortality associated with unsafe abortions

Timing of Counselling:

- Before the abortion procedure, it should be checked that the woman's physical condition and emotional situation is appropriate for counselling on contraception. Provider/counsellor should respect her right to accept or refuse post abortion contraception and services are provided

accordingly. Counselling before the abortion procedure offers the woman options of adopting

- various contraceptive methods. Thus she would have a chance for immediate IUCD insertion procedure or sterilization procedure while she is still on the table after the completion of abortion
- After the abortion procedure once the woman settles down, counselling on available contraceptive methods may also be provided

Assess Individual Situation

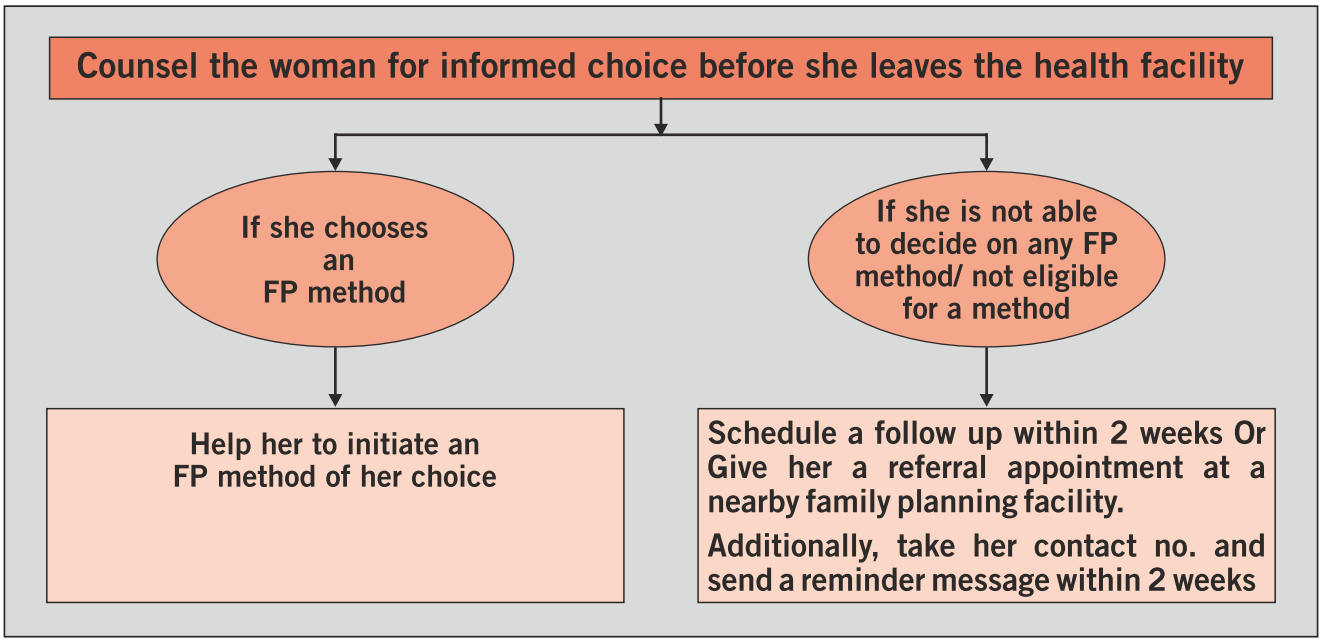
The service provider/counsellor should consider both, the woman's clinical condition and personal situation and discuss any potential barriers to the successful adoption of contraception in a sensitive manner.

Information on Methods

The service provider/counsellor should explain the characteristics, use (how it works), side effects and effectiveness of the available methods.

Method Specific counselling

The service provider/counsellor should aid/support the woman in selecting the contraceptive method which best suits her.



PAFP Counselling Messages

- Client should wait at least 6 months before trying to conceive again
- Fertility returns quickly - within 10 to 11 days after first trimester abortion or miscarriage and within 4 weeks after a second trimester abortion or miscarriage
- She can choose from available family planning methods that can be started at once
- If a woman decides not to use contraceptives at this time, providers can offer information on all available methods
- To avoid infection, she should not have intercourse until bleeding stops - If being treated for infection or vaginal/ cervical injury; she should wait until she is fully healed
- Method specific counselling should follow if she chooses any family planning method

LACTATIONAL AMENORRHOEA METHOD

Lactational Amenorrhea Method (LAM) is a temporary contraceptive method that uses a pattern of breast feeding that can effectively suppress ovulation and prevent pregnancy in the postpartum period.

Effectiveness of LAM- more than **98%** effective

If following criteria are met:

1. Exclusively breastfeeding of the baby at least 6 times during the day and 4 times during the night
2. No return of menstruation while this method is being followed
3. Baby is less than 6 months old

When can LAM be initiated?

LAM can be initiated at ANY TIME during the first six months postpartum

Within 2 months	2-6 months after delivery
1- Exclusive or nearly exclusive breastfeeding since delivery 2-Woman may still be having postpartum bleeding (lochial discharge) that may be similar to a monthly bleed	1- Exclusive or nearly exclusive breastfeeding since delivery 2-No menstrual bleeding till baby is 6 months old

LAM counselling can be integrated during

- antenatal visits, included with breastfeeding counselling
- intrapartum service delivery, packaged with Baby and Mother Friendly Initiatives
- the postpartum period
- primary health care, well baby or sick child visits

Advantages of LAM

- Effectively prevents pregnancy for upto six month
- Has no hormonal or other major side effects (for mother or for infant of breastfeeding mother)
- Facilitates transition to other modern contraceptive methods by allowing time for the

woman/couple to choose another method (if any of the LAM criteria is no longer met)

- Facilitates modern contraceptive use by previous non-users
- Is provided and controlled by the woman

Benefits to Child

- Decreases exposure to contaminants in water, in other milk or formulas, or on utensils
- Adapts to nutritional needs of growing infant
- Is more easily digested than other milk or formulas
- Promotes optimal brain development
- Provides passive immunity and protects against infections
- Provides some protection against allergies
- Strengthens mother–baby bond

Benefits to Mother

- Stimulates uterine contractions in the early postpartum and may reduce postpartum blood loss
- Promotes involution (return of uterus to pre-pregnancy state)
- Reduces iron depletion by suppressing menstruation

Limitations of LAM

- Is effective only for six months
- Offers no protection against sexually transmitted infections (STIs)/HIV
- If the mother has HIV and is not only/exclusively breastfeeding (i.e., is "mixed feeding"/alternating breastfeeding with other foods or fluids), increases the risk that HIV will be transmitted to the baby through breastfeeding

Dos for Exclusive Breastfeeding in LAM: To enable mothers to establish and sustain exclusive breastfeeding for six months, WHO and UNICEF recommend:

- Initiation of breastfeeding within the first hour of life
- Exclusive breastfeeding - that is, the infant receives only breast milk without any additional food or drink, not even water
- Breastfeeding on demand - that is, as often as the child wants, day and night

Dont's for Effective use of LAM

- Do not give the infant any additional food or drink, not even water
- Do not consider yourself protected from pregnancy if breast feeding is supplemented with other foods
- Do not consider yourself protected from pregnancy if menstruation starts before the baby is 6 months old

Some facts about LAM

- The vast majority of the infant's feeds comes from suckling at the breast:
  - Bottle feeding should not replace breast feeding
  - Breastfeeding intervals do not exceed 4 hours during the day or 6 hours during the night Supplementation does not exceed 5-15% of all feedings

- Difference between LAM, breastfeeding, and amenorrhoea:
  - LAM is a contraceptive method, based on the physiology of breastfeeding. LAM is a method of contraception that a woman consciously chooses to use to reduce her chances of becoming pregnant by adhering carefully to the three criteria
  - Breastfeeding is a feeding practice
  - Amenorrhoea, or the absence of menstrual bleeding, reflects a reduced risk of ovulation, but neither breastfeeding nor amenorrhoea is a family planning method

- For the purpose of determining whether the first LAM criterion is met (i.e., the mother's menstrual bleeding has not returned), consider any bleeding after two months postpartum to be menses/menstrual bleeding. Bleeding that occurs before two months postpartum may be considered normal postpartum discharge

- At the very least, a client needs to return for a visit to the provider if she perceives any breastfeeding difficulties or as soon as any one of the LAM criteria is not met

- An additional follow-up visit at five to six months postpartum is essential to determine the client's plans for switching to another contraceptive method and for introducing complementary foods when her baby is six months old

COMBINED ORAL CONTRACEPTIVE PILLS

Ingredients of available combined oral pills are Estrogen and progesterone.

Effectiveness- The combined oral pill is 99.9% effective if used correctly.

Advantages combined of Combined Oral Pill

- Women of any age can use oral pill as a family planning method
- Decreases both duration and amount of menstrual bleeding which helps to reduce anemia,
- Improves dysfunctional uterine bleeding by regularizing the menstrual cycle
- Decreases uterine cramps during menstruation, and reduces the incidence of endometriosis
- Decreases risk of fibroblastic diseases of the breast, ovarian cyst and cancer, ectopic pregnancy, and endometrial cancer, etc.
- Immediate return of fertility on discontinuation
- May be used as emergency contraceptive

Disadvantages combined of Combined Oral Pill

- Decreases breast milk secretion in breastfeeding women
- Need to be taken everyday
- May cause amenorrhea
- May decrease slipperiness of the vaginal canal
- During the first 3-4 months of beginning oral pill there may be some minor side-effects like, tenderness or pain in the breast, inter-menstrual spotting, nausea, headache, acne, weight gain,
- Cannot protect against HIV/AIDS and RTIs and STIs
- Increases the risk of myocardial infarction of women at increased risk of it
- Increases risk of stroke of women having risk of stroke (e.g., smoking, chewing tobacco leaf, hypertension),
- Increases the risk of venous thrombo-embolism. Therefore, women having past or present history of thrombo-embolism cannot take combined oral pills.

Checklist for Screening Clients Who Want to Initiate Combined Oral Contraceptives

To determine if the client is medically eligible to use COCs, ask questions 1–11. As soon as the client answers **YES** to **any question,** stop, and follow the instructions after question 11.

NO	1. Are you currently breastfeeding a baby less than six months of age?	YES
NO	2. Have you given birth in the last 3 weeks?	YES
NO	3. Do you smoke cigarettes and are you more than 35 years of age?	YES
NO	4. Do you have repeated severe headaches, often on one side, and/or pulsating, causing nausea, and which are made worse by light, noise, or movement?	YES
NO	5. Have you ever been told you have breast cancer or do you have an undiagnosed breast lump?	YES
NO	6. Have you ever had a stroke, blood clot in your legs or lungs, or heart attack?	YES
NO	7. Do you regularly take any pills for tuberculosis (TB), seizures (fits), or ritonavir for ARV therapy?	YES
NO	8. Do you have gall bladder disease or serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	9. Have you ever been told you have high blood pressure?	YES
NO	10. Have you ever been told you have diabetes (high sugar in your blood)?	YES
NO	11. Have you ever been told that you have a rheumatic disease such as lupus?	YES

If the client answered **NO** to ***all of questions 1–11,*** the client can use COCs. Proceed to questions 12–17.

If the client answered **YES** to ***any of questions 1–7,*** she is not a good candidate for COCs. Counsel about other available methods or refer.

If the client answered **YES** to ***any of questions 8–11,*** COCs cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

Ask questions 12–17 to be reasonably sure that the client is not pregnant. As soon as the client answers YES to any question, stop, and follow the instructions after question 17.

YES	12. Did your last menstrual period start within the past 7 days?	NO
YES	13. Did you have a baby less than 6 months ago, are you fully or nearly-fully Breastfeeding, and have you had no menstrual period since then?	NO
YES	14. Have you abstained from sexual intercourse since your last menstrual period or Delivery?	NO
YES	15. Have you had a baby in the last 4 weeks?	NO
YES	16. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	17. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to ***at least one of questions 12 – 17*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start COCs now.

If the client began her last menstrual period ***within the past 5 days,*** she can start COCs now. No additional contraceptive protection is needed.

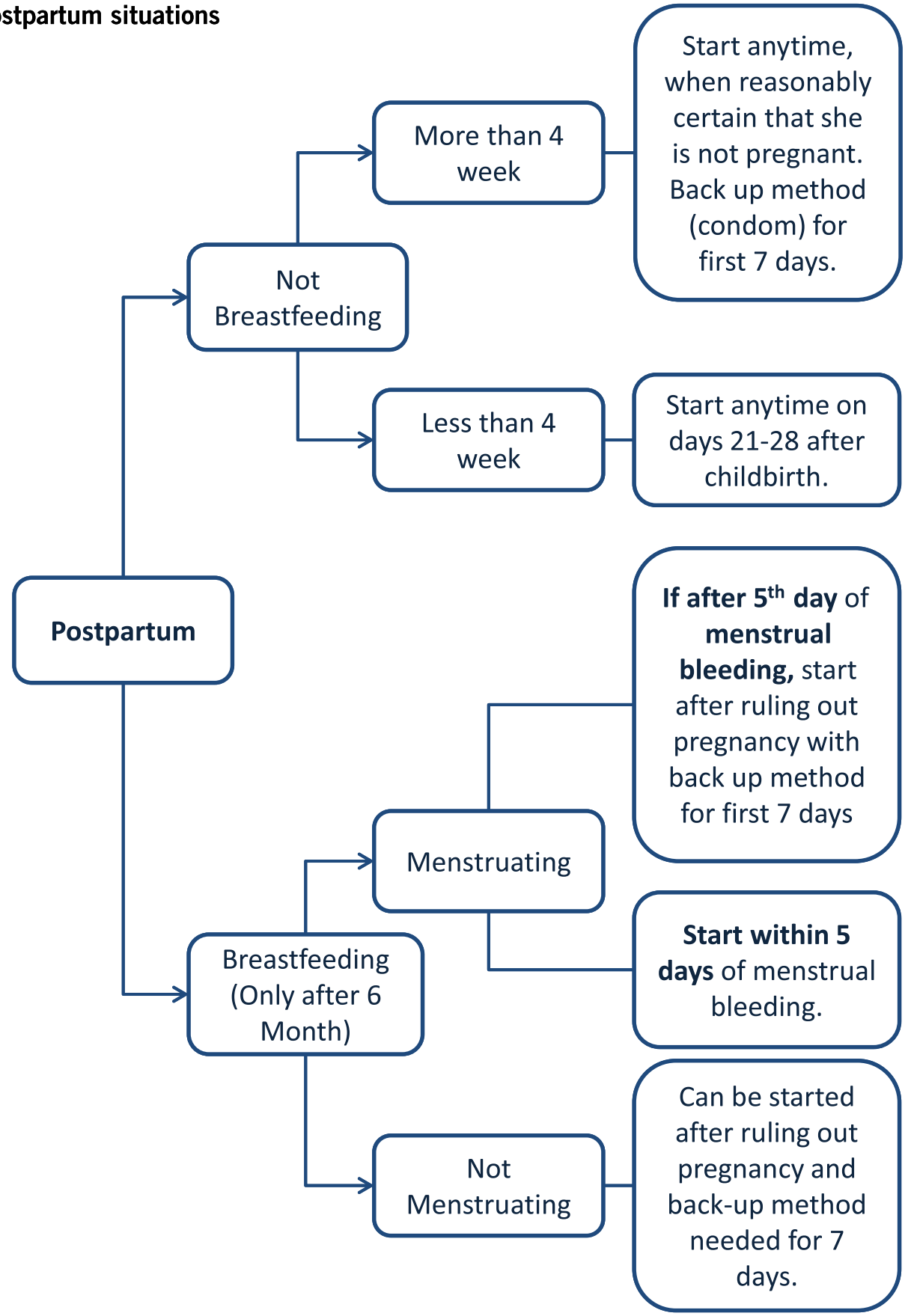
If the client began her last menstrual period ***more than 5 days ago,*** tell her to ***begin taking COCs now,*** but instruct her that she must use ***condoms or abstain from sex for the next 7 days.*** Give her condoms to use for the next 7days.

If the client answered **NO** to ***all of questions 12–17,*** pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

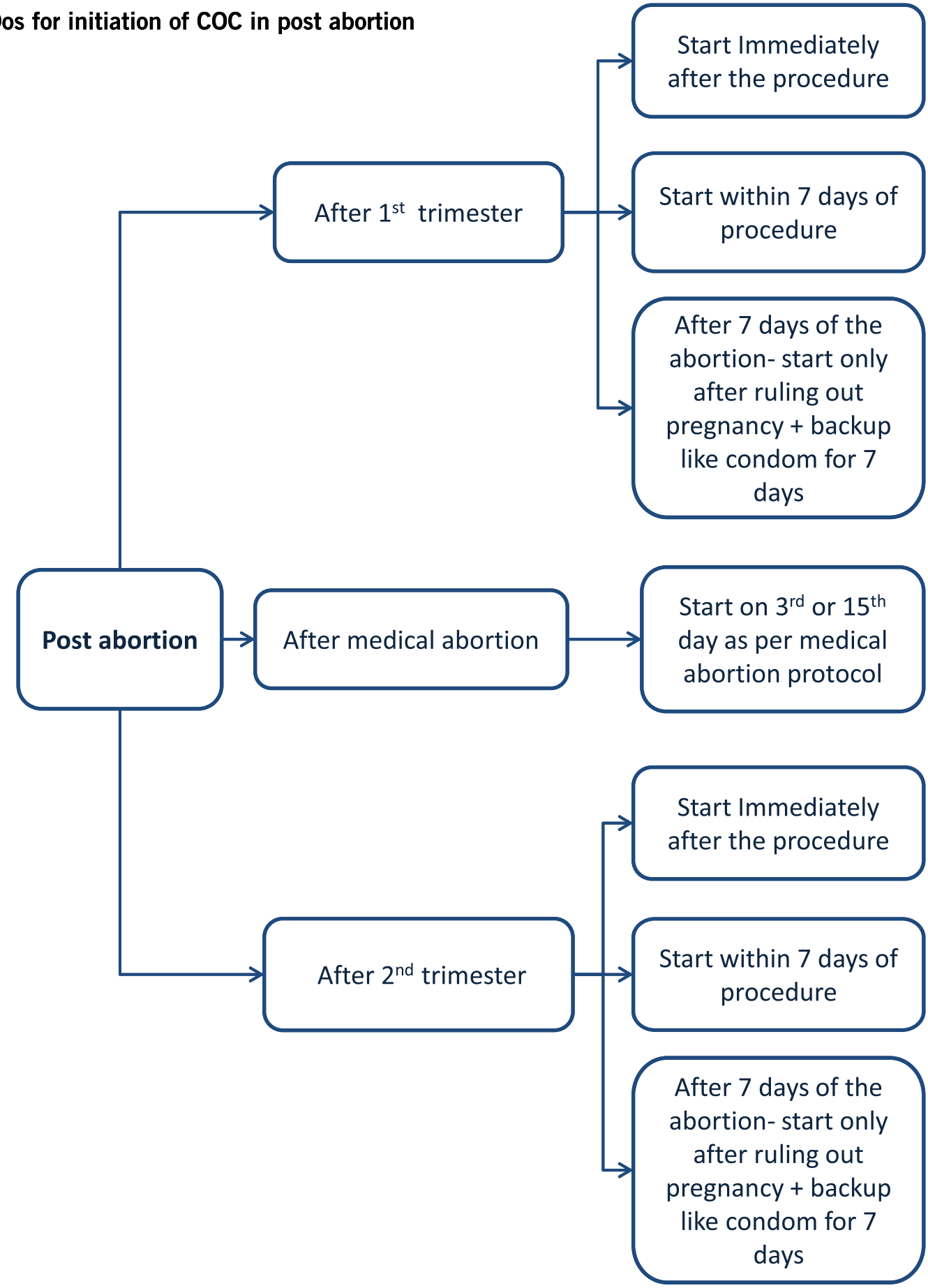
Give her the COCs but instruct her to start using the many time during the first 5 days of her next menstrual period.

Give her condoms to use in the meantime.

Dos for initiation of combined oral contraceptives in Postpartum situations



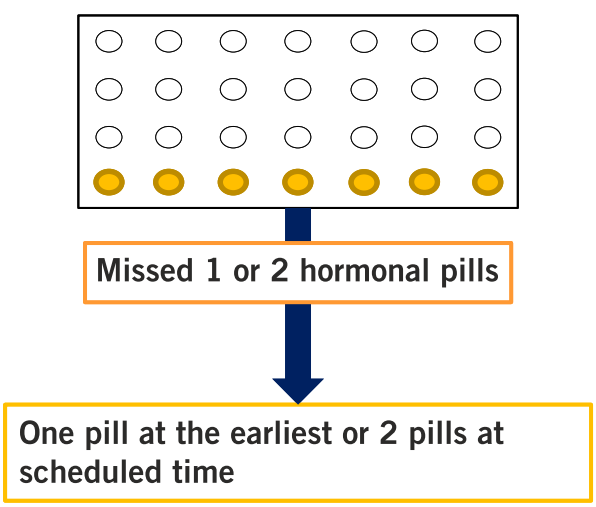
Dos for initiation of COC in post abortion



Dos about taking the pill

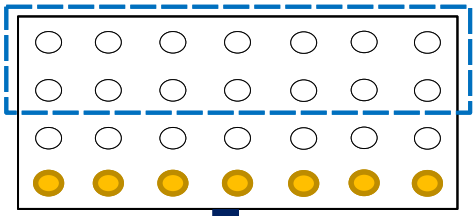
- **The first pill should be taken on the first day of menstruation. But, this can be started on any day between days 1 to day 5**
- For 28-pill packets (21 hormonal pills and 7 reminder pills containing iron)—when the client finishes 1 packet, she should take the first pill from the next packet on the very next day
- For 21-pill packets—after the client takes the last pill from 1 packet, she should wait 7 days and then take the first pill from the next packet
- Oral pill has to be swallowed with water. It is better to take the tablet at the same time every day
- The best time to take the pill is either after dinner or before going to bed
- Client must continue oral pills regularly even if the husband is frequently away from home

What to do if the Client forgets to take Pills



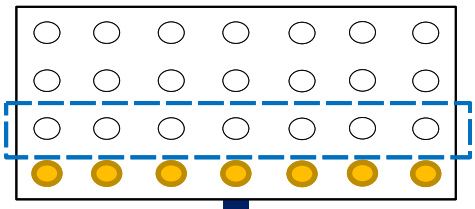
Missed 1 or 2 hormonal pills

One pill at the earliest or 2 pills at scheduled time



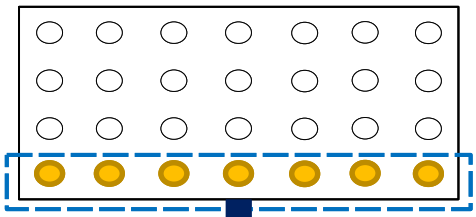
Missed 3 or more pills (1st/2nd wk)

- **One pill at the earliest and continue scheduled pill**
- **Backup method for next 7 days**
- **Use ECP if had sex in past 72hrs**



Missed 3 or more pills (3rd wk)

- **One pill at the earliest and finish all hormonal pills as scheduled. (throw away non hormonal pills)**
- **Start new pack next day**
- **Backup method for next 7 days**
- **Use ECP if had sex in past 72hrs**



Missed non hormonal pills

Discard the missed pill
Start new pack as usual

Counselling messages at initiation of method

1. Instructions to ensure correct and consistent use (detailed as above).Check client's understanding of information given
2. Instructions regarding missed pills since missing pills risks pregnancy and make some side effects worse. (detailed as above)
3. Information regarding side effects
   - minor side-effects of oral pills are nausea, headache and changes in menstrual bleeding (light bleeding, inter menstrual bleeding or irregular bleeding), weight gain or breast tenderness
   - These will disappear as the time passes
4. Information regarding **danger signs** If client has any of the following problems she must be advised to come to the nearby health facilities
   A- Severe abdominal/ pelvic pain
   C- Severe chest pain, cough or difficulty in breathing
   H- Severe headache, vertigo or numbness of any limb
   E- Not able to see/blurring of vision/seeing 2 images of everything/difficulty in talking
   S-Severe pain below the knee and in thigh muscles
5. The client should be advised to come to the clinic for resupply of pills

Counselling messages at Follow up- client with no problem

- Ask about client's experience with the method
- Answer questions if any
- Provide more supplies
- Schedule a return visit

Counselling messages at Follow up- client with problem

- Explore and understand the problem
- Help the client to resolve the problem – method use/side effects
- Support the client to choose another method if needed
- Schedule a return visit

Some facts about COCs

- COCs can be used for many years without having to stop them periodically
- COCs do not disrupt an existing pregnancy
- A baby will not have birth defects if a woman becomes pregnant while on pills or accidentally starts to take COCs, when she is already pregnant
- Most women do not gain or lose weight due to COCs
- COCs actually reduces the risks of ovarian cancer and endometrial cancer. In addition, there is a greater decrease in ovarian cancer risk in people who use the pill longer
- Breast cancer slightly more common in women using COCs

INJECTABLE MPA

Contraceptive Injection: Medroxyprogesterone acetate (MPA)

Contraceptive injection is a very safe and effective 3 monthly temporary method of family planning.

Types, composition and duration of Injectables

MPA-150 mg per 1 ml: Deep intra muscular every 3 months

Can be stored at room temperature

Effectiveness of MPA

Highly effective (0.3 pregnancies/ 100 women during first year of use)[12],

Advantages of Injectable MPA

- It is easy to use correctly and consistently because it requires no daily routine
- Can be used by women who are not able to take hormonal oral contraceptive pills like Mala N/Mala D etc
- Safe for breast feeding mothers as it does not affect quality and quantity of milk
- Does not interfere with sexual intercourse/pleasure
- Reduces menstrual cramps (in some cases)
- This actually takes care of anaemia by reducing menstrual blood loss
- Does not interfere with any medicine
- Protects from uterine and ovarian cancer
- The privacy of client can be ensured
- Does not require any laboratory investigation before starting the dose

Disadvantages

- Since MPA is long acting, its action cannot be stopped immediately if side effects develop or if the user wishes to become pregnant
- Return of fertility takes 7-10 months after last injection
- No protection against sexually transmitted diseases, including HIV infection

Checklist for Screening Clients Who Want to Initiate MPA

To determine if the client is medically eligible to use MPA, ask questions 1–8. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 8.

NO	1. Have you ever been told you have breast cancer?	YES
NO	2. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Have you ever been told you have diabetes (high sugar in your blood)?	YES
NO	5. Have you ever been told you have high blood pressure?	YES
NO	6. Do you have bleeding between menstrual periods, which is unusual for you, or bleeding after intercourse (sex)?	YES
NO	7. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	8. Are you currently breastfeeding a baby less than 6 weeks old?	YES

If the client answered **NO** to ***all of questions 1–8,*** the client can use MPA. Proceed to questions 9–14.

If the client answered **YES** to ***question 1,*** she is not a good candidate for MPA. Counsel about other available methods or refer.

If the client answered **YES** to ***any of questions 2– 7,*** MPA cannot be initiated without further evaluation. Evaluate or refer as appropriate, and give condoms to use in the meantime. See explanations for more instructions.

If the client answered **YES** to ***question 8,*** instruct her to return for MPA as soon as possible after the baby is 6 weeks old.

Ask questions 9–14 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 14.

YES	9. Did your last menstrual period start within the past 7 days?	NO
YES	10. Did you have a baby less than 6 months ago, are you fully or nearly-fully Breastfeeding, and have you had no menstrual period since then?	NO
YES	11. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	12. Have you had a baby in the last 4 weeks?	NO
YES	13. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	14. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to ***at least one of questions 9–14*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start MPA now.

If the client began her last menstrual period ***within the past 7 days,*** she can start MPA immediately. No additional contraceptive protection is needed.

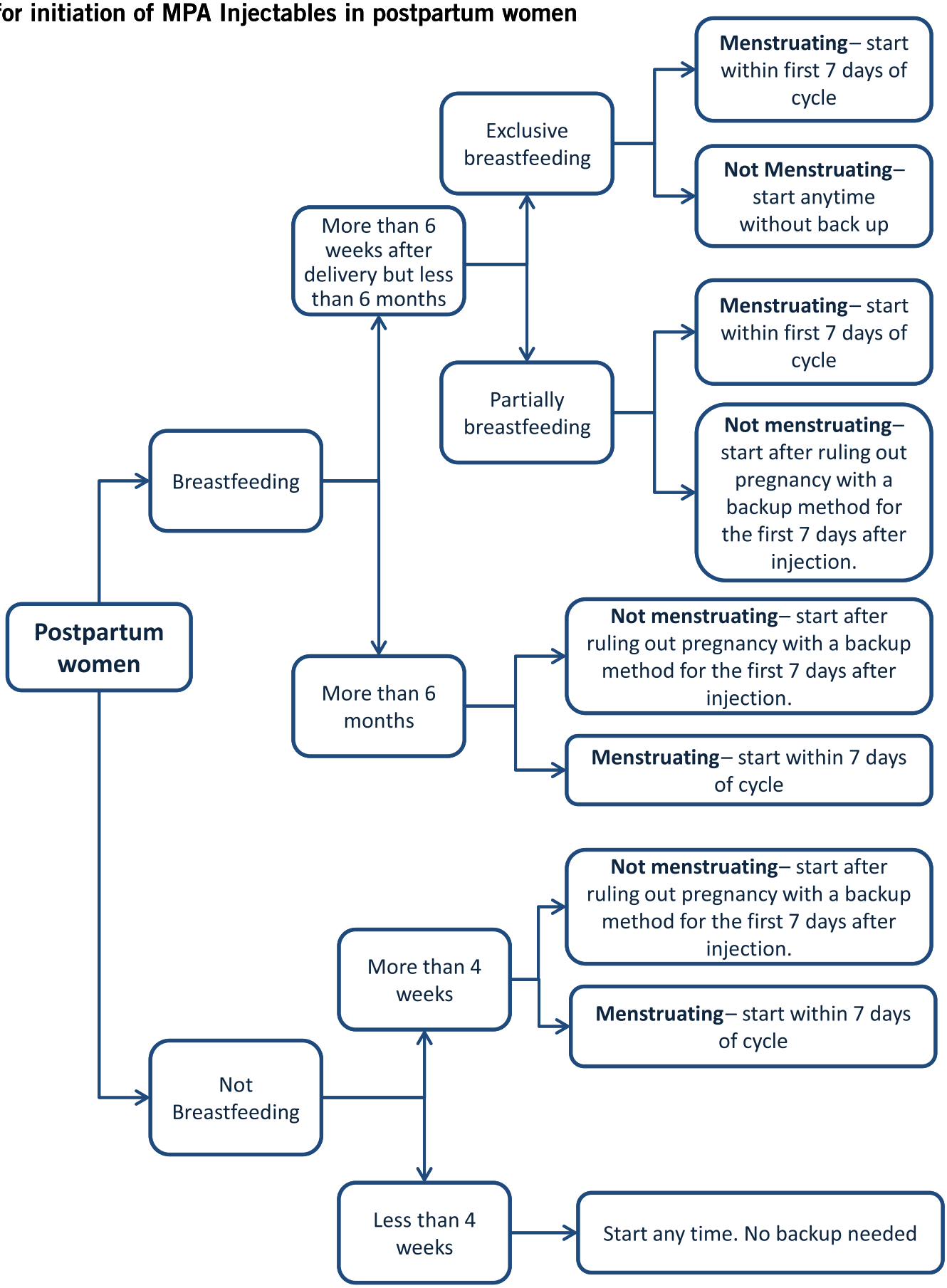
If the client began her last menstrual period ***more than 7 days ago,*** she can ***be given MPA now,*** but instruct her that she must ***use condoms or abstain from sex for the next 7 days.*** Give her condoms to use for the next 7 days.

If the client answered **NO** to ***all of questions 9–14,*** pregnancy cannot be ruled out.

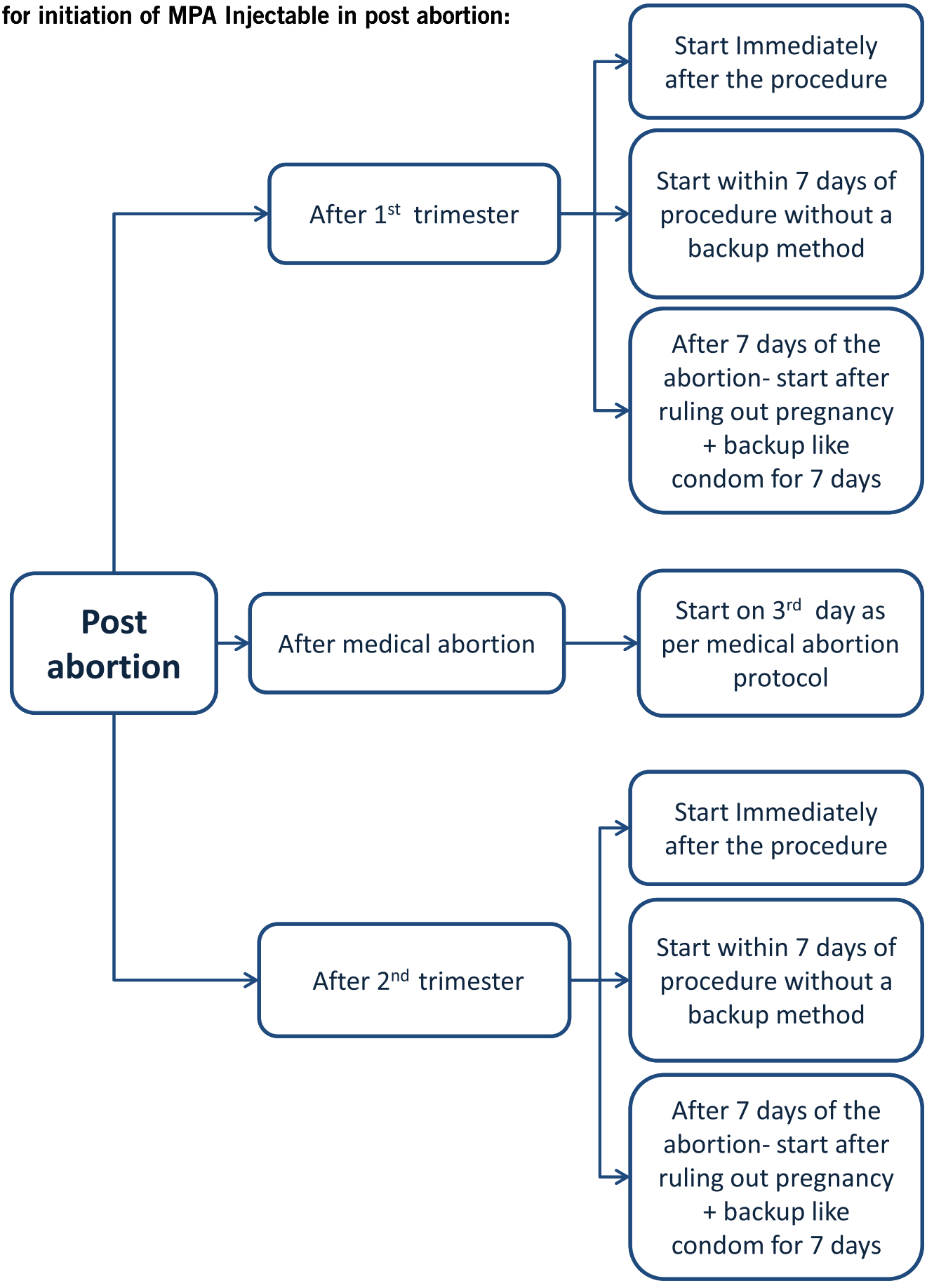
She must use a pregnancy test or wait until her next menstrual period to be given MPA.

Give her condoms to use in the meantime.

Dos for initiation of MPA Injectables in postpartum women



Dos for initiation of MPA Injectable in post abortion:



Storage of MPA Vials/Uniject

- To be stored at room temperature between 15 to 30 degree Celsius
- Storage place should be dry and dust free and not exposed to extreme heat or cold
- MPA vials may be kept in a cupboard, away from direct sunlight
- Vials to be kept in upright position, otherwise micro crystalized MPA may stick around the cap area or in deep corners of vial and may not be available during filling of the drug in the syringe
- Do not keep MPA vials in the refrigerator/freezer

Dos - first dose of Injection

The first dose can be administered by a trained doctor or a trained staff nurse/ ANM under the supervision of a doctor

Pre-Injection Preparation for MPA

- Check vial for expiry date
- Shake the vial well. If the vial is cold, warm to body temperature by rubbing between palms before giving injection. Ensure that all the microcrystals are dissolved completely in the fluid of the vial reservoir
- Wash hands with soap and water
- For intramuscular injection, withdraw full quantity of solution from the vial into the disposable syringe with needle, taking care not to push any outside air into the vial

Administering the IM Injection of MPA

- Intramuscular MPA is given usually in the deep muscle of the arm, antero lateral gluteal region of the hip or gluteal muscle of the buttocks. The choice of site should depend mainly on the woman's preference
- Clean site of the injection with an antiseptic
- Allow the antiseptic to dry before administering the injection
- Insert sterile needle deep into the chosen site for injection
- Aspirate first to ensure that the needle is not in a vein
- Inject the contents of the syringe fully
- If there is little oozing just apply gentle pressure for few seconds
- **Do not massage the injection site; just leave the site as it is.** Massage of the injection is strictly prohibited as that causes faster absorption of the hormone than desired
- Ask the client to remain within facility for 5-10 minutes after receiving the injection

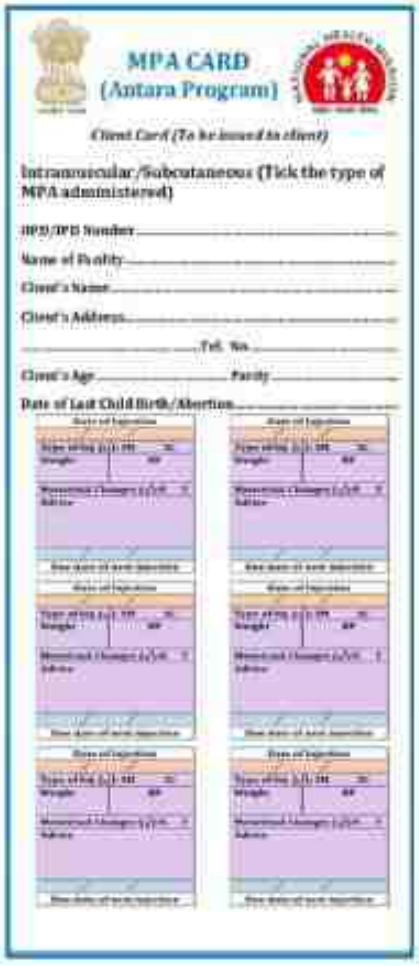
Dos & Don'ts for Safe Injections & Needles

DOs

1. Do carry out hand hygiene for 30-40 seconds before & after giving an injection
2. Do use sterilized disposable/auto disable syringe
3. Immediately after use, needles should be disposed off in a puncture-resistant container with a lid made of either metal or heavy rigid plastic or cardboard. These containers should be filled up to not more than 3/4th level and sealed before it is disposed off. Any delay in disposal of sharps will increase the chances of accidents

DON'Ts

1. Do not take apart the needle and syringe
2. Do not recap, bend or break or remove the needles from the syringe before disposal. Where recapping is unavoidable, do use one hand technique
3. Do not reuse the same syringe/needle to give injections to multiple people – even if the needle is changed


MPA CARD
(Antara Program)

Client Card (To be issued to client)

Intramuscular/Subcutaneous (Tick the type of MPA administered)

IPD/IPD Number

Name of Facility

Client's Name

Client's Address

Tel. No.

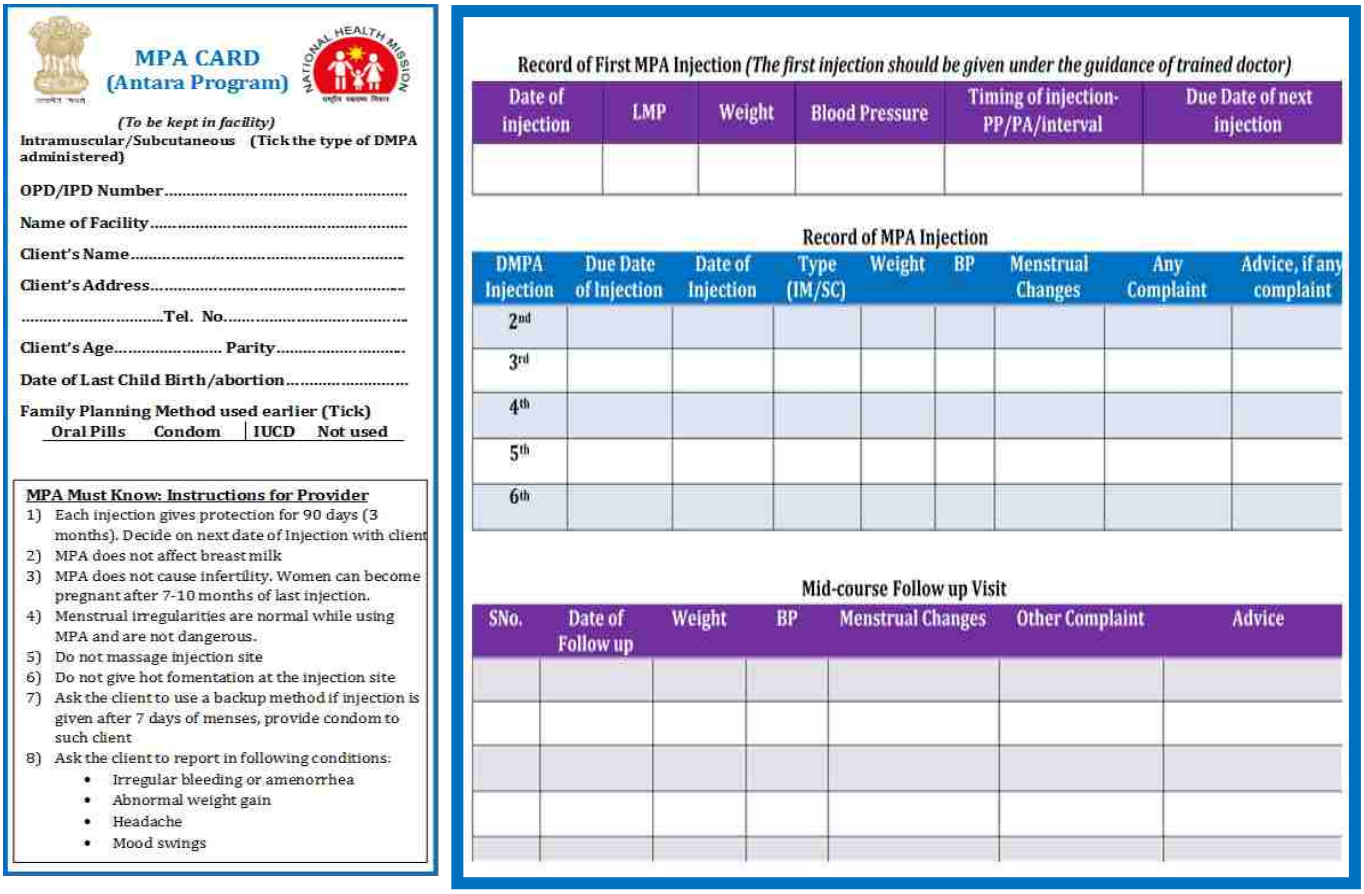
Client's Age Parity

Date of Last Child Birth/Abortion

General Information:
Type of injection (IM/SC),
OPD/IPD Number,
Name of Facility,
Client's Name,
Address, Tel. No.,
Age ,Parity
Date of Last Child Birth/abortion

Date of Injection	
Type of Inj. (√): IM	SC
Weight	BP
Menstrual Changes (√):N	Y
Advice	
Due date of next injection	

Client Card



MPA CARD
(Antara Program)

(To be kept in facility)

Intramuscular/Subcutaneous (Tick the type of DMPA administered)

OPD/IPD Number.....

Name of Facility.....

Client's Name.....

Client's Address.....

.....**Tel. No**.....

Client's Age..... **Parity**.....

Date of Last Child Birth/abortion.....

Family Planning Method used earlier (Tick)

Oral Pills	Condom	IUCD	Not used

MPA Must Know: Instructions for Provider

1) Each injection gives protection for 90 days (3 months). Decide on next date of Injection with client
2) MPA does not affect breast milk
3) MPA does not cause infertility. Women can become pregnant after 7-10 months of last injection.
4) Menstrual irregularities are normal while using MPA and are not dangerous.
5) Do not massage injection site
6) Do not give hot fomentation at the injection site
7) Ask the client to use a backup method if injection is given after 7 days of menses, provide condom to such client
8) Ask the client to report in following conditions:
   - Irregular bleeding or amenorrhea
   - Abnormal weight gain
   - Headache
   - Mood swings

Record of First MPA Injection *(The first injection should be given under the guidance of trained doctor)*

Date of injection	LMP	Weight	Blood Pressure	Timing of injection- PP/PA/interval	Due Date of next injection

Record of MPA Injection

DMPA Injection	Due Date of Injection	Date of Injection	Type (IM/SC)	Weight	BP	Menstrual Changes	Any Complaint	Advice, if any complaint
2nd								
3rd								
4th								
5th								
6th								

Mid-course Follow up Visit

SNo.	Date of Follow up	Weight	BP	Menstrual Changes	Other Complaint	Advice

Facility section

Post Injection Instruction to the Client

- Instruct client not to massage or apply hot fomentation to the injection site-explain that the drug needs to stay there for a long time and release very slowly for the next three months
- Hand over the MPA Client Card to her after explaining it to her, especially the scheduled date for next injection
- Explain the benefits of the help line and register her on it
- Instruct client to return on time for next injection. Tell her it is best to come on the scheduled date, though there is a flexibility of few days earlier or later than the exact date
- Counsel her again to expect menstrual bleeding changes (Irregular bleeding or spotting/Excessive or prolonged bleeding or amenorrhea or scanty menstruation)and not to get unduly alarmed
- Counsel her again to expect gradual weight gain and other minor problems like, heaviness in the lower abdomen, pain abdomen, headache, mental tension
- If injection is given between 'day one' to 'day seven' of menstrual cycle/abortion, inform the client that the effect of injection is immediate and no backup method is required
- If injection is given after 'day seven'–tell her that there is a need for using a backup contraceptive method (e.g. condom) for 7 days
- Assure the client that she can come back anytime if she has any concern or problem e.g,

Infection at the injection site, wants another method, has a major menstrual change, has a major change in health status or thinks she might be pregnant

Dos -Timing of Second or Subsequent Doses of Injection

- Should be given three months apart
- But can be given either two weeks before or four weeks after the scheduled dose

Follow-Up Counselling for MPA

- Ask client's experience and satisfaction with the method
- Discuss if she has any side effects, especially menstrual changes. If yes, ask how she feels about them
- Reassure about the side effects
- Ask if she has any question/concern about the method and answer appropriately
- If woman wants to continue MPA and her next injection is due, give the injection
- In case the woman does not want to continue MPA but needs protection from pregnancy, help her to choose another method

Some fact about MPA

- Most former users of MPA can expect to become pregnant within a year after their last injection if they do not use another contraceptive
- Research has clearly proven that MPA does not cause cancer. In fact, it has been demonstrated that it protects against endometrial cancer
- MPA has no effect on the quantity, composition of breastmilk, initiation or duration of breastfeeding or the growth and development of the infant
- Amenorrhea is an expected result of using DMPA because women using DMPA do not ovulate. This kind of amenorrhea is not harmful. It helps prevent anemia and frees women from the discomfort and inconvenience of monthly bleeding
- There is no limit to the number of years DMPA can be continuously used. Among healthy women it can be given until menopause, when contraception is no longer needed

CENTCHROMAN

What are Centchroman (Ormeloxifene) Pills?

Centchroman (Ormeloxifene) is a non-steroidal, once a week oral contraceptive pill which does not contain any hormone. It acts as selective estrogen receptor modulator (SERM). In some tissues/organs of the body, it has weak oestrogenic action (e.g. bones) while in others it has strong anti-estrogenic action (e.g. uterus, breasts, etc.).

Available in as a pill pack with each pill containing 30 mg

Advantages of Centchroman

- It is free from side effects of other oral pills such as nausea, weight gain, swelling, high blood pressure
- It is beneficial for anemic women as it makes the period lighter and interval of onset of periods longer
- Safe for breast feeding women and can be started immediately after delivery without waiting for 6 weeks
- It is the only contraceptive which does not affect ovulation, and does not disturb the hypothalamo-pituitary-ovarian axis, therefore there is immediate return of fertility on discontinuation
- Its weak oestrogenic action on bones will prevent loss of bone mineral density during lactation
- It has strong anti-estrogenic action on uterus & breasts providing protective action against cancers
- Do not interfere with sexual intercourse
- Can be provided by trained non-medical staff

Disadvantages on Centchroman

- Prolongation of menstruation cycle in 8% of women, usually in the first three months
- Does not provide protection against RTI/STI and HIV/AIDS

Checklist for Screening Clients Who Want to Initiate Centchroman

To determine if the client is medically eligible to use Centchroman, ask questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 6.

NO	1. Do you have chronic renal disease?	YES
NO	2. Have you been told that you have cervical hyperplasia?	YES
NO	3. Have you ever been told that you have Polycystic ovarian disease?	YES
NO	4. Do you have a recent history of jaundice or liver disease?	YES
NO	5. Have you ever been told that you have a severe allergic state?	YES
NO	6. Do you have tuberculosis?	YES

If the client answered **NO** to **all of questions 1–6,** the client can use Centchroman. Proceed to questions 7-12

If the client answered **YES** to ***any of questions 1–6,*** she is not a good candidate for Centchroman. Counsel about other available methods or refer.

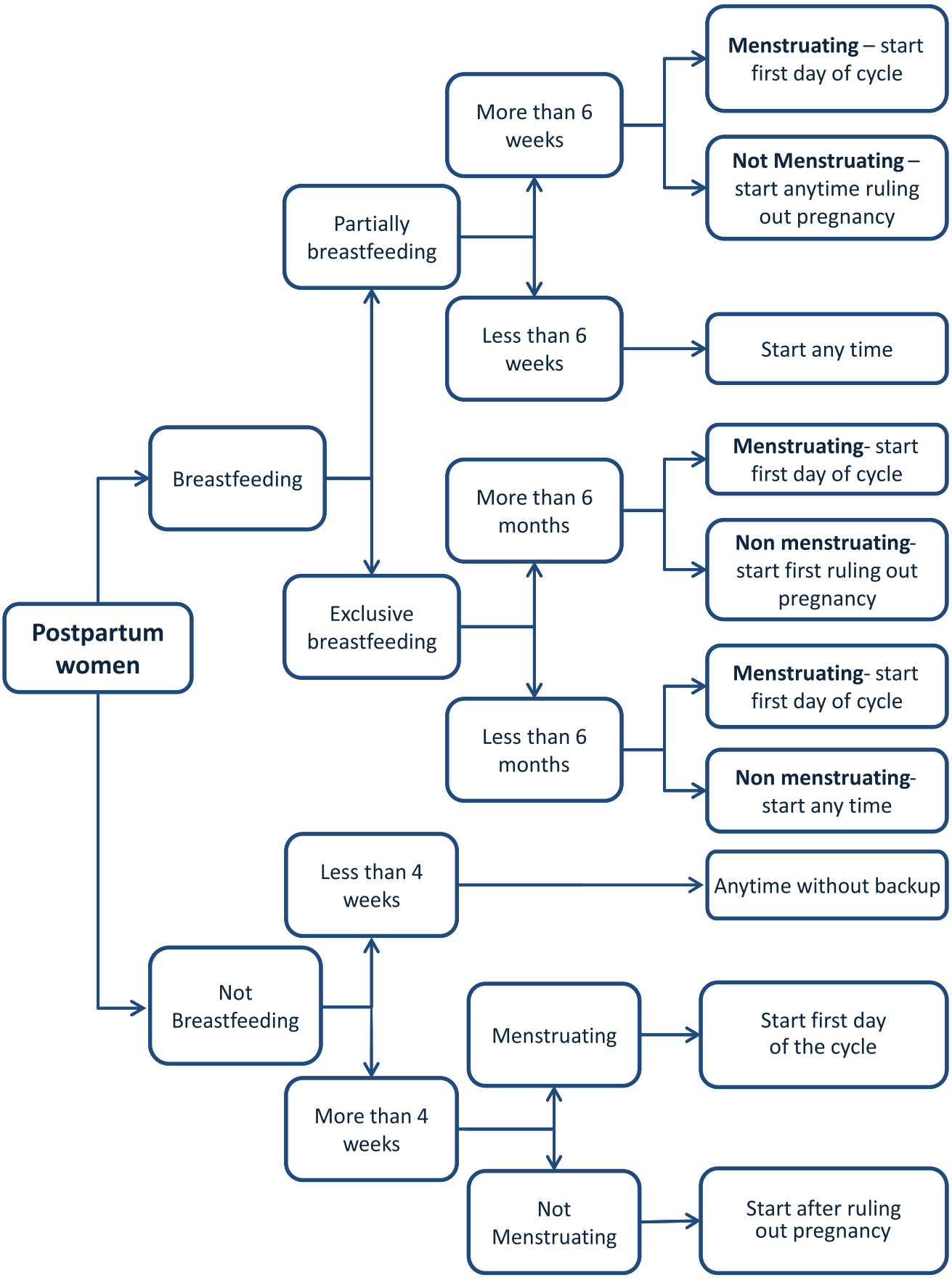
Ask questions 7–12 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 12.

YES	7. Did you start your menstrual period today?	NO
YES	8. Did you have a baby less than 6 months ago, are you fully or nearly-fully Breastfeeding, and have you had no menstrual period since then?	NO
YES	9. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	10. Have you had a baby in the last 4 weeks?	NO
YES	11. Have you had a miscarriage or abortion today?	NO
YES	12. Have you been using a reliable contraceptive method consistently and correctly?	NO

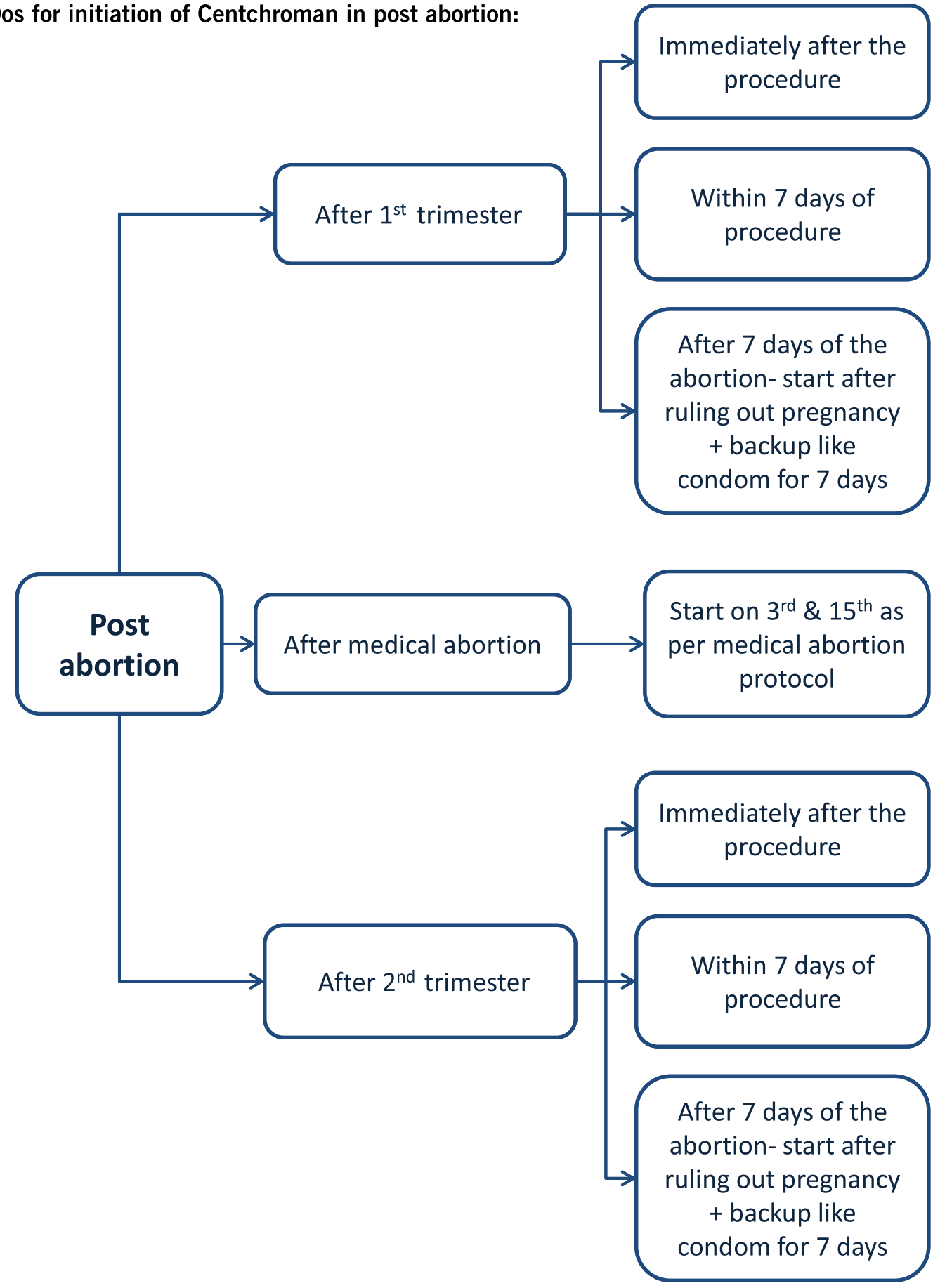
If the client answered **YES** to ***at least one of questions 7-12*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start Centchroman now.

If the client answered **NO** to ***all of questions 7–12,*** pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

Dos for initiation of Centchroman in Postpartum situations



Dos for initiation of Centchroman in post abortion:



Dos – schedule of dosage

- For initiation of the Centchroman (Ormeloxifene), the first pill is to be taken on the first day of period (as indicated by the first day of bleeding)
- Second pill 3 days later
- This pattern of days is repeated through the first three months
- From 4th month, the pill is to be taken once a week on the first pill day and should be continued on the weekly schedule regardless of her menstrual cycle. Refer table below to decide for fixed day(s)[2]

Schedule of Centchroman (Ormeloxifene)

If the first Day of pill is taken on	First 3 Months Pill to be taken on	After 3 months to be taken on
Sunday	Sunday and Wednesday	Sunday
Monday	Monday and Thursday	Monday
Tuesday	Tuesday and Friday	Tuesday
Wednesday	Wednesday and Saturday	Wednesday
Thursday	Thursday and Sunday	Thursday
Friday	Friday and Monday	Friday
Saturday	Saturday and Tuesday	Saturday

Dos counselling to ensure compliance of Centchroman (Ormeloxifene) Use:

- Assure every client that she is welcome to come back or ask question any time to the provider, if she has problems, wants another method, has any major change in health status or thinks that she might be pregnant
- Encourage her to come back for more pills before her supply is finished

Follow –Up counselling for Centchroman (Ormeloxifene):

- How she is doing with the method, whether she is satisfied and has any questions or anything to discuss
- Especially if she is concerned about bleeding changes. Give any information or help that she needs .Assure her that these changes get normalized with continuing usage
- If she often has problems remembering to take pills. If so, discuss ways to remember, making up for missed pills, ECP or choosing another method
- If there are major life changes that may affect her needs particularly plans for having children and STI/HIV risk, follow-up as needed

[2]For more information, please read Reference manual for Oral contraceptive methods, 2016

How to Manage Side Effects

- Centchroman (Ormeloxifene) causes delayed periods in few women. But this occurs in around 8% of users and usually in the first three months. The periods tend to settle down to a rhythm once the body gets used to the drug
- Periods can get scanty over time in some women
- Counsel and reassure her that some women using Centchroman (Ormeloxifene) have such problem. This is not harmful and will subside on its own

How to Manage Missed Pills?

- Take a pill as soon as possible after it is missed
- If pill is missed by 1 or 2 days but lesser than 7 days, the normal schedule should be continued and client needs to use a back-up method (e.g. Condoms) till the next period starts
- If pill is missed by more than 7 days, client needs to start taking it all over again like a new user that is twice a week for 3 months and then once a week

If Period is missed with Centchroman (Ormeloxifene)

With Centchroman (Ormeloxifene), occasionally the menstrual cycle may get prolonged in some users. The contraceptive makes the periods lighter and the interval longer, which is not harmful and can actually be helpful for anemic women, as user loses lesser amount of blood. However, if periods are delayed by more than 15 days, pregnancy needs to be ruled out

Some facts about COCs

- CENTCHROMAN is safe for both the mother and the baby, starting immediately after delivery since it in not a steroidal hormone. It does not affect either initiation or quality and quantity of milk production
- A woman who is satisfied with using CENTCHROMANs can continue using them when she has stopped breastfeeding
- CENTCHROMAN does not delay the return of a woman's fertility after she stops taking them
- CENTCHROMAN provide & preventive action against breast, ovarian and a few other cancers
- CENTCHROMAN reduce the risk of ectopic pregnancy

EMERGENCY CONTRACEPTION

Emergency contraception can be used to prevent pregnancy after unprotected sexual Intercourse, sex under coercion or contraceptive accidents like condom rupture or missed Pills.
The options available in the National Program are:

- EC pills which contains only progestin - Levonorgestrel (1.5 mg per tablet).

- IUCD either Cu 380A or Cu 375

Effectiveness of different methods of Emergency Contraception

- EC pill - 1 pregnancy/100 women
- IUCD (Cu 380A or Cu 375) - 1 pregnancy/100 women

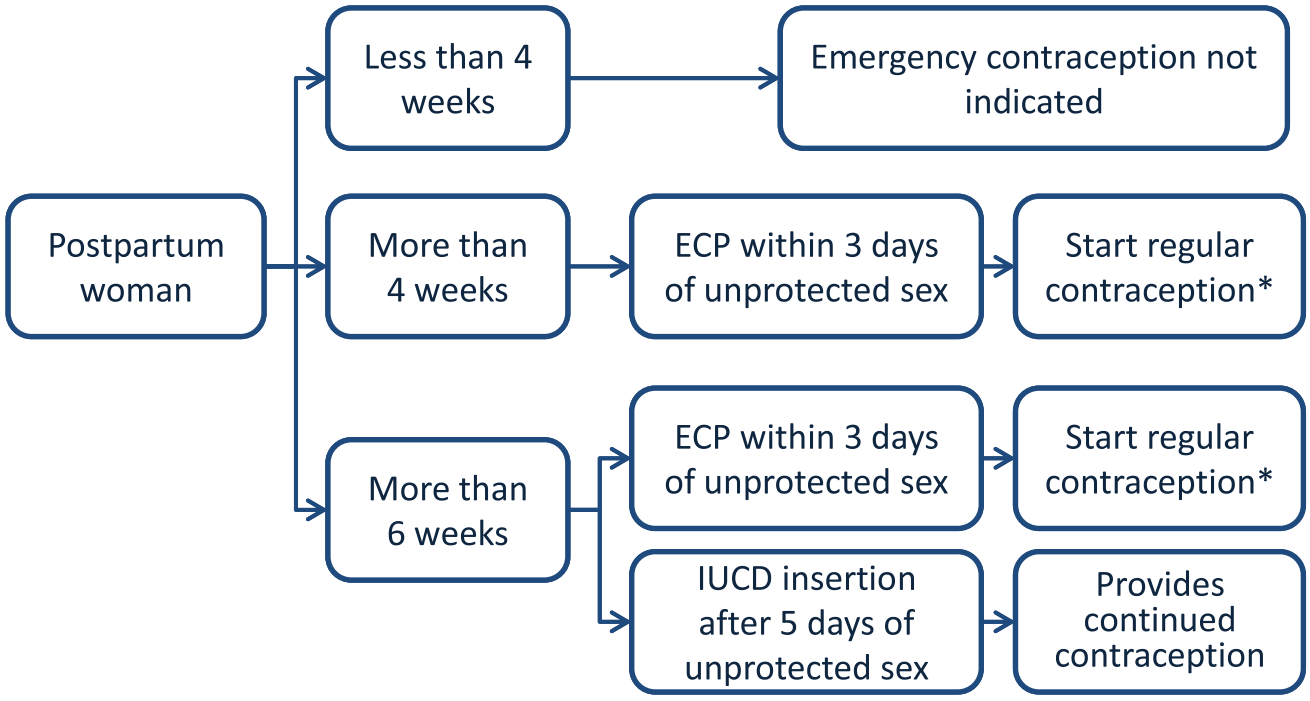
Advantages of EC Pills

- ECPs are safe for all women even women who cannot use combined hormonal contraceptive methods
- ECPs provide an opportunity for women to start using a regular contraceptive method

Disadvantage

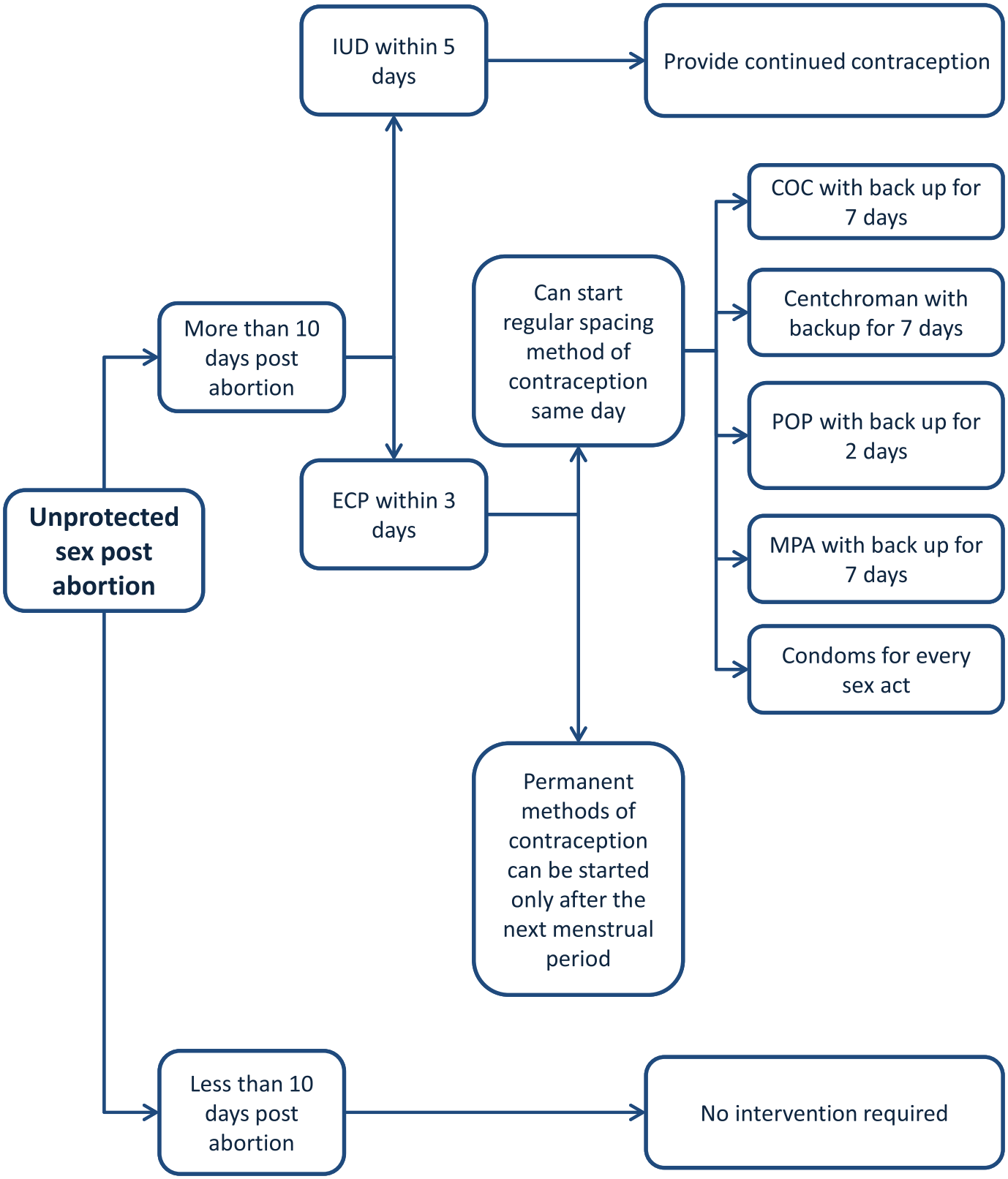
Frequent use of emergency contraception can result in side-effects such as menstrual irregularities

Do's for use of Emergency Contraception in postpartum women



***Refer to relevant section according the method of choice for further information**

Dos for initiation of ECP in post abortion:



Dosage

- EC Pill (1.5 mg Levonorgestrel) taken immediately after unprotected/accidental intercourse or as soon as possible within next 3 days (72 hours)
- If 2 pills of COCs are used as an emergency contraceptive, second dose to be taken after 12 hours of first dose

Management of Side Effects

- **Nausea:** If user have had nausea with previous ECP use or with the first dose of a 2-dose regimen, can take antiemetic 1½ to 1 hour before taking ECP
- **Vomiting:** If woman vomits within 2 hours after taking ECP, she should take another dose (she can take an anti-emetic with the repeat dose). If vomiting occurs more than 2 hours after taking ECPs, she does not need to take extra pills. If vomiting continues, she can take the repeat dose by placing the pills high in her vagina
- **Slight bleeding** or change in timing of monthly bleeding, which gradually subsides

Do follow-Up counselling for EC pills

- Explain that ECPs can at the most avert pregnancy resulting from the episode of unprotected/accidental sex after which pill was taken. It cannot protect her from future pregnancy, if unprotected sex occurs again any time. Therefore, it should not be used as a regular contraceptive method
- Counsel the client to choose a family planning method after the EC pill, if she does not plan for pregnancy immediately. Most contraceptive methods can be started on the same day of ECP use

Advise the client to return if her next monthly bleeding

1. is unusually light (possible pregnancy)
2. is delayed beyond one week of expected date of cycle. Client must undergo a pregnancy test/contact a doctor
3. is unusually painful (possible ectopic pregnancy)

Some facts about ECPs

- Efficacy of ECP declines with time, so it should be taken as soon as possible after unprotected sex
- ECP does not protect from STIs/HIV
- ECP will not harm an existing pregnancy
- ECPs do not cause abortion or birth defects
- ECPs only protect the women from current unprotected sex not **from future unprotected intercourse**
- ECP use among girls 13 to 16 years old is safe
- There is no evidence that ECPs increase the risk of ectopic pregnancy
- If a woman has failed to initiate a regular method she can use ECP again without any medical side effects
- Medical supervision is not needed for use of ECPs. ECPs are approved for over-the-counter sales or non-prescription use in India

PROGESTERONE ONLY PILLS

Progestin only pills are also called Mini Pill. They contain levonorgestrel or norethidrone or norgestrel-in tablet form and each packet contains 28 tablets.

Effectiveness of POPs

- Highly effective when taken at the same time every day (0.05-5 pregnancies/100 women during the first year of use)

Advantages of Progestin-only Contraceptives

- May decrease menstrual cramps and menstrual bleeding
- Protects against endometrial cancer
- Decrease benign breast disease
- Decreases the risk of ectopic pregnancy
- Protects against some causes of pelvic inflammatory disease (PID)
- Decrease sickle cell crises

Disadvantages of Progestin-only Methods

- Bleeding changes are common but not harmful. Typically, pills lengthen how long breastfeeding women have no monthly bleeding
- Some weight gain or loss may occur

Checklist for Screening Clients Who Want to Initiate POP

To determine if the client is medically eligible to use POP, ask questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 6.

NO	1. Have you ever been told you have breast cancer?	YES
NO	2. Have you ever had a stroke or heart attack, or do you currently have a blood clot in your legs or lungs?	YES
NO	3. Do you have a serious liver disease or jaundice (yellow skin or eyes)?	YES
NO	4. Do you have migraine with aura?	YES
NO	5. Are you taking medication for seizures? Are you taking Rifampicin?	YES
NO	6. Are you being treated with Ritonavir boosted Proteaseinhibitors?	YES
NO	7. Have you ever been told that you have a autoimmune disease such as lupus?	YES

If the client answered **NO** to ***all of questions 1–7,*** the client can use POPs. Proceed to questions 8–13.

If the client answered **YES** to ***any of questions 1– 7,*** POP cannot be initiated Refer as appropriate, and give condoms to use in the meantime.

Ask questions 8–13 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 13.

YES	8. Did your last menstrual period start within the past 7 days?	NO
YES	9. Did you have a baby less than 6 months ago, are you fully or nearly-full breastfeeding, and have you had no menstrual period since then?	NO
YES	10. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	11. Have you had a baby in the last 4 weeks?	NO
YES	12. Have you had a miscarriage or abortion in the last 7 days?	NO
YES	13. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to ***any one of questions8–13*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. The client can start POP now.

If the client began her last menstrual period ***within the past 5 days,*** she can start POP immediately. No additional contraceptive protection is needed.

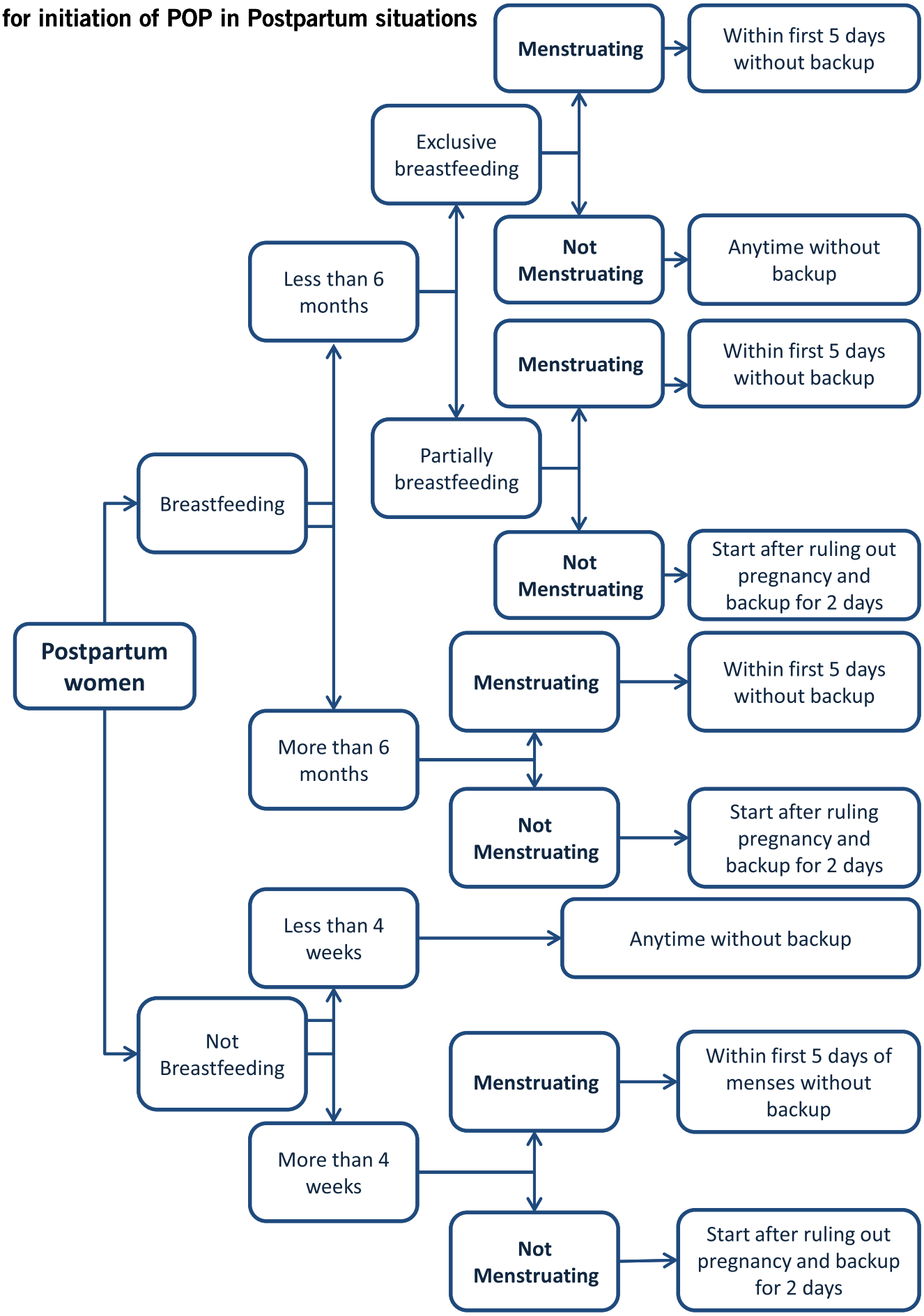
If the client began her last menstrual period ***more than 5 days ago,*** she can ***be given POP now,*** but instruct her that she must ***use condoms or abstain from sex for the next 2 days.*** Give her condoms to use for the next 2 days.

If the client answered **NO** to ***all of questions 8–13,*** pregnancy cannot be ruled out.

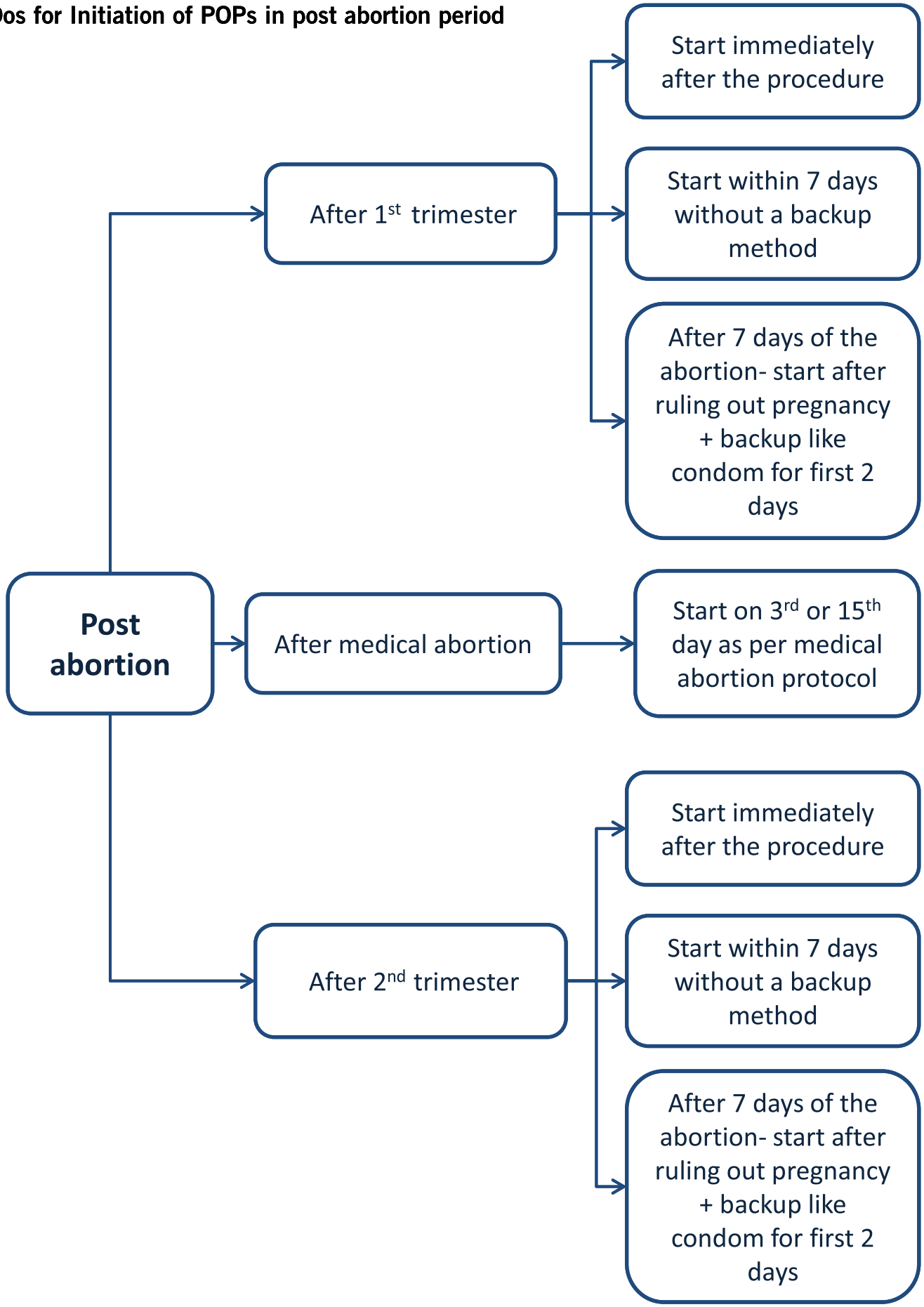
She must use a pregnancy test or wait until her next menstrual period to be given POP.

Give her condoms to use in the meantime.

Dos for initiation of POP in Postpartum situations



Dos for Initiation of POPs in post abortion period



Dos for Taking POPs

- One tablet to be taken at the same time, every day
- After taking all the pills another packet must be started from the next day. There will be no gap between two packets. There are no pill free days and all twenty-eight pills in a package contains active medication

Dos for missed POPs

- If forgotten should be taken as soon as remembered within 3 hours and the next dose at the usual time
- If more than 3 hours some backup has to be taken
- If pill missed for more than 3 hours, backup method is to be used for the next 2 days
- If history of contact in the past 3 days ECP may also be considered
- If there is vomiting within 2 hours after taking pill another pill is to be taken and the next dose to be continued as usual

Don'ts for effective POPs use.

- Don't delay pill dose more than 3 hours
- Don't take breaks between packs

Some facts about POPs

- POPs are safe for both the mother and the baby, starting immediately after giving birth. They do not affect quantity or quality of milk production
- POPs can be continued after stopping breastfeeding but the woman is less protected from pregnancy than when breastfeeding. She can switch to another method if she wishes
- POPs do not cause birth defects if accidentally taken when she is already pregnant
- POPs do not delay the return of a woman's fertility after she stops taking them
- The bleeding pattern a woman had before she used POPs generally returns after she stops taking POP within a few months
- POPs do not have an increased risk of cancer
- Majority of POP users do not report changes in mood and sex drive
- **POPs do not increase the risk of ectopic pregnancy**

CONDOMS

Condom is an effective barrier method that can be used for both prevention of pregnancy and protection against HIV and other sexually transmitted infections (STIs).

Condoms are made of latex which acts by causing a barrier for the passage of sperms.

Effectiveness

If the condom is used correctly and consistently its effectiveness is 98% in preventing pregnancy.

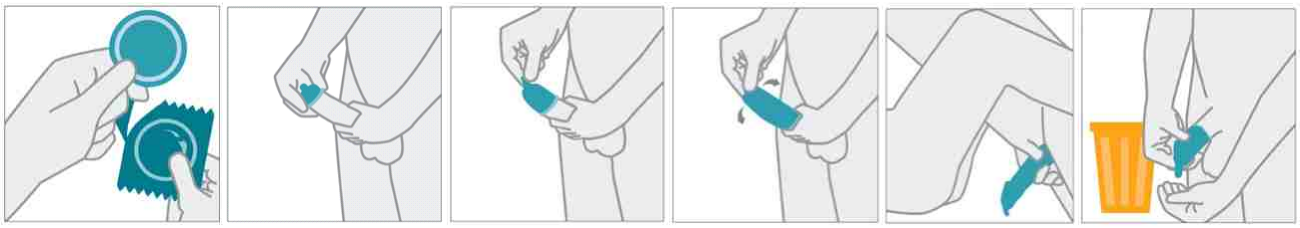
Advantages

- No hormonal side effects
- Can be used without seeking a health care provider
- Only barrier method that provides protection from HIV and STI besides passage of sperms
- No fixed timings of use so less chances of being missed
- No physical side-effects
- Ensures male participation in family planning

Limitations

- To be used with caution in patients with latex allergy
- Caution advocated in use with injury or acute infection in the penal region

How to Put On and Take Off a Male Condom



1 2 3 4 5 6

1. Carefully open and remove condom from wrapper
2. Place condom on the head of the erect, hard penis. If uncircumcised, pull back the foreskin first
3. Pinch air out of the tip of the condom
4. Unroll condom all the way down the penis
5. After sex but before pulling out, hold the condom at the base. Then pull out, while holding the condom in place
6. Carefully remove the condom and throw it in the trash

Storage of condoms

- Condoms should be stored at room temperature – not in extreme heat or cold

- Should be away from moisture and direct sunlight
- It should be away from the reach of children

Disposal

- Wrap it in a piece of paper and throw it in a dustbin or bury it in the ground
- Don't throw used condoms on the ground and should be out of reach of children

Condom Do's and Don'ts

- DO use a condom every time you have sex
- DO put on a condom before having sex
- DO read the package and check the expiration date, because old condoms can be dry, brittle or weakened and prone to break
- DO make sure there are no tears or defects
- DO store condoms in a cool, dry place
- Open the package carefully. Teeth or fingernails can rip the condom
- DON'T store condoms in your wallet as heat and friction can damage them
- DON'T use oil-based products like baby oil, lotion, petroleum jelly, or cooking oil because they will cause the condom to break
- DON'T use more than one condom at a time
- DON'T reuse a condom

Key Points that Providers must tell Clients

- Protects against both pregnancy and STIs including HIV/AIDS
- Very effective when used every time you have sex
- Can use another family planning method along with condoms for extra protection from pregnancy
- Also used as back-up for another method of family planning (for example, missed pills, late for injection)
- When concern arises due to wrong use the provider must demonstrate condom use on penile model
- Condoms are - readily available free of cost at the government health facilities or home delivered by ASHA at a nominal cost

Some fact about condom

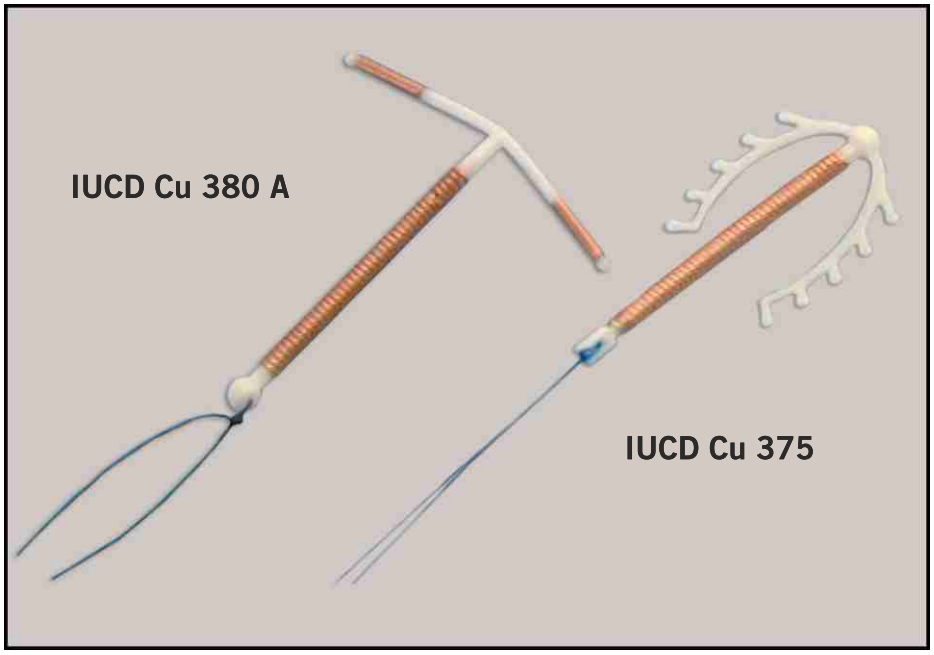
- Using two condoms is not better than one as they are more likely to break. **It's best to only use one at a time**
- Using a condom doesn't have to spoil the moment or **make a man less sensitive.** In fact, condom increases the sex duration
- All condoms are made of latex and quality of free condom is as good as others. Government bears the entire cost of the free supply of condom
- Condoms can be used by anyone who wishes to prevent pregnancy and transmission of STI including HIV
- Condom of any brand (free or branded) will break only if it is not used correctly when air fills in the tip of the condom and it breaks

INTRA UTERINE CONTRACEPTIVE DEVICE

Overview of IUCD

This small, flexible plastic copper bearing device is a long acting reversible method

- Available in 2 forms Cu 380A which is effective for 10 years and Cu 375 which is effective for 5 years
- **It can be used as Interval, Postpartum, Post abortion as well as an emergency contraceptive**



Efficacy: The CuT is a highly effective (>99% effective). There are 0.6 to 0.8 pregnancies per 100 women in first year of use

Advantages of IUCD

- Offers long-term, highly effective reversible protection against pregnancy
- It can be replaced, without any gap, as many times as she desires, during her reproductive life
- Is effective immediately after insertion
- Does not require daily attention from the user and does not interfere with sex
- Insertion is one time procedure
- Does not interact with any medicines the client may be taking
- Fertility returns promptly on removal

The specific advantages of an IUCD placed in the immediate postpartum/post abortion periods include the following

To the client

- Convenience- saves time and additional visit
- Meets the requirement of the woman/family for a reliable birth spacing method in the immediate postpartum/post abortion period
- Reduced perception of initial side effects (bleeding and cramping) in the postpartum period
- Reduced chances of heavy bleeding, especially among women having lactational amenorrhea
- No effect on amount or quality of breast milk
- The woman has an effective method for contraception before getting discharged from hospital
- Can be used immediately after uncomplicated first as well as second trimester abortion

Advantages for the service provider or the service delivery site

- High motivation of both woman and family for a reliable birth spacing method in the immediate postpartum/post abortion period
- Safe because it is certain that she is not pregnant at the time of insertion
- Saves time as performed on the same delivery table for post placental/intra cesarean/post abortal insertions. Additional evaluations and separate clinical procedure is not required
- Need for minimal additional instruments, supplies and equipment
- Perforation of the uterus while placing a PPIUCD immediately after delivery of placenta or during cesarean section or during the first 48 hours postpartum is unlikely because of the thickness of the uterine wall in the postpartum period. No such cases are reported in the literature
- Convenience for clinical staff; helps relieve overcrowded outpatient facilities thus allowing more women to be served
- Increased institutional deliveries are an opportunity to provide women easy access to immediate PPIUCD services

Disadvantages of IUCD

- Needs to be inserted by a trained ANM, nurse or doctor after examination
- Some women may experience irregular bleeding, pain in abdomen etc which usually subside in few months

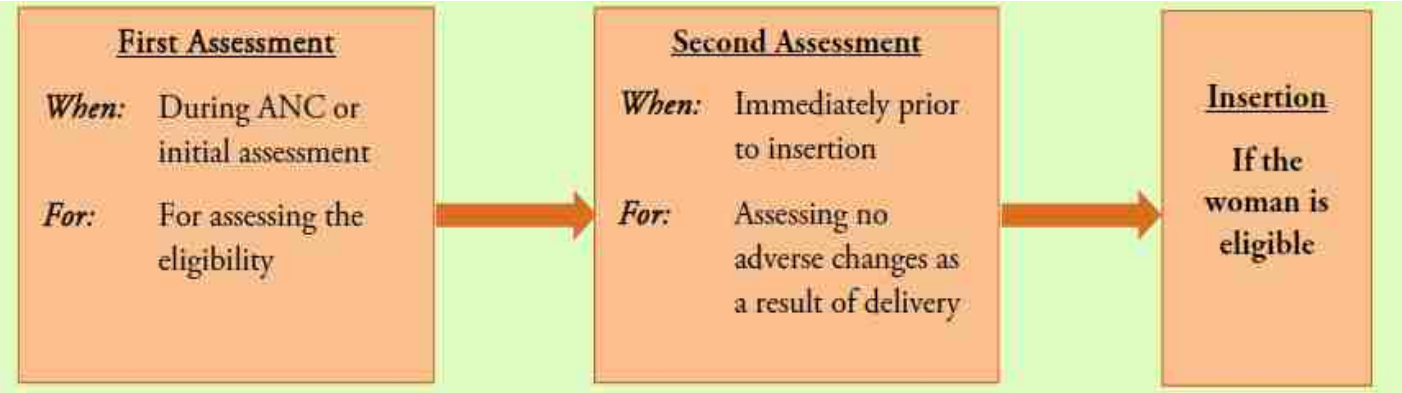
The specific limitations of an IUCD placed in the immediate postpartum period include

- Increased risk of spontaneous expulsion. The skilled clinicians with right technique of insertion are associated with lower expulsion rates

Screening or Client Assessment for PPIUCD services should be done in two phases

1. General review of the woman's medical history and eligibility for the method
2. Immediately prior to insertion
   - during caesarean
   - following delivery of the placenta
   - within 48 hours after birth

This second assessment is to review if there is any change as a result of the delivery



First Assessment in PPIUCD

A first assessment should be carried out with the pregnant woman during antenatal care.

For women who present to the facility in labour with no prior assessment in ANC period, the clinician must use her/his clinical judgment about the likelihood of contraindications to use. In the situation where a woman has just experienced a normal, cephalic, full-term vaginal delivery, it is reasonable to assume that she is eligible for PPIUCD.

Second Assessment

A second assessment should be done immediately prior to insertion by the person who will insert the IUCD to ensure that the process of labor has not created any clinical situation which may be a contraindication for insertion of the immediate PPIUCD.

If her clinical condition makes the IUCD unsuitable for her at this time, the reason should be explained to her and she should be offered another method of postpartum family planning. If she prefers IUCD, she may be informed that it can be provided to her after six weeks when she comes for postnatal visit or follow up visit.

Checklist for Screening Clients Who Want to Initiate Use of the PPIUCD

First assessment in ANC

To determine if the client is medically eligible to use an IUCD, ask questions 1–8. As soon as the client answers **YES** to ***question,*** stop, and follow the instructions after question 8.

NO	1. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUCD insertion?	YES
NO	2. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	3. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	4. Within the last 3 months, have you had more than one sexual partner?	YES
NO	5. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	6. Within the last 3 months, have you been told you have an STI?	YES
NO	7. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	8. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to ***all of questions 1–8,*** proceed with the Pelvic examination.

During the pelvic exam, the provider should determine the answers to ***questions 9–15.***

If the client answered **YES** to ***any of questions 1–3***, IUCD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to ***any of questions 4–7,*** she is not a good candidate for an IUCD unless Chlamydia and/or gonorrhoea infection can be reliably ruled out.

If she answered **YES** to the ***second part of question 8*** and is not currently taking ARV drugs, IUCD insertion is not usually recommended. If she is doing clinically well on Anti retro viral therapy, the IUCD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUCD use.

Second Assessment after delivery

NO	9. Is there any type of ulcer on the vulva, vagina, or cervix?	YES
NO	10. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUCD insertion?	YES
NO	11. Is there any sign of chorioamnionitis-does client have fever along with pain and tenderness in the lower abdomen?	YES
NO	12. Has it been more than 18 hours from rupture of membranes to delivery of the baby?	YES
NO	13. Is there extensive genital trauma?	YES
NO	14. Is there Unresolved postpartum haemorrhage?	YES
NO	15. Is there any sign of Postpartum endometritis/metritis /puerperal sepsis?	YES

If the answer to **all of questions 9-15** is **NO**, you may insert the IUCD.

If the client answer is **YES** to ***any of the Question 9-15*** do not insert the IUCD. Suggest alternative FP method.

Checklist for Screening Clients Who Want to Initiate Use of the Interval IUCD

Be reasonably sure that the client is not pregnant. If she is not menstruating at the time of her visit, ask the client questions 1–6. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 6.

YES	1. Have you had a baby in the last 4 weeks?	NO
YES	2. Did you have a baby less than 6 months ago, are you fully or nearly-fully breastfeeding, and have you had no menstrual period since then?	NO
YES	3. Have you abstained from sexual intercourse since your last menstrual period or delivery?	NO
YES	4. Did your last menstrual period start within the past 12 days?	NO
YES	5. Have you had a miscarriage or abortion in the last 12 days?	NO
YES	6. Have you been using a reliable contraceptive method consistently and correctly?	NO

If the client answered **YES** to ***any one of questions 1–6*** and she is free of signs or symptoms of pregnancy, you can be reasonably sure that she is not pregnant. Proceed to questions 7–14. However, if she answers **YES** to ***question 1,*** the insertion should be delayed until 4 weeks after delivery. Ask her to come back at that time.

If the client answered **NO** to ***all of questions 1–6,*** pregnancy cannot be ruled out. The client should await menses or use a pregnancy test.

To determine if the client is medically eligible to use an IUCD, ask questions 7–14. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 14.

NO	7. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	YES
NO	8. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	9. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	10. Within the last 3 months, have you had more than one sexual partner?	YES
NO	11. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	12. Within the last 3 months, have you been told you have an STI?	YES
NO	13. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	14. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to ***all of questions 7–14,*** proceed with the **PELVIC EXAM**.

If the client answered **YES** to ***any of questions 7–9,*** an IUCD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to ***any of questions 10–13,*** she is not a good candidate for an IUCD unless chlamydia and/or gonorrhea infection can be reliably ruled out.

If she answered **YES** to the ***second part of question 14*** and is not currently taking ARV drugs, IUCD insertion is not usually recommended. If she is doing clinically well on ARVs, the IUCD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUCD use.

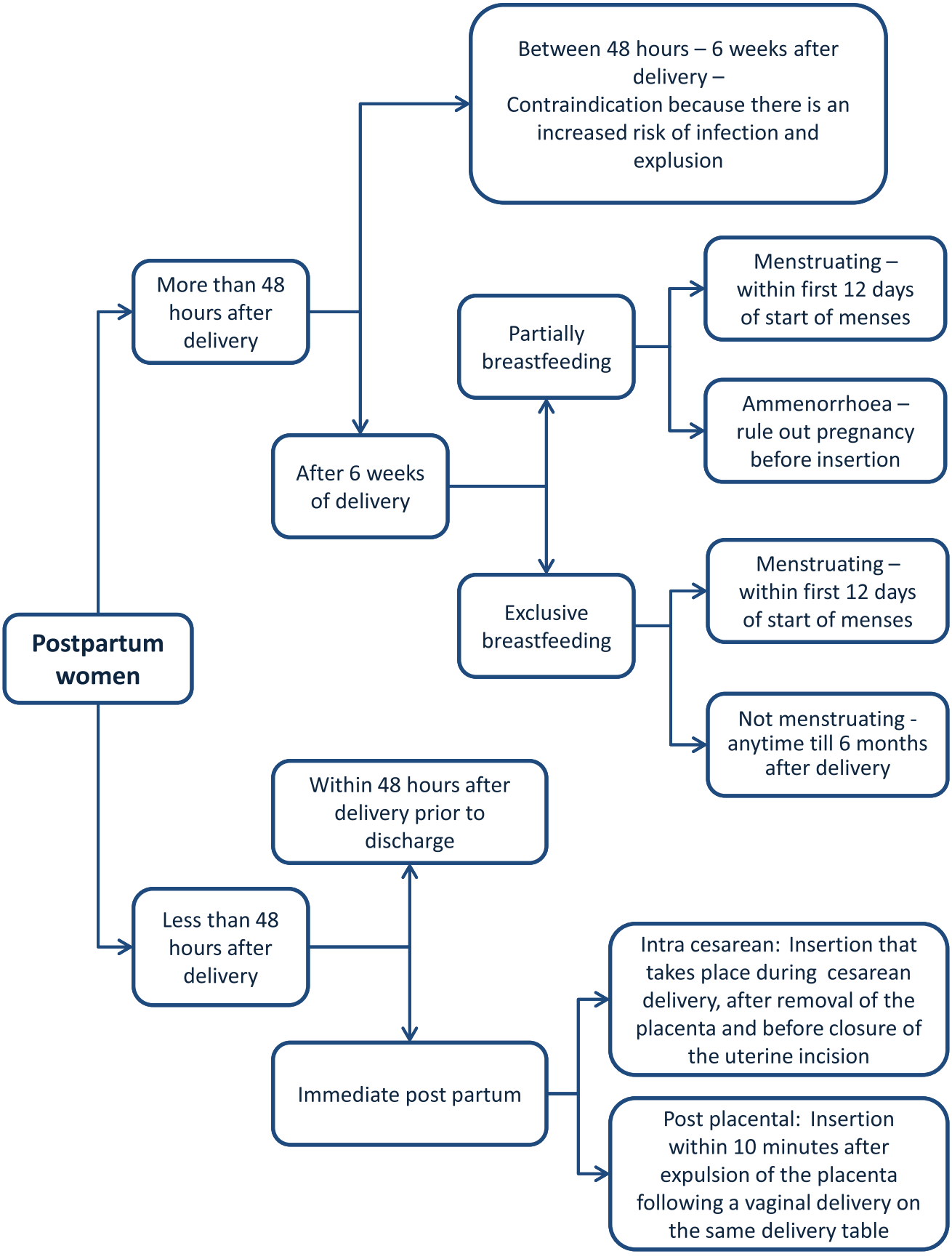
During the pelvic exam, the provider should determine the answers to questions 15–21.

NO	15. Is there any type of ulcer on the vulva, vagina, or cervix?	YES
NO	16. Does the client feel pain in her lower abdomen when you move the cervix?	YES
NO	17. Is there adnexa tenderness?	YES
NO	18. Is there purulent cervical discharge?	YES
NO	19. Does the cervix bleed easily when touched?	YES
NO	20. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUCD insertion?	YES
NO	21. Were you unable to determine the size and/or position of the uterus?	YES

If the answer to ***all of questions 15–21*** is **NO**, you may insert the IUCD.

If the answer to ***any of questions 15–21*** is **YES**, the IUCD cannot be inserted without further evaluation. See explanations for more instructions.

Dos for insertion of PPIUCD and interval IUCD in the extended postpartum period



The following standards of care must be maintained during the provision of PPIUCD:

- **Counselling**
  - It should take place in the antenatal period, in early labor or immediately postpartum
  - Counselling for informed consent should not take place during the active phase of labor
  - The PPIUCD must only be placed after the woman is counseled and gives informed consent
  - Woman must be counseled regarding advantages, limitations, effectiveness, side effects and problems related to IUCD
  - The woman must be counseled and offered another suitable postpartum family planning method if her clinical situation does not allow for insertion of the immediate PPIUCD
  - The provider must explain the procedure for insertion and/or removal of the immediate PPIUCD

- **Screening**
  - Woman must be screened for clinical situations as per WHO Medical Eligibility Criteria (MEC)
  - Screening should take place in the antenatal period, as well as immediately prior to insertion, immediate postpartum

- **Provider eligibility**

  The following cadre of service providers who has been trained to competency in immediate PPIUCD service provision according to national standards are eligible to insert PPIUCD/PAIUCD
  - MBBS (PPIUCD - trained)
  - AYUSH (SBA + PPIUCD - trained)
  - Nurses (PPIUCD - trained)
  - LHV (PPIUCD - trained)
  - ANM (SBA + PPIUCD - trained)

- **Storage of IUCD**
  - Storage place should be dry and dust free and not exposed to extreme heat or cold
  - Expiry date on the IUCD package refers only to the shelf life of the sterility of the package and not to the contraceptive effectiveness of the IUCD itself
  - Even if an IUCD is inserted on the day before the expiry date it is still effective for the full lifespan of contraceptive efficacy
  - After the expiry date, the IUCD package should be discarded
  - Tarnished IUCDs are safe and effective and can be inserted
  - Unless the IUCD package is torn or opened (or the shelf life has expired), a tarnished IUCD is still sterile, safe to use and effective

- **Place of insertion**

  PPIUCD insertion must be done in the labor room of the healthcare facility that provides delivery services and has acceptable standards of care especially infection prevention.

1. Privacy
2. Adequate light for proper visualization
3. Availability of running water and soap
4. Availability of sterile gloves
5. Availability of sterilized instruments + sterilized tray OR HLD instruments + HLD tray
6. Availability of antiseptics
7. Availability of IUCDs
8. Availability of chlorine solution for decontamination
9. Availability of waste management bins
10. Accessibility of boiler/autoclave

- **Adherence to steps of insertion as detailed in the GoI guidelines** especially the critical steps
  - The provider must insert the IUCD by following all recommended clinical and infection prevention measures for successful insertion
  - Using recommended infection prevention practices including loading of CuT in its sterile package can further minimize the risk
  - Insertion must be done using a long instrument, such as a PPIUCD insertion forceps, to ensure that the IUCD is placed at the fundus. (Refer IUCD Reference Manual, Ministry of Health and Family Welfare, Government of India 2006 for details)

- **Record maintenance**

  The provider must maintain records regarding PPIUCD insertions and services as per protocol.

  Maintain records and fill IUCD card after insertion

  - Facility wise data entry in HMIS
  - Registers for PPIUCD
    - PPIUCD insertion register
    - PPIUCD follow up register

- Woman must be followed up by a provider oriented to PPIUCD services.

Follow up visits

- 1st visit at 6 weeks postpartum
- Routine follow up care integrated with postpartum services
- Woman encouraged to visit anytime if she is experiencing problems
- Follow up visits by ANM and ASHA if inability to visit the health facility

PAIUCD – is the insertion of IUCD (Cu 380A or Cu 375) following a complete abortion upto 12 days of the abortion procedure by a trained provider at the same or another facility (if there is no infection)

Screening or Client Assessment for PAIUCD services should be done in two phases.

1. General review of the woman's medical history and eligibility for the method.
2. Immediately prior to insertion
   - after the vacuum aspiration in spontaneous or induced 1st trimester abortion
   - after completion of medical abortion on the 15th day
   - after dilatation and evacuation after a spontaneous or induced 2nd trimester abortion

   This second assessment is to review if there is any change as a result of the abortion

A first assessment should be carried out with the pregnant woman during pre-operative/period and it must include assessment for the following conditions, listed in the Medical Eligibility Criteria and relevant to PAIUCD services.

Reference: IUCD reference manual for medical officers and Nursing personnel September 2013, FP division, MOHFW, GOI

Second Assessment

A second assessment should be done immediately prior to insertion by the person who will insert the IUCD. The purpose of the second assessment is to

1. **Ascertain medical eligibility of the client:** Ensure that the process of abortion has not created any clinical situation which may be a contraindication for insertion of the immediate PAIUCD by ruling out the following conditions:
   - Current genital tract infection
   - Risk of haemorrhage
   - Presence of genital tract injury

2. **Decide the appropriate technique of insertion:**
   - If the size of the uterus is greater than 12 weeks after the evacuation of the uterine contents- the PPIUCD technique will be used
   - If the size of the uterus is less than 12 weeks after the evacuation of the uterine contents- the interval technique will be used

If her clinical condition makes the IUCD unsuitable for her at this time, the reason should be explained to her and she should be offered another method of post abortion family planning. If she prefers IUCD, she should be provided with a backup method for the rest of the month and may be informed that the IUCD can be provided to her after review of the situation when she comes for follow up visit

Checklist for Screening Clients Who Want to Initiate Use of the PAIUCD

First Assessment - To determine if the client is medically eligible to use an IUCD, ask questions 1–8. As soon as the client answers **YES** to ***question,*** stop, and follow the instructions after question 8.

NO	1. Do you have bleeding between menstrual periods that is unusual for you, or bleeding after intercourse (sex)?	YES
NO	2. Have you been told that you have any type of cancer in your genital organs, trophoblastic disease, or pelvic tuberculosis?	YES
NO	3. Have you ever been told that you have a rheumatic disease such as lupus?	YES
NO	4. Within the last 3 months, have you had more than one sexual partner?	YES
NO	5. Within the last 3 months, do you think your partner has had another sexual partner?	YES
NO	6. Within the last 3 months, have you been told you have an STI?	YES
NO	7. Within the last 3 months, has your partner been told that he has an STI, or do you know if he has had any symptoms – for example, penile discharge?	YES
NO	8. Are you HIV-positive, and have you developed AIDS?	YES

If the client answered **NO** to ***all of questions 1–8,*** proceed with the Pelvic examination.

During the pelvic exam, the provider should determine the answers to ***questions 9–15.***

If the client answered **YES** to ***any of questions 1–3***, IUCD cannot be inserted. Further evaluation of the condition is required.

If the client answered **YES** to ***any of questions 4–7,*** she is not a good candidate for an IUCD unless Chlamydia and/or gonorrhoea infection can be reliably ruled out.

If she answered **YES** to the ***second part of question 8*** and is not currently taking ARV drugs, IUCD insertion is not usually recommended. If she is doing clinically well on Anti retro viral therapy, the IUCD may generally be inserted. HIV-positive women without AIDS also generally can initiate IUCD use.

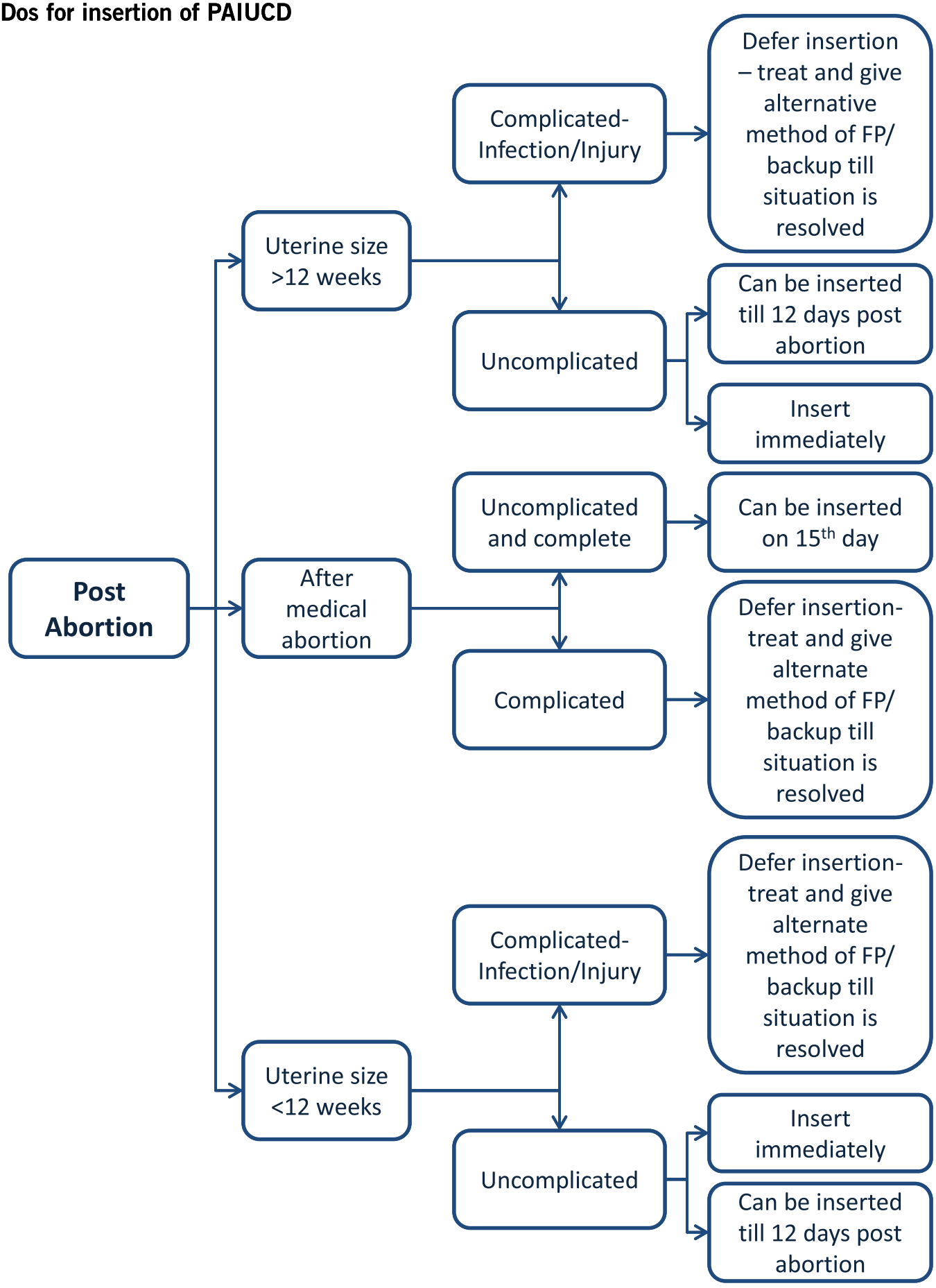
Ask questions 9–14 to be reasonably sure that the client is not pregnant. As soon as the client answers **YES** to ***any question,*** stop, and follow the instructions after question 14.

NO	9. Is there any type of ulcer on the vulva or cervix?	YES
NO	10. Is there an anatomical abnormality of the uterine cavity that will not allow appropriate IUCD insertion?	YES
NO	11. Is there any sign of post abortal sepsis-does client have fever along with pain and tenderness in the lower abdomen?	YES
NO	12. Is there extensive genital trauma for eg. cervical, vaginal tears or perforation of uterus?	YES
NO	13. Is there severe Post abortal Haemorrhage?	YES
NO	14. Is there any sign of Haematoma?	YES

If the answer to **all of questions 9-14** is **NO**, you may insert the IUCD.

If the client answer is **YES to any of the Question 9-14 do not insert the IUCD. Suggest alternative FP method.**

Dos for insertion of PAIUCD



The following standards of care must be maintained during the provision of PAIUCD:

- **Counselling for contraception**
  - It should take place after occurrence or decision for abortion has been taken
  - Counselling regarding the entire basket of choice should be given to the client to enable an informed choice
  - Informed consent should be taken
  - The PAIUCD must only be placed after the woman is counseled and gives informed consent.
  - Woman must be counseled regarding advantages, limitations, effectiveness, side effects and problems related to IUCD.The woman must be counseled and offered another suitable post abortion family planning method if her clinical situation does not allow for insertion of immediate PAIUCD
  - The provider must explain the procedure for insertion and/or removal of the immediate PAIUCD

- **Screening**
  - Woman must be screened for clinical situations as per WHO Medical Eligibility Criteria (MEC)
  - Screening should take place in the OPD immediately prior to procedure and immediate post procedure

- **Provider eligibility**
  The following cadre of service providers who has been trained to competency
  If uterine size less than 12 weeks- A service provider trained in interval IUCD insertion procedure (Medical officer/nursing personnel) after due orientation on PAIUCD procedure.
  If uterine size more than 12 weeks- A service provider trained in postpartum IUCD insertion procedure (Medical officer) after due orientation on PAIUCD procedure
  It is important to note that after 7 days of abortion, PAIUCD can only be inserted by a medical officer after ascertaining the completeness of the abortion and thorough medical check up.

- **Storage of IUCD**
  - Storage place should be dry and dust free and not exposed to extreme heat or cold
  - Expiry date on the IUCD package refers only to the shelf life of the sterility of the package and not to the contraceptive effectiveness of the IUCD itself
  - Even if an IUCD is inserted on the day before the expiry date it is still effective for the full lifespan of contraceptive efficacy
  - After the expiry date, the IUCD package should be discarded
  - Tarnished IUCDs are safe and effective and can be inserted
  - Unless the IUCD package is torn or opened (or the shelf life has expired), a tarnished IUCD is still sterile, safe to use and effective

- **Place of insertion**
  - PAIUCD insertion must be done in a labor room/ IUCD room of healthcare facility that has acceptable standards of care especially infection prevention

1. Privacy
2. Adequate light for proper visualization

3. Availability of running water and soap
4. Availability of sterile gloves
5. Availability of sterilized instruments + sterilized tray OR HLD instruments + HLD tray
6. Availability of antiseptics
7. Availability of IUCDs
8. Availability of chlorine solution for decontamination
9. Availability of waste management bins
10. Accessibility of boiler/autoclave/cidex tray

- **Adherence to steps of insertion as detailed in the GoI guidelines especially the critical steps.**
  - The provider must insert the IUCD by following all recommended clinical and infection prevention measures for successful insertion.
  - Using recommended infection prevention practices including loading of Cut in its sterile package can further minimize the risk.

- **Record maintenance**
  The provider must maintain records regarding IUCD insertions and services as per protocol.
  Maintain records and fill IUCD card after insertion
  - Facility wise data entry in HMIS
  - Registers for IUCD
    - IUCD insertion register
    - IUCD follow up register

- Woman must be followed up by a provider oriented to IUCD services.

In uterine size less than 12 weeks size- PAIUCD insertion technique is similar to the interval IUCD technique (no touch and withdrawal technique) with little adaptation

- Use of uterine sound for measuring the length of uterus for fundal placement is not recommended, as it may cause perforation
- Right after the confirmation of the completion of evacuation in vacuum aspiration and before withdrawing the cannula, check the length of uterus using the last cannula before completely withdrawing the cannula (For details refer to Post Abortion Family Planning Technical Update, Ministry of Health and Family Welfare, Government of India March, 2016)
- Load the Copper-380 A inside the sterile package and fix the blue gauge at the length measured by the cannula; Copper-375 does not require loading but will require the setting of blue gauge at the length measure by the cannula
- In case of Copper-380 A the insertion will be done by the withdrawal technique whereas Copper-375 will be inserted by the push technique
- Rest of the steps are same as in interval IUCD insertion technique

In uterine size more than 12 weeks size PAIUCD insertion technique is similar to the PPIUCD technique with little adaptation

The technique of insertion is same as that of postpartum IUCD insertion with little modification

- The insertion can be done with ring forceps or sponge holders because it might be difficult to introduce PPIUCD insertion forceps through the cervical os. (The length of uterus after

evacuation is smaller as compared to the size of uterus after full term vaginal delivery and the cervical os may be tighter. So it might be difficult to introduce PPIUCD insertion forceps into the cervix. Therefore, it is advisable to do the insertion with ring forceps/sponge holder following the same technique as that of immediate postpartum IUCD insertion)

- The provider must maintain records regarding PPIUCD insertions and services as per protocol.
- Maintain records and fill IUCD card after insertion
- Facility wise data entry in HMIS

Registers for

- Interval IUCD:
    - IUCD insertion Register
    - IUCD follow up and removal register
- Woman must be followed up by a provider oriented to IUCD services

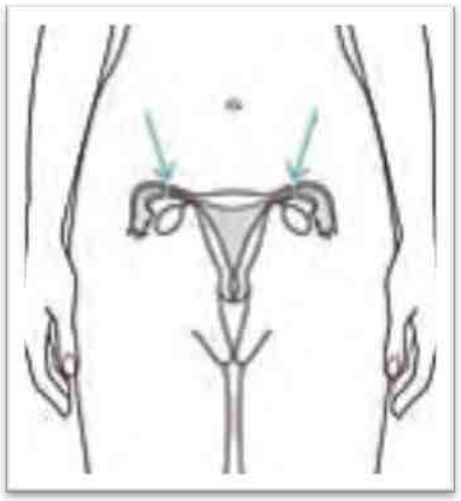
Follow up visits

- Before the woman leaves the health facility, she should be advised to
- Come for post abortion follow up within one to two weeks for assessment of her physical condition, ruling out continuing pregnancy, sepsis, incomplete abortion or any problem with IUCD.
- Come for a routine follow-up of IUCD after 1 month, preferably after the next menstrual bleeding.
- Come back immediately if any warning signs appear. These are:-
    - P: Period-related problems or pregnancy symptoms
    - A: Abdominal pain or pain during intercourse
    - I: Infections or unusual vaginal discharge
    - N: Not feeling well, fever, chills
    - S: String problems

Some facts about IUCD

- The IUCD usually stays in the uterus until it is removed. If it does come out by itself, it comes out through the vagina. IUCD does not travel to the abdomen,heart or brain.
- Copper IUCDs work by preventing sperm from fertilizing a woman's egg, rather than by destroying a fertilized egg.
- IUCD is located in the uterus, not the vaginal canal, neither the woman nor her partner will feel it during sex. It is possible that the partner will feel the strings, but this can be easily corrected if it becomes a problem.
- IUCD will not rust inside the woman's body, even after many years.
- The IUCD reduces the risk of ectopic pregnancy by preventing pregnancy. Because IUCDs are so effective at preventing pregnancy, they also offer excellent protection against ectopic pregnancy.
- IUCD does not increase the risk of contracting STIs, including HIV.
- IUCD does not cause infertility. In fact most women conceive soon after removal of IUCD.
- HIV-infected women who are clinically well can generally use the IUCD
- The IUCD cannot cause cancer. Studies have found IUCD use reduces the risk of endometrial cancer. The IUCD may also offer women protection against cervical cancer
- IUCD does not cause birth defects

FEMALE STERILIZATION



Female sterilization is the most widely used modern contraceptive method in the world, including developing and developed countries.

It is a permanent surgical method of contraception for women who do not want more children.

There are two surgical approaches

- Mini laparotomy involves making a small incision in the abdomen, and the fallopian tubes are brought to the incision to be cut or blocked
- Laparoscopy involves inserting a long thin tube with a lens in it into the abdomen through a small incision. This laparoscope enables the doctor to see and block or cut the fallopian tubes in the abdomen
- During Caesarean section involves making an incision in the abdomen and uterus to deliver the fetus and the fallopian tubes are cut and tied after the closer of the uterine incision

Female permanent method can be accepted any time, and even during postpartum and post abortion period

Effectiveness of female sterilization

Highly effective–Less than 1 pregnancy per100 women over the first year after having the sterilization procedure (5 per 1,000).

Advantages of female sterilization

- Helps protect against risks of pregnancy
- The procedure is permanent and is effective immediately
- After the procedure no further contraception is required
- No long term side effects

Advantages of Post-Partum Minilap Tubectomy

- Woman is already admitted in a facility and her current health status usually can be established from delivery and prenatal records
- Delivery of the baby and postpartum tubectomy procedure can be done during the same hospital visit
- The uterus is high in the abdomen and a small incision (1.5-3.0 cm) just below the umbilicus is usually sufficient to access the tubes
- Local anesthesia with light sedation/analgesia is usually sufficient
- Hospital stay beyond what is required for a normal delivery (often 48 hours) is not required after the procedure

Advantages specific to Post abortion Tubectomy

- Client is already at the facility for a service
- Having just terminated a pregnancy and does not want any more children, the client has achieved her reproductive goals
- Medical termination of pregnancy and post abortion tubectomy procedure can be done during the same hospital visit /procedure
- Convenient for both clients and service providers

Disadvantages of female sterilization

- Needs to be performed by a trained team of doctors and nurses after examination

Eligibility Criteria for Clients Undergoing Female Sterilization

(Self-declaration by the client will be the basis for compiling this information. No eligible client should be denied female sterilization service)

- Clients should be ever-married
- Female clients should be above the age of 22 years and below the age of 49 years
- The couple should have at least one child, whose age is above one year, unless the sterilization is medically indicated
- Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization)
- Clients must be in a sound state of mind, so as to understand the full implications of sterilization
- Mentally ill clients must be certified by a psychiatrist and a statement should be given by the legal guardian/spouse regarding the soundness of the client's state of mind

Client assessment (As per GOI guideline)

Medical eligibility to undergo female sterilization is a key factor in minimizing risk of complications and ensuring quality of service delivery.

A relevant medical history, physical examination and laboratory investigations need to be completed to ascertain eligibility for surgery.

No medical conditions prevent a woman from undergoing female sterilization but may limit when, where or how the female sterilization procedure should be performed.

Caution (C) The method is normally provided in a routine setting but with extra preparation and precautions as required.

Delay (D) Provision of the method should be delayed or postponed. These conditions need to be evaluated, treated and resolved before female sterilization can be performed. Alternatively, temporary methods of contraception should be provided.

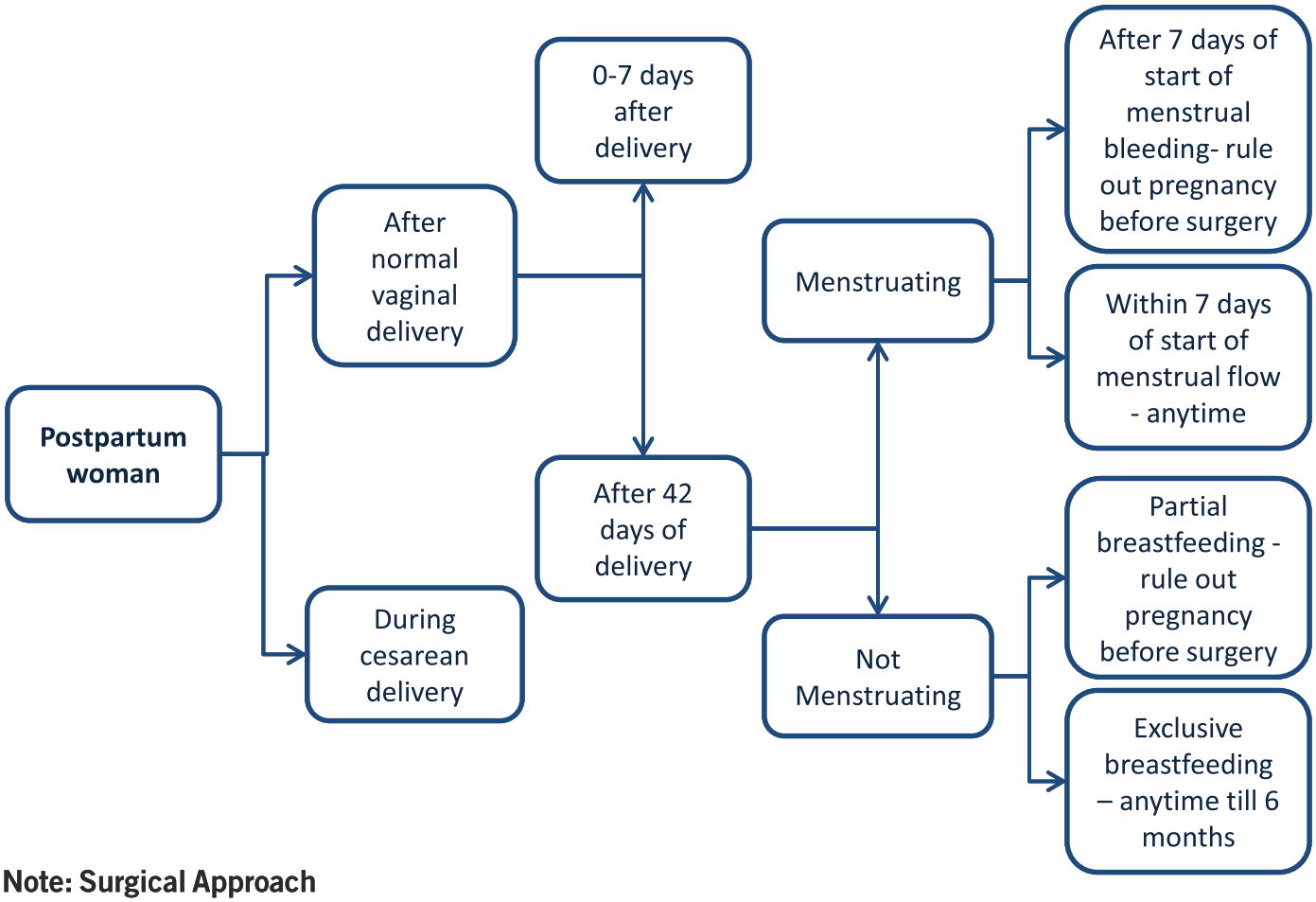
Special (S) Certain women have conditions that make operation difficult or increase the risks. The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed

to provide general anesthesia and other back-up medical support. The capacity to decide on the most appropriate procedure and anesthesia support is also needed. Alternatively, temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

CAUTION	DELAY	SPECIAL
Previous abdominal or pelvic surgery	Severe iron deficiency anaemia (Haemoglobin < 7 gm/dl)	Conditions that increase chances of heart disease or stroke i.e. older age, smoking, high BP or diabetes
Obesity	Current pregnancy	Blood Pressure > 160/100
Controlled BP (140-159/ 90-99)	8 – 42 days postpartum	Complicated heart disease
Uncomplicated heart disease	Pregnancy with severe pre-eclampsia or eclampsia	Coagulation disorders
History of ischemic heart disease	Post partum or post abortion complications (infection, hemorrhage and trauma)	Chronic lung diseases (asthma or emphysema)
Stroke	Current Deep Vein Thrombus /Pulmonary embolism	Endometriosis
History of cerebro-vascular accident	Major surgery with prolonged immobilization	Pelvic tuberculosis
History of deep vein thrombosis or pulmonary embolism	Abdominal skin infections	Fixed uterus due to previous surgery or infection
Epilepsy	Current ischemic heart Disease	Abdominal wall or umbilical hernia
Depressive disorders	Lung disease like pneumonia	Postpartum or post abortion uterine rupture or perforation
Current breast cancer	Systemic infection	Diabetes of 20 years standing with organ damage
Uterine fibroids	Unexplained vaginal bleeding	Hyperthyroidism
PID without subsequent pregnancy	Large collection of blood in uterus	Severe cirrhosis of liver
Uncomplicated diabetes	Malignant trophoblastic Disease	AIDS
Hypothyroidism	Cancers of the genital Tract	
Mild cirrhosis	Current PID	
Liver tumors	Current purulent cervicitis, Chlamydia, Gonorrhea	
Kidney disease	Current gall bladder Disease	
Thalassemia and Sickle Cell Disease	Uncontrolled diabetes	
HIV		

(for details of conditions , please refer to WHO MEC of reference manual for female sterilization)

When to do post partum female sterilization



Note: Surgical Approach

- Concurrently immediately after the delivery of the baby by Caesarean section.
- **Within 7 days after giving birth-Tubectomy can only be done by Mini lap approach.**
- **Any time after 6 weeks of childbirth**–Both Mini lap and laparoscopic approach can be used

Overview of post partum Tubal ligation

The following standards of care must be maintained during the provision of female sterilization:

- **Counselling**
  - It should take place in the antenatal period, in early labor or immediately postpartum
  - counselling for informed consent should not take place during the active phase of labor
  - The procedure must only be done after the woman is counseled and gives informed consent
  - Woman must be informed that mini lap Tubal ligation, under local anesthesia, is a safe and simple procedure and the steps of the procedure must be explained
  - Woman must be counseled regarding advantages, limitations, effectiveness, side effects and problems related to post partum female sterilization
  - The woman must be counseled and offered another suitable postpartum family planning method if her clinical situation does not allow for post partum female sterilization
  - If the woman decides to undergo sterilization, ensure that it is a voluntary decision and she is appropriately counselled

- Obtain a written consent in a language that she understands
- Before the procedure the client should not eat anything for 8 hours and should not take any medication for 24 hours

Screening

- Woman must be screened for clinical situations as per GOI norms
- Screening should take place in the antenatal period, as well as immediately after delivery
- Women undergo assessment as physical examination

Eligibility of Provider and facility

- DGO, MD/MS in ObGyn
- Specialists in other surgical fields who have been trained to competency in mini lap female sterilization procedure according to national standards
- MBBS -who has been trained to competency in mini lap female sterilization procedure according to national standards

- Doctors and staff should be trained and skilled in the female sterilization techniques, use of appropriate anesthesia and managing emergencies
- All instruments and equipment must be in optimum working condition
- The facility must be equipped with drugs and equipment to handle emergencies as appropriate
- Standard infection prevention practices must be adhered to

Preoperative Instructions

- Bath and wear clean and loose clothes to the OT
- Not to take anything orally (not even water) at least 4 hours prior to surgery and any solids, milk or tea at least 6 hours prior to surgery
- A responsible adult must be available to accompany the client after the surgery
- The operative area should not be shaved. The hair can be trimmed if necessary. However, shaving done just prior to surgery is acceptable
- The operative site should be prepared immediately preoperatively with an antiseptic solution, applied twice in a circular motion beginning at the site of incision and working out for several inches

Premedication

Reassurance and proper explanation of the procedure
If needed, preferably Tablet Alprazolam (0.25 to 0.50 mg) or Tablet Diazepam (5 to 10 mg) can be given one hour before the operation.

- **Sedation/Analgesia**
  The anxiolytic, sedative, light muscle relaxant and amnesic effect produced in the client following administration of sedation allow sterilization procedure to be performed smoothly under local anesthesia. Should be given 30-45 minutes before surgery
- **Adherence to steps of the** mini laprotomy **procedure as detailed in the GoI guidelines** especially the critical steps

- **Ensure client's bladder is empty. Catheterize, if indicated**
- The provider must follow all recommended clinical and infection prevention measures for successful procedure
- After donning appropriate protective attire, surgical hand wash and putting on sterile gloves the provider prepares the surgical site with antiseptic
- A local anesthetic agent will be injected at the site of surgery-**1%lignocaine without adrenaline is recommended.** In no case should the total dose exceed 3 mg per kg body weight of the client (i.e. about 20 ml) with maximum limit of 200mg
- A small incision (3-5 cm) is given **(transverse or longitudinal)**
- **Identify each fallopian tube clearly, following it right up to the fimbria.** Confirm that the tube and not the round ligament has been ligated by identifying the lumen in the portion of the tube which has been removed
- **The site of the occlusion of the fallopian tube must always be within 2-3 cm from the uterine cornu in the isthmal portion**
- **Modified Pomeroy's procedure** should be followed for excision and ligation of tube, using a square knot with **1-0 chromic catgut**
- **Excision/ Occlusion of 1 cm of the tube should be done**

Precautions to be taken while providing Post-Partum Mini lap Tubectomy

- Post-partum women should be carefully screened for problems like postpartum hemorrhage or other conditions that could lead to increased risk of infection
- Special care must be taken when exposing the tubes, since the engorged postpartum vessels can bleed vigorously, if injured
- The surgeon must ensure that ligatures on the tubes are secure to prevent slipping and hemorrhage after the procedure is completed

Monitoring

- **Medical records are to be maintained** relating to the vital signs (pulse, respiration and blood pressure), level of consciousness, vomiting and any other relevant information
- The name of the drug(s), dosage, route and time of administration must be recorded
- **Preoperatively:** Pulse, BP, respiration prior to premedication and thereafter every 10 minutes
- **Intra-operatively:** Check pulse, respiration and BP every 5 minutes
- **Post-operatively:** Pulse, respiration, blood pressure and also skin color recorded every 15 minutes for one hour following surgery or longer, if the patient is unstable or not awake

(Refer 2014- Reference Manual for female sterilization, Ministry of Health and Family Welfare, Government of India, for details).

Record maintenance

- The provider must maintain records regarding female sterilization as per protocol.
- Maintain records and fill case cards after surgery
- Facility wise data entry in HMIS

Discharge

She receives instructions on what to do after she leaves. She should:

- Rest for the remainder of the day and resume light work after 48 hours
- Should avoid heavy weight lifting or putting tension on the incision for 1 week
- Be able to return to full activities within 1 week after surgery
- Use medications as instructed
- Take antibiotics only if advised
- Resume normal diet as soon as possible
- Keep the incision area clean and dry
- Do Not disturb or open the dressing till the 7th day
- Bathe after 24 hours following the surgery but if the dressing becomes wet, it should be changed so that the incision area is kept dry until the stitches are removed
- Report to the doctor or clinic if there is excessive pain, fainting, fever, bleeding or pus discharge from the incision, not passed urine, not passed flatus and feels bloating of abdomen
- Return to the clinic, if there is any missed period/suspected pregnancy within two weeks of missed period for confirmation of pregnancy
- Be instructed to go for routine and emergency follow-up
- Establish contact with health worker within 48 hours
- Return for a follow-up visit on the 7th day of surgery or as early as possible after 7 days
- Have 2nd follow-up after 1 month or if menses do not return

Follow up

- **The first follow up contact within 48 hours of discharge**
- **The next follow-up visit should preferably occur on the seventh day after surgery** and should include an examination of the operative site, suture removal
- **Subsequent follow-up visit should be made after either one month or the next menstrual period, whichever is earlier**

Sterilization certificate

- To be prepared by clinic doctor or operating surgeon
- Time of Issuance-The procedure will be certified on that visit after confirmation of non-pregnant status
- Sterilization certificate to be issued as per guidelines and duplicate signed copy to be retained for clinical record
- Due to medical or other reason, if Sterilization is not done at all or only one side tube could be occluded/ cut, that must be documented in the case record and no Sterilization certificate to be issued. However the client will be eligible for compensation amount

Post abortion sterilization – is defined as a sterilization procedure conducted concurrently or within 7 days of abortion provided the woman is eligible for minilap/laparoscopic procedure (as per PAFP technical update 2016) by a trained provider at the same or another facility where sterilization services are available

Client assessment

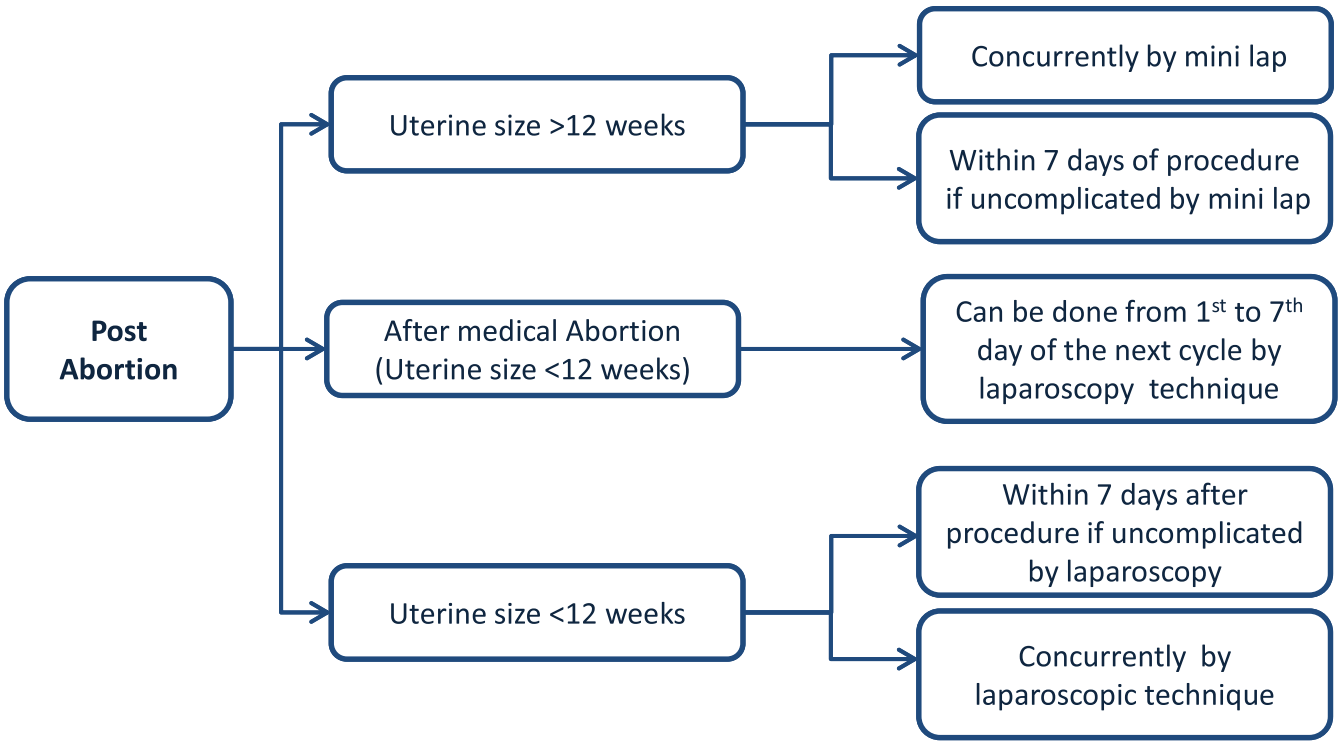
- A relevant medical history, physical examination and laboratory investigations need to be completed to ascertain eligibility for surgery

No medical conditions prevent a woman from undergoing female sterilization but may limit when, where or how the female sterilization procedure should be performed.

- If the abortion is uncomplicated the eligibility criteria listed before to be followed
- If there are complications the situations will categorized as listed below

DELAY	SPECIAL
Post-abortal sepsis or fever	Uterine perforation
Severe post-abortal haemorrhage	
Severe trauma to genital tract, cervical or vaginal tears	
Acute haematomata	

When to do female sterilization in post abortion period



The basic principles of the procedure remain the same as the postpartum sterilization with a few differences listed below:

- **Provider eligibility**

  The following cadre of service providers who has been trained to competency

  If uterine size less than 12 weeks- A service provider trained in Mini lap/laparoscopic sterilization procedure after due orientation on these procedures.

  If uterine size more than 12 weeks- A service provider trained in Mini lap sterilization procedure after due orientation on the procedures.

"All these providers must be trained in Mini lap/ laparoscopic ligation and empaneled in the district by the district quality assurance committee (DQAC)."

Adherance to steps of the laparoscopic procedure as detailed in the GoI guidelines especially the critical steps listed below **(The critical steps of Mini lap procedure remain the same as those described for post partum sterilization)**

  - **Ensure client's bladder is empty. Catheterize, if indicated**
  - The provider must follow all recommended clinical and infection prevention measures for successful procedure
  - A local anesthetic agent will be injected at the site of surgery-**1%lignocaine without adrenaline is recommended.** In no case should the total dose exceed 3 mg per kg body weight of the client (i.e. about 20 ml) with maximum limit of 200mg
  - **Precautions to be taken while providing Laparoscopic Tubectomy**

- **The client must not be placed in the Trendelenburg position in excess of 20 degrees**
- Pneumoperitoneum should be created with veress needle
- Insufflation of abdomen should be done preferably with carbon dioxide
- Intraabdominal pressure should not exceed 15 mm of mercury
- The skin incision should **not exceed** the diameter of the trocar
- A uterine elevator should be used to visualize the fallopian tube (optional)
- Tubal occlusion must always be done with Falope rings (no cautery is to be used)
- **After applying the second ring, the operator should systematically inspect the pelvis to verify that both tubes are now occluded, there is no unusual bleeding and that there is no visceral injury**
- **Do not apply the rings in case of thick, edematous or fixed tubes.** In such cases, tubectomy should be done with laparotomy under GA by conventional method

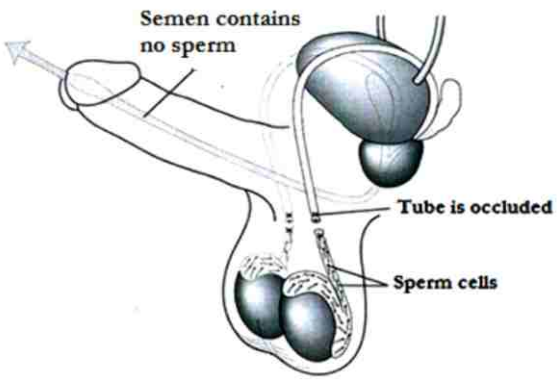
1. **The client can be discharged on the same day**
    - After at least 4 hours of procedure, when the vital signs are stable and the client is fully awake, has passed urine and can talk, drink and walk
    - The client has been seen and evaluated by the health care provider
    - Whenever necessary the client should be kept overnight at the facility
    - The client is accompanied by a responsible adult, while returning home
    - Postoperative and follow up instructions should be given along with post operative instruction card at the time of discharge of the client
    - Analgesics, antibiotics and other medicines may be provided and/or prescribed as required
    - Following should be emphasized at the time of discharge:
        - The client can resume sexual intercourse one week following sterilization if bleeding has stopped or whenever she feels comfortable provided there is no bleeding
        - She should return for a follow-up visit on the 7th day of surgery or as early as possible after 7 days. The client is also advised to return to the clinic, if there is any missed period/suspected pregnancy within two weeks to rule out pregnancy

Some fact about Female sterilization

- Sterilization does not affect the monthly bleeding of women
- After sterilization a woman will look and feel the same as before. She can have sex the same as before
- She will not gain weight because of the sterilization procedure
- Female sterilization is very effective at preventing pregnancy and is intended to be permanent. People who may want more children should choose a different family planning method
- Female sterilization greatly reduces the risk of ectopic pregnancy. Ectopic pregnancies are very rare among women who have had a sterilization procedure
- Surgery to reverse sterilization is possible for only some women. It is difficult and expensive and providers who are able to perform such surgery are hard to find. When pregnancy does occur after reversal, the risk that the pregnancy will be ectopic is greater than usual. Thus, sterilization should be considered irreversible
- Sterilization does not lead to lasting pain in back, uterus, or abdomen
- Female sterilization does not remove a woman's uterus or lead to a need to have it removed

NON SCALPEL VASECTOMY (NSV)

Vasectomy is one of the safest and most effective permanent contraceptive method having very low complication and failure rates



Vasa are occluded and sperms are prevented from mixing with seminal fluid/ejaculate

Currently, the two most common surgical techniques for approaching the vas during vasectomy are:

- The incisional method involves the use of a scalpel to make one or two incisions (each 1 to 2 cm in length) to deliver the Vas
- The no-scalpel vasectomy (NSV) technique- uses a sharp, pointed, forceps-like instrument to puncture the scrotum and deliver the Vas of both sides from the same puncture wound. **This is the preferred approach recommended by GOI**

Effectiveness

Highly effective- less than 1 pregnancy per 100 women over the 1st year after having the procedure (2 per 1000)

Advantages of NSV- to client

- Primarily, it is permanent for those men who do not want to have children, allowing them a convenient and simple method of birth control
- It will not affect male hormones. A man should be able to enjoy sexuality without any side effects as a result of NSV
- NSV is a very simple minor surgical procedure for which no fasting is required. It takes about 10 to 15 minutes to perform, with minimal bleeding during the procedure
- The acceptor can walk back home within 30 minutes after the procedure. Recovery is much faster with almost negligible post procedure discomfort or complications and client can resume normal work immediately

Advantages of NSV to provider

- Even MBBS can operate after training
- No hi-fi OT and anesthetic required
- No death reported so far
- Few complications and fewer failures

Limitations of NSV

- Permanent method
- Recanalization procedure is very complicated, expensive and not easily available and the success rate of recanalization after NSV is not very successful
- Surgical procedure
- Not effective immediately. It requires at least three months for vasectomy to become effective. Therefore, the client or his wife has to use a family planning method or abstain from sexual intercourse for three months
- Does not protect against STIs or HIV

Eligibility Criteria for Clients Undergoing male Sterilization

(Self-declaration by the client will be the basis for compiling this information. No eligible client should be denied female sterilization service)

- Clients should be ever-married
- Male clients should be above the age of 22 years and below the age of 60 years
- The couple should have at least one child, whose age is above one year, unless the sterilization is medically indicated
- Clients or their spouses/partners must not have undergone sterilization in the past (not applicable in cases of failure of previous sterilization)
- Clients must be in a sound state of mind, so as to understand the full implications of sterilization
- Mentally ill clients must be certified by a psychiatrist and a statement should be given by the legal guardian/spouse regarding the soundness of the client's state of mind

(Source-Reference Manual for Male Sterilization-GOI 2013)

Client assessment (As per GOI guideline)

Medical eligibility to undergo male sterilization is a key factor in minimizing risk of complications and ensuring quality of service delivery

A relevant medical history, physical examination and laboratory investigations need to be completed to ascertain eligibility for surgery

No medical condition prevents a man from undergoing male sterilization but may limit when, where or how the male sterilization procedure should be performed.

Caution (C) The method is normally provided in a routine setting but with extra preparation and precautions as required.

Delay (D) Provision of the method should be delayed or postponed. These conditions need to be evaluated, treated and resolved before male sterilization can be performed. Alternatively, temporary methods of contraception should be provided.

Special (S) Certain men have conditions that make operation difficult or increase the risks. The procedure should be undertaken in a setting with an experienced surgeon and staff, equipment needed to provide general anesthesia and other back-up medical support. The capacity to decide on the most appropriate procedure and anesthesia support is also needed. Alternatively, temporary methods of contraception should be provided if referral is required or there is otherwise any delay.

CAUTION	DELAY	SPECIAL
Young age	AIDS	Coagulation disorders
Depressive disorders	Scrotal skin infection	Inguinal hernia
Diabetes	Active STI	
Previous scrotal injury	Balanitis	
Large varicocoele	Epididymitis or orchitis	
Large hydrocele	Systemic infection or gastroenteritis	
Cryptorchidism	Filariasis; Elephantiasis Intrascrotal mass	

Timing of procedure:

- NSV or Male sterilization can be done at any convenient time on healthy and eligible clients irrespective of the post partum or post abortal status of their wives

Overview of NSV procedure

The following standards of care must be maintained during the provision of NSV

A. counselling

- It should be offered as a choice whenever possible
- The procedure must only be done after the man is counseled and gives informed consent
- Man must be informed that NSV will be done under sedation and local anesthesia is a safe and simple procedure and the procedure must be explained
- Man must be counseled regarding advantages, limitations, effectiveness, side effects and problems related to NSV
- Obtain a written consent in a language that the client understands

B. Screening

Man must be screened by history and physical examination for clinical situations as per GOI guideline

- Screen out the diseases mentioned under the medical eligibility criteria and also to rule out acute febrile illness, uncontrolled diabetes, bleeding disorders, sexual problems and mental illness
- Current medications, if any
- Current use of contraception by the couple
- Ensure wife not pregnant (ask LMP of wife)

C. Eligibility of Provider and facility

- Any provider MBBS and above who has been trained to competency in NSV procedure according to national standards is eligible to perform this procedure

- Doctors and staff should be trained and skilled in the female sterilization techniques, use of appropriate anesthesia and managing emergencies
- All instruments and equipment must be in optimum working condition
- The facility must be equipped with drugs and equipment to handle emergencies as appropriate
- Standard infection prevention practices must be adhered to

D. Preoperative Instructions

- Preferably trim the pubic, scrotal and perineal hair. Shaving of pubic hair, if warranted, should be done just prior to surgery
- Bath and wear clean and loose clothes to the OT
- Have a light meal on the morning of the surgery
- Empty his bladder before entering the OT

Premedication is not necessary in vasectomy

BUT if the client is very anxious- Alprazolam 0.25-0.5 mg or Diazepam 5-10 mg may be given one hour prior to surgery with a sip of water.

Procedure of No-Scalpel Vasectomy (NSV)

- After donning appropriate protective attire, surgical hand wash and putting on sterile gloves the provider prepares the surgical site with antiseptic
- Local anesthesia- 1% lignocaine without adrenaline
  - The maximum individual dose of lignocaine without adrenaline is 3 mg/kg of body weight.

- In general, it is recommended that the maximum total dose does not exceed 200 mg or 20 ml of 1% lignocaine or 10 ml of 2% lignocaine
- It is essential to ensure that both vasa have been anaesthetized before starting the surgical procedure so 5 ml of 1 % lidocaine is injected parallel to the both vas through a wheal in the median raphe at the junction of lower two-third and upper one-third

- The vas deferensis grasped by ring forceps at the wheal of the median raphe along with thescrotal skin and a tiny puncture made at the point by using a sharp and pointed instrument, vasdissecting forceps
- Expose the vas deferens through the tiny puncture using the dissecting forceps
- Ligate and excise the vas -tie both cut ends closed with a silk thread
- Dress the wound. No stitch is required
- (Refer 2013- Reference Manual for Male sterilization, Ministry of Health and Family Welfare, Government of India, for details)

Monitoring

- **Medical records are to be maintained** relating to the vital signs (pulse, respiration and blood pressure), level of consciousness, vomiting and any other relevant information
- The name of the drug(s), dosage, route and time of administration must be recorded
- **Preoperatively:** Pulse, BP, respiration prior to premedication and thereafter every 10 minutes
- **Intra-operatively:** Check pulse, respiration and BP every 5 minutes
- **Post-operatively:** Pulse, respiration, blood pressure and also skin color recorded every 15 minutes for one hour following surgery or longer, if the patient is unstable or not awake

Record maintenance

- The provider must maintain records regarding female sterilization as per protocol
- Maintain records and fill case cards after surgery
- Facility wise data entry in HMIS

Discharge

Discharge card/slip will act as proof of operation

- The client needs to rest for 30 minutes after vasectomy, usually can leave within half an hour
- The client should be discharged when the following conditions are met:
  - Thirty minutes have passed after the surgery
  - The client is alert and ambulatory
  - The client's vital signs are stable and normal
  - The client has been seen and evaluated by a doctor

- Analgesics and other medicines if needed must be provided/ prescribed
- Scrotal Support: Following vasectomy, the client should wear tight underpants or a loincloth to keep the scrotum from moving and the subsequent possibility of bleeding and haematoma formation
- Explain to the client:
  - How to care for the wound
  - What side effects to expect, what to do if complications occur
  - Where to go for emergency care
  - When and where to return for a follow-up visit
- Tell him that minor pain and bruising are to be expected, which do not require medical attention
- The man should seek medical attention if he has fever, if blood or pus oozes from the puncture site or if he experiences excessive pain or swelling
- Give the client a brief, simply written summary of the instructions
- Tell client that he should report to the clinic for semen examination three months after the surgery
- The client may resume sexual activity as and when he feels comfortable but should use either condom or another method of family planning until it is confirmed that sperms are no longer present in the semen
- A slight pain may be felt or blood may be noticed in semen which is normal

Follow up

- The first follow up contact within 48 hours of discharge
- The next follow-up visit should preferably occur on the seventh day after surgery and should include an examination of the operative site, suture removal

Subsequent follow-up visit should be made after either after three months for semen analysis or if the client has any questions, he should contact the health personnel or doctor at any time

Sterilization certificate

- **To be prepared by clinic doctor or operating surgeon**
- **Time of Issuance**
  - After 3 months if the semen shows no sperm upon semen analysis
  - If sperms are still present then semen is tested every month till six months
  - Failure of vasectomy should not be declared till six months
  - If sperms are still present after six months re-vasectomy should be considered

- **Sterilization certificate to be issued as per guidelines and duplicate signed copy to be retained for clinical record.**

Key points for clients, providers and counsellors

- Intended to provide life-long, permanent, and very effective protection against pregnancy
- Involves a safe, simple surgical procedure
- Three or some times more months delay in taking effect. The couple must use condoms or another contraceptive method for three or more months, till semen analysis shows azoospermia after the vasectomy
- Does not affect male sexual performance
- Reversal can be possible, but involves a complex surgery and success cannot be guaranteed

Some facts about Vasectomy

- After vasectomy, the male sexual physiology remains unaffected (aside from the desired change in fertility). The nerves involved in erection are not touched/ cut during the vasectomy procedure. Seminal fluid continues to be produced and the tubes that carry seminal fluid remain intact. The male sex drive, ability to have an erection and ejaculation of semen will be unaffected by a vasectomy and will remain the same as before. Testicles will continue to produce sperms
- Vasectomy does not start working immediately. After vasectomy, the male will still have active sperms in his semen for about 3 months or more. Not using another method for the first 3 months is the main cause of pregnancies among couples relying on vasectomy. Over the next few months the semen will be tested to ensure there are no active sperms and that the vasectomy is complete
- A man need to use another contraceptive method for the first 3 months after a vasectomy. If his partner has been using a contraceptive method, she can continue to use it during this time. Not using another method for the first 3 months is the main cause of pregnancies among couples relying on vasectomy
- Vasectomy is intended to be permanent and men considering vasectomies should not think of them as reversible. Clients must be told that a reversal of this surgery can be possible, but the reversal involves a complex surgery and its success cannot be guaranteed
- Most clients can return to work after two to three days of undergoing vasectomy, if they feel comfortable. After the vasectomy procedure a person can continue doing household chores same day

INFECTION PREVENTION

IP Practices prevent spread of Infections between clients, service providers and the community. Every person (client or staff) is considered potentially infectious. It is essential that all staff, including providers of family planning, follow infection prevention practices while at work. These include surgical methods such as female sterilization and vasectomy, as well as IUD insertion/removal, and the provision of injectables. Information about the basic principles of infection prevention practices is available elsewhere.

Hand Washing

Hand washing is the single most important practice for preventing cross-contamination.

Preferably wash hands with running water and soap for 10–15 seconds. Be sure to clean between the fingers and under fingernails. Dry with an individual clean towel, paper towel, or air-dry, or if water and soap are not available: rub hands with 3–5 ml of an alcohol-based solution until the hands are dry (if hands are not visibly soiled).

Always wash hands

- When arriving at work, after using the toilet or latrine, before and after eating, and when leaving work before and after examining or treating each client or giving an injection
- After handling soiled instruments or touching any blood or body fluids, even if gloves are worn
- Before putting on gloves, after removing gloves (the gloves may have very small holes), and whenever hands get dirty

Physical barriers to infection

Gloves

Wear gloves (both hands) when

- Performing a procedure that risks touching blood, other body fluids, mucous membranes or broken skin procedures such as the insertion of contraceptive implants
- Handling soiled items or disposing of contaminated waste (clean utility or heavy-duty household gloves)

A separate pair of gloves must be used for each client to avoid cross-contamination.

Gloves are not needed for activities such as taking a patient's blood pressure; giving injections; or providing pills, condoms, or counselling.

Protective gear

Use protective goggles, face masks, aprons, and closed protective shoes whenever appropriate.

Cleaning equipment

Buckets, brushes, and cleaning cloths should be:

- Decontaminated by soaking for 10 minutes in 0.5% chlorine solution or other approved disinfectant
- Washed in detergent and water
- Rinsed in clean water
- Dried completely before re-use or storage

Processing instruments

The steps of processing instruments (used during tubectomy, NSV, IUD insertion/removal, and implant insertion/removal) include first soaking in a 0.5% chlorine solution, physically cleaning any visible contamination with a brush, and putting them through a sterilization procedure.

1. **Decontamination**
   - Kills viruses (hepatitis B and C, HIV) and many other germs
   - Makes items safer to handle during cleaning
   - Makes items easier to clean
   - Common decontamination process: soak in 0.5% chlorine solution for 10 minutes immediately after use (extended soaking can cause instruments to rust)

2. **Clean**
   - Removes blood, other body fluids, tissue, and dirt, making sterilization or HLD effective
   - To clean: using a soft brush, gently brush items with soap and water and rinse with clean water

3. **Sterilize**
   - Kills all germs including endospores
   - Used for instruments that touch tissue beneath the skin such as surgical instruments
   - Can be done by dry (oven) or wet heat (autoclave) or chemically (soak in 2% glutaraldehyde for 10 hours)

4. **High-level disinfection (HLD)**
   - Kills all germs except some endospores (dormant, resistant forms of bacteria responsible for tetanus, gangrene, tuberculosis, etc.)
   - Use for items that have been in contact with broken skin or intact mucous membranes, such as vaginal specula and gloves for pelvic examinations and items which have been in contact

with blood

- Can be done by boiling or steaming items for 30 minutes or chemical disinfection using 0.5% chlorine solution for 20 minutes

5. **Storage**
   - Proper storage is as important as proper processing. If items are stored properly after processing they should not become contaminated. Items that are not being used should be stored in an HLD container, away from clinic traffic, for up to one week after completing the first three processing steps (before sterilization)

Waste disposal

The purpose of waste disposal is to prevent the spread of infection to people who handle the waste, prevent the spread of infection to the local community, and protect those who handle waste from accidental injury.

In family planning services, medical waste is produced during tubectomy and NSV procedures, IUCD insertion/removal, implant insertion/removal, and the provision of injectables.

- Place medical waste in a washable container with a leak-proof plastic bag
- Close and collect bags when three-quarters full, or daily if not three-quarters full
- Transfer the waste to medical waste carrying van for its safe disposal or burn and bury bags of waste in a deep pit
- Pour liquid waste down a drain, a flushable toilet, or pour into a deep pit and bury it
- Contaminated linens which will not be washed/bleached and re-sterilized should also be disposed accordingly
- Wash hands, gloves, and containers after disposal of medical waste

Sharps

- Place sharps in a puncture-resistant, single-use container (empty plastic container, metal container with small opening)
- Seal and collect containers when ¾ full and then burn and bury in a deep pit or dispose it accordingly

Tips for Preventing contact with infection agents

I. **Prevent splashes**
   - Avoid snapping the gloves when removing, as this may cause contaminants to splash into the eyes, mouth, or on to skin or others

- Hold instruments and other items under the surface of the water while scrubbing and cleaning to avoid splashing
- Place items gently into the decontamination bucket to avoid splashes

II. Use antimicrobial agents

- Wipe examination tables, bench tops, and other surfaces with 0.5% chlorine solution after each client
- Cleanse the client's skin prior to surgery with a water-based antiseptic for example Povidonelodine
- When giving an injection, no antiseptic is necessary. If the skin is visibly dirty, wash the injection site with water and soap
- Store instruments, gauze, and cotton wool in dry covered containers without antiseptics

III. Handling sharp with care

- Do not leave sharp instruments or needles ("sharps") in places other than "safe" zones:
- Use a tray or basin to carry and pass sharp items during surgical procedures
- Pass instruments with the handle (not the sharp end) pointing toward the receiver
- Announce to others before passing any sharp instrument

IV. Handle Needles and syringes

- Use each needle and syringe only once
- Do not take needle and syringe apart after use
- Do not recap, bend, or break needles before disposal
- Dispose of needles and syringes in a puncture-proof contain

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